

**The Problem of Pain:
A Heuristic and Structural Existential Analysis of Unexplained Physical Pain**

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RESEARCH APPROVAL AND ORIGINALITY STATEMENT

All work contained in this dissertation is original, unless referenced otherwise. It is the result of my own research, and has not been published elsewhere. The research proposal and title were approved at a Programme Approval Panel (PAP) viva in December 2013. Ethical approval was obtained from the NSPC/Middlesex Ethics Board in August 2015 (see Appendix A).

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Abstract

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This study was undertaken to increase understanding of recovery from chronic pain in the absence of medical intervention. Chronic pain is a debilitating condition that inflicts significant human suffering and costs the economy of the Western world £billions each year. Despite advances in modern medicine pain remains poorly understood and difficult to treat.

Applying a heuristic methodology, an in-depth exploration was conducted into the author's personal experience of recovery and participants (N=8) who had recovered from chronic pain were interviewed.

The results indicate:

- Chronic pain is a multi-dimensional phenomenon that serves a purpose and has personal meaning.
- Pain serves as a non-verbal communication whose meaning can be revealed through tuning in to the *felt sense* of the experience.
- Medical approaches were ineffective and often exacerbated pain.

- Recovery occurred after all medically prescribed interventions had been exhausted and participants hit *rock-bottom*. This triggered a radical epistemological shift from the commonly held medical perspective into one that considers the physical, psychological, social, and spiritual aspects of the experience.
- Chronic pain is difficult to define within the realms of medical pathology and might be alternatively viewed as a healthy response to an unhealthy social system and world which are inextricably linked to the body.
- Adult chronic pain was associated with physical pain during childhood as well as repressed childhood trauma.
- Key factors in recovery were engaging in a deep personal exploration that involved: (a) remembering and acknowledging childhood adversity, (b) reflecting on the current circumstances of life, (c) challenging previously held views of pain that were based on a medical understanding, (d) Confronting pain and the fear of pain, and (e) making significant life changes.

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Nomenclature

Definitions of terms used in this dissertation are included in two sections. One relates to pain itself and recovery the other to various approaches to recovery from medical and psychological perspectives.

Pain

Chronic pain: This is defined by a prolonged experience of pain that persists past the normal time of healing. It is generally agreed that chronic pain lasts 3 months or more (Iasp-pain.org, 2016; Medlineplus.gov, 2016), persisting for reasons apart from nociception due to injury (Merskey & Bogduk, 1994).

Psychosomatic pain is used to indicate the multi-dimensionality of pain and contribution of non-biological factors.

Recovery is used to denote the long-term resolution of pain rather than managing or learning to accept symptoms.

Medical/Psychological Approaches to Recovery

The medical approach to recovery is used in a broad sense to refer to the clinical or theoretical approaches below:

Postural-structural-biomechanical (PSB). PSB approaches base the understanding and treatment of pain on structural discrepancies and their correction. Treatment can include exercise, physiotherapy and other physical therapies. I often use the combined term ‘medical/PSB’ as these approaches are commonly applied simultaneously.

Pharmacotherapy. This approach involves the use of pharmacological agents such as non-steroidal anti-inflammatory drugs (NSAIDs), opioids, antidepressants, anticonvulsants and topical treatments.

Surgery. This approach involves the surgical entry into the body to alter the body's current state in an attempt to manipulate a more desirable state.

Psychological approaches. Recovery methods that focus on the role of mind in physical pain include psychological therapies such as counselling, cognitive behavioural therapy, psychoanalysis and various mind/body psychotherapies.

Chapter 1: Introduction

On the 28th of March in the year 2014, newspapers reported that Mark Goddard, a husband and father, cut off his hand using a homemade guillotine (Bartlett, 2014). The guillotine only partially severed his hand, so he completed the amputation with a knife and burnt his hand to prevent surgical re-attachment. Psychiatric assessment concluded there was no mental illness, which might lead most of us to ask why he performed such an act of self-mutilation. The answer he gave was pain. Sixteen years after a motorcycle accident Mr Goddard still experienced unbearable pain in his hand despite taking 40 painkillers a day. Surprisingly the pain persisted post amputation and Mr Goddard was threatening to amputate from the elbow unless the NHS offered him proper treatment for the pain.

This example shows the inexplicability of chronic pain and its urgent and drastic demands for action. Chronic pain is invisible and mysterious because unlike acute pain it appears without obvious reason (Leder, 1990) and healed injuries such as Mr Goddard's remain painful 16 years later to the extent that 40 painkillers a day and the subsequent amputation had no impact.

Could Mr Goddard's pain, whilst triggered by the motorcycle accident, have persisted for reasons beyond physiology? If so, what were they and why did the pain persist no matter what he did to try and alleviate it?

Unbelievable severity, resistance to treatment (Hansson & Hansson, 2000), and attribution to medical causes (Leder, 1990) are some of the hallmarks of chronic pain. Although such drastic action is rare, Mr Goddard's actions are consistent with the experience of chronic pain; he amputated his hand to be rid of the pain and incinerated the amputated site so there was no chance for the hand-pain to return. One common feature of chronic pain is that even when it

has gone, sufferers can still remain in a state of vigilance wondering if the pain will come back (Bakan, 1968; Leder, 1990). Mr Goddard's action presumably would have taken care of that unpleasant consideration, had the pain not changed location.

The Impact of Chronic Pain

Musculoskeletal pain is one of the greatest causes of disability with negative impact on overall health (Vos et al., 2012). Epidemiological studies suggest that musculoskeletal conditions have a greater negative impact on quality of life than cardiovascular conditions, cancer, endocrine conditions, visual impairments, and chronic respiratory diseases (Sprangers et al., 2000).

Approximately 30% of people in economically developed countries (Berman & Swyers, 1997; Harstall & Ospina, 2003) and 15-40% of Europeans experience chronic pain, 20% of which will suffer for more than 20 years (Europe against pain, 2016; Fricker, 2003).

In America, chronic pain is the third greatest health care problem after heart disease and cancer, and costs the economy up to \$79 billion each year (Fast, 1988). In the UK, it accounts for 208 million days of lost work with an annual economic loss of £18 billion (Elliott, Smith, Penny, Cairns Smith, & Alastair Chambers, 1999).

Almost 5 million General Practitioner (GP) appointments a year are made for chronic pain, which is close to five times more than other conditions. Often GPs cannot identify a cause (Elliott et al., 1999) and medically unexplained symptoms in general make up approximately 15% to 30% of all primary care consultations (Kirmayer, 2004; Kroenke, 1992).

Despite scientific progress, a precise medical explanation and diagnosis for chronic pain remains elusive (Deyo & Weinstein, 2001; Fast, 1988; Kirmayer, 2004). Structural aberrations

and pain correlate poorly; therefore, sophisticated medical imaging technologies (Boden, Davis, Dina, Patronas, & Wiesel, 1990; Borenstein, O'Mara, & Boden, 2001; Jensen et al. 1994; Johnson et al., 2001; Wiesel, Tsourmas, Feffer, Citrin, & Patronas, 1984) and electro-diagnostic techniques (Date, Mar, Bugola, & Teraoka, 1996) often fail to provide an accurate diagnosis. This leaves chronic pain in the *undefined or unexplained disorders* category, which presents a challenge for modern medicine (Malterud, 2000; Steihaug, 2005).

Results for chronic pain are often poor with one study showing that 90% of patients in primary care whose treatment was terminated within 3 months still had symptoms 1-year later (Croft, Macfarlane, Papageorgiou, Thomas, & Silman, 1998) and following surgical interventions, less than 20% of patients had an excellent result from lumbar fusion to treat chronic low back pain (Fritzell, Hägg, Wessberg, & Nordwall, 2001). The *Pain in Europe* report (Fricker, 2003) states that 66.6% of those surveyed in the UK reported inadequate pain control and a prospective, 2-year cohort study (Hansson & Hansson, 2000) in six countries concluded that almost none of the often-practised medical interventions in chronic low back pain had any positive results. Deyo (1991) described the medical interventions for chronic pain as a chain of novel treatments based on questionable rationale.

The lack of clear medical diagnosis and the failure of commonly practised pain interventions often lead doctors to suspect psychological factors (Bullington, 2013). However, the relationship between chronic pain and psychology is troublesome for doctors and patients. Patients often find any suggested connection between their symptoms and psychology to be insulting, and doctors struggle to understand it, let alone explain it (Bullington, 2013).

Personal Background to this Research

Two years after I recovered from chronic pain, I was curious what a disciplined exploration of subjectivity in research related to pain could reveal about recovery. Prior to recovery, I tried every treatment imaginable without success and became resigned to the unthinkable reality that I would always be in pain. However, not only did I recover but also I was astonished by how quickly and unexpectedly the seemingly interminable episode of pain ended.

Had I not recovered from pain I doubt I would be researching the subject. Relative to an in-depth explication of recovery, pain itself has been well characterised phenomenologically (Chapman & Nakamura, 1999; Hellström & Carlsson, 1996; Honkasalo, 1998; 2000; 2001; Raheim & Haland, 2006). Understanding recovery better would be especially useful for counselling psychologists as the prevalence of chronic pain makes clinical contact with this cohort of individuals likely. I wanted to better understand two related questions: “What are participants’ experiences of chronic back pain, and what do these experiences tell us about recovery?”

To answer this two-part question, I began an enquiry process broadly comprised of eight components that resulted in this dissertation. I have listed these components below in chronological order:

1. Immersion into my personal experience of recovery from chronic pain
2. Literature research
3. Further personal exploration/being interviewed by my therapist
4. Analysis of data from my personal experience
5. Recruitment and interviewing of participants

6. Immersion into participant experiences
7. Analysis of participant data
8. Production of dissertation

The beginning of this first chapter presents an introduction to chronic pain including statistics related to it, as well as my personal experience with both pain and recovery. It also provides an overview of the other chapters in what follows. Chapter 2 contains a review of the literature related to chronic pain. The review looks at psychoanalytic, psychological, and medical perspectives on chronic pain, and ends with an existential phenomenological account on the subject. Chapter 3 outlines my research method and the philosophical basis of my approach. I chose the heuristic research method because it is a well-established method that utilises the personal experience of the researcher as well as participants. I give a detailed account of my data collection and analysis before ending with some considerations on research validity and reflexivity. Chapter 4 presents the results of this research. The first part focuses on the results from my own personal experience, and the second part addresses participant experiences with chronic pain and recovery. Chapter 5 starts with a discussion of methodology before moving on to my key findings. Finally, chapter 6 looks at the overall contribution this research has made to counselling psychology and to the understanding of chronic pain. In this chapter, some limitations of the research are presented and areas for future research are suggested.

Chapter 2: Literature Review

Introduction

The references for this literature review emerged from a search for qualities that underlie the research question, which was, “What are participants’ experiences of chronic back pain, and what do these experiences tell us about recovery?” During this review, I received literature from my peers that resonated deeply with my research (such as the earlier account of Mr Goddard). I saw this as part of the heuristic process, as my personal involvement with the phenomenon created a community of co-researchers (Etherington, 2004) I met throughout the research. This reflected the ubiquity of *interconnectedness* in this research, where it appeared theoretically in the existential phenomenological literature and in the mind-body formulations of disease. It was also an important theme in a relational sense among participants, health professionals, and myself.

A key source of material for this review was the Middlesex University electronic library via the *Summon* search engine. I found most of the research data came from the medical disciplines with the search term ‘recovery from chronic pain’ yielding 96,453 published journal articles. There were far fewer articles from psychology and philosophy and no heuristic studies on the subject. Publications from non-medical disciplines tended to focus on identifying exacerbating/ameliorating factors and situations where symptoms were improved or managed rather than a detailed and global description of recovery itself.

The rationale behind my choices of coverage in this literature review was based on providing a clear background to the major theoretical and clinical disciplines that have been applied to chronic pain. I therefore elected to write this literature review using a historical format. I begin with the origins of psychoanalysis in 1895, and the ensuing development of

psychosomatic medicine through to current medical thinking. The chapter ends by exploring the existential phenomenological contribution to chronic pain. My aim is to present the development of thought and patterns that suggest how we have arrived at our current position on chronic pain and which direction might be taken next. My phenomenological approach to this study did not include a hypothesis or preference regarding the research outcomes beyond my priority of remaining open to participants' experience. I believe my choice in focussing on a historical overview of the subject was congruent with this stance.

The review is organised under the following three sections: (a) Psychosomatic Medicine and Psychoanalysis, (b) Modern Medicine: The Fight Against Pain, and (c) Subjectivity in Chronic Pain.

Review of the Literature on Pain from a Historical Perspective

Psychosomatic Medicine and Psychoanalysis. Inspired by Charcot, Freud (as cited in Symington, 1986), in association with Breuer (1885 /1955) connected psychic experience with physical symptoms and formulated the *conversion hypothesis* as the mechanism for this phenomenon in which psychological symptoms converted into physical symptoms. Conversion became an accepted medical term, and in the 1920s psychoanalysts were working with hospital doctors to treat psychosomatic symptoms. The subject became so popular that by the 1940's to 1950's it featured in magazines and psychosomatic terminology even appeared in the lyrics of a popular Broadway musical (Nim.nih.gov, 2016).

Freud's interest in the connection between mind and body led to the development of psychoanalysis to treat psychosomatic phenomena. What was unique about his treatment approach was that it was based on listening to patients rather than doing things to them

(Symington, 1986). Listening to patients' personal experience, as a central intervention, was eventually superseded by the medical models (Bullington, 2013; Honkasalo, 2001; Leader & Corfield, 2008; Leder, 1990; Wilberg, 2010), which are discussed in part two of this review.

Charcot, Breuer, and Freud. Psychosomatics developed into a prominent branch of medicine beginning in October 1885 and continuing onwards to the present when, according to Symington (1986), Freud left Vienna to study with the neurologist Charcot in Paris. Charcot was working with patients suffering from unexplained physical symptoms, usually paralysis, contractures, and seizures, which he suspected were psychogenic in nature. Freud had a great deal of admiration for Charcot and spoke of his approach to complex medically unexplained material saying:

He used to look again and again at the things he did not understand, to deepen his impression of them day by day, till suddenly an understanding of them dawned upon him. In his mind's eye the apparent chaos presented by the continual repetition of the same symptoms then gave way to order. (Freud, 1962, p. 12)

Freud (1914) stated, "I learnt to restrain speculative tendencies and to follow the forgotten advice of my master, Charcot: to look at the same things again and again until they themselves began to speak" (Freud, 1914, p. 22).

According to Symington, (1986) Freud was inspired by Charcot's methods and his work on psychogenic symptoms. Symington explained these were developed further with Freud's famous case study on Anna O, who was a patient of the eminent neurologist, Breuer. This was published in *Studies in Hysteria* (Breuer, & Freud, 1895/1962). Breuer was baffled by Anna's symptoms, which appeared during her father's illness and after his death. They included hysterical paralysis and anaesthesia in three of her limbs, distressing psychiatric symptoms, the

inability to turn her head, double vision, coughing, low appetite, hallucinations, agitation, mood swings, abusive behaviour, amnesia, somnolence, tunnel vision, and partial aphasia. Anna was a demanding patient; she often refused to eat unless Breuer brought the food to her and sometimes would need to hold his hands to recognise him. Her treatment was unorthodox and in total consisted of around 1,000 clinical hours between April 1881 and June 1882 (Launer, 2005). As part of her treatment she would make up fairy tales and Anna called this process *chimney sweeping* or her *talking cure*, thus, coining the famous phrase in psychology. In addition, Breuer would hypnotise her every morning to recover painful memories, and in the evening Anna would talk about these with strong and vivid emotion. With great excitement, Breuer told Freud that when Anna spoke about how a symptom started it would disappear, but only if she spoke with strong emotion. For example, by remembering her disgust when she saw a dog drink from a woman's glass, Anna could suddenly drink water again, freeing her from her reliance on eating melons to quench her thirst (Symington, 1986). Breuer named this technique of remembering with emotion, *catharsis*.

According to Symington (1986), Freud observed that Anna displayed strong sexual feelings towards Breuer and criticised him for not seeing them as relevant. This changed, however, when Anna imagined she was pregnant with Breuer's baby, which led him to abort treatment as the erotic transference became more than he could cope with (Symington, 1986). Despite acting like an *annoying young woman* performing *crazy theatrics*, Breuer took her seriously, and this had a therapeutic effect (Launer, 2005). By showing such interest to establish a diagnosis, he possibly unintentionally created a cure.

The Start of Psychoanalysis. According to Symington (1986), on Easter day in 1886, Freud set up private practice, and developed psychoanalysis, which was influenced by Breuer's

and Anna's *talking cure* and Charcot's methods with hysteria. Unlike today, patients attended psychoanalysis for physical symptoms. For example, Freud's first patient, Frau Emmy von N suffered from speech difficulties and facial tics, Lucy R could smell burnt pudding when there was none, and Elisabeth von R had unexplained pain in her legs (Webster, 2016).

Breuer and Freud (1895/1962) speculated that emotionally charged events were repressed and converted into physical symptoms, and this formed the premise of the conversion hypothesis. Freud diagnosed hysteria and treatment focused on uncovering the unconscious traumatic incidents that caused the symptoms. Freud's clinical method was very much focused on exploring human experience from a non-medical point of view. He described it in the following statement:

The fact is that local diagnosis and electrical reactions lead nowhere in the study of hysteria, whereas a detailed description of mental processes such as we are accustomed to find in the works of imaginative writers enables me, with the use of a few psychological formulas, to obtain at least some kind of insight into the course of that affliction. (Breuer & Freud, 1895/1962, p was p. 160–161)

According to Bullington (2013), Freud's interest in psychosomatics was eventually eroded, partly due to *the mysterious leap into the somatic*. He could not understand *how* unconscious psychic phenomena converted into somatic symptoms, and he abandoned the subject feeling that psychosomatic patients were unsuitable for psychoanalysis, and turned his focus to psychological problems.

However, interest in psychosomatics burgeoned (Medlineplus.gov, 2016) and from 1930-1950 the idea that specific psychodynamic conflicts caused certain disorders (Alexander, 1939) became popular. Pursuing this theme as cited in Corrington, 2003; Sharaf, 1983) Reich proposed

that Freud's jaw cancer was caused by his emotional *biting down response* as he confronted anti-Semitism instead of expressing his anger about treatment of Jews and was not caused by smoking cigars.

Attempts to correlate specific mental events with illness eventually died out as new ideas developed within psychoanalysis. McDougall's (1985) pioneering work in the field suggested that pain can be a way to feel alive, defending against feelings of inner death through the strongly felt sensations of bodily pain. In relationships, pain could also defend against engulfment or merging with the other through the strongly felt bodily boundary of physical pain symptoms.

McDougall's (1985) most popular theory was that physical symptoms have pre-symbolic meanings that circumvent language. She compared physical symptoms to psychotic states when she proposed that psychotic states use inflated and delusional language to fill the terrifying space of nothingness, but in psychosomatic states the opposite happens and language is drained of emotional significance. As a result, the body, instead, behaves in a delusional way that does not make sense physiologically, as if the body has gone mad! McDougall (1985) hypothesised that rather than being emotionally disconnected, psychosomatic patients just lacked words for their emotions, otherwise known as alexithymia (Sifneos, 1973).

Words are lacking because psychosomatic phenomena originate in early infancy prior to language. Without language to formulate thoughts, the trauma is deprived of mental representation and is expressed through the body, leaving a *sensorial mark* on the psyche (Rappoport de Aisemberg, 2010), which emerges as somatic symptoms. Sensorial marks are *frontier* concepts as they have psychic and somatic qualities.

Psychoanalysis converts these marks into *psychic tissue* through remembering or composing a narrative between the patient and analyst, which acts as a bridge allowing the somatic to move towards mental representation (Rappoport de Aisemberg, 2010).

Kandel (2012) considered that psychoanalysis offers the most coherent and intellectually satisfying view of the mind, but despite its compelling nature, psychoanalysis is better at generating ideas than testing them; therefore, it struggles to demonstrate the increasing need for empirical validity in medicine.

Psychophysiological models. This need was better satisfied with psychophysiological models, which gained popularity from the 1970s onwards. These models deemphasised intrapsychic events and broadened their focus to consider interactions between the environment, physiology, and personality types (Bullington, 2013). For example, the type A personality, characterised by traits such as ambition, determination, and aggression is more predictive of heart disease than major physical risk factors such as cholesterol levels, smoking and blood pressure (Friedman et al., 1986). The type D Personality, characterised by worry, irritability and gloom, alongside a pattern of social inhibition also correlates with heart disease and makes up 53% of cardiac patients (Pedersen & Denollet, 2006). Sarno (1991), a professor of orthopaedic surgery, also correlated personality traits with illness and chronic pain and proposed a physiological mechanism for this based on local ischaemic reactions in the connective tissues. However, psychophysiological models struggled to satisfactorily explain how the various factors involved interacted to cause symptoms (Bullington, 2013). This, and the advances in medical science led to a more medicalised approach to pain.

Modern medicine: The fight against pain. This section focuses on the underlying principles and clinical outcomes in the medical treatment of chronic pain. It includes an account of models, which explore the interaction between psychological and medical factors.

In the televised documentary, *Dancing in the Flames*, Woodman (2009) suggested that medicine views illness as something to obliterate rather than seek meaning for it. This separates the illness from the person and places diagnosis and treatment squarely within the physiological domain. In chronic pain, this is problematic, as a clear anatomical location (Honkasalo, 2001) and medical explanation (Kirmayer, 2004) are often lacking.

However, due to a lack of empirical validity the British Pain Society report advises against assuming psychological causation in pain and recommends primary care professionals employ the interventions listed below (The British Pain Society and the Royal College of General Practitioners, 2004):

- Physiotherapy
- Applying heat or cold packs
- Exercise programmes
- Transcutaneous electric nerve stimulation (TENS)
- Patient support group
- Complementary therapies e.g. acupuncture

If pain becomes chronic the National Health Service (**NHS**) website (Nhs.uk, 2016) recommends exercise classes and manual therapy, as well as the Alexander technique acupuncture, painkillers such as opioids, non-steroidals, antidepressants, and anti-epileptics. These analgesics have been the main medications for treating pain for the last 50 years (Borsook, 2011) despite being relatively ineffective in placebo-controlled trials (Backonja, 1998).

For severe pain steroids, analgesics or anaesthetics can be injected directly into the spine or facet joints and surgical excision procedures (discectomies) and spinal fusions are advised as a last resort due to inconsistent results. These recommendations are largely in agreement with the latest Nice guidelines (NICE Guideline NG59; Nov 2016) which advise:

- Manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) as part of a treatment package including exercise, with or without psychological therapy.
- Pharmacological interventions
- Radiofrequency denervation
- Epidural injections of local anaesthetic
- Surgery
- Spinal decompression

NHS clinical trials (Nhs.uk, 2016) for future treatments suggest a continuation of the above interventions as they mostly consist of methods such as injecting directly into joints, nerve stimulation techniques, and manual therapies.

Chronic pain remains poorly understood in medicine (Good, 1992; Raheim, & Haland, 2006) and medicine has been criticised for viewing its empirical epistemology as rational and everything else as irrational and invalid (Kirmayer, 2006). The emphasis on empirical validity results in viewing other approaches to pain as fanciful, misleading or even harmful (Borsook, 2011) and fears patients will be harmed or subjected to the placebo effect (The British Pain Society and the Royal College of General Practitioners, 2004).

Psychological factors interact with the body to cause pain. Scepticism of a purely medical approach has led to renewed interest in psychological factors in pain. Lampe et al.,

(1998) found that stressful life events aggravated symptoms of chronic back pain and a study of 5700 people found that stress more than doubled the likelihood of back pain (Power, Frank, Hertzman, Schierhout, & Li, 2001). Lower job satisfaction, monotonous tasks, unsatisfactory work relations, and high work demands also strongly correlated with back pain (Linton, 2005; Reigo, Tropp, & Timka, 2001). Sarno (1991) stated that most cases of chronic pain are psychosomatic and believed that pain acts as a distraction from strong emotions (typically rage), which can arise from self-imposed pressures like perfectionism and the external pressures of work, health, finances, relationships, ageing and death. Specific pain responses such as *catastrophising*, hypervigilance and pain related fear have also been linked to insecure childhood attachment (McWilliams & Asmundson, 2007).

Chronic pain conditions are also sensitive to cultural contexts and can spread in an epidemic fashion as patients rush to fill new diagnostic categories. This as has been mentioned as far back as *The Republic* (Plato as cited in Graham, 1974) which accused medicine of constructing diseases, saying “What is shameful, don't you think so, is filling oneself with fluids and grass as if one were some sort of lake ... compelling those clever sons of Asclepius to invent names for diseases like flatulence and flux” Historically speaking, chronic pain is relatively new and influenced by what the Western culture sees as legitimate illness (Shorter, 1997). Fibromyalgia for example is considered the modern-day counterpart of neurasthenia and is fuelled by the mass media (Groopman, 2000).

Mind and body interactions in pain. Approaches that extend beyond the somatic and are also interested in the emotional, social, psychological, and spiritual dimensions are often termed holistic as they aim to take the whole person into account (Bullington, 2013). However, the inclusivity of holistic approaches is problematic as they can potentially descend into excessively

complicated multi-factorial aetiologies. Endless possible connections between psychology, biology and environment become significant, putting the theory at risk of explaining nothing, as everything becomes important (Bullington, 2013). Also, too many parts become involved in the ‘indivisible whole’ the holistic approach started with, and having a mind and body that interact means they are separate; therefore, the holistic view is essentially dualistic. The attempt to remain open to both the qualitative aspects of the subjective whilst maintaining a quantifiable empirical stance is difficult to do simultaneously, and the approach invariably descends into a physiological account (Bullington, 2013).

According to Pollatos, Füstös, and Critchley (2012), Weizsäcker, a pioneer of psychosomatic medicine, saw mind and body as a hidden unity inaccessible to consciousness as they are “two sides of the same coin”. Mind–body interactions are further complicated as both terms lack clear definition, and although a distinction between mind and body is naturally assumed this might not stand up to scrutiny. This is not to say categories of ‘mental’ or ‘physical’ disorders are obsolete, as they can help locate the most troubling aspects in illness (Radden, 2003). For example “I can’t do certain things because my body is causing me pain; or I can’t do certain things because my body is being controlled remotely by aliens” locate the primary cause of concern in different domains.

Exploring the subjective in chronic pain. This literature review concludes with the existential phenomenological position and its potential contributions to the area. The emphasis on the subjective experience of the sufferer, the meanings given and its potential as a viable alternative to the problematic dualism found in the approaches described in part one and two are considered.

The basis of medicine on the anatomical studies of cadavers is concerning for some researchers (Weiner, 2008) and Kalinich (2010) questioned how much the dead can tell us about the living. This perspective lacks the subjectivity of a living person and paradoxically places the corpse at the origin of the living body (Sartre, 1956). Pain lies at the intersection of the subjective and objective (Iasp-pain.org, 2016); therefore, focusing on just one aspect of the experience will reveal more about the theoretical underpinnings of the perspective than about pain.

The opinions and accounts of patients' experiences of chronic pain are often underused (van Dulmen et al., 1994) and presented through what Carter (2002) called *professional ventriloquism*. This occurs when patients' words are transposed into the professionals' own paradigmatic understanding of the presenting issue. Patients are viewed through the beliefs and assumptions of healthcare providers who then articulate their perception of patients' experiences based on their professional paradigm.

The use of the patient's personal experience would reveal the subjective experience of symptoms, but this not integral to the ethos of biomedicine (Wilberg, 2010). Instead, doctors and patients participate in the mutual objectification of the body as a 'thing' that hurts (Leder, 1990), framing the experience in textbook representations of disease that are disconnected from the patient's subjectivity. This is appealing to patients as the strong wish to escape the experience makes medical diagnosis a welcome refuge that can explain and fix the experience (Honkasalo, 1998). This was emphasised by the Jungian analyst, Woodman (2009) in a televised documentary, titled *Dancing in the flames*, in which she stated:

Anything wrong with our body and we drug it. You will be silent and your body will be silent. You will not be better but you will be silent. Your body will be silent and that's what it should be; just shut it up.

Framing human experience in medical diagnostic jargon reifies medical constructs and risks shutting down personal exploration. This instance demonstrates a repressive, rather than expressive potential of language (Wilberg, 2010; Sela-Smith, 2002). In an essay, Orwell (1946) discussed how language has the potential to anaesthetise a portion of one's brain, and in reference to this essay, Symington (2008) stated that if words do not match the experience, the experience becomes crushed by words.

The agonising quest for diagnosis, which is commonly seen in patients with chronic pain, often confines potential meanings to biomedical models (Honkasalo, 1998). For example, *trapped nerves* or *degenerative joint disease* in medicine are possible explanations for chronic pain and choosing them may prevent exploration of personal meaning. The non-verbalised experiences are sent underground where they are doomed to a misnamed and poorly understood existence whilst the verbalised content becomes accepted in awareness (Sela-Smith, 2002).

An alternative approach would be to see physical symptoms as the bearers of pre-reflective meaning, which can be revealed through inward focus, which, in the process, makes them redundant (Gendlin 1978; Mindell, 1989; Wilberg, 2010). Alongside the rapid development of medical science Svenaeus (2015), argued there is a clinical necessity to learn more about the subjective experience of pain, which he described as a form of suffering and extreme distress. Whilst chronic pain may not be the most severe form of human suffering, often, it is more difficult to transform into a meaningful and rewarding experience than other forms of human suffering because it is so poorly understood (Svenaeus, 2015). According to

Cassell (1999), exploring subjectivity and meaning could be as useful as somatic factors, as they can explicate features of illness that would otherwise remain hidden and treat patients based on their experience (Raheim & Haland, 2006) alongside medical objectivity (Chapman & Nakamura, 1999; Malterud & Solvang, 2005; Thesen, 2005).

Kierkegaard (cited in. Raheim & Haland, 2006) says that the helper must know more than the person who needs help, but it is more important to understand what the person understands, otherwise the greater knowledge of the helper will be of no use.

Phenomenology. The section below provides a brief overview of phenomenology under the headings of its major proponents: Husserl (1936), Heidegger (1962), Merleau-Ponty (1962) and Sartre (1956). Phenomenology responded to the natural sciences by calling for a ‘return to the things themselves’ (Husserl, 1970). This meant experiencing phenomena as they are, without assumptions, bias, or metaphysical presuppositions about reality. My intention is to set out the philosophical underpinnings of existential phenomenology relevant to this study.

Husserl. According to Cohen (1987) and Polkinghorn (1983), Edmund Husserl (1859-1938) is widely accepted as the father of phenomenology and prominent exponents of Husserl’s work include Martin Heidegger (1889–1976), Jean-Paul Sartre (1905–80) and Maurice Merleau-Ponty (1908–61). In his *Cartesian Meditations*, Husserl (1960) described epoche as “parenthesising of the objective world” or putting aside assumptions and biases to reveal things as they appear to us through their invariant or essential aspects. Merleau-Ponty described this as “the spontaneous surge of the lifeworld” (van Manen, 2014).

In contrast to the natural sciences, Husserl’s phenomenology is rooted in the pre-reflective; the world prior to cognitive construction. It investigates how knowledge arises in the first place and clarifies the assumptions at the base of all knowledge.

Husserl (1935) referred to the *mathematisation of nature* in the natural sciences, which he said encourages the human sciences to also become sceptical about subjectivity. Natural science naively assumes its own validity and fails to see that it is also contingent on pre-reflective and subjective modes of experience that make up its worldview or *weltanschauung*. For this reason, no science or philosophy can claim universal and objective validity and legitimacy (Knies, 2011). Husserl viewed Western science as taking both subjectivity and intuition as pre-given and obvious ways to understand the world that are sufficient for everyday purposes, whilst seeking the *truth* in the objective and in the process detaching subjectivity from the truth (Husserl, 1970). Husserl did not doubt objectivism, but was concerned that objective science prevents the scientific study of subjectivity whilst using it naively and regarding it as simply available. Objective science is interested in understanding the world, but bypasses the world that appears in experience, and it is this impulse to go beyond the experienced world that prevents science from having the universally valid status it gives itself (Knies, 2011).

It is worth mentioning that Husserl's philosophy is often misunderstood as centring on an isolated and disembodied perceiver looking at the world of experience (this becomes apparent in the distinctions made between descriptive and hermeneutic phenomenology) but in *The Crisis of the European Sciences* Husserl (1936) turned from transcendental consciousness to pre-reflective modes of everyday experience; a shift that was later radicalised by Heidegger and Merleau-Ponty (Morley, 2008).

Heidegger. According to Morley (2008), Heidegger radicalised Husserl's phenomenology, and earlier, van Manen (2014) indicated that Heidegger did this by taking an ontological perspective through his interest in *being* itself rather than the relationship between things and consciousness.

Heidegger (1962) introduced radical interdependence by stating that experience is always already situated in the world and in being. Husserl's concept of intentionality was transformed into all experience being grounded in care, arguing that to describe experience properly means finding the *Being* for whom such an experience might matter. For Heidegger, Husserlian intentionality takes being-in-the-world for granted and is not characteristic of everyday activity but occurs when there is a disturbance or difficulty. Being-in-the-world is not intentionality but the ground on which both normal and disturbed intentionality is based. Heidegger's non-mental awareness is not determined by the external observation of a situation. Instead what occurs is prescribed by the situation and its own structure which we are interwoven, even absorbed into (Gurwitsch & Embree, 1972).

Merleau-Ponty. In *Phenomenology of Perception*, Merleau-Ponty (1962) said that it is the body, not rules or concepts that guides action and organises perceptual experience. Merleau-Ponty described the body as intelligent and moving towards an *optimal grip* in any given situation. In perceiving ordinary objects, the body moves around them, as if the object is communicating with the body in a way it could not with the mind. The body is continuously in a situation, which is concrete and unique, never to be repeated because having been in any situation once, the situation changes you; therefore, your assessment of the object or situation is also changed. The relationship between the body, world, and situations is one of mutuality and continual change through co-creation.

Merleau-Ponty (1962) saw the body as fundamental to all experience, both perceiving and dwelling in nature and used the example of touching one hand with the other to illustrate the reversible bi-dimensional nature of flesh; both touching and tangible, subject and object. He

regarded these two aspects as a single fundamental phenomenon; which is our *reversible flesh* (Carman, 2008).

According to Morey (2008), Merleau-Ponty reformulated dualist ontology by taking the gap between subject and object and conceptualising it as a *corporeal hinge*. He called the gap the *lived body*, later referred to as chiasm or flesh of the world, and it is from this gap that both subject and object emerge. From this perspective, there is an interdependence between the person and the world as the world and the person are of the same flesh, and to be in the world, one must be of the world, both perceiving and tangible (Merleau-Ponty, 1968). The self and the world are interwoven like threads of a fabric in a situation, where we are not separate from the world but intertwined with it through our intentionality. ‘The world is inside me...[through my personal experience of the world]...and I am wholly outside in the world...[through the intentionality of my perception]’ (Merleau-Ponty, 1962).

Like Heidegger, Merleau-Ponty (1968) saw the body and world as interwoven to the extent that they are constantly being changed by each other. In the *Visible and the Invisible*, Merleau-Ponty expressed this exquisite inseparability, when he said the sensate body has:

...an art of interrogating the sensible according to its own wishes, an inspired exegesis’ ... and later ‘If I wish to feel the cloth of a coat that I am about to purchase, it will not suffice if I pound it with my fists or quickly whisk my hand over it. Rather it must be touched as it wishes to be touched and for this my body needs no instruction. Like the cloth, my hand is a part of the tangible world; between it and the rest of the tangible world there exists a relationship by principle..... My hand, which touches the things, is itself subject to being touched. Through this crisscrossing within it of the touching and

the tangible, its own movements incorporate themselves in the universe that they interrogate, are recorded on the same map as it. (Merleau-Ponty, 1968, p. 135)

Sartre. According to Leder (1990) Sartre's, (1956) ontology of the body expresses an insoluble dualism, which has been adopted by contemporary researchers interested in chronic pain. Sartre's ontology consists of the "body for itself, the body for others and the third ontological dimension of the body". The body for-Itself and the body for others represent the body experienced by oneself and the body perceived by others, respectively. These two dimensions are irreconcilable because the body can either be a thing in the world or a personal opening into the world, but not both simultaneously. The body-for-others includes the body in medical science, which becomes an object of study and explained in terms of which we have no direct experience. Visceral organs for example are not felt from within or known until medicine tells us about them. When all is well, the body is disregarded in pursuit of projects. The body is, "The obstacle to be surpassed in order to be in the world" (Sartre, 1956).

The third dimension is characterised as *the body-for-itself-for-others*, which is the intersubjective and socialised body. This is the experience of the body as reflected in the experience of it by others (Moran, 2000). This includes the way the body is experienced under the *omnipresent* but often *absent* other, as in the case of shame, where one person experiences how the another sees and interprets him or herself. The 'other' is described as what Sartre (1956) interpreted as an *internal haemorrhage* who robs a person of the total control he or she seeks to exercise over his or her personal, experienced world. Leder (1990) applied Sartre's concept of objectification/alienation to characterise the phenomenology of physical pain and used the term the *self-effacing body*, inspired by Sartre's term the *disregarded body*, which denotes the body in ill health.

Internal phenomenology, the body and mood. Phenomenological theory can broaden and help redefine our understanding of health and disease by extending interest into the wider context of the sufferer's world. Wilberg (2010) saw illness as distortions in the patient's inward bodily sense of themselves, others, and the world and is felt as both a mental and a physical state. Bodily feelings, which Ratcliffe (2009) called *existential feelings*, form our background sense of reality and descriptions of bodily changes are usually entwined with descriptions of changes in how the world is sensed.

People frequently attempt to express something that is simultaneously a bodily change and a change in the overall structure of world-experience (Ratcliffe, 2009). For example, the sense of others as threatening is also connected with a feeling of bodily fragility (Laing, 1960) and as shame regarding the body and our sense of others, which feels different (Sartre, 1956).

Van den Berg (1972a) stated there is no internal phenomenology separate from the experience of the body and world and unusual bodily experiences are inextricable from changes in world experience, "When the psychiatric patient tells us what his world looks like, he states ... what he is like" (van den Berg, 1972a).

Existential feelings, a term used by Ratcliffe (2009), are connected to Heidegger's (1962) term *befindlichkeit*, which denotes always finding ourselves in the world through some kind of mood, and that mood discloses and gives us access to our entire world pre-reflectively (Elkholy, 2008).

Stolorow (2007) discussed the developmental basis of mood and bodily experience, which ensues in a relational context. The infant gradually develops distinctive emotions out of the basic affect states of pleasure and displeasure. The affect states gradually evolve from primitive bodily states into emotional experiences that can be verbally articulated or "somatic-

linguistic unities” (Stolorow, 2007). If this ontogeny is disrupted, emotional experience remains inchoate, diffuse, and predominantly somatic. Mood, therefore, becomes inextricably linked with the lived body, which Stolorow linked to psychosomatic states in adults.

The phenomenological theory outlined above views the person and the world as inseparable; each acting upon and changing the other. It is through the world, through something other than our own self that we experience ourselves, and this also determines *how* we experience our self. Being in the world expands our sense of self and modifies our identity through the different experience we have of ourselves in different situations. In response to commonly occurring experiences in the world, psychological structures or habits form (Carman, 2008). Also referred to as sedimentations, they are in constant interplay with the world, which is in turn shaped by them. Sedimentations are challenged by the world as the person is invited to take in new elements from experiences that were previously *other than self*, constantly choosing to accept or reject them (Wilberg, 2010). By choosing to not allow new experiences to alter us, or by finding them excessively challenging, our bodies respond, and illness may develop because of resistance to the world. In these situations, illness serves a healing purpose by giving us time to assimilate a situation (Wilberg, 2010) or by expressing its impossibility.

Psychosomatic problems might arise from a breakdown in communication between the person and the world, as the existing psychological structures are unable to obtain an optimal grip on the new challenges. If a solution is unavailable or the challenge is not met by higher level human functioning, such as reflection or active participation, then a bodily solution is instigated (Bullington, 2013).

Reciprocity between difficult environments and the person reformulates physical symptoms as normal adaptive responses to negative conditions rather than just signs of

pathology (Wilberg, 2010). Van den Berg (1972b) implicated estrangement from others in illnesses, which combined with corresponding changes in bodily experience leads to a world that appears constricted and without future as one becomes stuck in what is interpreted as an unacceptable here and now.

The alien body in pain. Leder (1990) described the body in health as being naturally self-effacing and in his Zollikon seminars Heidegger (2001) defined the experiential contribution of the body as not being a conspicuous ingredient of experience. The healthy body is experienced primarily as a system of opportunities that the world presents, not a thing from which one distinguishes oneself. In health, the person *is* his body but in illness the body becomes foreign and thing-like (van den Berg, 1966). Leder (1990) argued that Cartesian philosophy and the body's natural concealment in health underlie its deprecation in Western philosophy. According to Leder, in pain, the normally self-effacing body emerges as a site of danger and distrust and accentuates the Cartesian deprecation of the body, as the world suddenly stops and the body speaks up through millions of screaming pain receptors.

Leder (1990) described pain as a unique sensory experience because it epitomises the unpleasant and can hold the sufferer's attention in a way that other experiences cannot. Leder suggested that even strong pleasures such as sex allow the mind to wander but in pain this would require an impressive feat to move it from awareness. Leder (1990) contrasted pain with pleasure, saying that pleasure is in and from the world whereas pain is just inside the sufferer's body. Eating delicious food is a pleasure because of the food in conjunction with the taste buds, whereas pain feels like it is in and from the body. Scarry (1987) saw pain both as a spatial contraction that reduces the world to a painful body part and a bodily expansion that fills the whole universe.

Chronic pain imposes a goal to find a solution, meaning or explanation regarding its cause (Leder, 1990) and often triggers obsessive physical palpation and endless research about the body parts affected, whilst scouring the past searching for clues of its origin. Even when the pain has gone, there is a need for confirmation that it has gone, and if it has, there remains a wondering why it has gone, and vigilance persists in case it returns through endless testing to see if the body part involved is still painful. In comparison; pleasure does not inspire this degree of corporeal hermeneutics (Bakan, 1968).

The experience of body in pain is also expressed by Heidegger's (1962) concept of what he called *the tool and ready-to-hand*. The tool is largely absent from experience when working properly and forms a seamless extension with the body as the concern is with the work rather than the tool. However, when the tool ceases to function properly our attention is suddenly drawn to it, and it becomes *present-at-hand*.

In pain the pre-reflective link with the body is broken as specific body parts assert their independence rather than participating in the overall activity. Hegel (as cited in Leder, 1990) described the disease state as one in which a body part establishes itself in isolation and persists in an activity in opposition to the activity of the whole.

As well as states of pain and dysfunction, the body also stands out in times of physical transformation such as puberty (Levy, 2010), pregnancy (Young, 1984) and old age. These experiences disclose the body as unfamiliar and unpredictable. Fanon's (2008) account of racism demonstrated the excruciating experience of the body as *other* when one believes he or she has the *wrong body* for the social milieu in which he or she lives.

The uncanny body: Not the alien body. An alternative to theories that emphasise the body's 'otherness' in pain comes from Zaner (1973) who said in illness the body reveals itself as

unheimliche, or uncanny. Unheimliche is a useful concept because it addresses proposals that the body in pain provides experiential grounds for dualistic philosophy (Leder, 1990), which has implications in how pain is understood and addressed clinically.

Zaner (1973) defined unheimliche as strange and uncanny and contrasts this with *heimliche*, which is the *familiar and homelike*. The contrast suggests that heimliche reflects the experience of the *body as mine* and the unheimliche represents the *body as alien*. The word heimlich itself conjures up two contradictory meanings; that which is familiar and congenial, and one that is concealed and kept out of sight.

Burwood (2007) doubted the extent to which the body is experienced as alien because however strange and unfamiliar it feels it is never experienced wholly as an alien thing. Even in pain, identification with the body is robust, and unlikely to appear as something external to oneself. Burwood considered the bodily sense of otherness as a valid feature of embodied experience often overlooked in the stampede away from objectifying medical paradigms of the body.

Rather than revealing the body as alien, pain reveals the body as unheimliche, which discloses the body through a deliberate and uncomfortable *mentalised* intentionality. Unheimliche reverses the concept of the alien body because the horror is that the body is *not* alien, but “familiar and old-established or something that should have remained hidden but has come to light” (Freud, 1895/1962).

Self-alienation, when in pain, can be seen as an experience of the uncanny. It is not because the body appears as a ‘thing’, but because I realise I am my body. For example, the changing body in adolescence or ageing might inspire a sense of the body as alien and unrecognisable, but what is seen is horrific precisely because it is recognised as the self. The

uncanny captures the ambiguity of the body as alien and the body as mine (Burwood, 2007), at once “intimately alien, strangely mine” (Zaner, 1981). This experience reveals a single reversible existence rather than two separate phenomena we have in dualism (Burwood, 2007). The paradoxical uncanny feeling is because the foreignness, which is supposed to create the strange feeling is feigned. The uncanny is, in fact, something homely, close, and well known but forgotten.

Literature Review Summary

Psychoanalysis elaborated the connections between psychic phenomena and physical symptoms and devised a clinical method whose clinical efficacy was based on psychological insight from careful listening. The emerging demands for empirical validity alongside patients’ discomfort with psychological models due to the implication that their symptoms are imagined, rendered psychoanalysis obsolete as a treatment for chronic pain (Bullington, 2013).

In its place, promising scientific developments established empirical medicine as the treatment of choice for chronic pain. However, treatment outcomes were poor, which led to holistic approaches that aimed to counter mind-body dualism. These approaches were also disappointing as the insoluble dualism that beset the preceding models remained problematic in holistic epistemology. Bullington (2013) suggested that existential phenomenological theory would allow for a characterisation of chronic pain that does not rely on dualism.

The present research aimed to learn about the recovery from chronic pain. My two-part question was, “What are participants’ experiences of chronic back pain, and what do these experiences tell us about recovery?” I have attempted to answer the question through utilising my own personal experience and exploring the subjective experience of participants who identified themselves as sufferers using the methodological devices of the heuristic research

method. Heuristic enquiry approaches questions, such as the ones this study proposed, from a personal, subjective, experiential, perspective, rather than from an objective, empirical perspective and research, which would not be capable of answering such questions. Therefore, it is not a surprise that there are no empirical studies in this area, but also, the review of the literature reflects there is a lack of studies in the existential phenomenological literature regarding the subjective experience of pain. This study has the potential to offer promising insights.

I will now move into the methods chapter where I explain how I researched the phenomenon and the rationale behind my research method.

Chapter 3: Methodology

Comprehension of an entity has the same structure as the entity it comprehends.

—Polanyi, 1966

Summary Overview

This first part of this chapter is devoted to the theoretical basis of research methodology prior to moving onto the design of the study, which is covered in the second part of the chapter. .

This section covers the following areas:

- My research question and personal connection to it.
- The philosophical basis of phenomenology in research.
- The heuristic method and its qualities relevant to this research.
- How I conducted my research under the headings of the 6 stages of the heuristic

research process.

- Recruiting participants, consent, and ethical considerations.
- Interview procedures and data analysis.
- Reflexivity and research validity.

Theoretical basis of Heuristic Research

My research question, my personal connection to it, and choice of method. Heuristic research methods fall under the umbrella of qualitative phenomenology. I chose the heuristic method in particular because I was interested in the value of using my personal experience, alongside that of participants. Other qualitative phenomenological methods such as interpretative phenomenological analysis (IPA) also facilitate an in-depth exploration of experience and take into account the involvement of the researcher in the

research process (Brocki and Wearden, 2006). However, as discussed more fully later in this chapter, such phenomenological methods are interested in ‘*the experience*’ whereas my intention was the exploration of the *terra incognita* relating to ‘*my experience*’ of the phenomenon (Sela-Smith, 2002). Perhaps closer to the heuristic method lies autoethnography as it legitimises and encourages the use of self in the research.

Autoethnography has its origins in anthropology and sociology and it places the self within a social context (Etherington, 2004). The heuristic method however is firmly rooted in psychotherapeutic practise and its emphasis on deep internal work and the resulting change that occurs in the researcher made this method seem the best fit for this project and the field of counselling psychology in general.

For ease of reading, the use of the term ‘participants’ throughout this research includes myself, unless stated otherwise. Phenomenological methods in general require approaching the subject with an open mind to allow findings to emerge naturally (Rossman and Rallis, 2016) and the heuristic method involves accessing what we do not consciously know through deep and disciplined immersion into the phenomenon (Polanyi, 1967).

I had no clear predictions or preferences for the outcome of this study, as I strongly favoured a spirit of open investigation. I wondered if there would be any shared patterns amongst the participants’ experiences and if so, I wondered if they would be relevant to counselling psychology. Sela-Smith’s (2002) compelling writing on the use of the self in research evokes a sense of adventure and awe. She described the subjective as a great *terra incognita*, comparable to the wonders of the physical universe such as great mountains, vast oceans, deep outer space, and subatomic structure. Whilst readily available to us and worthy of

investigation, the subjective world is often overlooked in favour of empirical knowledge (Polanyi, 1967; Husserl, 1970).

The philosophical basis of phenomenology in research methods. The power of heuristic research lies in its ability to explore the unknown. Feeling is used to enter the interiority where felt responses to external circumstances meet to create meaning and form the basis of our reality (Sela-Smith, 2002). Polanyi (1967) stated, if we approach research searching for an answer, there would be an implication of knowing what to look for; therefore, there would be no problem to explore. If problems exist nonetheless and discoveries are made by solving them, then we know important things that we cannot tell.

Qualitative methods allow a greater range of investigation that is receptive to the subtleties and nuances of human experience. Participants are able to describe an experience more freely, which allows the emergence of unanticipated findings (Barker, Pistrang, Elliott, & Barker 2003). I will now outline the role of phenomenology in research methodology.

Phenomenology is the study of the subjective experience of phenomena in the consciousness of a subject. The raw material for phenomenology is description as it aims to understand what an experience is like for the subject and its meaning as it is lived (Polkinghorne, 1983). This is referred to as *lived experience* or the *life world* (van Manen, 2014).

Phenomenology emphasises subjectivity because understanding the subject to whom phenomena appear is key to understanding why phenomena appear as they do and the meaning they have; meaning and reality are always a meaning and reality for somebody.

The pre-reflective dimension, prior to categorisation or conceptualisation is a focal point of study in phenomenology. Unlike empiricism, phenomenology is not concerned with precise

and factual descriptions of objects or experiences but is a type of inquiry that looks at the way reality is given to us in experience by using methodological procedures called *epoche* and the *transcendental reduction*. Epoche is a suspension of the natural attitude through bracketing, whilst the transcendental reduction is concerned with the relationship between subjectivity and the world. In research, the reductions disclose our acceptance of the natural attitude and the contribution of our own constitutive assumptions and biases.

The intentionality of consciousness, central to Husserl's phenomenology, refers to consciousness as being directed. Consciousness involves an intentional subject, an object, and a perceptual process that connects the two and phenomenological research methods give equal importance to each component (van Deurzen, 2014). The reductions are sophisticated research tools and are not used in the naïve hope of gaining access to *pure experience*. It is impossible to un-think or un-know anything, but one can become aware of the inescapability of bias and interpretation and see it as a vital part of understanding the phenomena (van Deurzen, 2014). Bias and interpretation also come from participants as they do not present their experiences in a pure and transcendental form because the act of verbalisation adds a layer of interpretation to the experience (Serning, 2011).

The heuristic method and its qualities relevant to this research. Research methods make ontological and epistemological statements, which indicate the general orientation of the researcher to the world (van Manen, 2014). Carefully considered research protocols will, therefore, consider the congruence between the researcher, the method, and the question (Etherington, 2004). My choice of a qualitative design and the heuristic method reveals my belief in aspects of human experience that are not quantifiable and that there is a valuable type of knowledge lying outside awareness, and accessible through a disciplined internal process. By

reflecting on my philosophical stance in relation to the research question, I felt confident the method, question, and researcher were congruent. The heuristic method inspired me through my belief that personal experience, employed in a skilful manner, can illuminate complex phenomena, and I felt confident in my capacity for internal reflections.

My research approach falls under an interpretivist philosophy, which broadly speaking is a counter-position to positivism and groups together diverse approaches including social constructivism, phenomenology, and hermeneutics. *Interpretivism* differs from objectivist approaches, as it does not view reality as independent from consciousness (Collins, 2010) and supports the existence of multiple realities that are constructed and can be altered by the knower (Denzin & Lincoln, 1995). Interpretivism sees a relationship between the knower and the known and challenges the notion of value-free research and sees knowledge as the best understanding we have so far rather than a statement of what is ultimately real (Polkinghorne, 1983). In Polkinghorne's (1983) words, research is essentially a human activity in which the researcher occupies a central position, and I was both investigator and passionate participant in this study.

Sela-Smith (2002) stated that heuristic research can take the researcher into the tacit dimension through its use of personal experience, where the phenomenon exists in its global form. In contrast, descriptive phenomenology explores through gathering data from observations of others and does not fully access the tacit dimension.

The heuristic research method was developed by Moustakas (1990) as a means of investigating and developing a deep and comprehensive understanding of complex human experiences, portrayed in vivid, alive, accurate, and meaningful language (Moustakas, 1994).

Moustakas (1990) was inspired by a number of theorists including:

- Maslow (1999) and his concept of self-actualisation

- Bridgman's (1950) emphasis on the dependence of validity on the subjective judgment and interpretation of the researcher.
- Buber (1958, 1961) and Jourard's (1968, 1971) concepts of I-Thou, mutuality, mystery, and self-disclosure: These formed the backbone of my interview procedure and my research ethics.
- Polanyi's (1962, 1966, 1969, 1983) concepts of the tacit dimension, indwelling, and intuition. Polanyi's polemic philosophy of science informed my thinking on research validity.
- Gendlin's (1978) contribution came from his focusing methods. Such methods were indispensable throughout my research process, providing access to deep internal content and means of testing its potential relevance to the research.

Heuristics is the investigation of human experience where attention is focused on the feeling responses of the researcher to the outward situation (Moustakas, 1990). Polanyi (1959) and Gendlin (1978) both connected knowledge and embodiment and Gendlin's term *felt sense* refers to a felt embodied experience that reflects a situation in the outside world. Through focussing on the felt sense we can access deeper knowledge regarding phenomena (West, 2011).

The heuristic method does not follow formal steps and procedures as these would not be well matched for exploring personal experience. Instead, the researcher enters each stage of the research relying on core processes (Sela-Smith, 2002).

Moustakas (1990), identified 7 core processes of heuristic inquiry, listed below:

Identify with the focus of the inquiry. The heuristic process involves getting inside the research question and becoming one with it.

Self-dialogue. This connects the phenomenon directly to one's own experience and involves self-inquiry, and openness to one's own experience.

Tacit knowing. Tacit knowledge is implicit and usually outside of conscious awareness and forms the basis of all heuristic discovery.

Intuition. Intuition helps integrate explicit and tacit knowledge

Indwelling. This is the deliberate process of ‘crawling into oneself’ to seek a deeper understanding of phenomena. It requires holding an unwavering attention and concentration on an aspect of human experience.

Focusing. Focusing is exploring the felt responses to external phenomena. It enables one to see something as it is and to contact new awareness and insight.

Internal frame of reference. The outcome of the heuristic process is placed in the context of the researcher's own internal frame of reference, and not an external frame.

Moustakas (1990) extensively utilised Polanyi's term *tacit knowledge*, which he described as, “the deep structure that contains the unique perceptions, feelings, intuitions, beliefs, and judgments housed in the internal frame of reference of a person that governs behaviour and determines how we interpret experience” (p. 32).

The tacit dimension is fundamental to heuristic methodology as Moustakas (1990) considered that underlying all discovery is the power of revelation in tacit knowing. The tacit dimension is outside normal awareness, and Polanyi (1967) captured this type of knowledge with his phrase, “We can know more than we can tell” (p. 4)

Inward focus allows the researcher to discover the internal organisational systems of the self not normally known in waking consciousness. With this new and expanded understanding, internal reorganisation naturally occurs, resulting in self-transformation (Moustakas, 1990) through assimilating our discoveries that become an aspect of our reality. This has social implications as it challenges others to also transform themselves in response.

How I conducted my research under the headings of the 6 stages of the heuristic research process: A chronology of the main components of my research process. Heuristic research is a highly demanding process involving disciplined self-commitment, rigorous self-searching, reflection, and surrender to the process (Hiles, 2016) which is internally guided by the research question and intuition (Moustakas, 1990; Sela-Smith, 2002). In the research process, the six stages need to be completed; however, they proved to not be linear, as I moved back and forth between them when immersion and incubation led to partial enlightenment that required me to return to earlier stages until deeper answers were discovered. In the end, I found each stage of the heuristic method needed to be completed fully before the research was complete, and by using the method in a focussed and disciplined way, each of the stages revealed a clearly defined function. The paradox of the method was that despite the absence of formalised steps and procedures the method felt systematic, reliable, and predictable whilst allowing freedom from externally imposed restrictions to explore the phenomenon. However, it was also uncompromising and did not tolerate any deviations from the process through rushing, taking shortcuts, or imposing external deadlines, which would have rendered the process inoperable.

The present research involved a comprehensive cycling through the six stages of the heuristic method which is more accurately described as interdependent and non-linear, rather than consisting of discrete stages. Figure 3.1 below illustrates a cycling process between immersion, incubation, and illumination that took place at the start of this research.

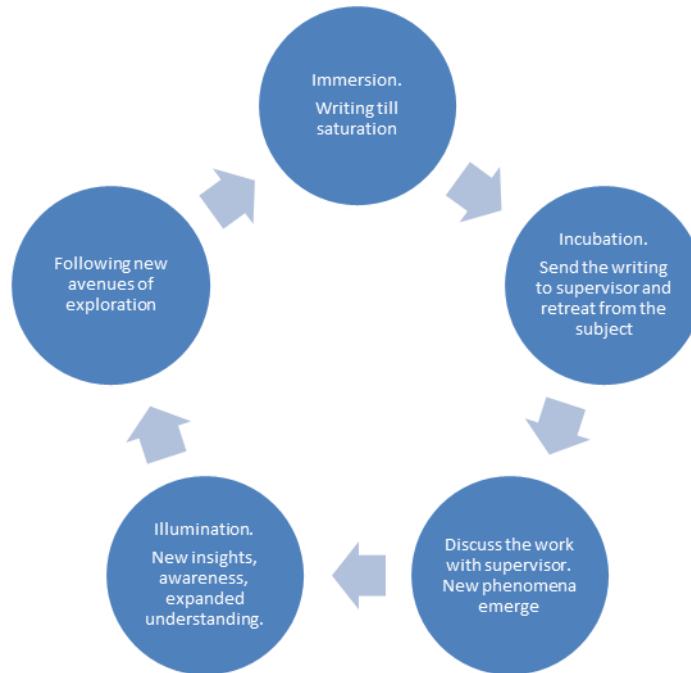


Figure 3.1. *The Cyclic Movement of the Heuristic Process*

I will now present my research process under the headings of the six stages of the heuristic method, as articulated by Moustakas (1990).

Stage 1 - Initial engagement. Moustakas (1990) explained, “Within each researcher exists a ... question that represents a critical interest. ... The task of the initial engagement is to discover ... a passionate concern ... that holds important social meanings and personal compelling implications (p. 27). According to Moustakas, the heuristic process begins with a research question that has personal meaning. The personal meaning transfers an intense interest into the research that would otherwise not be present. (Douglass, & Moustakas, 1985). This research came from an unexpected opportunity to use my personal experience to find out more about the recovery from chronic pain. I had a convincing intuition that such a poorly understood and complex phenomenon would benefit from an in-depth heuristic enquiry.

After a lecture on heuristic methods with my eventual supervisor, my research question began to feel increasingly compelling. I also considered other interesting questions, which lacked personal significance but would have spared me from committing to a process involving difficult personal material.

As my awareness of the question grew, it became more difficult not to explore the subject. In heuristic research, if the topic is personally painful, the researcher could unconsciously resist it; however, the unconscious self responds by pushing the question into the research that is focusing on an incomplete question or another question (Sela-Smith, 2002). As I moved into the immersion stage my engagement with a defined subject became an engagement with a much wider and deeper process. I experienced a mixture of absorption, exhilaration, and anxiety that would not have been present with a less personal subject.

Stage 2 – Immersion. Barber (2002) explained, “the researcher begins to live, sleep, dream and merge with the research question to the extent that he/she becomes it, so as to appreciate its intimate effects from the inside” Immersion requires alertness, concentration, and self-searching. Virtually anything connected with the question becomes raw material for immersion (Moustakas, 1990). Having committed to my research question, I noticed something astonishing was beginning to happen. The research question seemed to take on a life of its own and was pulling up material from all areas of my life, leaving me with the task to make sense of it and working out how it related to the question. Moustakas (1990) clearly articulated this experience with *delight*, which resonates with my experience except instead of delight I had pain. Moustakas explained:

If I am investigating the meaning of delight, then delight hovers nearby and follows me around. It takes me fully into its confidence and I take it into mine. Delight becomes a

lingering presence; for a while, there is only delight. It opens me to the world in a joyous way and takes me into a richness, playfulness, and childlikeness that moves freely and effortlessly. I am ready to see, feel, touch, or hear whatever opens me to a fuller knowledge and understanding of the experience of delight. (p. 11)

During the immersion stages I felt there were two parallel processes; a deliberate inwardly focused attention on the phenomenon through activities like journal writing and a second more spontaneous process that consisted of seemingly random distractions, unrelated to the research that would persistently go round and round my mind until I stopped to explore them.

I had not predicted that spontaneous themes and ideas would arise when I started this research, so I was worried about needlessly going into random places. However, they always persisted until I explored them as if the “unconscious self continues to push the whole personal question into the research” (Sela-Smith, 2002).

I started the immersion process by journaling my experience of pain and recovery. I found sitting with the intention to write fostered a reflective attitude, as van Manen (1990) indicated would occur and this generated a vast amount of material. I would begin to write about a subject and the content would flow until I felt I had fully expressed it. I would reflect on the writing, which would bring other ideas, thoughts, and memories to the surface. Through the process of journaling, intimations of unexpected insights were beginning to emerge. My first piece of writing took place over a few weeks during which I wrote until the flow naturally stopped. I then immersed myself in the writing to contemplate the experience more deeply and used my felt sense to ensure the words were as close to the phenomenon as possible. The felt sense was a vital resource for navigating through material that was rapidly emerging and tangential. My felt sense of resonance (or dissonance) felt unquestionably real yet intangible in a

measurable or observable sense. Polanyi (1967) articulated the relationship between tangibility and reality by saying that cobblestones are more tangible than minds and problems but minds and problems are more real than the cobblestones.

External time scales do not apply to the heuristic method. Instead, I was guided by a clear internal sense that indicated when each piece of writing (or stage) should finish, as I would always reach a point where the seemingly endless flow of material would end, and I would literally have nothing further to write. I felt my first piece of writing, which was over 10,000-words, captured my entire experience of recovery, as I had reached a stage where it felt like there was nothing left to write.

During the solitary process of reflection, I would revisit my experience of chronic pain, and this would also occur in an intersubjective format during discussions with my supervisor who had assimilated my experience from my writing. I found that I used supervision during this research far more regularly than in other types of research to help make sense of the complex emerging material.

After my first supervision, I decided against removing some writing about a family holiday, which felt irrelevant other than coinciding with the onset of pain. The rationale for not removing it was that as it had found its way into the writing, perhaps there was relevance to it. I also followed my supervisor's suggestion to try and describe the pain in more detail and my second supervisor added that research students often make the mistake of not going into enough depth.

The holiday, more detailed descriptions of my pain, and an insufficient depth of exploration would not have occurred to me. However, a day later these suggestions came to life, when sitting on the end of my bed at home, I attempted to describe the pain in more detail. I

struggled to find words because I assumed pain is pain and does not need any further description but persevered and found myself going into and staying with the felt sense of the pain. From doing this process, words, images, and metaphors started coming up from the felt sense, which, to my surprise, clearly corresponded to how I felt on that holiday. This unexpectedly led me to see the connection between sexuality and pain for me, personally.

This was wholly unpredicted and seemed irrelevant to the research question, yet the more I explored this the more the resonance felt undeniable. This literally was a case of the idea that “virtually anything connected with the question becomes raw material for immersion” (Moustakas, 1990). This level of personal involvement was unforeseen, and I had to tolerate my unease of exploring material I did not expect to address and that I might be doing something wrong. I found myself having to surrender to what Sela-Smith (2002) termed *the feeling state of the subjective I*, the *I who feels*, to allow intuition to connect with tacit knowledge. I was continuously relinquishing any rigorous planning and control of the research process to remain open to whatever emerged (Sela-Smith, 2002). This was far from haphazard, as it required much discipline, courage, and skill to surrender to the feeling state of the subjective I.

An example of abandoning planning and control was at one point in the research I was experiencing what appeared to be random music going around and round in my head that persisted for days. I eventually thought this might somehow be related to the research and decided to reflect on the music. Upon reflection and after some investigation, I realised that it was all music that was either released in 1989 or that I listened to in that year. I listened to the music to access the experiences of that time, and I also wore the aftershave I used in that period, which was Obsession for Men, by Calvin Klein, as a way to help the immersion. The ‘random’ music took me back to my teenage years when I started to explore the gay scene and my

sexuality. I was concerned that this was unrelated to the research, but I needed to give up control and explore what was presented to me because as Sela-Smith (2002) stated, each phase in heuristics is like moving into uncharted territory until the inquirer creates both the territory and the path by remaining open to the unknown and seeing what is there. Moments like this in the research felt magical.

I also immersed myself in journals I kept when I was suffering from chronic pain and a set of journals I wrote years later during my recovery. This gave me a first-hand account of what was happening as it was happening and verified my exploration.

As the immersion phase progressed, new areas of exploration would constantly open up, and the research would expand limitlessly. I remembered Goethe's poem written in 1797, *The Sorcerer's Apprentice*, where the Sorcerer leaves to attend a convention and asks his apprentice to fill his bath whilst he is away. Bored with this task the apprentice decides to use magic to help him and vivifies a broom to fetch the endless buckets of water needed to fill the bath. The broom, however, does not stop filling the bath, so to prevent a flood the apprentice takes an axe to the broom, but each time he does this the number of brooms doubles and the bath is overflowing uncontrollably. The sorcerer comes home in time to stop the brooms and warns the apprentice of using magic he does not yet understand.

Conversations, especially in supervision provided moments of illumination, and opened other avenues of exploration. The process felt exciting and produced a vivid collage of subjects that would eventually merge into coherent narrative form. I was continually testing the validity and relevance of emerging material by seeing if it resonated with my inner sense of the research question.

The sorcerer's apprentice almost causes a flood by dabbling in something he did not understand. For me, the material seemed inexhaustible, and I was worried I would be flooded in it all. The heuristic process felt like an exercise in how much more I could let go and surrender to the *subjective I*. This phase of the research came to a pause, and I began to focus on writing my literature review. Researching something with personal meaning allowed me to see if the academic material resonated with my felt sense of the phenomenon; material that resonated with my experience deepened my understanding and that which not match my experience helped expand my understanding of the phenomenon. It was a communication between the theoretical and the personal and a pleasure to be able to use my felt sense in this way.

Once I had made progress with the writing, and had obtained ethical clearance, I continued with the immersion by being interviewed by my psychotherapist. This interview occurred prior to interviewing participants. I informed my therapist about the purpose and design of the study and gave him a copy of the interview questions. I asked him to use the questions as a loose framework and that he could ask questions and explore as the interview progressed. As an existentially trained psychotherapist he could facilitate rich descriptions of the experience without interpreting, which was in line with the aims of this study. The interview was to last for approximately 90 minutes but we went over time and had to complete the interview in another meeting, which lasted approximately 50 minutes. It was important that, as a participant, I was not rushed and allowed to express myself freely. The procedure and questions used in my interview were later applied to the participant interviews. The questions my psychotherapist asked me, which I later asked the participants were:

1. What attracted you to this study?
2. Thinking back, can you describe your experience of pain?

3. Can you describe the process of your recovery from pain?
4. What were things like before the onset of pain?
5. What are things like now?

I began transcribing my interview within 24 hours of its completion and analysed the transcription using the same procedure used for the participant data (see below).

Stage 3 - Incubation. Part of the genius of the heuristic method is to intersperse intense focus with periods of incubation. Deep sleep seems like a good analogy for this stage, as the apparent inactivity of deep sleep hides a period of concentrated physiological and psychological activity that is vital for waking life. Similarly, the apparent inactivity of the incubation stage hides activity essential to the whole process. The purpose of incubation is to allow an expansion of knowledge on a more subtle level where tacit knowledge and intuition can clarify and extend understanding (Moustakas, 1990). During the immersion phase I would absorb myself in the phenomenon until I reached a natural saturation point. I would respond by sending the work to my supervisor or by withdrawing from it entirely. As with the other stages in the heuristic method, incubation begins without planning. Each stage of incubation would begin and end independent of any external time frames, requiring faith in the process unfolding organically to guide the researcher (Sela-Smith, 2002).

Only by reaching a natural and not planned saturation point could the phenomenon become absent from my conscious mind and, thus, allow entry into the stage of incubation. Discussions with my supervisor or withdrawal would end the incubation stage as new ideas would emerge regarding the contents of the previous immersion phase and the pattern would begin again. This felt like Polanyi's (1967) concept of rising stages of emergence, which he borrowed from the biological sciences. In this case the term refers to a stratified arrangement of

knowledge/development separated by boundary points and increasing in depth with each layer. The boundary point is the uppermost limit of the lower layers and acts to stimulate the layers that follow. Supervision would engage with ‘uppermost boundary point’ of the writing which would stimulate a further layer exploration.

Stage 4 – Illumination. Illumination is the result of material from the incubation phase breaking into conscious awareness. The expanded awareness, new ways of thinking, or new discovery occurs naturally in the illumination stage as Moustakas (1990) stated:

The process of illumination is one that occurs naturally when the researcher is open and receptive to tacit knowledge and intuition. The illumination as such is a breakthrough into conscious awareness of qualities and clustering of qualities into themes inherent in the question. (p. 2)

Sometimes illumination would occur as a flash and other times it felt more gradual. The connection between chronic pain and childhood trauma was an example of illumination being like a flash as it suddenly revealed itself towards the final stages of the research.

Throughout this research illumination would mark the end of each period of incubation through the revelation of new connections, insights, or greater awareness (some examples are listed in the summary of Part One of my results chapter).

Stage 5 – Explication. Experiences of illumination induce the act of explication. During this stage all the threads are brought together and the aspects of the phenomenon begin to make more sense in relation to the research question. This cannot occur, according to Moustakas (1990), if the major source of data is the experience of others. The explication stage was interesting to observe in this research because the heuristic process was creative and lively, requiring me to move my mind around in different directions to follow the emerging data. As

with dreaming, bizarre and surreal fragments often appeared in an unpredictable and random fashion. My desire for thoroughness encouraged me to engage with whatever came to mind and see where it would lead, and it was satisfying and exciting to observe the heuristic process in full flow. However, I was also fearful of generating so much material that I would not be able to bring it all together.

I was familiar with Structural Existential Analysis (SEA) in my clinical work, especially its application in dream analysis (van Deurzen & Adams, 2011) where it has the capacity to organise and find meaning in complex and surreal material with minimal interpretation. Numerous researchers in chronic pain have made associations between somatic symptoms and dream material (McDougall, 1985; Mindell, 1986; Wilberg 2010), which contributed to the suitability of SEA to this data.

The heuristic method and SEA reflect aspects of my clinical practice. The heuristic method relates to my inclination to immerse myself in the patients' rich inner world and allow impressions, thoughts, and ideas to come over me. Tuning into my embodied reaction to the patients and working inter-subjectively is key to my clinical work as experience tells me that meaningful therapeutic work requires a genuine mutually felt relational process. My aim in research and clinical practice is to explore whatever emerges, however bizarre, bland, disturbing, or ordinary it might seem. Staying with the bizarre, bland, disturbing, or ordinary requires courage and discipline and a skilful letting go of control to experience these phenomena as fully as possible. SEA is a tool that can provide a structured framework in my clinical work to allow me to work in the way I have described above. I also decided to include SEA in my heuristic research process in response to the vast amount of data I generated from this study. I had

amassed over 200,000 words in my reflective journal and interview transcripts, and I also immersed myself in journals I had written in the years before and during my recovery from pain.

The data was immense and its closeness to me left me unsure where to start. Using SEA facilitated a systematic and thorough exploration of the experience without altering or interpreting it and was flexible enough to be guided by the research. SEA emphasises description and meaning, and as with the technique of Imaginative Variation (Moustakas, 1994, p. 99), it is concerned with the universal structures related to the phenomenon that precipitate feelings and thoughts such as time, space, bodily concerns, materiality, relation to self and others. For these reasons, SEA fit well with my data and the aims of this research.

Stage 6 - Creative synthesis. The creative synthesis is how the research from the previous stages expresses itself in the world to allow the discovery to expand beyond the individual or individuals who conducted the research. Hiles et al. (2016) pointed out:

The researcher is now thoroughly familiar with the data ... the researcher puts the units and core themes into the form of creative synthesis expressed as a narrative account, a report, a thesis, a poem, story, drawing, painting, etc. The invitation here is for all the strands of the research to finally come together as a more coherent form. An understanding, which incorporates the relative, and [the] universal can take place with the potential of affecting a change in the researcher.

This doctoral dissertation represents the creative synthesis from the introduction to the conclusion. Once the analysis of my own process was complete, I began seeking participants for interviewing.

Recruiting participants, consent, and ethical considerations. I obtained ethical clearance to conduct participant interviews, including my own (appendices 1 and 3) and

circulated advertisements for research participants within my current training institute electronically and on the general noticeboard by the college administrator. I contacted moderators of two online support chronic pain groups who agreed to publicise my study to their members, and I advertised on a nationwide online psychotherapy directory and the Division of Counselling Psychology notice board. I also contacted a physiotherapist who specialises in non-medical approaches to pain who agreed to advertise my study, and I placed an advertisement on the 'research' section of a well-known nationwide online noticeboard (Gumtree).

I interviewed adult participants who recovered from chronic lower back pain that had no clear medical explanation and whose recovery was not due to surgical, postural-structural-biomechanical (PSB), pharmacological or any other commonly practised medical intervention for back pain. The participants' experience of pain was within the last 5 years and they were pain free for at least 12 months.

Participants' suitability in relation to these inclusion criteria was assessed in the pre-interview communication and during the interview and was based on self-report. Respondents to the advertisements were given a participant information document so they could self-select, and I confirmed they met the inclusion criteria in a pre-interview telephone conversation and at the beginning of the interview.

I had more responses than I needed from my advertisements and based my decisions on whether the above recruitment criteria were met. I screened for this during the initial informal conversations via telephone or email and at the start of the interviews. I recruited on a first come first serve basis, as I did not want to influence the data by being selective beyond the inclusion criteria.

I had no demographic criteria for recruitment, as I felt that being more inclusive would give me richer descriptions of recovery from chronic pain. In total 14 people offered to participate in this study:

- Six were former patients of the physiotherapist who advertised my study, of which four were selected. The 2 that were not selected had recovered from pain but not specifically chronic lower back pain.
- One was from my current training institute, and was selected because this person met the criteria.
- Three had recovered from chronic pain and became involved in various support groups for chronic pain. All 3 met the criteria and were selected.
- Four came from Gumtree; none were selected from this source as their participation was dependent upon being compensated financially.

Participants ranged from mid-30s to mid-60s and came from diverse cultural, ethnic, and socioeconomic backgrounds, but I chose not to include demographic information in order to further protect participant confidentiality and because this study views pain as a universal human phenomenon and demographics did not form part of the selection procedure.

The objectives of my study were made clear to the participants prior to any agreement to participate, as was any other information that could influence their decision to participate. I informed participants that this study was interested in seeing what could be learnt about chronic pain and recovery through hearing about their personal experiences. I included a copy of the research questions in the recruitment information (see appendix B). I was mindful of the practical and emotional demands of taking part in the research as participants would need to travel to me and give me 90

minutes of their time. They would be required to talk about a difficult experience, and although the questions were included in the participant information, the interview was semi-structured, which meant the content could be unpredictable (West & Byrne 2009). My overriding priority was that the participants' welfare would come before anything I could possibly get out of them. I was mindful not to use my clinical skills to obtain interesting material and felt that conducting the interviews as if participants were research objects would have affected the data and would have been incongruent with my approach to chronic pain which was to listen to and not objectify.

This research aimed to expand clinical and theoretic understanding of a severely debilitating and poorly understood condition. More specifically the intention was to increase counselling psychologists' confidence in working clinically with a presentation they might otherwise exacerbate, avoid, or automatically refer back to the medical profession (Anderson & Sherman, 2013). Those who participated in the study could receive an altruistic benefit by knowing there is a possibility of helping those who suffer with pain, and that this dissertation in the future might help sufferers find a pathway to their healing from chronic pain. Participants could potentially derive personal benefit through recounting their experience during the interviews as recovery, as well as pain is poorly understood and isolating. These factors had the potential to counterbalance some of the concerns regarding participants' involvement in this study. Participants were advised they could withdraw from the research at any time by contacting my supervisor or myself, whose details were supplied in the recruitment information as presented in appendix B.

Interview procedures and data analysis. I took steps to ensure that the interview process took place in an atmosphere of safety and trust, which was established before the

interview and maintained during and after the interview. I informed participants before and during the interviews that they could withdraw at any point in the research process and that the data would be confidential and anonymous.

Participants were aware that this was a heuristic research project and meant that there was a shared experience between us. This reduced the likelihood of feeling judged and not believed, which is commonly experienced in chronic pain. I applied my clinical judgement to help gauge participants' reactions to the interview process to avoid probing and subtly exerting pressure to reveal more than they felt comfortable doing. Marcel's (1971) protocol emphasises the presence of a caring relationship to facilitate exploration, as it is from this relationship that the data will be generated.

My interview questions were open giving participants the opportunity to say whatever they felt was important about their experience, to facilitate getting as close to the lived experience as possible. Geertz (1973) described this as understanding what participants experienced from the inside out, not simulations of what they thought they experienced.

Prior to the interviews, I expected, as Kvale (1999) recommended that I would need to go beyond the verbatim material of what was *said* and *read between the lines*. However, whilst I certainly have this inclination in my clinical work, it transpired not to be the case here. In fact, I felt the verbatim material captured the experience in such illuminating style that interpretation or reading between the lines would have been detrimental to understanding.

During the interviews and beyond, I felt connected and engaged with participants' experiences. My response to participants' narratives was frequently accompanied with surges of tingling body sensations.

Once the interviews were complete, I remained connected with the participants' experiences through an overall *felt sense*, which was unique to each participant and through images and scenes that related to each participant's narrative. Sometimes I had images that symbolised something a participant said, for example, I have an image of an old, worn brown carpet, which represents one participant's story of staring down at the floor trying not to cry during a meeting with a health professional.

As with my personal exploration, material relating to the participants *hovered* in my consciousness awaiting some sort of further exploration or processing. I found that the advantage of working with personal material is that *the use of self* is more available. As the experiencer of the pain, I could tune into the felt sense of my personal material, and potentially take the exploration to a deeper level, whereas with participant material I had to tune into my felt sense of their experience based on one interview. An advantage of the participant data was that it offered a more vivid and colourful depiction of the phenomenon than my personal experience alone could have.

I transcribed verbatim the interviews, typically completing one transcription before conducting another interview. I began this process within 24 hours of each interview while it was still fresh in my mind and immersed myself in listening to, transcribing, and reading the transcripts for each participant and often sent the transcripts to my supervisor for comment. I would go into cycles of immersion and incubation as I would reach my mental cut-off point and need to withdraw from the data. Returning to the data would give me a fresh perspective, and with each repetition of the cycle, my understanding of the phenomenon would grow.

The next stage of the participant process was to analyse the interview data. I used Moustakas's modification of the Stevick-Colaizzi-Keen Method of Analysis (Moustakas, 1994, p. 121-122) and SEA (van Deurzen, 2012, p. 75-110), both of which are explained in a later section.

During my 1-year-long personal exploration into pain and recovery, as presented in the first part of this chapter, I frequently felt as if I were in unpredictable and unknown territory. A year later, when I began interviewing participants the territory felt less alien, as I felt my personal exploration had given me a map of the terrain. Participants were aware that this was a heuristic study, and I could sense they felt understood by me, which facilitated their self-expression. During the interviews I would experience what I have come to call *spine chills*, as I often heard material that was so nuanced and original but still resonated with my experience or with something I had heard from other participants.

My meticulous self-exploration helped me to remain more open to participants' narratives regardless of whether or not they matched mine. It gave me a map of the terrain, which differs from having a pre-set view of what the experience should be like. The terrain was more like a *neutral/universal framework* that was without content and able to contain the different experiences relating to the phenomenon. As an example, in my experience, I did not disclose my years of pain to anyone other than health professionals. This located communication on the map in my mind and set out communication as a parameter in pain. This differs from expecting that sufferers of chronic pain would not communicate this to others; instead, it set up a potential for different configurations between pain and communication making it easier to grasp in the interviews.

The introduction of unfamiliar parameters in relation to pain in the interviews would result in me not having this level of familiarity and connection, although I cannot recall this happening as the parameters I refer to from this *map of the terrain* are broad and universal.

More challenging examples of the effect my personal exploration had on the participant data have been articulated in the results section where I disclosed my pre-reflective responses to participant data. In one section, I recorded my surprise and disappointment during an interview when a participant stated that they did not experience bodily symptoms in childhood. However, noticing my surprise allowed me to stay open to the participant's experience of the body in childhood, and this, I believe, was facilitated by the thorough exploration into my own experience.

I will now describe the steps used to analyse the interview data. As I stated previously, the term *participants* also refers to me unless specified otherwise.

In phenomenological research, methods may be developed to suit the study (van Manen, 1990) and the research method should always flow out of the process of the research with intuition playing a fundamental guiding role (van Deurzen, 1997; van Deurzen, 2012; Moustakas, 1990). I needed to bracket my quantitative research skills and structured approach to the data. Although I was aware of the potential tension within the research community who might find concepts such as intuition and the tacit dimension too vague, I did not want to put the method of analysis at war with the content and process of this research. It was, therefore, important to allow the principles of the heuristic method, such as those described under the six headings of the heuristic process above, to continue into the data analysis. I did, however, desire a framework for my analysis and chose to employ Moustakas's modification of the Stevick-Colaizzi-Keen Method of Analysis (Moustakas, 1994, p. 121-122) and SEA (van Deurzen, p. 2).

The analysis, which I have outlined below, involved multiple cycles of the six stages of the heuristic process. In all, there were 4 main points of focus for my analysis of the data, and the second point had 7 sub points that I listed from a-g to explicate the analysis of point 2, with one supplementary stage between sub points d and e of point 2. The points and sub points that occurred for analytical focus are as follows:

1. Obtain a phenomenological description of the experience (See the ‘Initial Engagement’ stage of the heuristic method above).
2. From the transcript complete the following:
 - a. Consider each statement with respect to significance for description of the experience.

In order to perform point 2, a, I listened to the interviews before transcription and then read the transcripts several times. I looked at the verbatim material intensively each day and moved away when I lost touch with the material, returning to it the following day. Moving back and forth gave me a sense of what was relevant in the transcript.

The adjustments I made to the data at this stage were minimal as I just removed junk words such as *eerrm*, as well as repeated words and phrases, which I considered conversational artefacts. Below is an excerpt from my interview transcript where I have done this. The excerpt is my response to being asked by my interviewer (my therapist) to describe what my experience of childhood discomfort felt like.

(L: 136-144) Well it felt like dullness, or stiffness, so I first remember it when I was at primary school and it was a feeling of not wanting to run, I could run, but I didn't want to because my ankles and knees felt stiff and that would put me off and when I think back to it

now, it's quite a strange thing because it's a normal thing because once you warm up it goes but at the time it felt really off-putting so I didn't want to do any physical activity and looking back on it when I remember that pain in the ankles or in the knees, the stiffness not the pain, when I go back it's quite hard to work out what it is because it was a physical sensation but it was also sadness as well and it's quite hard to separate out what it was so that's what I mean when I say that something was both psychological and physical at the same time.

b. Document all relevant statements.

I documented relevant statements by paraphrasing what had been said to reduce statements to the essence of their meaning, taking care not to alter meaning or lose content. Repeated content was removed. This maintained a natural sounding sentence structure, which felt more natural to work with than lists of short statements. The black text below shows the transcript material and the red text denotes the paraphrased version.

(L 136-138) Well it felt like dullness, or stiffness so I first remember it when I was at primary school and it was a feeling of not wanting to run, I could run, but I didn't want to because my ankles and knees felt stiff and that would put me off.

At primary school I never did sports because my ankles and knees felt stiff, which would put me off running/being physical. It felt like dullness or stiffness.

c. Catalogue each non-repetitive statement: these are the invariant horizons/meaning units.

All non-repetitive statements were organised together, taking care not to remove any statements that were non-repetitive. This step was carried out as part of Step D as I did not create any themes at that stage.

d. Cluster these meaning units into themes.

I did not generate explicit themes at this stage, as I felt this would add a layer of interpretation to the text and prevent relevant themes from naturally emerging in due course. Instead, I went through the interview transcripts and clustered together data that referred to the same phenomenon or were related/relevant to it. I then intertwined the statements by paraphrasing them, again taking care not to change the meaning.

In the excerpt below the black text represents interview data that has been intertwined with data from other parts of the interview, which I have shown in red text. Once the red text (from L:156) was incorporated into the black it was deleted. Sometimes relevant sounding red text is deleted and not inserted into the black text because it may occur in another part of the data. I inserted explanations in brackets for clarification if material taken out of context.

In childhood, I felt discomfort in my body. I wouldn't call it pain, I couldn't do anything comfortably with my body even standing or sitting. At primary school, I never did sports and my ankles and knees felt stiff and that would put me off running/being physical (L:

156: ... I wouldn't do any sports). It felt like dullness or stiffness. The only position that was comfortable was lying on the floor at home. (131: when I was at home. we used to lie on the floor rather than sit on chairs and that was the only position that was comfortable). The pain was like an overall mood, probably there all the time. It didn't make me feel nice about being in my body (L: 963-965 At the time I had no vocabulary for it, it was experienced as just an overall thing, mood and physical sensation. It wasn't really one or the other) + (L: 170-172: and it made me avoid doing things, physical things because it didn't make me feel nice about being in my body).

Talking about the pain I said:

It was an atmosphere, a vibe and I think I was just experiencing it as one thing. It's like the mood of the body? (L: 970-71: It was an atmosphere, a vibe, or and it was, I can't separate them, and even then I was just experiencing it as one thing, like, it's like the mood of the body? The body's mood?). I think it represented not being myself. It also represented the atmosphere at home which was very sad and miserable, my mum was always upset, overwhelmed, threatening to leave. Always a morbid atmosphere at home. I knew I was gay early on, so I was hiding that from a very earlier age. (769-774: I think it did represent not being able to be myself. It also represented a lot, because when I think back on the childhood and that pain and the atmosphere at home it was very sad and miserable and my mum was always very upset and overwhelmed by everything and she was always threatening to leave because everything was always too much for her. There was always a

morbid atmosphere at home and I knew I was gay from very early on so I was always hiding that).

(Supplementary Step 1: Structural Existential Analysis (SEA) and the Four Worlds Model.)

At this stage in the analysis, I applied the four worlds model of SEA to the data, which is the first framework of analysis SEA. This looks at human existence across four dimensions and explores the paradoxes/tensions particular to each dimension. The four dimensions are the physical, psychological, social, and spiritual dimensions (van Deurzen, 1997; 2012), which are universal structures precipitating experience. These dimensions intertwine and are not as separate as the diagram would suggest. They are used to locate and orientate oneself in the experience and are not to be confused for the territory (van Deurzen, 1997; 2010).

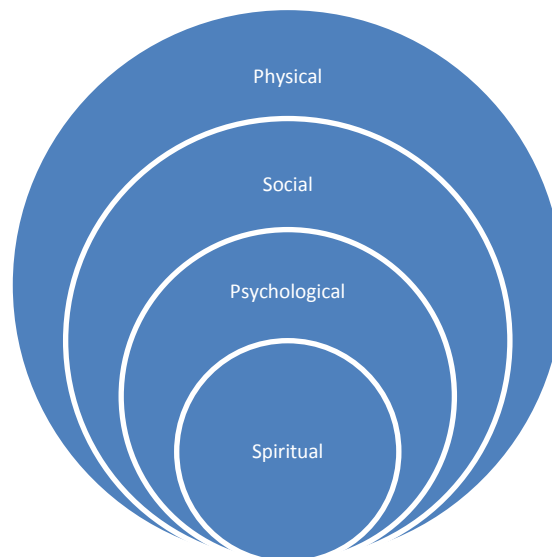


Figure 3.2. *The Four Worlds Model (van Deurzen, 1997)*

I started the process by reflecting the four dimensions in relation to my data. Van Deurzen (2014) sketched out some of the major tensions people are inevitably exposed to within each of the four dimensions (see table below) and a more exhaustive list of tensions can be found in Van Deurzen (2014).

	Desires	Fears
Physical	Life Pleasure	Death Pain
Social	Love Belonging	Hate Isolation
Personal	Identity Integrity	Freedom Disintegration
Spiritual	Good Purpose	Evil Futility

Figure 3.3. *Tensions within the four dimensions*

As SEA is a flexible research tool, I experimented with my data and devised a method through a process of fine-tuning until I, eventually, had a method that fit with the data.

I began by reading through the data and considered each piece of text in terms of the four worlds and their paradoxes, noting my observations relating to each dimension. PHY, PSY, SOC, SPI denoted the physical, psychological, social, and spiritual dimensions respectively. I reflected on the paradoxes for each dimension and the prominent position of the tension. For example, having identified a tension between *comfort seeking/challenge* in an experience, I reflected on which end of the polarity participants chose to locate their position.

At first I found the process mechanical and disruptive to the flow analysis as my anxiety of overlooking something important in the data led me to constantly refer to the lists and tables such as the one above (unlike in my clinical sessions). However, as my confidence grew, I found I could apply the method without needing to stop and consult the tables, lists and *blue text* that I used as an *aide memoire*. I found this more flowing method benefits SEA as a flexible research tool that is sensitive to the data as my former approach risked “forcing it along the lines of its protocol” (van Deurzen, 2014).

The four dimensions provided clear and systematic entry points into the complex data, helping me orientate myself in the *terra incognita* and draw out important themes regarding pain, which can be seen in the example below (I have used blue text to show the application of SEA).

In childhood, I felt discomfort in my body. I wouldn't call it pain but I couldn't do anything comfortably - even standing or sitting. At primary school I never did sports because my ankles and knees felt stiff and that would put me off running/being physical. It felt like dullness or stiffness. The only position that was comfortable was lying on the floor at home. The pain was like a constant overall mood. It didn't make me feel nice about being in my body. **PHY: health/dis-ease, self-care/neglect, movement/restriction, comfort seeking/challenge, deficit/sufficiency. PSY: anxiety, aloneness. SPI: despair/hope. SOC: belonging/isolation, disengagement/engagement**

The above example shows that looking at the experience through the four worlds model supports the notion of pain as a multi-dimensional phenomenon. Experience in one of the dimensions was reflected across the others. For example, the body as 'restricted' and in a state of 'dis-ease' is mirrored in the psychological, social, and spiritual dimensions where restriction is experienced in the context of anxiety, aloneness, isolation, disengagement, and despair. This is demonstrated in the excerpt below and the prominence of rejection and isolation in the social world is also clarified.

Looking back, I can't say whether it was physical or a mood. It's hard to differentiate. The pain [that came in 2006] was definitely physical. Before that I can't say which it was, it's impossible, it was neither. I had no vocabulary for it. It was experienced as an overall thing mood and physical sensation. It was an atmosphere, a situation, a vibe and I think I was just experiencing it as one thing. It's like the mood of the body? I think it

represented not being myself. It also represented the atmosphere at home, which was very sad and miserable, morbid. My mum was always upset, overwhelmed, threatening to leave.

I knew I was gay early on so I was hiding that from a very early age. **PSY:**

Perfection/defectiveness, right to exist, dread, Integrity/disintegration, SOC:

Acceptance/rejection, discord/resonance, strength of self, having a voice, assertion,

belonging/isolation. SPI: despair/Hope

The tensions revealed the propensity during chronic pain to find oneself at the extreme end of the polarity, lacking awareness of the spectrum of experience possible. For example, **comfort seeking/challenge** tension highlighted a polarisation towards comfort seeking to avoid pain, which obscured the possibility of challenging the body on the other end of the pole.

- e. Synthesize these invariant meaning units and themes into descriptions of the texture of the experience, including verbatim illustrations.

I was very focussed on using the participants' words to describe the experience and where possible would use their own words to create textural descriptions. This was a closer description of the experience and felt respectful to the participants' narratives. The excerpt below is a vivid textural description of how pain felt and is largely created using the participant's own words (blue text) The black text represents my words.

Pain is sadistic and torturous, like sharp knives being twisted inside M's body. Pain is irresistible and inescapable. **Like someone put a really sharp thin knife into your SI joint and then started twisting it. Really sharp like needles and just relentless, whichever way you**

move you couldn't stop it. Every little micro movement you made was like the knife was being twisted again and you couldn't get it out. If I moved too much I'd aggravate it.

f. Reflect on the description.

This step runs throughout this research project. At each stage of analysis, I would return to the data almost daily to check that I had accurately portrayed and brought the experience to life. My concern was to create a textural description that stayed close to the data and accurately portrayed the experience. I used my felt sense of the text to see if it resonated with my understanding of the experience. It was a process of verification extending over many months.

g. Create a textural structural description of the experience.

The purpose of this step is to explore the meaning and underlying dynamics of the phenomenon. The processes used to achieve this were reflection, analysis, and imaginative variation which Moustakas (1994, pp. 97-98) defined as:

The task of Imaginative Variation is to seek possible meanings through the utilisation of imagination varying the frames of reference, ... approaching the phenomenon from divergent perspectives, different positions, roles or functions. The aim is to arrive at structural descriptions of an experience, the underlying and precipitating factors that account for what is being experienced ... How did the experience of the phenomenon come to be what it is? ... ' There is a free play of fancy; any perspective is a possibility and is permitted to enter into consciousness. (pp. 97-98)

So far, I had emphasised staying close to the participants' voices, and I was interested to see what new possibilities imagination could introduce to the data. I found not rushing into interpretation too soon in the analytical process gave me a stable foundation for "a free play of

fancy; where ‘any perspective is a possibility and is permitted to enter into consciousness’ (Stones, 1988). Stones defined imaginative variation as a process of reflecting on imagined possibilities inherent in the experience and discarding those that do not withstand criticism. I immersed myself in the data to allow a free flow of ideas and impressions to come together, which I then used to create a structural-textural account for each participant. In the excerpt below I expressed my internal reaction to the data and elaborated a connection between Evelyn’s pain and family relationships using Greek mythology.

Evelyn described how after an exhausting day of work she was never allowed to rest: The thought of sitting was met with the following reaction: **Oh god no ... It was painful. I would probably get up and take paracetamol ... you've done a full day's work and you get home do the tea and put the kids to bed and get ready for the next morning and then your inclination would be to sit on the sofa and you couldn't ... if I lay down at the end of the day I'd fall asleep.**

Evelyn’s pain had a taunting quality that reminded me of King Phineus in Greek mythology. He was plagued by the harpies, who are mythical creatures, half bird and half woman. They were sent by Zeus to punish him by having him observe a feast whilst not being allowed to partake in it. As soon as this exhausted, semi-starved man would try to sit and eat something the harpies would snatch it from his hands and defecate on the rest. King Phineus was eventually rescued by Jason and the Argonauts, who banished the harpies but did not kill them on the request of Iris who promised they would never bother him again.

The harpies bear an uncanny parallel with Evelyn’s mother and adopted daughter. Evelyn described her pain as: **A pain in the ass. That's what it was like a pain in the ass.**

3. Complete the above steps for each of the research participants.
4. From each of the structural-textural accounts create a composite.

After the analysis of the individual transcripts, I wanted to present the overall findings in a composite account. The participant accounts provided a striking and poetic depiction of pain, so I decided to preserve their individual voices alongside a cohesive, universal portrayal of the phenomenon.

In the excerpt below I use composite and individual data to connect the experience of physical pain and relationships with caregivers in childhood. The black text is my thematic account and the red text represents the individual participant voices. Although this excerpt contains findings, it provides an example of the methods used in this study.

A comparison between participants' descriptions of their pain in adulthood and how they described their caregivers in childhood provides an intriguing connection between the two. The following comparisons interpret pain as a physical manifestation of a hostile parent. Columbine described her pain as:

Imagine the nerves around your lower back and legs being like guitar strings and someone running electricity through them and ramping up the temperature so it's very hot. Like a burning sun shaped sensation and electrical sensations ... as if someone was pulling on them and pinging them from time to time and they're very sensitive ... they're so tight, might snap ... The lower back pain was very sharp and deep like a knife going in ... like if you cut yourself ... that level of sheer pain but inside somewhere and maybe being tweaked, moved around. The description Columbine gave of her relationship with her mother was:

Over responsibility for the emotions of my mum. The instability, the ups and downs, one minute being hyper and fun and the next minute something's gone wrong and the cold

silent treatment. It was very unstable and unpredictable. It's weird, it's all hidden quite well ... it would be clear that she was absolutely raging mad inside though there was never much on the outside. It's ... a silent violence. I don't think I realised it ... I idolised my mum ... and the pain of later in life of realising ...

Do the taught guitar strings that might snap match the highly-strung mother? Or perhaps they match Columbine as a child who had the responsibility of regulating and appeasing her mother's moods? The image of someone engaged in the intricate process of running electricity through the guitar strings which represent the nerves in Columbine's back and heating them up to a hot temperature resonate with her mother's calculated 'silent violence' whilst 'absolutely raging inside'.

Similarly, J's mother was a powerful and sadistic figure and was described in the following way: She would ... do this weird stuff ... I'd ask if I could do something and she'd always say no, or she'd say yes but make me jump through loads of hoops first ... and then when I'd done everything she asked, she'd just snatch the thing away from me in front of me ... she was being totally vindictive. She would watch me wanting something and promise I could have something ... but only after I've done a hundred things first ... and once I'd done everything she'd asked for she'd take great pleasure in taking it away from me again ... when it was just in front of me ... She was just being a bitch ...

J's description of his back pain does not sound very different from how he experienced his mother growing up: ... evil ... it felt really vindictive and nasty. Like it was saying "I'm going to stop you, you're not doing anything" ... It was so sharp, so strong. It just stops you in your tracks; you freeze, paralysing. There's no way you could move through it or fight it

... It made me scared to move because I kept thinking that I could do further damage to my back ...

Personal reactions to the data recorded: Supplementary Step 2. Inspired by West (2005), I recorded my personal reactions to participants' data that occurred during the interview or analysis stage (a fuller explanation is given in the Reflexivity section below). My reactions during the interviews were recorded (blue text) from memory and my interview notes and can be organised under four prominent categories, which I describe and give examples of below:

- a. ***Feelings of resonance or dissonance with my own experience.*** During Columbine's interview, I felt resonance when she expressed difficulty in providing a subjective description of pain: Columbine's statement struck such a chord of familiarity in me. It never occurred to me to describe my pain in any detail either. Just assumed it was painful, what else was there to say? An example of dissonance came when Evelyn spoke about a good experience she had with acupuncture: My heart sank when she mentioned acupuncture. Was so useless and I had 100's of treatments.
- b. ***Emotional reactions to the material*** were frequent due to the dramatic content of the narratives. I often felt horrified by the intensity of the experiences and admiration for how challenges were met. When Melania reported how she rejected her MRI scan results because they were illogical I could feel a surge of respect and warmth towards Melania for being able to think this through. For me imaging results was the Holy Grail. I never would have questioned mine.

c. *An aspect of my own experience would suddenly become clearer.* When J was talking about ‘bizarre somatic events’ marking the onset of his pain my reaction during the interview was: *The bizarre onset of pain is new to me. But actually, I had it too. On holiday when I was hanging off the door frame and felt that funny feeling in my body, that was a bizarre sensation’.* I never forgot that doorframe incident and that odd feeling in my lower back.

d. *Visualisations of participants’ experiences* would frequently enter my mind spontaneously whilst they were being narrated in the interview. The visualisations were either straightforward representations of what was being said, or I would visualise myself and the participant as merged having the experience. The visualisations usually occurred when a particularly difficult experience was being presented. When Marianne reported her difficulties at school I was: *Visualising her in a classroom but was my classroom at primary school. She looked disproportionately large and stood out. Could feel the atmosphere.*

Reflexivity and research validity: How I demonstrated reflexivity in this study.

Reflexivity is often not sufficiently emphasised by qualitative researchers but its centrality in heuristic research (West, 2001; Etherington, 2004) encouraged me to go beyond what West (2005) referred to as the valiant, yet unconvincing attempts to avoid bias and bracket one’s assumptions. I, therefore, followed West’s (2009) methodological procedure of including my uncensored and immediate personal reactions to the participant material in my results chapter. West (2009) described the researcher’s willingness to be frank and honest about his or her reactions to the data as pure gold in terms of research. Maintaining an awareness of reactions to

the data as a researcher is important as they can influence the outcomes on an unconscious level and are a valuable adjunct to the primary data (Etherington, 2004; van Deurzen, 2014; West, 2009). I included my immediate reactions to the participant data during the interviews and data analysis stage in the results chapter, presenting them in colloquial language to reflect their pre-reflective and uncensored nature.

I was aware that making the researcher apparent to this extent risks pushing participant voices out into the margins (Edwards & Ribbens McCarthy, 1998). However, as demonstrated in the results chapter, participants' original and vibrant depictions ran through the entire study and appeared at little risk of being subdued by any excessive reflexivity.

Reflexivity: My experience of chronic pain. In what follows, I have further clarified my position with a summary of the personal experiences that led to this study: Four years ago, I recovered from years of debilitating pain that had not responded to any treatment. At the time of onset, I was an advanced yoga practitioner, practising daily and teaching; therefore, I concluded that being debilitated by pain made no sense to me. I spent years consulting an enormous number of doctors and health care professionals, but none could satisfactorily explain or treat the pain. By chance and at my lowest point, I came across a book about psychosomatic pain, and then I met a physiotherapist who specialised in the approach outlined in the book. After an initial physical assessment, I started a *talking-based treatment* with her, which consisted of a weekly 30-minute telephone conversation for 12 weeks. A few weeks after the program had begun, I started to experience a rapid improvement until all the symptoms had gone. My pain and symptoms were explained within a psychosomatic framework whereby psychological factors caused physical pain by inducing local transient *ischemia* in joints and muscles. After recovery,

I did not reflect on my process, as I was just relieved to be well. This research was my opportunity to examine the process of recovery from pain, and I felt having personal experience would enhance this exploration. Although my experience was explained within a psychosomatic framework, I maintained a strong sense of curiosity and openness to the data. I wanted to maintain intellectual honesty by not presenting intentionally biased views to discredit a treatment modality because I found it unhelpful when I was suffering from pain. For example, during my experience of pain I had numerous acupuncture treatments, which were expensive, painful, and had no positive impact on pain. A participant in this study, however, reported an excellent response to acupuncture; however, the benefits only lasted a few days and thereafter the treatment was ineffective. I remember at the time being aware of thoughts running through my mind such as “Acupuncture is useless, it must have been a fluke, change the subject quickly.” Being aware of these thoughts as they were rising allowed me to stay open and listen to the experience. I preferred to allow multiple perspectives to exist in the same subject and to be able to hold different viewpoints at the same time without the need to disprove one or another. This is in fact also a part of Husserlian phenomenology (1970) where the same material generates multiple adumbrations (to use Husserl’s word) of what might be. I believe this attitude towards the research produced more interesting and relevant results. It felt liberating to me having no preferences regarding the findings and not needing the results to support an ideology or bias. My previous research background was in quantitative methods, which frequently employed powerful statistical software to determine if results are significant. Polanyi (1967) stated the futility of seeking only impersonal criteria of research validity as many phenomena cannot be formalised, and to attempt to do so would destroy the subject matter.

The belief that positivist approaches have greater validity compared to the subjective comes from the idea that they are based on observable facts, which anyone can verify for themselves. Polanyi (1967) disputed the democracy of this statement, stating it would require access to specialist equipment and years of training. He said if the man on the street somehow gained access to the equipment and tried to verify some results himself, he would probably damage the equipment beyond repair, and if he did manage to make a successful observation and it contradicted current scientific thought, then it would probably be taken as an experimental error and rejected.

My criteria for validity. My validity criteria are congruent with the principles of the heuristic research method, which is an established and valid method (Moustakas, 1990). Sela-Smith (2002a, b) considered several key factors to be intrinsic to Moustakas' (1990) method, which I list below to support the validity of the present study.

The first entails a *free-fall-surrender* to the process, which is perhaps most clearly evidenced in the section on the Immersion Stage. The second is to report personal, subjective experience, which I fulfilled by presenting the results of my year-long personal exploration. I have also included my reactions to the participant data in the results chapter. The third is that the heuristic process determines the phases of the research rather than conducting the research by the clock/calendar or procedural rules. I clearly stated in my method how each stage would start and end as a result of the heuristic process and how I followed this naturally occurring rhythm. I also allowed the data analysis to flow out of the research process and resisted applying rigid procedural rules of analysis. The fourth is the researcher's internal discovery of the tacit dimension rather than from participants. Whilst I used participants, many discoveries emerged through my personal experience of the phenomenon. The next factor is that there is evidence of

transformation based on what Sela-Smith (2002b) identified as the *I who feels* finding access to tacit knowledge. The ‘Explication’ section in this chapter and the ‘Experience of Life after Pain’ section in the Results chapter show how the research has changed me. I am, therefore, satisfied that I did not replace self-search with a “phenomenological explication of an experience” (Sela-Smith, 2002b).

Further criteria for validity. Moustakas (1990) saw descriptions, which are vivid and faithful to lived experiences as signs of validity. In this research, I produced rich and vivid descriptions of the phenomenon, which stayed close to the lived experience and were supported by embedded participant verbatim material. Moustakas (1990) summarised this by asking the question, “Does the ultimate depiction of the experience derived from one’s own rigorous, exhaustive self-searching and from the explications of others present comprehensively, vividly, and accurately the meanings and essences of the experience?” (p. 32). I have concluded this text accurately depicts the experience and can be understood by others (Hall & Stevens, 1991), which was verified from my work being read by supervisors, colleagues, and friends. In fact, during this research I sought greater input and verification from my supervisor than I have done in previous research projects I have conducted (see immersion process). I demonstrated transparency and reflexivity (Creswell and Miller, 2000) by clearly documenting my rationale and the steps taken as clearly as possible in my methods section and reflective journals. I wanted to show how I arrived at my findings and conclusions, and how and why I decided to pursue each line of enquiry in the research.

Prolonged persistent engagement with the data also provides a mark of validity (Creswell and Miller, 2000). This research is the result of 3 years of daily engagement with the data involving cycles of reflection, immersion, and withdrawal, constantly checking if I had written a

valid depiction of the phenomenon. Moustakas (1990) stated that the constant appraisal of significance through checking facilitates achieving a valid depiction of phenomenon.

The product of this research is a doctoral dissertation, with an intention to submit publications in academic journals, which links with Polanyi and Grene's (1969) statement that the ultimate verification is left to the researcher who can assume responsibility by communicating the work in print.

Chapter 4: Results

Introduction to Results

The first part of this chapter presents the results from my personal experience of chronic pain before presenting participant results, which is in the second part of this chapter. In the participant interviews the red text represents verbatim excerpts. My reactions to the participants' material during the interviews/data analysis are recorded using blue text.

The terms medical, and postural–structural–biomechanical (PSB) are often used interchangeably to refer to the commonly practiced clinical/medical approaches to back pain, including general medicine, physiotherapy, osteopathy, chiropractic, orthopaedics and pharmacotherapy. As noted earlier, the use of the word *participant* also refers to me unless specified otherwise.

Investigation of my Personal Experience of Chronic Pain

Summary. Two of the first prominent findings to emerge from this study were the involvement of the social world and childhood experiences in chronic pain. Prior to recovery, I assumed chronic pain was a discrete, encapsulated, physical phenomenon that lived in the body. My experience of recovery, then, gave me a sense of how connected physical pain was with my life as a whole, but it was only through this research that I began to think that inextricably woven into the experience of pain, right down to the details of how it felt, was a vivid depiction of life that was both historical and current. Who I was determined how the pain felt to me, why it was there, and the effect it had on my life. Key findings from my personal exploration include:

- Body phenomenology and the outer world are inseparable. Focused attention on internal embodied states revealed through a feeling of resonance that the outer world and the

subjectivity of the body were inseparable and inextricably intertwined in a continual dialogic co-creation.

- Social isolation in childhood is related to pain. Social isolation creates a split between the self that is presented to the world and a hidden inner-self. Childhood bodily discomfort is the correlate of the stress of maintaining this split and a mirroring of the situation.
- Social isolation in childhood is accompanied by pain in the body or by social discrimination of the body. Having what is considered the *wrong body* for the social milieu creates an uncomfortable bodily awareness parallel to the physical pain, which is the correlate of social isolation.
- Pain in childhood is often more like a mood than either a physical or psychological condition. Mood is comparable to an embodied emotion; it is neither physical nor psychological but has qualities of both.
- How the body feels determines how the world appears. The subjectivity of the body or its *mood* is the entrance to the world/reality. The mood of the dull, aching discomfort in childhood opens into a corresponding reality.
- In adulthood health practitioners were initially viewed as *all-knowing experts* but outcomes were generally poor.
- Full recovery came after hitting rock bottom.
- Recovery was more than the absence of pain in the body; it was a transcendental experience across all dimensions of life.

Details regarding the findings from my personal exploration. My personal exploration of pain has been organized and developed under the following subheadings.

- a) Discomfort during childhood
- b) Onset of adult pain
- c) Contact with professionals
- d) Recovery from pain
- e) The period before the onset of pain
- f) Life after pain

Discomfort during childhood. Throughout childhood, embodiment felt physically uncomfortable. I experienced a dull, stiff, and aching feeling in my joints and a sense of dis-ease, which was not painful in the same way as the later occurrence of adult chronic pain. In childhood, I avoided activities because of how they made me to feel. In adulthood, I literally could not do things because activity hurt. Childhood discomfort made sitting, standing, walking, and playing sports difficult, and the only comfortable position was lying on the floor. It felt like an overall bodily dis-ease and restriction, being stuck, trapped, and unable to move, as if the body were a concrete, solidified thing that was entirely non-adaptable. Therefore, I avoided physical activity, which disrupted engagement with other children and contributed to a feeling of social isolation. The feelings of physical defectiveness and social isolation were inextricable, and they combined to produce an overall internal sense that something was unacceptable about me.

Whilst the discomfort was not painful, the accompanying mood that emanated from it was enmeshed with the situation in which I lived and it felt unbearable. Addressing the physical aches felt futile likely because, even then, I had a sense that they were just motifs of a more complex picture. My somatic subjectivity resonated with the sad atmosphere at home and the discord between who I was and who others expected me to be.

My psychological shame and sadness, social alienation, and spiritual understanding of my right to exist as myself created the background position in my consciousness, whilst the stiffness and dull aches took a foreground position. This complexity, represented by pain, meant I was misunderstood and not taken seriously when I tried to seek help. I remember an uncle derisively saying that only old women have joint pain. It was equally problematic with professionals, as I remember telling a paediatrician my knees hurt when it was my ankles. Unable to find a cause she referred us to family therapy, which I rejected, as even at the age of 9, I had a vague awareness of the connection between the physical symptoms and my sexuality. I felt this would be exposed in family therapy and did not feel safe to explore this. My avoidance spared me the difficulty that would come with exposure to such topics, but it meant the physical discomfort and all that was attached to it remained unresolved, and some 20 years later it re-emerged as severe chronic pain in adulthood.

When I started secondary school, embodiment became even more problematic because in addition to the pain, I was deemed to have the wrong body shape and the wrong sexuality.

Onset of adult pain. In early adulthood, I started to challenge my bodily aches by engaging in physical activity. This was difficult as my body felt recalcitrant and unable to adapt but after many failed attempts, my efforts eventually paid off, and I was engaging in regular physical activity. Group physical activities led to more validating relationships with others and with my own body. As the familiar aches and pains reduced, the social world responded in kind, and embodiment, through these newfound-skills, became a source of positive reinforcement instead of hostility and alienation.

My first serious yoga teacher unknowingly reversed the negative connection between my body and my sexuality. On our first meeting, he said, “You have a very soft feminine body, and you will become an advanced practitioner.” The term *soft* in this context is commonly used in yoga to denote an innate capacity to perform advanced yoga postures, but there was a double meaning, and the allusions to sexuality felt clear. For the first time, I was presented with a positive connection between sexuality and physical capacity and this led to me becoming an advanced yoga practitioner.

A few years later, a lengthy episode of physical pain interrupted this golden period of the experience of being in my body, and the social world responded by becoming uncomfortable again. In pain, embodiment felt uncomfortable and self-consciousness, as it did during my school years, and it made me feel marginalised and defective again. The pain was intense and incapacitating, and I kept it hidden, which encouraged a split between how I felt and how others saw me.

I suspected something horrific was wrong and I would sometimes be immobilised on the floor, scared of causing permanent damage to my spine. I lost all confidence in my body and would leave the house for yoga only to hide in a coffee shop until it was time for work. The pain made me feel defective and I needed to keep it hidden. On the other side of the polarity was yoga, which felt transcendent and represented freedom, but I was in too much pain to do it.

Contact with professionals. Healthcare professionals were the only people to whom I disclosed the pain. When I could no longer disguise the pain, I told my yoga teacher. She was initially supportive, but later, she became exasperated and suggested I was mad, telling me to just do it, referring to yoga positions I could not do because of pain; she insinuated there was nothing wrong with me. She was asking for a leap of faith. She expected me to just move and trust it

would be okay, but I was too fearful of damaging myself. By this point, I was desperately searching for a cure, while vacillating between despair and hope. I saw healthcare professionals as omnipotent, convinced they would understand and cure the pain, but this always descended into mutual confusion and awkwardness when the pain remained.

I soon developed a daily routine of remedial exercises starting at 4 a.m. before going to yoga practice and experimented with long rest periods. but no matter who I saw, what I did, or what I did not do, the pain stayed the same. It was remarkably impervious to everything I tried. Health professionals ranged from being alarming, dismissive, or reassuring, and the diagnoses/prognoses I received varied widely from the many practitioners I consulted. They fluctuated from spinal damage that could lead to paralysis and incontinence to being told I was in impressive shape and given exercises to help me increase my physical ability rather than focus on the pain. I remember seeing a specialist in lower limb disorders who was bemused, saying he could not match what I was telling him about pain and what he saw. Although clearly preferable to the alarming forecasts, positive prognoses were confusing because I would go home and not be able to stand up or brush my teeth. The years of searching for answers ended in despair and failure. After trying everything I could think of I felt like I had lost everything. It was from this point that my recovery started.

Recovery from pain. Yet again, I was in a bookshop searching the health section for anything that might somehow help. I stumbled across a little paperback about back pain, picked it up, and within minutes, I could not believe what I was reading.

A professor of orthopaedic surgery wrote it, and the startlingly authoritative language reversed my perspective on pain; he stated pain was *painful but benign*. This short statement was enormously relieving, as one of the most difficult things about chronic pain was the terror

that it meant something was seriously wrong with my back. Also, if the pain was benign, that meant I could abandon all my remedial pain routines and resume normal activities without fear of damaging myself. There was something about the way the message was communicated in the book that was very convincing. The statements in the book were presented as fact, and the author was an orthopaedic surgeon with decades of clinical experience. I am not clear exactly what was different about the book, as I had seen numerous health professionals in the past, all expressing numerous *opinions as facts* with utter authority.

I remember frantically writing the following statements from the book in the back of my diary; “Resume all activity straight away. Don't be frightened of the pain. Modern diagnoses and structural models of pain are invalid. When you're in pain don't think physiologically think psychologically. Don't be afraid of pain.” As soon as I returned home, I tested out not being afraid of the pain. I was about to run a bath, dreading how excruciating leaning over to turn on the taps would be, but I told myself not to be afraid of the pain. This was an entirely new concept for me. and I started experimenting with feeling the pain without fear. The book had greater impact on me than anything else I had read and more than any of the health professionals I had consulted over the years. However, I remained terrified of causing more damage to my back. Ironically my back was not actually damaged, but the severe pain convinced me it was.

My recovery began after I found a physiotherapist who worked with the same principles as were presented in the book. After so many failures. I vowed she would be the last person I ever saw for pain. She had an unwavering self-assurance and she *told* me why I was in pain. Unlike other professionals, she undoubtedly understood the severity of my pain, which was the first time my pain became visible to anyone. I was told to stop seeing pain from a purely physiological perspective and take a broader view. She suggested I start journaling to record

what was on my mind. Factors like my career, relationships, how I saw myself, and personality traits soon seemed implicated in the pain. The professional as the *all-knowing expert and ultimate authority* was an important factor in my recovery. This approach differed from person/patient centred approaches, and I likened it to Voltaire's *enlightened tyrant/absolutist* who held power by improving the lives of the subjects and knowing their interests better than they did. Being told by a professional what was happening and why as opposed to being asked was fundamental to my recovery; it seemed to resonate with me, and I was starting to see results.

As this approach was not based on medical/PSB formulations of pain, it did not refer to medical abstractions that were out of my control; I could not see or feel specific spinal discs, obscure involuntary muscles such as my L4/L5 vertebrae, psoas, *quadratus lumborum*, and hip flexors, or imperceptible pelvic misalignments and leg length discrepancies. In contrast, taking a clear, overall look at my life moved things into an arena of personal control. After years of intractable pain, recovery was sudden. Usually after just a few minutes of sitting I would get unbearable leg pain, but I remember one afternoon sitting in a lecture and after an hour or so suddenly realising there was no pain. I went from not being able to sit, to having no pain at all. . Prior to the onset of pain, I started studying for a Ph.D. in Biotechnology, which might seem an odd choice coming from a psychology background. As expected, the change was difficult academically, but it was the unanticipated culture shock with which I struggled most. I felt very out of place and self-conscious. During that period, romantic relationships were controlling, and restrictive and family relationships felt inauthentic, as communication was restricted to avoid disclosing information regarding my sexuality. The pain started weeks after coming back from a stressful family holiday (see Immersion section in Methods Chapter) and failing my Ph.D. *viva*.

In the viva failure, my romantic relationships, and my family situation; I felt as if I always had to pretend to be someone I was not.

The experience of life after pain. My recovery from chronic pain was a transformative process with many positive and courageous changes such as starting a psychology doctorate and leaving a negative relationship. The feeling of not being able to be myself had been present during the periods of childhood discomfort and adult pain. and this research led to greater awareness of sexuality and subtle oppression. I realised that in not being myself with partners and hiding my sexuality from my family, I was implicitly saying there was something bad about me. Being who I thought others wanted me to be felt easier, but when the pain began, it was no longer workable. The physical discomfort in childhood that later evolved into pain in adulthood was linked to feeling the need to hide myself. After recovery, I saw embodiment as a physical representation for how life is lived.

Investigation of Participants' Experience of Chronic Pain

In this section, I have used individual participant voices and composite accounts, presented under the five themes as identified below:

- **The Physical World and Pain:** The subjective experience of pain in which participants provided descriptions of what pain feels like through each participant's descriptions are presented.
- **The Onset of Pain:** The events preceding pain and the actual onset are explored.
- **The Social World and Pain:** Pain in social, family, and healthcare contexts are examined.

- Embodiment and Childhood: Problematic embodiment and childhood adversity are explored.
- The Spiritual World and Recovery: The processes of recovery and life after recovery are charted.

In what follows, the red text represents interview verbatim material. The blue text represents my pre-reflective reactions to the participants' material during the interview/data analysis (See Methods Chapter).

The Physical world and pain. What does pain feel like? This section begins with a summary of the findings and concludes with comments made by participants regarding their experience of pain.

Summary. The following seven subheadings represent the seven themes found in the descriptions and stories told by the participants in their interviews regarding their experience of pain.

- Pain was described anthropomorphically; as being intentionally evil, sadistic, and overpowering.
- Healthcare professionals did not explore the subjectivity of pain.
- Participants readily and complacently adopted medical formulations of pain.
- Severity was a common feature of chronic pain, frequently exceeding the limits of tolerability.
- The level of impairment, the fear of never recovering, and causing catastrophic spinal damage, were arguably more distressing than the physical pain itself.

- The effects of pain extended from the body and negatively transformed the physical environment.

What does pain feel like? Participants initially struggled to describe pain during the interviews perhaps, partly, because pain does not seem to be something that requires description. Pain is also difficult to put into words through its paralysing physical intensity.

Columbine: *I've never explained the detail of my pain before. How can you describe something so personal? It's like it's almost too much to explain.*

Marianne: *I struggle to describe it because I couldn't think at the time. I was completely consumed with it so feels as if almost I didn't make any words or proper memories for about 5 months.*

Correspondingly, healthcare professionals rarely extended their enquiry into the subjectivity of pain. Medical formulations inhibited the expression of the subjective experience as participants confounded these formulations with their experience of pain. Statements such as, “I slipped a disc”... “bad back” ... or “classic sciatica pain” blocked enquiry into the experience by superimposing ready-made meanings that differed from the actual experience of pain.

Columbine: *When I described it (the pain) to physios, chiropractors, osteopaths, I didn't have an exact sense of where it was. I created quite a story with all the information I got about what was causing it so I had an image where it was in my lower back.*

Columbine's statement strikes such a chord of familiarity in me. It never occurred to me to describe my pain in any detail either. Just assumed it was painful, what else was there to say?

I'm sitting here asking them to describe it as if I did not find it an odd thing to do. I knew they would struggle.

The cruelty of pain. Beyond its usual characterisation, such as sharp, dull, or shooting, lay startling anthropomorphised accounts of pain. Pain was intentionally sadistic, omnipotent, and possessed of its own intelligence. Death, losing a limb, or being confined to a wheelchair felt like preferable alternatives.

Graham: I couldn't move off the bed, disabling ... omg I've never felt this before, I'm scared, confused' ... It was very very angry, very strong, it took me to my knees, it broke me. It took me to a dark place. In hindsight I was already in that place and I just didn't know... and before you know it mental and physical health is rock bottom ... It was pure and utter, a caged animal, looking like a monster, it was like a gremlin, demondy. Just so ugly, and angry, vicious, venomous, venomous, venom. It was also very sad, gripping, and absolutely vile. The pain took a hold of me, my body... I wanted to die. If it was my foot, I would have chopped it off ... I've never had suicidal thoughts ... It was the worst feeling through the body.

I just feel stunned by the intensity he felt. I never had suicidal thoughts. I feel so sad he experienced that.

Columbine: Imagine the nerves around your lower back and legs being like guitar strings and someone running electricity through them and ramping up the temperature so it's very hot. Like a burning sun shaped sensation and electrical sensations, as if someone was pulling on them and pinging them from time to time and they're very sensitive; they're so tight, might snap. The

lower back pain was very sharp and deep like a knife going in ... like if you cut yourself ... that level of sheer pain but inside somewhere and maybe being tweaked, moved around.

Feel sickened by the cruel intensity of her pain. Amazed to see her sitting in front of me recovered telling me about it.

J: ... evil ... It felt really vindictive and nasty. Like it was saying "I'm going to stop you, you're not doing anything." It was so sharp, so strong. It just stops you in your tracks; you freeze, paralysing. There's no way you could move through it or fight it ... It made me scared to move because I kept thinking that I could do further damage to my back ... I was thinking I would be paralysed for the rest of my life. I thought what if this doesn't get better and I stay like this permanently or what if I do something wrong and ... become ... paralysed from the neck down.

Melania: Like someone put a really sharp thin knife into your SI joint and then started twisting it ... just relentless, whichever way you move you couldn't stop it. Every little micro movement you made was like the knife was being twisted again and you couldn't get it out. If I moved too much I'd aggravate it. It was really unfair because I was 30 years old and walking like an 80 or 90 year old.

It's scary that pain can be so painful. Mine was totally overpowering but this sounds awful.

My pain resonated with different moods and people. I wonder if theirs would too. Was surprised to find this was the case with every participant. Feels too good to be true. Did I create this discovery by creating the question? Mmmm, unlikely, their accounts are too nuanced and personal to be a result of my assumptions. They describing it better than I managed, and I had

time to get used to the idea of describing it. Their descriptions are so vivid! I'm surprised at how forceful and original their descriptions are. This really resonates with my experience.

Their way of describing pain fits with my experience, but I am actually shocked and moved by the level of intensity in their description. Theirs is more intense than mine. It was totally unexpected as I thought my pain was as bad as it could be.

The different faces of pain. Participants commonly had different types of pain that would occur in different situations. I had a sharp, alarming pain during movement that was instantly incapacitating and a deep dull pain when sitting or lying in bed. Melania described something similar: ... it's ... like ... you had someone's knuckles to the side of your spine and they are putting too much pressure on and it's getting uncomfortable and you can't ease it because the pressure is still there ... with knuckles going in at different pressures in different places. It was mainly when I was sitting, watching telly or sitting in the car or sitting at my computer.

That's so like my experience, feels uncanny. Makes it easier to connect with participants. Her narrative brought up an image of an occasion when I was in bed and in pain, unable to sleep because of the intensity of the dullness, just waiting for the morning to go to the physio.

The psychological terror of pain. The anxiety of never recovering was equally if not more disturbing than the actual physical pain. The imagined personal and social impact was gruesome. Marianne: The thing I remember more than the physical pain was the ... absolute sheer terror that I'll feel like this forever ... I'm letting my kids down, I'm ruining my family's life ... The panic was about ... my life just closing in and all the things I ... wanted to do, one by

one were all being blacked out like some sort of reverse advent calendar ... and feeling I was going to be dependent, and trapped, and a burden.

Being in pain led to the fear of more pain and of causing severe damage to the spine.

Melania: I was afraid of taking painkillers because I was worried I would further do damage if I couldn't feel what was going on.

The advent calendar sounds shocking. I had the same fear, but hearing them, I feel more aware of it now. Never had that worry about painkillers though, I never experienced that sort of relief from them to justify the worry. Benzodiazepines, opiates, anti-inflammatories had no effect at all on my pain.

Pain becomes the entrance into the world and creates a corresponding reality. It diverted interest into painful body parts that are normally unnoticed. J: It was excruciatingly painful physically ... I realised the importance of the lower back, basically it's where everything's connected and I felt really vulnerable and all sorts of worries and thoughts came into my mind. Amazing, I remember thinking that about the lower back connecting everything. Used to have image of a point in the lower back that connects the legs with the torso and feeling how fragile that is. Like those wasps in Cyprus who have two body segments connected by a really fine string.

The internal phenomenology of pain is inseparable from the environment. The bodily restriction of chronic pain sweeps through the physical environment, altering spatial dimensions and making the most normal activities nigh impossible. J found it difficult to change direction while walking! I could walk in a straight line but every time I had to turn I had to really plan and organise, and it was painful every time. My version of this was getting off from public transport, wondering each time if I would manage it. But changing direction, sounds severe.

Melania: He (dad) said let's go to mamas and papa's, and I said I can't get that far ... It was probably 200 or 300 yards. When I had really bad days I used to get a wheelchair and my husband would push me around (The wheelchair is mentioned several times in Melania's narrative. I refer to this again later).

Pain seeped in J's familiar environment and created a threatening atmosphere. The internal threat of pain synchronised with the external environment to make passers-by potential attackers against whom he would be defenceless. I was standing at a bus shelter. I hope no one comes up to me and pushes me because I am just going to fall because ... I don't have the strength to withstand any... force ... that would be less painful than withstanding ... I was sad at how unpleasant this must have been. I remembered preferring to fall on my head in yoga than experience the back pain!

As the pain intensifies, so does the bodily restriction and the world shrinks to a single room or to a motionless body position. Columbine would be motionless on the floor too scared to move in case she made the pain worse. Her entire focus was looking for a single position that did not hurt. Pain is like a strait jacket: The best positions were lying flat with my legs up or with something under my knees ... The excruciating pain left me trying to find one position that would relieve the pain. It was hard to find, and there was lots of fear in having to move out of that position again. I used to do all that stuff on the floor.

However, there was never any escape from pain. The comfortable, immobile position would be cold comfort, as it would soon have to be paid for with more pain. J: I started to find positions I could sit in that were comfortable ... but from sitting still another pain would start. I would feel my body getting stiff, and I would be scared because I knew ... that when I moved it would be so painful.

Evelyn's pain did not restrict movement; instead she was *restricted* to constant movement in what sounded like an utterly exhausting daily regime. The only comfortable position was lying down and the thought of sitting was met with the following reaction: **Oh god no ... It was painful. I would probably get up and take paracetamol ... you've done a full day's work, and you get home do the tea and put the kids to bed and get ready for the next morning and then your inclination would be to sit on the sofa and you couldn't ... if I lay down at the end of the day I'd fall asleep.** I did not experience pain in this way and felt interested to explore it. I was rummaging through my mind to find some sort of meaning for it. I had sitting pain but I would move around to make it bearable. Standing up again was my biggest issue.

Evelyn's pain had a taunting quality that reminded me of King Phineus in Greek mythology. He was plagued by the harpies, or mythical creatures—half bird and half woman—sent by Zeus to punish him by having him observe a feast but not allowing him to partake in it. Each time this exhausted, semi-starved man would try and eat something the harpies would snatch it from his hands and befoul the rest. King Phineus was eventually rescued by Jason and the Argonauts, who banished the harpies but did not kill them on the request of Iris who promised they would never bother him again. The harpies bear an uncanny parallel with Evelyn's mother and adopted daughter.

Evelyn described her pain as: **A pain in the ass. That's what it was like a pain in the ass.** She seems really reluctant to describe her pain compared with the others. Maybe because she's a doctor, and she thinks I'm stupid? She thought she was coming to a scientific interview. She might think I'm some sort of charlatan or *quack*. I'm feeling annoyed and intimidated. She won't *play nicely* and give a nice description. I bet there is one. Her description of pain being like *a pain in the ass* sounded like she was making fun of me but actually her answer was very

apt. Her face changed after she said it, as though she said something by accident that meant something important. I thought, “yeah, that pain in the ass is your mother and daughter.”

Pain is irresistible: Impossible to subdue. Pain is overwhelming, uncompromising and takes precedence over everything. Melania: **Once I was in the shopping centre, they were 4 or 5 (her children) and all of a sudden they just went but I couldn't move. It was so painful, and I could see my kids getting further and further. There's nothing that could entice you more than the safety of your own children.**

“Pain as irresistible” was something I was more than familiar with, but again the intensity of the participants’ experience surprised me. I was visualising Melania’s story as she was talking. I’m still reminded of it. I, sometimes, have spontaneous images of a shopping centre with her kids running off.

The onset of pain. As in the previous presentation of the theme regarding pain, this section begins with a summary of the findings and concludes with comments made by participants regarding their experience of the onset of pain.

Summary. Five sub themes were found in the data related to the onset of pain.

- The onset of pain is sudden and without warning, occurring in unremarkable circumstances.
- Pain is automatically attributed to physical causes.
- Major life events coincide with onset but are not seen as contributory by participants.
- The body imitates life. Sensory somatic experience is the correlate of life.

- The first episode is shocking but seen as an anomaly until severe pain starts to occur with increasing regularity and debilitation.

Participant comments regarding the onset of pain. The participants all shared information about the moment they first experienced the pain that had taken over their lives.

Onset is sudden and unexpected. The onset of pain occurred without rhyme nor reason, always during normal day to day activities. Graham was experiencing some unremarkable low-grade pain and then suddenly he was in an ambulance. The day it happened was **like any other day. It all happened at 11 o'clock. It had been creeping on about 24 hours before that, but I just slept and went to work and then it was 'you're going to have to call an ambulance'.**

Alexia woke up one morning and she explained she **couldn't stand up. I was tilted to the left and in intense pain ... I probably took Advil and used ice ... I thought I pulled a muscle or got out of bed funny or over-exercised ... I wrote the first episode off ... but then I had another episode or two.**

Major life events are ignored: The body imitates life. Evelyn's pain, which she described as *classic low back pain* began at 18 when she left home to study medicine. It persisted throughout her training, and she believed high-heeled shoes were responsible. After graduation and a respite from the pain, Evelyn moved to Jamaica to work as a hospital doctor, and the pain re-emerged. Evelyn did not acknowledge the impact of this major life change and attributed the pain to long hours of standing. **It was really hard when I think back on it. I went straight into a different environment ... and used to get back pain on the wards and again I thought it was from the standing.** The pain stopped when Evelyn left the hospital to work as a GP, which gave her professional autonomy and was very fulfilling. Evelyn described it as a **great job, really really good job and I had no back pain in those years that I did that job.** In

comparison, her previous hospital job was rough. It was really hard. You're working under a lot of pressure, and I was very junior, foreign, female, and white. For Evelyn, the pain was contingent on whether she was sitting or standing. As a hospital doctor, Evelyn was standing for many hours in a hostile and stressful environment. As a GP, Evelyn was sitting in a calmer setting feeling she was making a difference to people.

Evelyn moved back to the UK and had to unexpectedly adopt her brother's daughter. This coincided with an episode of severe foot pain which she attributed to physical causes. I could barely get out of bed to walk to the bathroom. It would come when I got up. When I was lying down there was no foot pain. I felt sad that Evelyn had gone through so much. I resonated with her inability to correlate life events with pain, as that was also something I never did. Even when you do make the connections, it's such a conundrum, it seems so counterintuitive, at first.

Marianne was doing some minor car work when the back pain suddenly appeared. She attributed it to an awkward movement. The pain was severe and she saw her GP who told her that she would have back pain for the rest of her life. Marianne: (the doctor said) it will always come back, you'll always have problems with it. I was just completely devastated really. Marianne did not doubt her doctor's prognosis and linked it with the years of lifting and carrying as a nurse. The onset however, coincided with buying a house, the death of her mother, the birth of child and finding out her son had autism ... we just brought a house. My mum had died. I never thought of that. (How could you not have thought of that?) She died when Tristan was born ... I'm thinking now and this never occurred to me either. We found out that Phil was autistic. That wasn't handled well by the person who diagnosed him. We thought we were going for a normal speech therapy appointment. He said 'in my opinion he'll never cope in mainstream school'. He was only in nursery at that stage. It's like damned forever. I wanted my

kid to be normal and have a normal life. (Instead of) difficulty, struggles, never fitting in. This is what he's having now at 20. That prediction didn't come true, he went to a mainstream primary school. Now he is struggling ... It was encouraging to see a child who was bright, intelligent, funny, but now it's hitting us. Is he ever going to manage, be independent and I think it's because it's hitting him ... when people are talking about GCSE's and you're not doing GCSE's and they're starting having girlfriends and you're not and they're going to university and driving ... (At 16) that's when it hits you he's aware of it and then it's hard to be positive about those differences.

Marianne's pain process and her son's autism ran in parallel. The speech therapist told her about Phil's autism in the same fatalistic way her GP told her about her back pain.

Marianne's pain went from "having a bit of a bad back" into pain that left her incapacitated. This sudden change in pain coincided with her son turning 16 where it became apparent he would be unable to live independently. When Marianne felt her actions could positively affect her son's autism her pain was mild but as her son got older and her powers became limited, the pain escalated and she became incapacitated. When he was little at school it did cause him problems but, I could teach him ways of coping. At 16, there weren't things you could do that would make a difference.

I was surprised this level of revelation happened during the interview. I thought anyone reading this would think it was staged.

The onset of pain is marked by bizarre somatic events. For some participants, the onset of pain is heralded by a bizarre bodily event which, although unremarkable in terms of pain captured participants' attention and became a motif for the onset of pain proper.

Soon after a long-term relationship had ended Columbine remembers sitting on a bus. She feels numb and then suddenly sneezes: ... There's a sense of numbness on the bus, like a numb veil, just prior to the sneeze that led to the back pain episode. The 'numb veil' is pierced by the sneeze and the screeching pain that came with it. I was sitting on a bus and sneezed. I felt a strange sensation. I remember a not very loud poppy sound and a feeling of cold fluid across my lower back. It felt strange. There wasn't any awful pain until I tried to get off the bus ... and it was very, very, very painful and got more painful ... I remember getting off the bus and meeting my grandmother and feeling panicky ... It wasn't the pain, it was feeling I can't stand up straight, what's going on here? ... I made a connection between the sneeze and the pain... I went straight to a mechanical reason. I didn't know any other ... I'm struck by the very, very, very painful. I'm searching through my personal memories to find a similar pain. I can visualise her on the bus.

J described a similar situation ... I was in the gym doing deadlifts ... It was something I did loads of times before, but I don't know what I did that day ... I was bending at a slightly different angle ... I bent down and I heard this noise ... It was so loud ... I went all fuzzy, I saw stars ... It lasted about 10 seconds and I just got up and carried on as normal with my workout ... It wasn't painful ... I didn't really think about it ... The next day ... I couldn't get out of bed ... I couldn't move ... It was so painful ... I was so scared I didn't know what had happened ... I thought I had really done some serious, some permanent damage to my spine and that I would be paralysed.

The bizarre onset of pain is new to me. But actually, I had it too. On holiday when I was hanging off the door frame and felt that funny feeling in my body, that was a bizarre sensation'. I never forgot that door frame incident and that odd feeling in my lower back.

Melania: I was walking along the road and I got a sudden sharp pain in my back ... I just thought that's a bit weird and ... carried on walking and that sort of episode got more and more frequent ... I just thought it was muscle twitches or weird things going on in your body. I might have gone a week with nothing else happening. Around 6 or 8 months later, I was having pain most days, all day pretty much.

Melania attributed the cause of pain to the metal rods inserted into her spine as a teenager to correct a scoliosis condition. After her surgery, she was told her back was fragile and to avoid certain activities. During her episode of adult pain, Melania had sinister images of the metal rods snapping in her spine, which fit with the image she used of sharp knives inserted and twisted in her body to describe her adult pain ... I thought it (the adult pain) was because when I was 17, I ... had a spinal fusion, and I've got two Harrington rods in my back. Since then, I was always told "be careful of your back, you can't do this, you can't do that." I wasn't in pain with the scoliosis but when this started happening I thought, "Oh my god, maybe one of the rods had broken ... or something really horrible ..."

I'm visualising Melania's spine and the rods, imagining the fear. Can feel myself itching towards a psychodynamic interpretation. Does she have fantasies of being in a wheelchair to replay her childhood trauma. Don't say anything, shut up. Just listen, let her describe it.

The Social world and pain and the search for a cure. A person experiencing chronic pain is not separate from the world in which he or she lives and those with whom he or she interacts. Five subthemes emerged from this theme.

Summary. The five subthemes that appeared in the data regarding the interaction of the participants with the medical/social world included:

- Pain is poorly understood by those around the sufferer.
- PSB/medical approaches were the only options considered.
- PSB/medical approaches were ineffective and often exacerbating.
- The relational aspects of clinical encounters were often overlooked but had profound effects on the pain.
- The long succession of failed clinical encounters spanning many years precipitated a cure.

Participant comments regarding their interaction with the outside world related to pain. The absence of a clear medical explanation was as intolerable as the pain. Having a diagnosis was a priority for participants who spent years moving from one professional to another in a desperate search for answers.

Pain is poorly understood by those around the sufferer. Many of the participants found those from whom they sought help did not understand what they were experiencing and did not know what was needed to resolve their diagnosis. Melania's comments are reflective of this experience.

Melania ... I wanted to find out what was causing it so I could try and do something about it ... even if it is arthritis, that would be an explanation, or to say 'you're going to be in a wheelchair' because if I was in a wheelchair I could adapt my life around that and move forward, whereas I didn't know from one day to the next how I was going to be. (Not having an explanation was) really frustrating and depressing.

Surprised by Melania's response. I also wanted a diagnosis but never would have found a wheelchair preferable to the absence of a diagnosis. That would have been my worst nightmare. Kept thinking about the wheelchair as a desire for re-enactment of her traumatic spinal surgery. *The unquestioned validity of PSB and medical models.* Most participants, as well as doctors, only considered specialisms based on PSB and medical models as valid treatment options. The validity of these models endured despite participants experiencing one failed clinical encounter after another.

Evelyn: You would go to an approach, and it would work for a bit, and then it wouldn't work so you would go to somebody else. It was a sort of circle. When Melania's MRI results provided no useful information, she decided to investigate rheumatology: I was wondering if I had arthritis so I went to see a rheumatologist. Nothing must have come of it. Can really tune in to this endless 'merry-go-round' of medical specialisms and how grim it was.

PSB/medical approaches were ineffective and often exacerbating. Participants initially assumed doctors would provide answers and a cure. Ultimately this was never the case as the pain only worsened with time. On rare occasions Evelyn experienced significant improvement after some treatments but this was short-lived: I remember after I'd been to him (osteopath) thinking 'wow he was brilliant' and once I had acupuncture and was pain free for 3 or 4 days. I thought it was miraculous. My heart sank when she mentioned acupuncture. Was so useless and

I had 100's of treatments. Melania: Each time you start something like that (PSB treatment) you're quite hopeful and so are they ... and months down the line ...you start to doubt whether they can do anything for you. Feels so familiar. Like I was listening to my own experience but from others over and over again. This felt exciting. How come it's so similar? Could feel my spine tingling every time participants said something that I could have said.

Explanations for pain from PSB formulations were overly-complex, inconsistent, and counterproductive. The complex biomechanics involved in the formulations were beyond the layperson's level of expertise, which supported the exalted position of the expert and made otherwise implausible explanations plausible. Structural deficiencies were used to explain the pain and this inadvertently reinforced the idea of bodily weakness. Melania: ... my sacrum is tight and maybe unstable and uneven, one of my hips was higher ... There's always medical jargon ... because you're a layman you don't really know much, they know what they're talking about.

Columbine's osteopath formulated that her pain was caused by sitting with spinal rotation on a bumpy motorcycle whilst having her arms in a certain position and then sneezing several weeks later: I was sitting on the back of a motorbike with one arm in front and the other arm holding the back, and the chiropractor told me I had been in a twisted spine position and the movement of the motorbike put my back out of alignment and it was in a vulnerable position when I sneezed.

Alexia's clinician proposed that one of her flare ups was caused by an interaction between walking with a slight spinal flexion (bent forward) uphill on holiday (her accommodation was in a hilly area) and with an existing spinal weakness ... on vacation ... we were staying on top of a hill ... and I had a really bad episode ... We explored it (physiatrist and

Alexia) and thought walking up and down the hills made me do more bending forwards and it disrupted the delicate balance in my back. And I felt that I had this delicate back that could be thrown off easily and just a little bit thrown off was enough to cause me intense pain.

Evelyn completed a specialised 12-week course in core strength training but the proposed correlation between weak core muscles and lower back pain did not apply. At the end of the course Evelyn's back muscles were stronger than ever, but so was her pain. Approaches not primarily based PSB models were more effective. Evelyn participated in a class combining yoga, tai chi, and Pilates and attributed the improvement to the stretching (PSB factors): ... after class I used to realise. "Oh, this is great, I haven't got the pain anymore'. I thought it was the stretching, so I did it once or twice a week.

Feel so annoyed that I believed all the countless convoluted formulations of pain I had received and how much anxiety they caused me. Was having images the osteopath at the yoga centre and going straight to yoga practice believing I was going to break my back after what he told me. Would never have thought to question him or other health professionals. I feel intolerant of them and their formulations.

Relational factors in the clinical encounter. The value of relationship was acknowledged but only as secondary to the procedures offered. Graham: I felt a little bit hopeful about this Dr's appointment because I felt like he cared.

Clinical encounters that felt distant or neutral were either minimally therapeutic or exacerbating.

Columbine: My osteopath was really helpful ... But ... there was one appointment when I didn't feel the same connection with him ... I felt I hadn't received benefits from that treatment ... He was initially a soft and gentle man ... but over time I felt he ... was distant and not in tune

with my body ... so I stopped seeing him ... On another occasion Columbine: saw a young physiotherapist who just gave me a set of exercises from a book. I remember saying 'look can you help me understand why at such a young age I am having such debilitating pain that makes me unable to walk?' I couldn't get my head around it ... I wanted to understand and didn't feel people had the answers or cared.

Relationships that were warm and trusting were also unsuccessful if the focus was on medical/PSB factors. Alexia had excellent relationships with the clinicians she consulted, but this did not reduce the pain: ... If I had a problem I could call them. I worked with top-notch people who really cared about their work, and I felt they cared about me. I don't think they understood the pain because I don't think they got the diagnosis right, but they believed I was in pain. They didn't have a way of understanding it that was helpful to me. All these different experiences. There's nothing here I hadn't experienced countless times when I was in pain.

Quite amazing, really!

The anti-therapeutic clinical encounter. The medical encounter can often be anti-therapeutic, going against the therapeutic aims of the clinician and patient. Probably one of the most counterintuitive concepts in chronic pain is that structural-biomechanical variables correlate poorly with symptoms. Medical imaging interventions were often seen by participants as the gold standard in diagnosis but frequently produced confusing results when applied to chronic pain.

Melania: I had an MRI, and they couldn't see anything wrong ... Five years later ... I couldn't go anywhere with my kids because I was worried about how I'd cope. I went for another MRI. and they said I had annular tear or fissure and that might be causing the pain, but then I

thought that fissure wasn't there when they did the last MRI, but I was in a lot of pain so I'm not sure that fissure can be responsible. Could feel a surge of respect and warmth towards Melania for being able to think this through. For me imaging results was the Holy Grail. I never would have questioned mine. The results from MRI and PSB assessments are accepted as objective facts lying outside participants' subjective experience and control. Any meaning attributed to them risks having finality about it that would rarely absolve sufferers but rather condemn them to a life of pain. Columbine avoided MRI scans because: ... I was worried that even if they didn't make an explicit link between that torn disc, that fractured disc, I would make a link and would worry about what that meant. I remembered my fear when a link was made between imaging results and my pain and how this made my pain real and out of my control. I'm impressed she was able to avoid MRI.

The authority and power of the medical expert imbued negative prognoses with a sense of validity. They were nearly always accepted, resulting in more pain and for longer. Patients contributed to this by automatically rushing to find substantiating evidence to reinforce the prognosis. In Marianne's case ... (the doctor said) it will always come back, (lower back pain) you'll always have problems with it. I was just completely devastated, really. It sounded sensible after years of lifting and carrying people. You hear of people having bad backs ... I'd just had my youngest child, and he was a few months old ... and I was like, "I can't pick my baby up, I can't change him."

Participants rarely experienced the medical encounter as a source of comfort. Even during a rare occasion when Marianne's pain was successfully relieved pharmacologically, there was an increased anxiety of causing further damage without realising due to the decreased pain sensitivity. Ironically, the reduction in pain led to an even greater physical restriction.

Marianne: I had diclofenac, paracetamol, codeine, Valium, but when he gave me the gabapentin, he said when you take this the pain will go but you mustn't start doing things because that will cause more damage and you won't be able to feel it ... I felt like I had to move as though the pain was still as bad [because] I'd had this image of this unknown damage I might do. What a dire situation, so many drugs and the effects so temporary. My experience of analgesia was it never even came close to alleviating the pain. I was never believed enough to get to hospital, and I never tried gabapentin! Scary sounding drug.

Health professionals struggled when presented with symptoms that did not respond to treatment. Sometimes this was expressed as a lack of concern, irritation, and frustration, which put a strain on the therapeutic relationship.

Marianne: ... my husband had to call the GP to the house, and he tried to examine me, but I couldn't move the way he wanted me to ... He was almost annoyed ...

Melania: They (medical professionals) don't have answers ... It was just frustrating. It felt like I was pushing ... for blood tests and MRI scans ... and they don't want to do them ... but in the end you just wear them down ... They'd say your backs gone into spasm; take anti-inflammatories, and it will settle down ... we can't do anything for people like you, they were probably thinking 'oh god here comes Melania again ... What am I going to say to her this time?' Remember reaching a stage where I felt too unwelcome and embarrassed to visit my GP.

Chronic pain is invisible to those around the sufferer and without a medical diagnosis the sufferer feels fraudulent despite being physically incapacitated. This steadily erodes self-esteem.

Melania: Even my really close friends had no idea the impact it had on my life ... couldn't change the sheets, couldn't Hoover, couldn't carry the washing up the stairs, I just felt completely

useless. Pain is so poorly understood that even benign expressions of interest from others is stressful as sufferers are often asked to explain the very thing they understand least.

Melania: **People would ask 'well what's wrong?' ... You feel like a fraud because if there was anything wrong they'd find it, so you start to wonder if your friends or family think you're making it up for attention ... It's frustrating you can't say "I've got a ruptured disc" ... At work I got a disabled disc ... It would be reviewed every few months and they'd ask 'do you still need this badge. Sorry, what's exactly wrong with you, can you just explain it to me' ... it was so depressing because I couldn't, and I thought they thought 'she's making it up because she wants a disabled badge so she can park right outside the door of the building ...'.** Could hear the sadness in Melania's tone. I was having vivid images relating to her situation as she was describing it and was thinking how unpleasant it is to suffer and feel fraudulent at the same time. I never experienced this as much as Melania because I only told health professionals about my pain.

I keep reminding myself that Melania's interview was conducted over Skype. I felt and still feel as connected to her as to the face-to-face participants. Doesn't feel like I did a Skype interview.

The long succession of failed clinical encounters spanning many years precipitated a cure. Years of unsuccessful treatments led clinicians to suspect the involvement of non-physical factors in pain. A lack of detailed understanding led to psychological factors being communicated in a way that felt insulting or unclear. Doctors and patients were also reluctant to pursue psychological factors in case a *real* physical cause was neglected and led to damage. Columbine's mother was a physiotherapist ... **she works a lot using mind-body work but she wasn't ... sure that was happening with me ... She felt stress was exacerbating things but ... something mechanical was causing it.**

Non-physical factors in pain are poorly understood making them difficult to convey to patients. Sometimes doctors unintentionally mentioned them like when Marianne was being discharged from hospital: ... (the doctor) said I don't think there's anything structurally wrong; you just need to go home and relax your muscles. This led Marianne to Google 'tense muscles' when she got home, which was the beginning of her recovery process.

Patients and doctors both required a long history of consistently disappointing medical/PSB interventions before they could re-evaluate how they saw pain. Alexia talked about the years of disappointment and pain that were necessary to abandon PBS/medical perspectives ... At first I totally bought into the physical explanation ... but it seemed that my range of activities were getting narrower, and the perception of my back was more and more delicate. The chiropractor always made me feel bad about my back ... she felt ... if only I'd come to her in my 20's, and here I was in my 50's ... that never felt good to always be told that you're back is really damaged and it's too bad getting to it so late. Alexia's prior medical encounters felt warm but it was this negative interaction that led to her rejecting the medical model and recovering.

I will now step back from the pain in adulthood to explore participants' experiences growing up and their relevance to pain.

Embodiment in childhood. This theme is investigated based on a number of subthemes related to pain in childhood with a summary list of those subthemes as shown below. This is followed by comments made by participants regarding problems they experienced related to their bodies and body image beginning in childhood.

Summary. Seven themes arose regarding embodiment of pain in childhood. These included:

- Recovery from pain was connected to remembering forgotten childhood traumas and unhappiness.
- Chronic pain in adulthood could mirror undigested trauma from childhood.
- The phenomenology of bodily experience mirrors the environment.
- Caregivers during childhood were often described as hostile, disinterested, or overwhelmed.
- The overwhelmed parent led to a corresponding caretaker/people-pleasing role for the child.
- Pain in childhood was less physically debilitating than in adulthood and was ‘mood-like’. Private and unspoken emotions were expressed through achy body sensations that felt psychologically overwhelming and sad.
- Embodiment was problematic in childhood for reasons other than pain, such as body shape and size, facial features, and skin colour. Like pain, these factors made the body stand out painfully.

Participants comments regarding childhood embodiment of pain. Comments regarding a link between childhood events and the experience of pain in adulthood are presented, not consistently presented as listed in the seven themes above, but rather the themes were found interspersed among various topics, and the presentation of results is based on representative comments from participants.

Remembering childhood during recovery. Childhood experiences emerged as a significant area for pain and recovery. Prior to recovery, participants viewed their childhood as happy or non-eventful, but during recovery they recognised they had grown up in an atmosphere of pervasive hostility, coldness, or feeling unloved. Evelyn: *A few years ago ... it would never have occurred to me that my childhood was not happy.* Marianne realised what she accepted as normal growing up was on reflection, *“mmm, slightly weird.”*

Frozen, dissociated, or disavowed memories thawed out, were remembered, and owned during recovery, which participants concluded were relevant to their recovery.

How could they think everything was lovely at home and then go on to remember a childhood full of traumas? I was expecting to hear about childhood difficulties in participants' accounts because during my personal exploration my felt sense of pain resonated with difficult childhood events. Whilst I never connected childhood events with adult pain prior to this research, the view of my childhood did not differ that much before and after pain. This must be because of my psychology training and personal therapy.

Prominent features of participants' childhoods included hostility and alienation from parents, caregivers, schoolmates, and self-directed hostility. Alienation from others was common in participant accounts, and this was mediated through embodied characteristics like size, weight, skin colour, elocution, or facial features.

The overwhelmed parent was a common figure in participants' accounts, and parental need elicited a helping response from the child. In the absence of parental hostility or any role reversing behaviour, some parents provided basic care but found it difficult to show love or affection. Melania: ... mum did a lot for us ... She found it hard to show her love ... She showed (her love by) being generous with her time and material objects, but if you tried to connect with her emotionally, she wouldn't know how to ... That sounds vague. Is holding back? She doesn't want to talk about this fully. I'm aware her mother recently passed away.

Marianne: ... she (her mother) wasn't particularly demonstrative or empathetic ... and I came along as a surprise child, and they regularly told me they were so happy to have me. but I don't think there was much accommodation for the fact that I was a child ... Marianne's mother sounds so vacant/absent.

Evelyn: I used to come into their bed in the middle of the night for years and years, and my mum used to say, "Ooh, Evelyn always knew never to come to my side always went to her dad." She would say Evelyn would know never to come to me. She knows she wouldn't get any comfort there or affection there. Although Evelyn was hardworking and did well at school her achievements were rarely encouraged or validated. I remember once doing a painting for a competition and bringing it to mum, and she said, "Oh, that won't win any prizes." This feels sad. I'm sensing a child who was never really loved yet managed to have a successful career and family. The power of human spirit. I feel touched. I can tell she is not finding it easy to talk about herself. I'd better do something good with the data to make this worthwhile for her.

Marianne's childhood was marked by a surprising level of disinterest from her parents. When she was 16, her parents agreed she could move back to London after her parents decided to relocate to Saudi Arabia. Finding life difficult alone, Marianne asked if she could return to Saudi

Arabia with them when they next came to London, to which they happily agreed ... we went to the airport ... and my visa had expired so they jetted back to Saudi Arabia and left me at Heathrow airport. I was terrified. That evening Marianne indirectly connected with her disavowed feelings of being neglected by her parents. I had this vivid dream that night. We'd flown out and it was only me and my mum and the plane crashed. I was holding her up, but I couldn't hold her up any longer; so I let her go and I could see her going down and down and down and down like never ending seeing her face going down in water. I remember waking up thinking, "there she is going away, going away, going away. There is she is flying off". It was really horrible because I could see her drowning. Really sad. I think I woke up crying. She wasn't thrashing around. She was just floating and getting smaller and smaller and smaller but really clear. Marianne was vulnerable and alone, oblivious to the fact that she was homeless, and her parents were in Saudi Arabia equally oblivious. I was in in London with all my possessions in one suitcase wondering where I was going to sleep that night ... I never thought of myself as homeless until years later ... Such an unusual experience, and I can't imagine it properly. The level of disinterest is unbelievable. I'm getting images of empty space, vacuum. I'm thinking ADHD.

From the outside, Alexia's childhood felt warm and loving, yet her internal world was full of sadness. The frequent moves at her mother's behest made her anxious and she experienced bodily symptoms. Alexia was unhappy at school and found it hard to be separated from her parents. We moved a lot ... until ... age 5 or 6 ... I didn't like school ... I remember wanting to stay home and be with my mum, and I still have a memory of my parents coming to the school ... and ... watching them from the classroom window as they left ... being so sad because I ... didn't want to be left in this school ... So I used to I complain about tummy aches

and not want to go to school and say I didn't feel well. That internal darkness and sadness of Alexia's childhood matches mine. I could visualise the colour black and a heaviness as she was talking. She sounds so vibrant when she speaks, hard to believe things were so different then.

Graham took on a parental role. He listened to his mother, looked after her when she had back pain, and withstood the worst of her fierce outbursts: ... At home, it wasn't good ... my mother is bringing up three very boisterous boys on a council estate, and I'm not getting on with my siblings ... and mum was doing her best to cope. Mum used to talk to me like an adult, and I used to listen like an adult; but I'm a child so I didn't really get it ... mum ... could be explosive, unstable. That would scare me. ... My mum was washing up, facing the wall ... She's crying, saying please leave me alone, and before you know it, a plate goes flying across the room like a Frisbee and smashed just above my head ... The world was unstable, violent, unsecure, unsafe, unsupported. The fighting with siblings sounds like my childhood. I felt sad and protective over Graham as he spoke. He was in such a precarious position as a child.

Chronic pain in adulthood could mirror undigested trauma from childhood. In adulthood, Graham become aware of his childhood difficulties and the impact they had on him. Doing so led to a cure to his back pain: Re-reading the stuff I wrote (journals written during his most difficult episodes of pain) cut deep to my emotional level. I don't know why or how but it just did, but that's what cured me and convinced me there is a link between (pain and) emotions you've got to address ... During the recovery ... all sorts of things came up, my dog, being bullied at school, parent's divorce ... I moved around a lot as a child ... I'd never be angry with people, more self-sabotage ... suppressing through cannabis, partying, drinking from a young age ...

Growing up, Columbine was exposed to criticism and pressure to achieve. Her mother's unpredictable mood swings betrayed the calm veneer under which lay seething passive aggressive rages and resentment. Moments of closeness and warmth between them would be swiftly severed by a blast of cold, silent treatment. Columbine: **Over-responsibility for the emotions of my mum. The instability, the ups and downs, one minute being hyper, fun and the next minute something's gone wrong and the cold silent treatment. It was very unstable and unpredictable. It's weird, it's all hidden quite well ... it would be clear that she was absolutely raging mad inside though there was never much on the outside. It's ... a silent violence. I don't think I realised it ... I idolised my mum ... and the pain of later in life of realising ... shocked at the psychological violence and instability. Her mother's behaviour reminded me of my mother, but the intensity of her situation and Graham's feels greater than mine, which I was surprised at. They all look OK now but things were so bad. Didn't expect that.**

Her grandmother, who lived with them, was equally unsatisfactory as a caregiver and Columbine's role in this triad was to appease them through being a good child. ... **She (grandmother) is a very emotionally manipulative ... abusive woman ... The triad of grandma, mum and me ... I was ... appeasing it ... if I'm funny or ... achieving or distraction from their massive tensions ... I had those feelings, wanting them both to be happy, which was an impossibility to be honest.**

Prior to recovery Columbine's childhood was repressed and crowned with the imago of an idealised mother. The re-emergence of these difficult memories into conscious awareness was part of her recovery process.

Her grandmother was the person she was meeting just minutes after the onset of pain. I assumed her grandmother was a sweet old lady until now. I wonder if she expected to be talking about her mother and grandmother?

As a small child, J was powerless against a sadistic and calculating mother ... **She would ... do this weird stuff ... I'd ask if I could do something, and she'd always say no, or she'd say yes, but make me jump through loads of hoops first ... and then when I'd done everything she asked she'd just snatch the thing away from me in front of me ... she was being totally vindictive. She would watch me wanting something and promise I could have something ... but only after I've done a hundred things first ... and once I'd done everything she'd asked for she'd take great pleasure in taking it away from me again ... when it was just in front of me ... She was just being a bitch ...** This is horrible! Why go to such efforts to be nasty? This is a calculated nasty. I bet his pain is a mirror image of his mother.

Problematic embodiment in childhood. In childhood, the body was inseparable from the environment; what was happening in one was reflected in the other. Participants reported that embodiment was enormously problematic through things like having the wrong body shape, size, facial features, accent, and skin colour in a childhood marred by alienation and isolation. As a result, the body became a source of alienation by standing out visibly, shoved into the foreground of an agonising self-consciousness, as shown in how the body stands out in awareness when in pain. Alexia referenced to being self-conscious about her size. Her comment, **“I was very painfully aware of my physical self,”** suggests a connection between pain and discrimination against the body. Can't believe Alexia accidentally made that connection. She was surprised too. Feel a bit self-conscious interviewing her, she's a psychologist more experienced than I. I feel my questions are really clumsy. She's very kind though.

Participants commonly felt unacceptable and discriminated against due to some aspect of embodiment. This was suffered secretly and in isolation without support from parents or other adults. Graham said, ... names that hurt me were *big nose* ... They're sort of your mates, but they'd say nasty stuff and play fighting so it's an overlap of boundaries that I couldn't untangle, but it didn't feel right but I accepted stuff like that. I went to several ... schools and presented a different self at each school. In one school, I felt racism because I was the only white person. I remember walking in the playground pretending I was doing something when ... I had no one to talk to and no friends. In another school, I became a comedian ... in another school, I was naughty; it got me accepted. If I was one of the bad lads, then I wasn't being bullied ... It has only been in recent years I can admit I was bullied. Sounds excruciating, feel humbled listening to it. I wish I could help. I connected particularly with the name calling regarding his facial features. Feeling gratitude at Graham's generosity in sharing all this.

Alexia: ... in fifth grade ... some boys came up to my waist, and I was wearing a bra already, and I felt so uncomfortable in my body. I felt clunky, unattractive, and big ... I got teased sometimes. I was never athletic ... I remember playing volleyball, hoping the ball wouldn't come to me, not wanting to take the risk of trying to hit it ... Transported me back to the football pitch at school and always being the last person to be picked for a team. The material is so rich and evocative.

Columbine suffered from eating disorders after her parents separated when she was 4. A disturbing memory illustrates the self-hatred of her body; I remember as a young child really hating my body, like really hating it ... Maybe 8 or 9. There's a particular image I have standing in front of the mirror and hitting myself, really angry, hating myself and hitting myself... Having

this image of her standing in front of a mirror in a dull room hitting herself on the head with an object. Intense.

J's body stood out, and being the only mixed race child, he was subjected to racism at school. His body also stood out through his talent for sports. In fact, it was whilst doing sports, years later, that triggered the onset on adult back pain ... I was good at sports ... but I felt uncomfortable ... I was the only mixed race kid at school ... I really stood out there ... When I was old enough to start dating girls, I knew I couldn't ask some girls out because I was mixed race, and it wasn't the thing to do ... I was bullied a bit at one point ... being called a monkey ... I felt an outsider, an outcast. Like I didn't belong ... separate from everyone else. Like there was something wrong with me, something bad about me. The monkey comment is disturbing. Getting a jarring sense of how nasty racism is. Feel humbled he is sharing with me. I was visualising myself as J as a child standing in the playground.

J was attacked from all angles. In addition to the bigotry from the outside, his inner world was filled with deathly hypochondriacally based anxieties. He was fearful of illness and in phantasy, his body was at the mercy of cruel biological calamities ... I was terrified. I thought I was going to die if I had a cold. J's mother was dismissive of his anxieties leaving him with the intense storms of his inner world ... I would tell my mum, and she'd say 'Aaaah don't be silly'. Totally dismissive. J compared the hypochondria and the bigotry saying: ... There was a lot of loneliness with both experiences ... I was the only person in the whole school that was mixed race ... and the hypochondria felt lonely ... I was alone with it, totally alone. What does this all mean?

Marianne felt different from other children because of her weight and her accent. I never really felt like I fitted in. I ... was ... picked on ... I didn't come from the area so my accent was

different. My mum and dad were probably a generation older than other people's parents ... I felt on edge all the time, ready for somebody to make a nasty comment. I was overweight ... also waiting for the next thing I would get wrong with teachers ... Constantly being wary of doing ... something that would draw attention leaving me exposed ... I was holding things in and not reacting to things that would give people the opportunity to make more of it ... Visualising her in a classroom but was my classroom at primary school. She looked disproportionately large and stood out. Could feel the atmosphere.

Bodily pain in childhood. Childhood pain was common for participants and was connected with the pain in adulthood via the subtleties of its hidden emotional expression. It was less severe than in adulthood and alluded to the emotional tone of the time: a chimera of physical and psychological states. The pains were often achy with a miserable or scary quality to them; a lament for the sad and scary situations that could not be expressed verbally. Alexia described her childhood aches as being lonely. And I'd say that's true with my back pain, too. A lot of anxiety but also a lot of feeling alone and alone in dealing with this and sadness too. Sounds like my childhood pain, which was very mood-like and hard to separate from what I was feeling.

In all cases, childhood pains were dismissed as 'growing pains' and not properly investigated. Marianne: I used to get knee pains when I was little, quite intense in the night, really painful, and I would be crying. They were described as growing pains.

Graham remembered an episode of frightening pain in his legs before another move and change of school ... I went down the stairs and I started crying ... I didn't know why I started crying apart from feeling scared, but there's nothing I could say I was scared of.

Columbine: the knees are a constant achy, like I feel sorry for myself to have those ...?.

Alexia: In high school I used to ... wake up with pain ... I had a pain in my leg and remember going to the doctor ... and they called it growing pains ... I'd be walking and feel muscle pain, like a pull or 'eekiness' ... I felt this really uncomfortable pain in my thigh and was really scared by it ... I felt alone.

Felt uncanny to hear the same experience described by different people in different ways. Really resonates with me.

Not all participants experienced bodily pain in childhood. J, Evelyn, and Melania had the opposite experience and were all highly accomplished in sports. How will this fit in with the research? Aren't we all supposed to have experienced childhood pain?

However, Melania's achievements in sports were drastically and suddenly curtailed through having major surgery for life threatening scoliosis that was developing at an alarming rate and threatened to crush her internal organs: I wasn't in pain at all as a child, I was athletic, did sprinting and county sports, I had two horses, did gymnastics and netball. I never had any problems. Until I (had surgery when) I was 17 and ... obviously with spinal fusion I couldn't do gymnastics anymore. The scoliosis, like her 10-year bout of adult chronic pain came unexpectedly, was unexplained, and the surgery carried a risk of putting her in a wheelchair. The curvature of my spine came on so quickly and so severe they said left untreated my internal organs would start to pack up. Within months ... I was completely hunched over ... they said they could put the Harrington rods in, do the spinal fusion and then take the rods out so I would just have a fused spine, but because the operation is so horrendous and painful, I could not bear the thought of them taking those rods out, so I didn't go for that option ... They said I could be dead by 35 if I don't have the surgery, and if I had it, I could be paralysed and end up in a wheelchair ... I was in denial; I didn't want to know what they were going to do. I shut it out and

tried not to think about it. Decades later, in an episode of a chronic pain, she was haunted by the steel rods coming loose, and on occasion, she had to use a wheelchair, which was an associated risk of the corrective surgery. Felt flabbergasted by this whole story and the possible interpretations. The idea of reliving old trauma by being in a wheelchair is so outside of anything that Melania has said. I'm going to stay with what she says.

The spiritual world and recovery from chronic pain. As in the previous themes, this final theme that resulted from this study is reflected by the summary, which lists 10 subthemes. These are followed by participants' comments that include data that reflects these subthemes.

Summary.

- Onset and recovery from pain shared many similarities; both were sudden and unexpected.
- Sheer desperation instigates a leap of faith out of the prevailing medical epistemology and into an impassioned personal search that forms the backbone of recovery.
- Personal research, usually reading, formed the start of recovery.
- Recovery involved an extensive reformulation of how participants viewed pain.
- Iatrogenic maintenance of pain through medical perspectives was observed.
- Recovery involved shifting attention from the body to what is happening outside the body.
- The inability to express anger was implicated in recovery.
- Recovery was characterised by a dramatic initial improvement followed by a second stage, which resolved the remaining pain and established confidence in the recovery.

- Instrumental to recovery was having others who understood the experience, including health professionals and peer support from others who had recovered.
- Recovery extended beyond the absence of pain into an experience of transcendence, self-discovery, and meaning.

Participants' comments regarding the spiritual world and recovery. The subthemes that were clarified from this study were uncovered by careful consideration of the data included in participants comments regarding their recovery from pain.

Onset of pain and recovery are similar. Pain and recovery occurred alongside major life events and were interwoven with the general situations of day to day life. The inextricability of body and world was observed from early childhood to recovery, where participants' somatic experience reflected their world and relationships with others.

Participants descriptions portrayed pain as an isolating experience and poorly understood by those around them. This also applied to recovery. Evelyn: *I think the hardest thing is that if somebody hasn't experienced it (recovery), I don't know how you can communicate it. I find it really hard with colleagues ... they just look at me as if I'm completely nuts.* Alexia: *... Pain is very isolating and a lot of this is working on stuff in your head and it's hard to work it through always in your head by yourself.*

Pain is a psychological issue. Fundamental to recovery was an epistemic manoeuvre away from medical models of pain, catalysed by the considerable succession of failed clinical encounters. Alexia changed how she viewed pain and consequently abandoned her extensive regime of remedial practices: *... it took a month maybe to get off all my pain meds, and I had my own home stim unit (electrical stimulation for pain) that I would do daily if not more ... and I*

had all these different back supports, and I just gradually got rid of all that stuff. Got rid of the orthotics in my sneakers. I planted a garden that summer for the first time in several summers ... I gradually resumed a lot of the activities that I love like yoga ... the more I resumed stuff and saw it wasn't triggering a horrible flare up, it reinforced I was on the right path, and I did a lot of reading, success stories ... 95% pain free, and I don't not do anything because of my back, I'm not careful in my movements, I don't use any of the props I had, I'm not taking any pain meds, and I don't have my heating pad, which used to be a permanent feature on my bed ... I do meditation now ... being much more aware of my stress, how I'm expressing my stress, what I do with my stress and trying not to let it create pain. Similar to my experience. So much of my time was taken up with pain. Researching it, treating it, doing endless things throughout the day to improve it, not make it worse. It was endless.

This ideological shift was not easy to make as Columbine demonstrated: It was big because I had a huge history of mechanical understanding, and this book turned that completely on its head, and for the first time hope started to rise in me.

Also, the suggestion of pain being anything other than a somatic event felt alien and insulting to sufferers. Evelyn: If anybody had told me back then that I needed to sit and meditate or go to a yoga class, I probably would have slapped them ... I don't know back then whether I could have made the changes I'd made now. Melania: The GP said sometimes these things can be in the mind. I was saying the pain is not in my mind it's in my body. I'm not imagining it. I was a bit affronted, so I didn't do anything about it.

Ironically the 'insult' was a turning point as shortly after Melania stumbled upon a book about psychological factors in pain; it had an immediate and powerful effect. I was Googling "anular fissure" and somehow got reading and could not believe it ... All the people I'd spoken

to over the 10 years had no idea what I was talking about, but in that book, on every page I could relate to all those other patients ... I highlighted all the sections and was pointing to my husband saying that's me, that's me ... so I thought there must be something in this; it's worth a try and it just made sense. I also remember reading about people how recovered but didn't find this helpful. I just assumed their pain was different from mine.

The shift away from pain as a physiological event reveals a direct connection between psychology and pain. Melania: ... I'd find a direct correlation between what I'd been thinking and the pain. It felt unbelievable ... I could see it ... Pain changes from an indicator of physical dysfunction to having important functions such as distracting sufferers from difficult emotions and signalling areas in life that need attention. I would walk around work mantra-ing, "I'm healthy; stop trying to protect me from whatever you're trying to protect me from; stop trying to distract me ... I don't need you anymore, go away" ... you say ok I'm in pain ... let's switch from pain to emotional things ... work, family, kids, parents, husband, and money, health, and you go through these things and go, "Ohhh yeah, that will be what it is ... Resonates with my experience. I remember going through lists of things that were going on. Felt unusual hearing experiences like mine yet expressed so uniquely.

Pain becomes less terrifying, and its nonsensical nature becomes noticeable; it seems randomly appearing, disappearing, lessening, and changing anatomical location whilst remaining unmodified by remedial interventions. The haphazard presentation was a clue on the way to recovery.

Graham: I didn't experience the intense back pain but ... it was a 3 (out of 10) and sometimes it would flit to five and bearing in mind I'm doing exercises/physiotherapy ...

Alexia: I went to this last physiatrist ... and he said you're a perfect example of someone who is a good weight, exercises, does everything right, and you're still coming with back pain and we have no answers for you. My pain moved around, would change sides sometimes. I was in really good shape on the outside too.

The suddenness of recovery. Unlike acute pain, the onset of chronic pain for participants occurred in the absence of clear biological or physical insult, and along parallel lines, participants recovered in the absence of medical intervention.

Onset and recovery were sudden and sprang from unspectacular day-to-day activities that would not be expected to elicit either. They occurred in a binary fashion as participants jumped from one type of bodily experience (pain – no pain, no pain – pain) into another.

Recovery occurred in two phases. The first was marked by a dramatic and sudden improvement that left some residual pain, but more significantly, it left a fear that the pain might return. Graham's first phase of recovery occurred after all medical interventions had been exhausted and came from an unexpected place. Graham: ... I started to explore new solutions ... I had to travel 30 miles (to see a spiritual healer) ... which, at the time is a massive journey. I gritted my teeth. Throughout this process, I saw a dentist because I ground my teeth. It was jaw-clenching pain. Years of intractable, jaw clenching pain dissolved in under one hour. Despite this huge relief, Graham began to feel uncomfortable about his reliance on regular treatments and wanted to take control of his health. Graham was a recipient of specialist interventions from both the healer (although successful in treating Graham's pain) and medical practitioners, and Graham felt these had little impact on his understanding of bodily experience.

Graham's second phase of recovery was also unexpected and began when he found a 'little e-book' that linked emotions and difficult childhood experiences with pain. Despite

believing he had no traumatic experiences as a child or adult, Graham continued reading the book and decided to read a personal journal he kept during his episode of severe pain. The result was an emotional catharsis, which released him fully from pain. I dug it out (the personal journal) and read the first two pages and broke down in tears. (He had written about)...what it was like in that period, describing how intense the pain was, I felt scared ...

After the first phase of recovery, the fear of pain returning makes former medically advised remedial pain strategies difficult to abandon, despite their ineffectiveness. Melania: Me and my husband were going for a walk and ... my back started [to] twinge, and my husband ... said he thought it was happening because I was frightened that if we went a long way I won't be able to get back. He was right because it's happened in the past, and also I had a support belt ... and I decided not to wear it because it's a crutch, so I was thinking subconsciously, "Oh my god, you've left that belt at home." Confronting the pain was key and by continuing to walk and using positive affirmations the once relentless sadistic and uncompromising pain just dissolved, and finally there were no more sharp twisting knives and broken metal rods in her spine ... so I kept going, one foot in front of the other, kept saying all this positive stuff about myself, and within 300 yards the pain had subsided. I lived with the fear [of damaging myself/making it worse] all the time ... "Don't be afraid, loads of people have disc degeneration, and they're walking around with no pain whatsoever" [is what] I'd say to myself. That was a massive turning point; I can actually control this with how I'm thinking.

Melania experienced this turning point using a non-medical perspective but needed confirmation and reassurance from a doctor that she was on the right track. I wanted to know from someone in the medical profession if I had [psychosomatic pain] ... he [the doctor] said to me "Melania you've got [it]" and I just broke down with relief because there is something I can

do, the first time in 10 years I had hope I could get better ... up to that point, I just didn't think there was any hope for me.

Columbine's recovery also started when she came across a book: ... **It was the first book to talk about how some triggers for back pain may not be physical. I started doing things out of his book, which I read in 2 days. I couldn't stop reading it.**

The book led to a dramatic decrease in pain, but the fear that her back was weak and damaged was difficult to shift. Columbine consulted a physiotherapist who was the first person to unequivocally reassure her that she will recover and that there was no underlying structural damage.

Hearing this from a healthcare professional inspired confidence, perhaps because concepts like *weak backs* and *underlying structural* damage originate from medical discourse, which can, therefore, also neutralise it.

Columbine abandoned all physical interventions and replaced them with things like journaling, reassuring self-talk, and mindfulness. The nagging fears that the pain could return faded, as she witnessed the continuing improvement. **It was important for me to have (the physiotherapist) face-to-face ... whenever I had fears and doubts ... Seeing ... those changes and direct results of how an emotional situation would make my body feel, those gradual experiences really helped me, but having somebody that really understands and helps you ... that process and making those links for my recovery was essential.**

The fear of pain returning and the heightened vigilance of body sensations. Alexia: **I haven't had any bad flare ups in close to 2 years, but I do get twinges from time to time, sometimes in the morning, there's a bit of stiffness and I'm aware of my back ...** Alexia was unsure if she had recovered, as it wasn't clear which body sensations were part of day-to-day

living and which belonged to pain. ... my husband and I took a really long bike ride and ... My husband got off the bike and was holding his back and said ""That's me for the day; I'm not moving"" and I was [amazed] because if I'd said that, I would think it's because my back isn't doing what it's supposed to do? [I would wonder if there is] some anger there, or some underlying stress that I should be thinking about, and his reaction was so normalising. and I was like ok, maybe I am supposed to feel that way, hahaha.

Marianne's recovery started when a hospital doctor casually remarked she had tense muscles and should go home and relax. This led to researching the words, *tense muscles*, online and stumbled across case studies from people who had recovered from pain like hers ... a big bit of my mind thought this wouldn't be right, but I'd give anything a go. It just seemed to be too good to be true to read about people who felt like me and had ridden from John O'Groats to Lands End on a bike. Marianne attended support groups where she met people who had recovered from chronic pain. Just the grim prognosis from her GP had a negative impact on her symptoms; hearing others talk about their recovery had the opposite effect. Prior to the group, Marianne's hopes for recovery were low, but in the group, she believed she could recover ... The guy who'd done the bike ride was there ... and other people were talking about their experience, and I think that was really helpful. That was the first time I thought you can feel like this and get completely better ... that 10-year period, my most optimistic thought was if I'm really careful with my back I'd just have a bit of grumbling pain ... so to hear people saying 'I went for a long bike ride' it's possible, even if it's not going to happen to me, it is a possibility. The speed of Marianne's recovery was astonishing and started whilst sitting in the group: And I realised that I had sat for quite a long time listening and hadn't been in pain.

I recalled sitting in college and suddenly noticing that my legs were not in agony. My *flashback* merged with the images of Marianne sitting and then realising she wasn't in pain. It's odd the way pain just disappears.

The first step to recovery was reaching a diabolical state of rock bottom. When Columbine gave birth, the realisation that she would be physically incapable of caring for her baby triggered a burst of energy to find a solution. **I started searching online a lot. I had to do something; I just couldn't see myself like this anymore, becoming a mum. I was creating images of not being able to lift my son or look after him.** Sounds heroic, courageous. This last big effort to recover.

Confronting intense pain was Evelyn's forte; travelling by bicycle because walking was physically impossible was a testament to this. Pain wasn't enough for Evelyn to reach rock bottom but the addition of anxiety symptoms that came from nowhere suddenly made her life unbearable. Evelyn never saw her pain as catastrophic, but she started having intrusive thoughts which included beloved family members being killed in accidents. As with the pain, Evelyn found a physical explanation and blamed the menopause, until, for the first-time, Evelyn connected her symptoms with what was happening in her life. She realised the anxiety coincided with the time when her adopted daughter, Sally, was coming back home from boarding school. **She (Sally) was worse than ever ... She used to go out all night and disappear, get in trouble with the police... I never really thought about it until now but those years were awful. That's when the anxiety and rumination started ... it was always a catastrophe to the children or my husband and work. I mean, I hadn't done anything wrong, but I'd do something, and then all the way home I would go over it, and I would have to go back and check that I'd done it right.**

First time Evelyn was emotional in the interview. Feel sad and guilty. She didn't come here to tell me about her daughter, she came here to talk about how she recovered and how this could help others with chronic pain. I was awed at how courageous she was in revealing whatever she felt was important in her recovery.

A common feature of recovery was personal research into the experience that was private and did not involve health professionals.

Evelyn's recovery started after reading about psychological factors and pain. It enabled her to connect her coping strategies in life with what was happening in her body. Evelyn experienced a sudden improvement, but as with other participants, she was left with residual pain. Further progress came from attending a talk about personality types and pain ... **I remember ... listening to them talking about how the brain produces pain and the personality types and thinking, "Oh my god, that's me."** I never would have found talks or the experiences of others useful because if others recovered, then they must have been suffering from something different than me.

Many participants connected with repressed anger and resentment as part of recovery. The anger usually came from feeling unentitled to express their desires and needs and becoming 'useful extensions' for others. During recovery, Evelyn remembered her mother pressuring her to adopt her brother's daughter, Sally ... **I remember her saying to me "Oh well, she fits into your family doesn't she?" I remember saying to her she might fit into my family mum, but that's not what I wanted.** This was an extremely difficult undertaking, and although Evelyn did as her mother asked, she also felt undermined by her ... **I could never be a mother to her because there's this other mother (Evelyn's mother), so if I ever I said no ... she had this other mother to go to and give her sympathy and take her out ...** Couldn't relate to this at first. Didn't feel convinced

about repressed anger from doing things for others but all the participants are saying it. Dawned on me, however, that I was angry at not being able to be myself in terms of sexuality and how this was key to my pain and recovery.

Sally required a lot of attention and Evelyn's guilt over neglecting her own children coincided with a lengthy episode of severe hip pain. Exploring the role of psychology in pain was fundamental to Evelyn's recovery ... *all of those years I was always on the go. I never stopped from morning till night. Just perpetual motion ... I never had any time for myself, but I just thought I'm raising four children; I've got a job; I'm running a house.* Evelyn's formulation of back pain switched from feeling like pinched nerves, to not feeling allowed to rest from her endless responsibilities. Like Alexia, Evelyn focused on the needs of others without complaining or expressing anger. *I sort of saw the back pain and the not sitting as you ... can't possibly sit down until you actually lie down at the end of the day and go to sleep. (laughs) It is funny isn't it, really! (she cries).* So impressed she went from finding a physical explanation for everything to thinking like this. Felt difficult seeing her cry.

Part of Marianne's recovery was acknowledging her right to feel anger and resentment and connecting this to freedom and choice. This transformed previously denied emotions into something empowering. Through this she realised she had more freedom than she thought to make choices. *I probably had quite a lot of resentment because I'd started to care for my dad at that point ... resenting the fact I didn't have a choice ... and it felt like I was caring for him more than he'd done for me. I'm always thinking what the best thing is for his future, and that didn't happen to me ... A big part of the recovery ... was recognising I did feel angry and resentful, but that's OK. Before I was resenting stuff and thinking I shouldn't, he did his best for you. Also, realising I did have a choice and taking ownership of that... instead of being angry with him and*

the world thinking I have no choice. I did have another option even if the other option is pretty shitty'. Was surprised at this formulation, trying to work it out. Makes so much sense linking anger and resentment with the freedom to choose. Goes beyond just expressing it. Very existential...Sartre.

Alexia also connected pain with anger through reading: ... I was going through that journey with all those physical therapists ... It was intensifying, and I was having more episodes of back pain ... It was like a light bulb going off but I think the timing was right ... When I read that the pain is often a way of keeping us from recognising our underlying anger it was really powerful, intense reaction from me ... crying because it just so resonated for me ... I prided myself on the fact I never got angry, and now I see that as false pride. I recognise I get angry ... and that's a totally ... normal reaction to life, and it's ok ... It's like I had to be happy and joyous. Giving of my time without any resentment or anger and I didn't have any awareness that that could be there for me.

Recovery extended beyond the absence of pain into the realms transcendental experience. The long episodes of chronic pain and their eventual resolution were pivotal life events that led participants into greater self-awareness. Columbine described herself as ... more awakened and enlightened, enjoyable, grateful, a lot of awareness and insight into who I am ... and I don't think I'd had this insight into my emotions, my relationships without my pain experience and the journey that's taken me on, a journey of self-discovery. There is something genuinely powerful in Columbine's words, which makes me more aware of the effect recovery has had in this area of my life. I probably underplayed this, whereas Columbine didn't, which helps amplify my awareness of my experience.

Pain is a multi-dimensional and multi-functional phenomenon, intertwined throughout lived experience. It was only through recovery the functions of pain were revealed as it switched from the diabolical sadism described at the beginning of this chapter to something quite different.

Pain revealed and then transformed the deep, concrete-like patterns into authentic living. Marianne's recovery showed her she could make choices and was not a passive recipient of whatever life dished out. She could now take responsibility for her decisions and knew that she could exercise her freedom at any point ... *my recovery gave me a chance to ask if I actually want the alternative. Do I want a bloke completely different [from] Morris ... no I want him (laughs) so stop whinging about it ... also having a plan B. I might choose not to live with Morris.* Marianne could see caring for her father as an empowering choice in which she could take pride. *(Dad) lives with us, he needs 24/7 care. We couldn't find a care home that met my standards (laughs). We can do better and save some money.*

A key feature of chronic pain for participants in this study was its utter severity. This severity is necessary if it is to penetrate deep enough to hit deeply embedded behaviours and belief systems.

Because of his recovery, Graham said he feels: *Fantastic, physically and mentally. I'm the best I've ever been.* During recovery, Graham took a radically new direction by being the first person in his family to go to university where he pursued his childhood ambition to study psychology.

Such a massive step considering he needed to improve his basic literacy whilst on the degree. I did the same and went to train as a psychologist. I had always convinced myself that it would not be possible.

As much as pain wreaks havoc and turns living into mere existence, recovery turns existence into a meaningful life. Finishing university was a peak moment for Graham and led to a big career shift by working for the NHS. *I left university as proud as anything. I was the first person in my family to have a degree ... Then I did some volunteering in mental health and ... I applied for this job ... I love this job because I'm good at it. I've always been into fitness and psychology. I'm respected; people always ask my opinion, doctors, nurses. I feel valued and that's a big one. As a mechanic, I didn't feel valued.* During this work, Graham had his first major episode of back pain, and he believed it was the back pain that allowed him to get out of that job, literally taking him out in an ambulance. His pain reached a level that decimated everything, and in recovery, he rebuilt something that was meaningful to him ... *I felt really undervalued [as a mechanic] ... on some level I knew I wouldn't be doing that for ever, and it was my pain that took me out of that environment, I wouldn't have done it myself.*

Pain can act as a defence against knowing but recovery acts as a powerful vehicle for insight. Columbine; ... *different things are a defence for not knowing your feelings, not being able to know what you're feeling ... [recovery has been] a huge a mirror into myself and the fortune of having found the right people on my journey, which has had a positive impact on my body, and my pain, and how I see my body.*

Pain breaks through embedded patterns of behaviour that might otherwise repeat interminably.

Evelyn recovered from pain, but during some family difficulties her pain returned. She said, *"I had a traumatic few months with Sally and the pain came back."* This time, Evelyn connected the circumstances with her pain, and her pain was short lived. She accepted the relationship she had with her adopted daughter was not healthy, and decided they could not live

together again, which marked a profound shift from her previous pattern of accepting any situation and just getting on with it ... *She can't live at home again. I've written a letter to myself telling myself that ... I knew the pain was back because she was back living at home and I was just so irritated ... and I think it's my anger when she started raking up the past again.*

Interventions used during recovery. Participants presented information about the interventions that they used during their recovery period.

Evelyn: *I've started doing a lot of yoga, and I have acupuncture every few weeks; I have a massage every week. I only work half-days and instead of working at 10 minutes, I work at 15 ... I started meditation, chi gong, running ... complete change of life.*

Marianne: *I talked to myself as a 16-year-old ... to the part of me had gone through that experience of feeling lost and abandoned and homeless and acknowledging it wasn't nice ... I felt like a complete grown up; I didn't need them ... looking back, I'm thinking you were a baby, you needed someone to look after you. Looking at self-care was important, realising that life wasn't all about fulfilling responsibilities. [Previously] I was not doing things I enjoyed, which brought me pleasure. Part of [my recovery was] to force them into the schedule ... Even if things get done a bit *crappily*, at least it's not a picture of all responsibility ...*

Interventions that encouraged reflection, self-awareness and emotional release were commonly used. **Melania:** *... I did things like journaling, a big questionnaire that made me go back to my childhood, tapping, visualisation techniques, meditation ... writing letters to people you're never going to send ... I got loads out of my system ... I realised losing my job and losing my partner at the same time had probably kicked off the whole sorry affair ... I kept this dot diary so I'd put a green, orange or red dot for what sort of day I'd had, and over the 6 weeks, I can see that the greens were getting more ... so I had a way of measuring ... I think staying in*

the now [was most helpful]. Felt so impressed by Melania's vigorous approach to recovery and how she used so many different tools to help herself. She wants me to put these in the research to help others.

Consulting healthcare professionals who had recovered from chronic pain was validating and inspired confidence. Melania: He'd been through what I'd been through [healthcare professional], it's validation of your situation, and if someone else has got 100% better by meditating and confronting issues in their lives ... I can do it ... I felt 95% better after the program [10-week program about living in the 'Now']. I've done it three times. It's like a cleansing ... you think about things that have happened in the past ... it flushes emotions that are deeply buried. Reminded me of things I tried when I was in pain that ultimately ended up being a disappointment.

Communicating the involvement of non-physical factors in pain. Psychological involvement in pain is an intricate matter and centres on not equating *biological/physical* with being *real* and *psychological* with being in the *mind* or a euphemism for imagined and, therefore, not real. The ability to explain the intricate concepts involved in chronic pain requires a level of specialist knowledge, without which the message is miscommunicated or not heard.

Melania: Where the doctor had said it's all in your mind, that book is not written like that, all the pain is 100% real but it's been kicked off by a thought process. It explained it in a way I could understand, and I thought I've got nothing to lose because I've tried absolutely everything else and nothing has worked, so I tried positive thinking - there's nothing wrong with me; my back's 100% healthy; any pain is just due to triggers.

This study demonstrates the severity of chronic pain and how the involvement of psychological factors can appear to invalidate this. It is important that this is acknowledged and clearly articulated by health practitioners. Melania expressed this by saying, “It's my thought processes that's causing the pain, but the pain is the most painful pain you can imagine. I've had two children naturally, and it doesn't compare with the pain I had in my back.” Very well put. It's so important to clearly articulate this, and she said it better than I can.

The unexpected finding from this study, which indicated that all participants experienced some form of early childhood trauma, and for the majority of these people, this lay outside conscious awareness, provides a probable cause for participants not being able to recover from adult pain until the early childhood trauma began. This led participants to formulate a link between the forgotten trauma and pain.

Chapter 5: Discussion

This discussion is divided into 6 sections:

- Some methodological issues in heuristic research.
- The theoretical assumptions of medical and postural-structural-biomechanical (PSB) models and their impact on participants' symptoms.
- The subjectivity of pain in contrast with medical approaches.
- Pain in childhood and other difficulties of embodiment. The link between childhood trauma and adult pain is discussed.
- The conditions surrounding the onset of adult pain and the immediate recourse to medical/PSB treatment approaches.
- The key features of recovery and their clinical application in counselling psychology.

Some Methodological Issues in Heuristic Research

One significant issue regarding heuristic research concerns the use of participants. Moustakas (1990) included the use of participants, while Sela-Smith (2002a) did not. Sela-Smith's observation that the use of participants in heuristic research can be a defence against accessing personally painful phenomena led me to reflect on this in the present study.

On an absolute level, I could argue that participants were not needed as the data from my personal experience contained much of what ultimately emerged from the combined participant data, and this can be seen in part one of the results chapter which presents the results of my personal exploration. However, it is also clear by looking at the progression of the results that the two data sets were mutually enriching and revealed significant patterns and insights with a

clarity that would have been difficult to achieve otherwise. Much of what was intimated in Part one was clarified and expanded in Part two and vice versa. Polanyi (1967) expressed this as “knowing more than we can tell.”

To produce this research with comparable depth based solely on my own experience would require greater confidence in my abilities as a heuristic researcher and a far deeper exploration into my experience than I would have imagined.

Based on the final findings of this study it is difficult to overestimate the combined value of my personal experience and that of participants in this research.

Theoretical Assumptions of Medical and PSB Models and Their Impact on Participants’ Symptoms

Freudian concepts, such as the conversion hypothesis and relational phenomena that dominated the complex field of psychosomatic medicine (Freud, 1895/1962; Symington, 1986; Launer, 2005), have since been usurped by modern medicine. However, over 100 years later chronic pain remains problematic and largely untouched despite the exponential technological progress (Kleinman et al., 1988; Morris, 2003). The disappointing clinical outcomes (Brattberg et al., 2004; Eriksen, Sjøgren, Bruera, Ekholm, & Rasmussen, 2006; Zimmermann, 2002; Fricker, 2003) confirm chronic pain is multi-dimensional and not an exclusively medical issue (Fricker, 2003; Bullington, 2013; Raheim & Haland, 2006).

Results from the present cohort of participants showed that medical approaches had no positive impact on pain but instead prolonged and intensified suffering. The exacerbation of symptoms seemed to occur within an inadvertently disempowering process that focused on the symptoms but overlooked the person experiencing them.

Medical therapies illustrate a tendency to place pain outside the sufferers control and experience by basing it largely on physiological and postural-structural-biomechanical factors. Medical or manual therapies are, then, prescribed as corrective measures. Participants in this study used these therapies extensively with disappointing outcomes, supporting research that finds no reliable correlation between structural deviations and chronic pain (Boden et al., 1990; Borenstein et al., 2001; Date et al., 1996; Jensen et al., 1994; Johnson et al., 2001; Wiesel et al., 1984) and sees their correction as neither desirable nor possible (Lederman, 2011).

Medical formulations and diagnostic labels were readily accepted and reified by participants out of reverence for the expert, which triggered a cascade of *remedial pain behaviours* to rectify or manage the bodily deficits deemed responsible for pain. The pain behaviours, however, soon become exacerbating as they turned into time consuming rituals that disrupted normal daily living (Henriksson, 1995; Henriksson, Gundmark, Bengtsson, & Ek 1992; Schaefer, 1997).

Participants avoided formerly pleasurable and normal activities because they were told, “They are not good for your back”. I propose that this has the unfortunate side effect of confirming physical disability, a conclusion other researchers have made (Clarke, 2007; Hanscom, 2012; Sarno, 2006; Schubiner & Betzold, 2010).

The longer the remedial pain behaviours continued the more pain and disability became part of participants’ identity. Pain hung over participants like a *Damoclean sword* that threatened permanent spinal damage and never recovering. The effect of this threat is inestimable, and not surprisingly, the anxiety and the growing restriction of activities were often exacerbating and more distressing than the physical pain itself.

In Marianne's case a medical prognosis of permanent back pain led to a profoundly negative effects as pleasurable activities were abandoned and a sense of hopelessness ensued. Such prognoses are depressing and symptomatically exacerbating in equal measure. Physical movement became a source of dread for participants, and the constant self-vigilance drained interest out of the world and diverted it into the pain filled body, which moved from being a self-effacing vehicle of worldly engagement to being the focus of attention (Heidegger, 200; Leder, 1990; Sartre, 1956).

The unchallenged validity of dualistic medical models, that placed pain firmly in the body, lent a power and validity to formulations that might otherwise have appeared dubious. The results of this research strongly suggest that the way pain is formulated to patients plays a part in how pain is experienced; the formulation becomes the phenomenon.

This study also shows that pain does not reside solely in the somatic dimension as chronic pain is supported by its four horsemen, and exists in each dimension of existence. The *psychological* dimension of existence is dominated by *fear*; the fear of pain worsening or becoming permanent through not being careful enough and exacerbating some unknown severe abnormality in the body. The *physical* dimension is taken up with noxious *sensory* experience. In the *social* world, there is *isolation* through the cold hostility of others and the *spiritual* world is filled with *despair*, set against the belief that things will never improve and life will remain hopeless and devoid of any meaningful future.

As much as pain is a multi-dimensional phenomenon, so is recovery. Recovery was a process that involved many different layers of experience across multiple domains in participants' lives. One aspect of recovery for participants involved directing the flow of interest back into the world by resuming the activities that were abandoned and stopping all pain

management behaviours (Oldfield, 2014; Sarno, 2006). It is reasonable to speculate that remedial behaviours contributed to the construction of *a fragile self in danger of breaking* and unintentionally verified the structural deficiencies upon which medical formulations were based. The fragile self led to an escalation of pain that was driven by intense somatic vigilance and conditioned responses to body sensations (Madden et al., 2015).

All participants, and the doctors they consulted, reacted to pain by turning the body into an objective *it* that hurts and needs to be fixed (Leder, 1990); perhaps this objectification was influenced by the fact that the complexity of pain is not amenable to a 10-minute GP consultation, whereas a mechanical formulation can be.

Prognoses and diagnoses presented in convincing medical terminology had strong *nocebo effects* on participants and created the notion of a fragile spine that could collapse from normal activity. Although the alleged physical fragility foretelling imminent spinal disaster was central to this fear, participants and health professionals rarely reflected on anxiety or on what constitutes a *delicate back* and how everyday activities causes excruciating pain.

The discourse of health practitioners had a hidden power that was equal to the interventions they prescribed and was used largely unknowingly. It came from health professionals' aura of authority and expertise that meant even statements said in passing were internalized, gradually becoming reality. For example, two separate doctors casually articulated both statements below to Marianne:

Once you have an episode of back pain, you will always be in pain,

Versus

There's nothing wrong with your back, you have tight muscles, you just need to go home and relax your muscles.

The first statement came after the initial incident that triggered her back pain. Over time the terrible prophecy materialised, and what may have been an isolated incident persisted for years, becoming the most unbearable pain Marianne had ever experienced. Years later, a doctor casually made the second statement whilst discharging Marianne from hospital following a severe pain episode. This statement stayed with her long enough for her to get home and look up *tight muscles* on the Internet, which eventually led to her cure.

Patients reinforce the validity of negative prognoses by unwittingly searching for evidence to substantiate them. After Marianne was told she would always be in pain she automatically recalled lifting and carrying people during her career as a nurse many years before, and retrospectively determined that she always had *a bit of a bad back*.

By relying on physiological deficiency models, medicine risks concretising pain rather than understanding it. Medical formulations have a prophetic element to them and terms such as weak back, fragile back, or delicate back become reality and are confirmed by the prescribed remedial countermeasures. It makes sense, therefore, that participants' recovery involved the rejection of both the formulations and the remedial countermeasures.

The insidious displacement of former activities with remedial pain behaviours, in an atmosphere charged with anxiety gave rise to a *fragile self* tentatively perched on the crest of interminable and escalating pain. A cycle of diminishing worldly engagement and snowballing pain were the sequela of medical formulations and diagnoses for participants.

The quest for cure/diagnosis and the unquestioned validity of the medical model.

Chronic pain is alarming by nature, and it demands urgent attention and explanation (Leder, 1990). In agreement with Honkasalo (2001), this research caused me to conclude that having a medical diagnosis was paramount for participants who hoped it would explain and fix the problem. However, medicine often led to heightened anxiety and confusion for participants through disturbing prognoses and restrictive remedial measures, both of which were justified by the alarming nature of pain. The absence of diagnosis left participants fearful of being seen as frauds, which added more distress to an already intolerable situation.

This study confirmed how the difficulty in locating chronic pain anatomically (Honakasalo, 2001) and the poor correlation between structure and pain (Boden et al., 1990; Borenstein et al., 2001; Jensen et al., 1994; Johnson et al., 2001; Wiesel et al., 1984) meant many medical interventions were unhelpful, or in some cases, harmful. This study also confirmed that attempts to *medicalise* pain diminished personal narratives and meaning, which were fundamental to participants' recovery. The focus on impersonal variables subtly erases the person-in-pain, as participants were indirectly engaged with through some form of a machine or via a 10 minute GP consultation, in the hope that the pain could be objectified, excised or located anatomically.

Pharmacotherapy is complicated by tolerance and addiction (Borsook, 2011) and does not fulfil the key treatment goals of pain relief such as improved quality of life and improved functional capacity (Eriksen, et al., 2006). This study found that even on the occasions pain was successfully managed pharmacologically, anxiety and physical restriction increased due to a fear of causing serious damage whilst the pain was subdued. Fundamental to this was participants' construct of a fragile-self on the verge of collapse and permanent disability, which was naively

assumed as real and, therefore not adequately addressed throughout the years of frequent medical consultations. The powerful combination of drugs participants reported were required also supports this study's finding of relentless severity as a common feature of chronic pain and the high negative impact on quality of life in relation to other major illnesses (Sprangers et al., 2000).

Due to the ineffectiveness of medical interventions for chronic low back pain, participants eventually exhausted treatment options available via their GP, which led to years of consulting private health professionals at their own expense. The additional financial commitment added to the stress especially as some participants had become too incapacitated to work.

The literature shows the presentation of chronic pain is disproportionately high in primary care settings compared to other conditions (Kirmayer, 2004; Kroenke, 1992) and participants' own painful awareness of this and feeling like a nuisance, or a drain on medical resources, provided an impetus to seek private healthcare. Interestingly the NHS website (Nhs.uk, 2016) encourages patients to seek private treatment for chronic pain.

The clinical relationship. Reminiscent of Freud's chastisement of Breuer (as cited in Symington, 1986), health professionals usually overlooked the full impact of the therapeutic relationship. Participants consulted professionals in distress expecting a solution for their pain, only to be confronted with the shocking realisation that there was no solution and that their pain was somehow getting worse. Any initial improvements were short-lived which was confusing for both parties. Viewing doctors as omnipotent healers is counterproductive as it diminishes personal responsibility (Bullington, 2013; Honkasalo, 2001) and the search for one's own answers, both of which were elements of recovery in this study.

Participants reported that good therapeutic relationships, which they defined along the lines of connection, genuine care, and attention from the clinician, facilitated a positive, albeit transient outcome. After recovery, participants stated that positive clinical relationships had minimal impact on their pain symptoms if the practitioner viewed pain as primarily physiological.

Medicine, as an area of *not knowing* was neither comfortable for doctors (Malterud, 2000; Steihaug, 2005) nor for participants who wanted answers. The intricacy of using the clinical relationship therapeutically with complex presentations is not to be underestimated and takes psychological therapists many years of training. According to Launer (2005), Breuer's reluctance to manage the interpersonal complexities in the clinical setting is evident today when patients present with baffling symptoms that do not respond to interventions (Bullington 2013; Malterud, 2000; Steihaug, 2005). Indeed, participants reported that health professionals became irritated and frustrated when they could not understand their symptoms, leaving the patients feeling like unwelcome nuisances.

During their experience of chronic pain, participants amassed more private medical consultations than they had throughout the rest of their lives, and this was influenced by the desire to avoid being a *nuisance* or burden on statutory health resources.

The subjective nature of pain. As explained earlier, this study revealed pain does not reside solely in the somatic dimension as chronic pain also involves the *psychological*, the *social* and the *spiritual* dimension which are dominated by fear, isolation and despair. Because these aspects of pain are experiential, they cannot be limited by external, objective observation of researchers who might not have experienced what they are studying. Therefore, this research had to have been conducted by way of qualitative, subjective enquiry. During this research, I found

the exploration into subjectivity revealed more relevant and rich information regarding participants' recovery than did the previous explorations of the body which used hi-tech medical scans. This illustrates that the internal subjective realm is as valuable as the realms of the natural sciences, and in this instance, even more valuable (Sela-Smith, 2002).

However, describing pain beyond the parameters of anatomical location and sensation (sharp, dull or shooting' etc.) initially seemed like a foreign concept and counterintuitive for participants, which perhaps underlies their complacent acceptance of medical approaches. This suggests that phenomenological reflection was not part of participants' recovery from pain. However, whilst deliberate phenomenological reflection 'on demand' in the interviews felt foreign, recovery involved de-emphasising the somatic and exploring feeling states and other subjective phenomena over a period of time. In a research interview or clinical setting, exploration of the subjective realms can happen in a very short space of time, facilitated by the researcher/clinician and their appreciation of concepts such as bracketing (Husserl, 1970) and focussing (Gendlin, 1978). These strategies deliberately move from medical abstractions to the phenomenon as it appears in consciousness and its meaning for the sufferer. I speculate that the deliberate use of these techniques in research or in a clinical setting is the correlate of what occurred naturally during participants' recovery. This could be an effective therapeutic strategy for chronic pain, potentially mimicking some of the processes involved in recovery and one that counselling psychologists would be well placed to deliver.

How did participants describe their pain? In what resembles Husserl's (1970) *mathematisation* of human experience, there was a marked difference between the subjective descriptions of pain participants gave in the interviews and the medical formulations they had accepted over the years.

The potential of language to disconnect what is experienced from what is expressed (Sela-Smith, 2002; Wilberg, 2010) and the habit of health professionals to engage in *professional ventriloquism* (Carter, 2002) were apparent in this research, as participants used the same objective medical language as doctors, such as '*typical sciatica pain*' or '*it's a slipped disc*' to define their experience.

However, pain is such a common and universally experienced phenomenon that it may appear to not warrant any description beyond basic spatial and sensory parameters. In addition psychosomatic patients are thought to lack words for their emotions (McDougall, 1985; Sifneos, 1973). Based on these results, I suggest, rather than having a lack of words, participants seemed unfamiliar with verbalising their experiences, but once given the opportunity to do so, they could express themselves in extremely vivid and clear language.

De Aisenberg (2010) stated that a personally meaningful narrative could bridge the gap between the somatic and mental representation. During recovery participants found themselves engaged in a process of constructing a rich and detailed narrative around pain that had personal meaning and involved a re-evaluation of their childhood (discussed in a later section below).

McDougall's (1985) term, *the body is doing the talking* gives pain the function of expressing in body sensations what cannot be said in words and resonates with the pain participants described in childhood that felt mood-like and inextricably linked with the difficult situation of the time.

Bound up in the depths of somatic pain, both in childhood and adulthood were untenable situations filled with feelings and reactions that could only be communicated through the bodily symptoms participants experienced because their life situations did not allow them to express their feelings and reactions verbally. Body sensations are to the body what words are to the

mind, and sensations can be tuned into and transposed into language revealing rich narratives relating to a situation (Gendlin, 1978). The transposing of body sensations into words was clear in this research as each participant generated startling anthropomorphised accounts of pain by reflecting on how it felt physically. The pain they described was no longer sharp, dull or ‘typical sciatic pain’. Instead it was nerves likened to taut, burning hot guitar strings, sharp knives being twisted into joints and knuckles pressed hard into the spine. The pain was so intense and relentless that it took participants to the lowest point imaginable and made some of the most devastating human traumas such as death, losing a limb, or being confined to a wheelchair feel preferable. All participants readily accessed alarming accounts of pain in the interviews despite feeling unfamiliar with subjective description. The pain had gone from the impersonal to personal and intentional torture, and I speculate that the descriptions of pain were an allegory for participants’ overall experience of the world, both past and present and in particular early relationships.

Recovery reveals another side of pain, one that is positive and transformative, through the abolition of longstanding, sedimented patterns of living that had become almost entirely resistant to change. Relentless and severe pain is capable of breaking through such patterns, and this study confirms these characteristics were defining features of chronic pain; as one participant said, “It exceeds that of childbirth.”

Pain and the environment. The interdependence between the person and environment (Heidegger, 1962; Merleau-Ponty, 1968) is harshly revealed in pain. Just as the smooth engagement with the body is disrupted, participants experienced the physical landscape as obstructive, as normal day-to-day activities became impossible in world that is simultaneously vast and tiny. Pain turned short distances into vast and unmanageable terrains, whilst shrinking

the world down to a single room or single motionless position to which participants eventually became confined, as the only way they knew to escape pain. The single motionless position was counterproductive, as it provided temporary relief that soon had to be paid back as the pain inevitably seeped into the comfortable position and demanded a change of position leading to an intense burst of the pain the sufferer was originally trying to avoid.

Perhaps more disturbing than the pain itself is the fear of pain, which like a psychological strait jacket, restricts freedom and movement. It held participants hostage and unable to move. In a literal hostage situation, an enemy takes a person prisoner to force that person or others to do what the enemy wants. If the sufferer is a hostage to pain, then what is it that the pain wants? The present study suggests this question is important to recovery and needs to be answered. Participant accounts revealed pain as uncompromising and impervious to all therapeutic interventions. If there is a meaning and function to pain, then it will understandably remain resistant to medical treatment until this has been revealed and satisfied. Perhaps there are clues in the actual recovery.

The period after recovery is characterised by profound and positive life changes, which participants attributed to pain. Radical changes were a defining feature in recovery, and perhaps, these were the hostage demands of pain upon which recovery was contingent.

Childhood Experiences and Adult Pain. Childhood was an intensely difficult time for participants, characterised by physical pain, feelings of isolation, and family difficulties. Pain was saturated with a *mood-like* quality synonymous with the difficult situation of the time; a communication that was never converted into words and forgotten by adulthood. Rather than just disappearing however, it lay frozen until years later when it was thawed by a terrific peak of intensity that marked the end of a lengthy episode of chronic pain in adulthood. At this stage

childhood memories flooded out as recovery ensued, suggesting that a function of pain was to go back and process the past.

Childhood Pain as the Origin of Adult Pain

The unexpected finding from this study, which indicated that all participants experienced some form of early childhood trauma, and for the majority of these people, this lay outside conscious awareness, provides a probable cause for participants not being able to recover from adult pain until the recognition of childhood trauma began. This led participants to formulate a link between the forgotten trauma and pain.

Trauma is a broad term and takes many forms (Etherington, 2003; Meares, 2000). Participants reported growing up with hostile and punitive caregivers who demonstrated explosive and unpredictable moods, passive aggressive behaviour, disinterest, and neglect. The *overwhelmed parent* and the corresponding child *caretaker* (Winnicott, 1960) also appeared frequently in participant narratives.

Participants' experience of embodiment in childhood was complex and challenging, supporting the theory that childhood pain and concurrent psychological challenges might form the basis of adult pain (Brattberg, 2004; Ståhl et al., 2008;).

Participants often complained of physical symptoms, which were always dismissed by parents and doctors as *growing pains*. This is invalidating and confusing and could have contributed to a mistrust of personal bodily experience, thus, increasing susceptibility to medical discourse as discussed above.

The inseparability of inner phenomenology, body, and the world. Participants experienced the body in childhood through the *mood* of the sad, aching, bodily discomfort,

which mapped onto a corresponding world. In the Heideggerian (1962) sense of moods, this was the entrance into a corresponding world through the inseparability between internal phenomenology and the experience of body and world (van den Berg, 1972a).

This study drew important distinctions between adult and childhood pain. In adulthood pain was physically overpowering with terrifying symptoms, whereas childhood pain lacked this physical power but had an overwhelming psychological intensity housed within a pervasive mood of sadness and anxiety. In adulthood, the pain ground life to a halt; whilst in childhood, there was a grim effort to continue as normal in an aching body.

These differences could be related to childhood and adult pain having different functions. I suggest that in childhood, pain was a way of communicating distress beyond the child's capacity to express it verbally. The communication was expressive but sufficiently vague to keep the family alive as it prevented exposing and jeopardising an already tenuous family system. In fantasy, whilst this maintained the family, it also kept traumatising situations in a fossilised state until they were excavated after many years of severe pain in adulthood.

Many participants demonstrated caretaker behaviour in childhood, which persisted into adulthood, and during recovery participants connected this with their pain symptoms. McDougall's (1985) hypothesis of pain as being a defence against engulfment and merging with the other through the strongly felt bodily boundary seems apt, as it was only through the experience of pain that participants in adulthood could separate themselves from the overwhelming needs of others. Participants also operated under the unquestioned assumption that they were not entitled to express anger, supporting the theory that the pressure to be selfless generates rage and that chronic pain acts as a distraction to prevent its expression (Sarno, 1991). Feeling entitled to express anger was revelatory for participants and occurred as part of recovery.

Problematic embodiment and remembering childhood during recovery. As well as pain, participants reported other embodied factors such as height, weight, early pubertal development, sexuality, weight, skin colour, elocution, and facial features as a source of concern. These factors led to social marginalisation and rejection, as the *unacceptable body* was violently shoved into an overexposed foreground of shameful and agonising self-awareness. This is phenomenologically similar to how the body stands out in awareness when in pain (Leder, 1990) and suggests a connection between feelings of social alienation and illness (van den Berg, 1972a).

Alexia's reference to early onset of puberty: 'I was very painfully aware of my physical self' epitomised this. Participants felt the hatred of others directed at the unacceptable body, as well as a self-hatred of the body. This was agonisingly illustrated by Columbine who said that at the age of: maybe 8 or 9 ... [remembers] standing in front of the mirror and hitting myself, really angry, hating myself and hitting myself...

Hypochondriac-based anxieties were also levelled at the body, which added to the pain and social exclusion to create an environment of threat, insecurity and isolation.

In adulthood, these experiences were largely forgotten, but during recovery, the heavy veil of repression was pulled away and participants who previously regarded their childhoods as happy or non-eventful were presented with recollections in stark contrast to their previous narrative. Parents who were once idolised were now revealed in monstrous clarity. It never would have occurred to Evelyn that she had an unhappy childhood, and Marianne realised that what she accepted as normal when she was growing up was "mmm, slightly weird". During recovery Graham connected with losing his dog, being bullied at school, his parents' divorce, frequent moving and changing schools, and his mother's unpredictable outbursts that swung

from violent to tearful. This supports research connecting poor attachment with psychosomatic pain symptoms (McWilliams & Asmundson, 2007).

It is striking that glaring failures in care, came into awareness only when the chronic pain escalated to unbearable levels, which marked the start of recovery. The *mysterious leap into the somatic* remains unanswered but participants were convinced that remembering their childhood experiences was relevant to recovery. The compelling participant narratives help us to understand why the commonly prescribed medical interventions slavishly adhered to for so many years were ineffective.

Chronic pain demanded a reappraisal of childhood and an explicit acknowledgment of the difficulties that took place there. If glaring childhood deficits were replaced with glaring pain in adulthood, then perhaps the loving and soothing acknowledgement of the past can soothe the pain in the present. Stolorow (2007) proposed that difficulties between infant and caregiver disrupt the process where bodily and emotional experiences can be verbally articulated. Instead emotional experience is condemned to a *diffuse, inchoate and largely bodily existence*.

Maudlesey's (1835-1918) quote "The sorrow that finds no vent in tears, makes organs weep" is an apt expression for adult pain as a bodily re-enactment of childhood trauma.

Onset of Adult Pain

Prior to the onset of pain, the world generally took on a less challenging and hostile character for participants than it had in childhood. Compared to the storms of growing up, life was perhaps relatively uneventful - until the onset of adult pain.

The pattern of onset and the attribution of pain to physical causes. Years of chronic pain occurred without any warning or obvious cause such as an accident or injury. In many

cases, the pain appeared amidst unremarkable daily activities such as walking back from the sandwich shop or stepping off the bus and was utterly incapacitating and shocking.

Participants automatically began searching for physical causes without even imagining that other lines of investigation might exist. The immediate recourse into physical explanations meant that medical approaches were participants' treatment of choice. This course of action was exacerbating and its underlying ideology accords with the pervasive Cartesian split between mind and body that is dominant in the consciousness of the Western world and empirical medicine (Leder, 1990). According to Leder (1990), the Cartesian view is prevailing because of the way the body in pain suddenly appears as alien and separate from the self; an 'it' that hurts. Pain becomes something that must be treated and belongs to the body, separate from the mind. This epistemology was implicated with the poor clinical outcomes in pain treatment seen in this study, and yet, it was so ingrained it required many years of suffering and disappointment before participants could detach from it.

Participants exclusively attributed the pain to a myriad of potential physical causes, despite experiencing major life events such as bereavement, adoption, emigration, and relationship breakdowns at the time of onset, which have been shown to strongly correlate with chronic pain (Leader & Corfield, 2008). These were all, without exception, overlooked and demonstrate how counterintuitive non-physical factors are to someone in pain.

Evelyn attributed her severe back pain to wearing high heeled shoes and standing for long hours, but at the time of onset, she had moved half way around the world to work in a stressful hospital job, and on the way back had to unexpectedly adopt her niece under duress. Similarly, I failed an important academic course, which put me in considerable financial hardship, and experienced some troubling family and interpersonal issues, but I attributed the pain to hanging

off a door frame 2 weeks prior to my first episode. In both cases a fruitless 10-year search for a physical explanation and cure followed.

Non-physical causes seemed highly counterintuitive and questionable yet, paradoxically, were the key to recovery from pain. The hegemony of the medical model of pain coupled with a natural distrust of the subjective (Kirmayer, 2004) were contributory factors in the long-term suffering before participants could envisage alternative approaches.

Melania attributed years of pain to major surgery she had as a teenager to correct a scoliosis. Whilst this seems a plausible explanation, she had been pain free for almost 20 years post-surgery. Like Mr Goddard, who I mentioned in the introduction to this dissertation, Melania attributed her pain to old injuries that had since healed. An alternative hypothesis is that the first incident of pain in adulthood that marked the start of her lengthy episode might have remained an isolated event had she not attributed it to the surgery she had years before. The psychologically traumatising surgery and the introjected belief from medical authorities and her parents that her back was weak eroded the bodily confidence she had as a young sportswoman and replaced it with an ever present fear of damaging her fragile spine. This thought coupled with careful behaviour to avoid this happening, created years of pain. Below the radar, phrases like “Melania’s got a bad back” materialised into reality and took precedence over her actual experience of her body.

Her heightened vigilance meant that when she was walking back from the sandwich shop and suddenly experienced some strange and painful twinges, her mind was flooded with images of the metal rods inserted into her spine as a teenager, snapping and doing major damage; images which match her descriptions of sharp knives being inserted and twisted in her body when she described her pain in adulthood.

Melania's surgery as a teenager came with a risk of spending the rest of her life in a wheelchair, but there was minimal intervention after surgery to deal with the psychological trauma, so the whole experience was pushed away and forgotten. Years later, however, when the chronic pain was at its height, Melania would be forced to use an office chair as a wheelchair to do household chores. Melania also stated that during one point of her experience she would have preferred to have been diagnosed with a serious condition and be in a wheelchair for the rest of her life than not know the cause of her pain. This demonstrates the dire need sufferers of chronic have for a diagnosis, and participants often expressed that amputations and major illness would be preferable to the pain.

Also, around the time of onset, Melania was overcoming significantly challenging life events, but as with all participants, these events were never considered as contenders for causing pain. Melania's account shows that chronic pain is complex and is unlikely to be confined to a single causative factor. Perhaps, for others like Melania, the physical and psychological effects of surgery and the significant life events at the time of onset are all valid contributors to pain, and they come together to form a situation whereby chronic pain is triggered.

Melania's case exemplifies some key points in the genesis of chronic pain; the immediate recourse to physical explanations, beliefs of bodily fragility, somatic self-vigilance, and the need for diagnosis.

The recovery from pain. This study revealed that radically reformulating the understanding of pain was essential to recovery for the participants. The shift from *painful and dangerous* to *painful yet benign* and *fragile spine* to *healthy spine* disarmed the threat of pain causing irreparable damage to the spine and in the process turned pain into a *paper tiger*. This meant that the remedial pain behaviours, which conveyed a therapeutic veneer whilst in fact

inflaming the situation, could be abandoned. This was an extremely bold move considering the severity of the pain and imagined consequences. It required a leap of faith, and it flew in the face of everything participants had believed.

Finding others who understood their experience countered the isolation of pain and gave a therapeutic home for their experience, which is often lacking for patients in chronic pain (Honkasalo, 1998). Participants felt deeply moved reading case studies that resonated with their experience, as this was proof to themselves and those around them that they hadn't been making it all up. Knowing that others had recovered from chronic pain meant that participants also felt they had a chance to recover, and this was healing.

Marianne spoke about attending a support group for sufferers of chronic pain and listening to talks from people who had recovered. This was therapeutic because for the first time, she was engaging with her pain in an environment that was not a hospital or a clinical consulting room and there were no frightening prognoses. In the support group, the burden of having to prove she was in pain was removed, and she could just listen to how people had recovered from experiences like her own. It was at that point, sitting in the group listening that Marianne suddenly noticed the deep, excruciating pain she had always had in her legs when sitting was not there. It was gone and it never returned.

Having the pain validated through case studies, knowledgeable professionals and support groups made the formerly invisible pain, visible. Once the intolerable paradox of a suffering that is so great, yet impossible to verify, ends, so does the pain. Unlike the abstractions from previous medical formulations, during recovery, participants linked pain to things they could influence and test for themselves. For example, participants noticed flare ups of pain would coincide with stressful events, and by acknowledging these, the pain would *miraculously*

subside. Also, the presence of structural damage could be tested by continuing as normal during severe flare-ups and seeing if the pain subsided or if it actually led to damage.

Aggressive medical discourse such as “Once you start getting pain you’ll always be in pain” or “Do you realise one spinal disc is falling over the other, ... you could become incontinent”, place the experience outside participants’ sphere of control. Consequently participants were unable to alter their situation, and in a state of panic, they had to defer increasingly to the medical expert, which over time, led to more anxiety and pain.

At times, the process of recovery felt magical. Melania would: ... walk around work repeating her mantra, “ I’m healthy, stop trying to protect me from whatever you're trying to protect me from, stop trying to distract me ... I don't need you anymore, go away.”

Melania’s mantras’ highlights a reformulation of pain that is implicated with recovery. Firstly, she was rejecting the belief that pain signalled physical damage or disease by repeating that she was healthy. This helped neutralise fear, which proved to be one of the primary exacerbating factors in chronic pain for participants. She also assigned pain the protective function of distracting her from difficult emotions, indicating that not meeting life’s challenges is linked to her pain. During recovery, participants would commonly switch from focussing on their bodies and look at what was going on in other areas of their life, demonstrating the concept of inseparability discussed throughout this dissertation.

The Wizard of Oz: Pain as a harmless nonsense. Participants vivid portrayals left little doubt about the omnipotence of pain. It was unreasonable and could only be approached with the utmost caution otherwise it would flare up and floor the sufferer. It constantly and emphatically communicated that ‘something’ was seriously wrong in the body and promised a

bleak and deadening future. An essential factor in participants' recovery was facing pain and learning not to be afraid of it by viewing it as something terrifically painful but harmless.

It occurred to me that a vivid metaphor for confronting pain could be seen in the final scene in the film *The Wizard of Oz* (1936). The protagonists, Dorothy, the lion, the tin man, and the scarecrow had successfully executed the unimaginable task of securing the Wicked Witch of the West's broom. To even attempt such a thing was madness, but out of sheer desperation, they risked their lives as this was the Wizard's condition upon which Dorothy's return home was contingent.

With the broom in hand the protagonists are cowering before the terrifying figure of the unbelievably powerful wizard who surprisingly goes back on his word and refuses to help. This is a devastating blow, as all options had been exhausted and Dorothy would never return home. The protagonists are too terrified to confront the wizard, but somehow Dorothy finds the courage to do the unthinkable and challenge him, which coincides with Toto the dog pulling back a curtain to reveal a harmless old man operating a contraption, which projected an image of the wizard. Once seen for what he really is, the old man became vulnerable and had to concede his dishonesty to the protagonists.

This is how chronic pain suddenly dissolves once it is confronted and revealed as harmless. The realisation that there is no powerful wizard temporarily plunges the characters into despair as they now imagine they are trapped forever in this strange land. Reaching this point of despair, however, mobilises them to find their own solution. The wizard's outrageous demand to secure the witch's broom can be a profound metaphor for the endless and frightening search for a solution to pain. The wizard represents the pain, which was once almighty and terrifying and demanded endless action, only to be exposed as harmless and nonsensical. The

spasms, shooting pains and other symptoms of pain are like the wizard's projected blustery display. Once this has been exposed and the myth of a 'saviour expert' has been denounced a personal solution emerges. The wizard conceded he could not solve their problem for them but gives each character valuable advice about interpersonal relationships, courage, and use of the intellect. Used as a metaphor for pain, each character can be seen as representing different aspects of Dorothy's world that once engaged with led to taking responsibility and finding her way home.

By noticing the nonsensical nature of pain, which is randomly appearing, disappearing, lessening, and changing location, whilst remaining unmodified by remedial interventions that should ameliorate it, something of the true nature of pain is revealed. Alexia: **I went to this last physiatrist ... and he said you're a perfect example of someone who is a good weight, exercises, does everything right, and you're still coming with back pain, and we have no answers for you.** Noticing the haphazard presentation of pain is a clue on the journey to recovery.

The experience of life after pain. Recovery from pain was an experience marked by transcending long-standing, even lifelong limitations and obstacles and moving into a position of authenticity and meaning. The effects of recovery extended well beyond the absence of pain. Recovery removed the feelings of isolation and alienation associated with being in pain (Scarry, 1987), which mirrored the isolation participants described during childhood. The move out of isolation came through developing the self-assurance to be oneself and not to be or do what others expected. Major life changes were made during recovery that required a great deal of courage and were pushed forward, perhaps even enforced by the unbearable nature of pain. The episodes of chronic pain remained severe and relentless until the familiar life of participants was demolished, making space to build something new.

The major transformations cannot simply be explained by just the absence of physical pain. Graham stated that without being carried out of his unfulfilling job in an ambulance, he never would have left and studied for a university degree. Similarly, in the absence of pain, would I have left the relationship I was in and embarked on a doctoral training? Marianne responded to her enduring pattern of passivity by taking responsibility for her decisions and acknowledging that she could exercise her freedom at any point. Columbine studied to become a health professional and J reached a landmark stage in his training. Alexia discovered the right to express anger and not feel the need to be everything for everybody, and Evelyn finally realised she could sit down and have a rest.

Why did recovery involve such significant positive life changes, and was such a level of pain necessary to bring those changes about? Pain made things so intolerable that the only choice was to continue in pain or to rebuild life, and participants chose the latter. Perhaps this is the difference between those who recover from chronic pain and those who suffer for 20 years or more (Fricker, 2003) until they become old, ill, or pass away. Internal phenomenology is considered inseparable from our experience of the body and world (van den Berg, 1972a) and this research has shown it applies to both pain and recovery.

Participants needed to be at their lowest point ever, despondent after endless failed attempts to get better before they could see that their pain was a healthy response to an unhealthy system of which they were an inextricably part (Wilberg, 2010).

Communicating non-physical factors to patients. There are many difficulties in communicating non-physical factors in pain, which is perhaps why participants all needed to come to this understanding themselves rather than being told. Evelyn stated that: *if anybody had told me back then that I needed to sit and meditate or go to a yoga class, I probably would*

have slapped them ... I don't know back then whether I could have made the changes I'd made now.

The suggestion of non-physical factors in such a physically debilitating condition demands an in-depth understanding of chronic pain from a health professional. Merely relying on an inkling that psychology must be involved because the patient keeps presenting with the same symptoms will not inspire confidence in the sufferer, who will sense this is an unfamiliar area for the doctor.

The intricacy of communicating a psychological involvement in pain lies in not implicitly equating physical with real and psychological as a euphemism for imagined, fraudulent, or hysterical. Suggesting that psychogenic pain is imagined and not real is inaccurate and causes a fracture in the therapeutic relationship as the suggestion is at odds with the sufferer's experience. Epidemiological studies also show the impact of musculoskeletal disorders, of which chronic pain forms a high percentage, on quality of life is greater than many of the major illnesses (Sprangers et al., 2000) and according to Melania, *it's the most painful pain you can imagine. I've had two children naturally, and it doesn't compare with the pain I had in my back.* It is for this reason that psychological factors in pain need to be communicated very carefully, with respect, and with great skill.

Useful interventions in recovery. The details of participants' pain and recovery reflect the unique subjectivity of each person and their worldview. Having created a vivid portrayal of participants' recovery, I will resist the temptation to construct formulas, protocols, or generic solutions, as the existence of such solutions is doubtful and because doing so would be another stampede away from the individual subjectivity that was instrumental to recovery.

Participant accounts indicated some commonly practiced interventions are relevant to recovery such as yoga, mindfulness based practises, and keeping a daily journal. However, many of these practices were also applied at various stages during the episodes of chronic pain with minimal impact, which raises the question as to why they were later seen as effective by participants. A possible explanation is that it wasn't the interventions themselves that were therapeutic, but rather it was the rationale behind their use that determined effectiveness. If the practice of mindfulness for example is applied to pain from a medical understanding, the basis of its use might be that relaxation is helpful in reducing pain symptoms and learning to manage pain. The rationale behind the intervention concretises the phenomenon as it assumes pain is a predominantly physical and one can only expect to learn how to relax and live with pain.

Looking at a different rationale behind mindfulness, Evelyn's narrative indicates when she practised mindfulness during recovery, it was based on the realisation that she had always been heavily focused on the needs of others at a huge personal cost. The practice of meditation reflected this realisation and was a physical expression of allowing herself some space from the tyrannising drive to be there for others.

Similarly, Alexia practised yoga during her episode of pain, which was carefully modified by physical therapists to take her pain into account and address her physical imbalances, misalignments, and weaknesses that were assumed responsible for her pain. Her yoga practise was continually adjusted as her back pain worsened and more and more movements became contraindicated. The underlying assumptions of this yoga practice were grim; they were based on the belief that her back was weak, fragile, and prone to pain or damage. Understandably this could have limited the meaningful impact yoga on her pain. In contrast, during the recovery process, Alexia practiced yoga on the basis that it was something she always

enjoyed. She did not omit any types of movement, thus, avoiding the construction and confirmation of a fragile self.

The underlying principles of any intervention can, therefore, influence the type of outcome it can generate.

And to finish ...

Columbine believed that pain is ... a defence for not knowing your feelings, not being able to know what you're feeling.

Post recovery Columbine described herself as; 'more awakened and enlightened ... awareness and insight into who I am, my thoughts, beliefs, and behaviours, my relationships ... [recovery has been] a huge a mirror into myself, ... which has had a positive impact on my body and my pain and how I see my body.

Chapter 6: Conclusion

The present research supports the view that chronic pain is a complex multi-dimensional phenomenon, thus, being resistant to medical intervention and diagnosis.

Recovery involved a drastic epistemic shift away from dualistic medical models, into an understanding of pain based on psychological factors, subjectivity, and meaning. This shift was so counterintuitive that it was only possible after years of failed medical interventions. The findings of this study contribute to our understanding of recovery and have important implications in how pain is understood and treated clinically. I end this chapter by drawing the results together, to form the beginnings of a coherent a clinical strategy that is relevant to counselling psychologists, other health professionals and those experiencing chronic pain.

Summary

The purpose of this study was to explore the experience of recovery from chronic pain. Eight participants (including the researcher), who had recovered from chronic pain without medical intervention, were interviewed using semi-structured interviews. The interviews explored the periods before, during, and after the occurrence of chronic pain. The subsequent results provide an original contribution to the literature through the individual findings and the findings taken as a whole, which give an in-depth and multi-faceted account of participants' experience recovery. The heuristic methodology defined clear patterns in recovery, which I summarise below.

Conclusions Regarding the Process of Recovery from Chronic Pain.

Medical intervention worsened pain symptoms. Medical approaches exacerbated the severity of pain symptoms. I speculate this was due to the unquestioned assumption of doctors

and patients that anatomical deficits were responsible for pain. Basing pain on a deficiency-model undermined participants' confidence in their health and generated fear, yet doctors and participants were unaware of the negative impact this model had on pain.

Commonly prescribed remedial interventions only aggravated pain and anxiety through the attendant restriction of previously normal physical activities; the basic rationale was that pain signified structural damage, and a restriction of activity was required to avoid causing further damage.

The pre-eminence and unquestioned validity of the medical model meant it was the only therapeutic and explanatory option considered by participants. Medical formulations usurped participants' subjective experience of pain and the major life events that coincided with the onset of pain.

Chronic pain defied medical explanation, and this was one of the most distressing elements of the experience. Regardless, participants continued to pursue medical solutions and found the implication of non-medical factors in pain insulting. The potential involvement of non-physiological factors was poorly understood by doctors and, therefore, difficult to communicate to patients.

Recovery depended on all possible medical interventions being exhausted. Hitting rock bottom in terms of sheer pain and debilitation was vital to recovery. Recovery was triggered once all medical interventions available to participants had been exhausted, and this was required to shake the unquestioned validity of the medical model and mind/body dualism that located pain exclusively in the body.

Participants embarked on deliberate personal research into their experience and inadvertently came across some form of non-medical perspectives relating to chronic pain. Once these perspectives were embraced, participants abandoned medical interventions.

Recovery involved remembering childhood trauma. A spontaneous and self-motivated re-appraisal of childhood was a clear feature of recovery. This brought into awareness profound deficits in caregiving that were in stark contrast to their usual evaluation of childhood. These insights were startling, and participants considered this discovery as key to recovery.

Pain as multi-functional vs. senseless. Recovery was a radical shift in how pain was understood. It moved from being a meaningless physiological event to having important functions relating to various complexities in participants' lives. Pain acted as a non-verbal communication of difficulties in childhood and adulthood, as well as a distraction from challenging emotions. Through its relentless and escalating severity, pain broke through deeply held patterns of living to allow the major life changes and personal insights seen in recovery. Dissolving sedimentations was only possible through the persistent severity of pain that demanded change and made current patterns of living unbearable.

Inseparability between person, body, and world. The results suggest that pain is not simply a somatic pathology but is a healthy response to a diseased system. The experience of pain contains the participants' entire lifeworld, expressed through the complex language of bodily sensations, which when explored, revealed vivid, highly anthropomorphic descriptions of pain that related to an aspect of their lived experience. Descriptions of pain often matched participants' caregivers during childhood, which proposed a connection between childhood trauma and adult chronic pain.

Embodiment was problematic during childhood. Participants commonly experienced pain during childhood, which appeared inextricably linked with the childhood adversity that was also commonly experienced. As well as pain, embodiment during childhood was also problematic due to social discrimination based on body size, physical features, and skin colour. Pain and social discrimination were connected phenomenologically as they both brought the body into an excruciatingly painful self-conscious awareness.

Pain and recovery are two sides of the same coin. Recovery and pain were similar; both had an unexpected and sudden onset, and lacked obvious explanation occurring during the unremarkable circumstances of day-to-day living. Both experiences incurred strong feelings of alienation and isolation from others, as they were equally complex and misunderstood. The present research supports the value of heuristic research, and more generally phenomenology, in the medical discourse on chronic illness. My chosen method centred on the movement between the theoretical mind and the tacit dimension, allowing a transfiguration of the phenomenon to take place and, in the process, to reveal new insights into pain. This process was a flow between the internal subjective and external objective. Despite the, perhaps, polarised comparisons between these two ways of knowing in earlier chapters, this was never a question of either/or, as the theoretical mind enriched the deep inner states, which in turn were a wellspring for the conscious mind. Reciprocity between these states flowed through the liminality between self-conscious knowledge and the tacit dimension where the 'felt sense', which can refer to both ways of knowing, simultaneously acted as a channel.

The intricacy of this process and the richness and depth of understanding would have been difficult to achieve without the use of my personal experience or by using larger sample sizes. However, I acknowledge that this depth lacks a corresponding breadth and that larger

quantitative studies would be useful to further clarify these results across a larger group of chronic pain patients especially if these results are to have clinical implementation. I also acknowledge that I might have aborted my own personal exploration prematurely as I was concerned with being flooded by the material, and perhaps as Sela-Smith (2002) suggested, to protect myself from personally difficult material.

The heuristic research method proved extremely useful in the exploration of this complex subject matter, which has continued to defy explanation and successful treatment. The entire research process, from connecting with the question and onwards was supported by the clearly set out stages of the heuristic method, which allowed a relinquishing of control and a free-fall into the subjective I. The data generated benefitted from the organising capacity of SEA, which also led to new insights. Both these methods allowed for a descriptive phenomenology that stayed close to participants' experience whilst allowing space at the final stages of analysis to make bolder interpretative gestures. The openness of the method generated many unexpected results, which can be taken as a further indication of the validity (Serning, 2011).

Applications for Counselling Psychology and Clinical Practice

The present results potentially contribute to how counselling psychology, health professionals and patients view chronic pain. Through looking at the patterns of chronic pain and recovery in participants, I feel that the findings of this study could have assisted them during the most challenging aspects of their experience.

The relevance of subjectivity and meaning in the results demonstrate clear clinical indications for counselling psychology. Recovery only began after years of medical investigation and intervention proved unsuccessful. Thorough prior medical investigation might, therefore, be a pre-requisite before patients are open to the possibility of non-medical approaches

in pain. In this clinical scenario, it seems sensible to adopt a psychological approach aimed at recovery rather than a pain management approach, as the latter will not differ from previous medical treatment in terms of concretising symptoms. Counselling psychologists might also consider that psychological approaches to pain in the absence of a clear medical reason are not globally advised (NICE Guideline NG59; Nov 2016; The British Pain Society and the Royal College of General Practitioners, 2004) and be aware of their own personal limitations before taking on such complex work.

From a clinical interest, it is possible to formulate the patterns observed in participants' recovery into the beginnings of a therapeutic strategy for counselling psychologists based on the following areas:

Explanation. Psychological practitioners need to verbalise the involvement of non-physiological factors in pain without alienating or insulting the patient. This would involve being able to convey a thorough understanding of key aspects involved in chronic pain.

Meaning and subjectivity. Using the 'felt sense' can be employed clinically with chronic pain patients to try and increase insight into pain and any potential meaning.

Medical models viewed pain with a heavy physiological bias. An alternative view would be to explore the possibility of symptoms signifying something beyond the somatic, which when discovered would render pain as a signifier redundant. The subjective dimension of pain has been neglected by healthcare professionals, but this study found that tuning into the subjective experience or felt sense of pain transposed the physical symptoms and sensations into words and produced important insights relevant to recovery.

Explore childhood trauma. Becoming newly aware of significant failures from caregivers during childhood was implicated in recovery, making this a potentially useful area to explore with patients.

I remain cautious of using the word *trauma* in a clinical setting as participants' gave a nuanced and intricate illustration of childhood adversity, which makes trauma seem like a blunt and alarming term, and one they did not use. Patients might be more open to descriptors such as challenging conditions they faced in childhood or difficulties in the family that might have been avoided, but caused pain or anxiety.

Anxiety and confronting pain. Addressing patients' terror of causing irreparable damage through normal activities is another clinical priority. Clinicians can capitalise on patients' prior (and extensive) medical investigation to indicate there is no rationale for such damage. The medical exploration that was once a source of confusion and anxiety can form the basis of an epistemic shift in patients' minds from *painful and immanently disastrous* to *painful but harmless*.

Remedial pain behaviours: Participants reported an extensive regime of remedial pain behaviours that were clinically ineffective and included abandoning enjoyable and normal daily activities. This was counterproductive for overall wellbeing and pain symptoms. Considering the previous intervention above, clinicians can explore the idea of resuming normal activities and abandoning remedial pain behaviours that proved unhelpful over the years.

Sedimentation. Major positive life changes came about through recovery in this research. It would, therefore, be useful to investigate sedimented patterns that are perceived as unsatisfactory by patients. This might include persistent unsatisfactory styles of interpersonal

relating, sense of meaning and purpose in life, unfulfilled dreams and ambitions, and job dissatisfaction.

Personality traits. Personality traits such people pleasing, inability to express anger, self-sacrificing tendencies, and excessive perfectionism were implicated in chronic pain. These longstanding and complex patterns of relating to self and others were ultimately experienced as unsatisfactory, and an awareness of more personally fulfilling relational styles developed. The presence of these traits/relational styles can be explored with patients and could be engaged with psychotherapeutically.

Differentiating pain from normal aches. After recovering from years of chronic pain, participants sometimes struggled to differentiate pain from normal day-to-day body sensations such as stiffness in the morning or soreness after physical activity. It might, therefore, be helpful to think about which body sensations require attention and which can be ignored.

Future Research

I believe further research based on subjective experience and its meaning for the sufferer is required. As a direct progression to the findings that emerged from this study, further research can be conducted in the following areas:

- The connection between childhood adversity and adult chronic pain.
- Exploration into the subjective 'felt sense' of pain; the transposition of sensation into language.
- Embodiment in childhood as a reflector of the traumatising environment and as a strategy to maintain the family system.

- The acceptance of a mind/body dichotomy in pain which was evidenced by participants' immediate recourse to medical explanations and treatments.
- The transcendental quality of the post-recovery stage.
- The development and refinement of clinical strategy for psychologists and health professionals working with chronic pain.

It would also be interesting to conduct similar studies into other chronic illnesses to see if they observe a similar pattern.

Whilst it remains impossible to understand the mysterious leap into the somatic or precisely define the *what and how* of recovery, we can free our thinking from the customary constraints associated with empirical validity and propose new ideas. Creative thinking, metaphor, and the unique subjectivity of each person can be studied to create a narrative for the pain that resonates with the sufferer. The construction of a rich and nuanced narrative that encapsulates the sufferer's experience can, as de Aisemberg (2010) suggested, form a bridge between the psychological and the physical.

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Appendix A: Ethical Documents

Middlesex University, Department of Psychology

REQUEST FOR ETHICAL APPROVAL (STUDENT)

Applicant (specify): UG PG (Module:.....) PhD

Date submitted: May 2014.....

Research area (please circle)				
Clinical	Cognition + Emotion	Developmental	Forensic	Health
Occupational	Psychophysiological	Social	Sport + Exercise	
Other Counselling Psychology _____			Sensitive Topic <input type="checkbox"/>	
Methodology:				
Empirical/Experimental	Questionnaire-based	Qualitative	Other _____	
<p>No study may proceed until this form has been signed by an authorised person indicating that ethical approval has been granted. For collaborative research with another institution, ethical approval must be obtained from all institutions involved.</p> <p>This form should be accompanied by any other relevant materials (e.g. questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information and debriefing sheet for participants¹, consent form², including approval by collaborating institutions).</p>				
<ul style="list-style-type: none"> Is this the first submission of the proposed study? 				Yes/No

<ul style="list-style-type: none"> Is this an amended proposal (resubmission)? Yes/No Psychology Office: If YES, please send this back to the original referee Is this an urgent application? (<u>To be answered by Staff/Supervisor only</u>)¹ Yes/No <p style="text-align: right;">Supervisor to initial here _____</p>			
<u>Name(s) of investigator</u> Mr Christos Christophy			
<u>Name of Supervisor (s)</u> Dr Rosemary Lodge and Professor Emmy van Deurzen			
Title of Study: The Problem of Pain: A Heuristic and Structural Existential Analysis of Unexplained Physical Pain			
<u>Results of Application:</u> <p style="text-align: center;">REVIEWER – please tick and provide comments in section 5:</p>			
APPROVED	APPROVED SUBJECT TO AMENDMENTS	APPROVED SUBJECT TO RECEIPT OF LETTERS	NOT APPROVED

SECTION 1

¹ See Guidelines on MyUnihub

1. Please attach a brief description of the nature and purpose of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.

SEE ATTACHED PROJECT PROPOSAL

2. Could any of these procedures result in any adverse reactions? **YES/NO**

If "yes", what precautionary steps are to be taken?

To make sure participants are fully informed about the nature of the research and what will take place during their participation in the research. Participants will be fully debriefed after the interviews and will be given my contact details and will be able to contact me up to one month after their participation in the research study. My supervisors contact details and those of the college principal are also given. Information for further support should they wish to access it will also be given.

3. Will any form of deception be involved that raises ethical issues? **YES/NO**

(Most studies in psychology involve mild deception insofar as participants are unaware of the experimental hypotheses being tested. Deception becomes unethical if participants are likely to feel angry, humiliated or otherwise distressed when the deception is revealed to them).

Note: if this work uses existing records/archives and does not require participation per se, tick here

.....

and go to question 10. (Ensure that your data handling complies with the Data Protection Act).

<p>4. If participants other than Middlesex University students are to be involved, where do you intend to recruit them? <i>(A full risk assessment <u>must</u> be conducted for any work undertaken off university premises)^{6,7}</i></p> <p>I will be recruiting participants from an organisation that provides support to people who are experiencing chronic pain conditions</p>	
<p>5a. Does the study involve:</p>	
Clinical populations	YES/NO
Children (under 16 years)	YES/NO
Vulnerable adults such as individuals with mental or physical health problems, prisoners, vulnerable elderly, young offenders?	YES/NO
Political, ethnic or religious groups/minorities?	YES/NO
Sexually explicit material / issues relating to sexuality	YES/NO
<p>5b. If the study involves any of the above, the researcher may need CRB (police check)</p> <p>Staff and PG students are expected to have CRB – please tick YES/NO</p> <p>UG students are advised that institutions may require them to have CRB</p> <p>please confirm that you are aware of this by ticking here _____</p>	
<p>6. How, and from whom (e.g. from parents, from participants via signature) will informed consent be obtained? <i>(See consent guidelines²; note special considerations for some questionnaire research)</i></p> <p>Consent will be gained by participants signing an informed consent form after they have read the Participant Information Sheet provided. See attached form</p>	
<p>7. Will you inform participants of their right to withdraw from the research at any time, YES/NO</p>	

without penalty? (*see consent guidelines²*)

8. Will you provide a full debriefing at the end of the data collection phase?

YES/NO

(*see debriefing guidelines³*) See attached debriefing form

9. Will you be available to discuss the study with participants, if necessary, to monitor any negative effects or misconceptions?

YES/NO

If "no", how do you propose to deal with any potential problems?

Participants will be informed that they may contact me up to one month after their participation in the event of any negative effects or misconceptions that have come about as a result of participation in the research

10. Under the Data Protection Act, participant information is confidential unless otherwise agreed in advance. Will confidentiality be guaranteed?

YES/NO

(*see confidentiality guidelines⁵*)

If "yes" how will this be assured (*see⁵*)

Data will be anonymised so that participants are not identifiable in any published material. The data will be stored on a password protected computer in encrypted files. The interview recordings will be destroyed after transcription.

<p>If “no”, how will participants be warned? (<i>see</i>⁵)</p> <p>Participants will be informed in the Participant Information Sheet that under certain circumstances confidentiality will be broken. These include disclosures of terrorism or money laundering and if I believe the participant or someone else is under serious risk of physical harm</p> <p>(NB: <i>You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals</i>).</p>	
<p>11. Are there any ethical issues that concern you about this particular piece of research, not covered elsewhere on this form?</p> <p>If “yes” please specify:</p>	<p>YES/NO</p>
<p>12. Is this research or part of it going to be conducted in a language other than English?</p>	<p>YES/NO</p>
<p>If YES – Do you confirm that all documents and materials are enclosed here both in English and the other language, and that each one is an accurate translation of the other?</p>	<p>YES/NO</p>

(NB: If “yes” has been responded to any of questions 2, 3, 5, 11, 12 or “no” to any of questions 7-10, a full explanation of the reason should be provided – if necessary, on a separate sheet submitted with this form).

The likelihood of any risk in taking part is extremely low. Participants are however informed that by talking about their recovery from Chronic Lower Back Pain they may be reminded of some difficult experiences prior to recovery.

SECTION 2 (to be completed by all applicants – please tick as appropriate)

	YES	NO
13. Some or all of this research is to be conducted away from Middlesex University	x	
If “yes” tick here to confirm that a Risk Assessment form has been submitted	x	
14. I am aware that any modifications to the design or method of this proposal will require me to submit a new application for ethical approval	x	
15. I am aware that I need to keep all the materials/documents relating to this study (e.g. consent forms, filled questionnaires, etc) until completion of my degree / publication (as advised)	x	
16. I have read the British Psychological Society’s <i>Ethical Principles for Conducting Research with Human participants</i> ⁴ and believe this proposal to conform with them.	x	

SECTION 3 (to be completed by STUDENT applicants and supervisors)

Researcher: (student signature) Christos Christophy date 28/04/2014

CHECKLIST FOR SUPERVISOR – please tick as appropriate

YES NO

1. Is the UG/PG module specified?		
2. If it is a resubmission, has this been specified and the original form enclosed here?		
3. Is the name(s) of student/researcher(s) specified?		
4. Is the name(s) of supervisor specified?		
5. Is the consent form attached?		
6. Are debriefing procedures specified? If appropriate, debriefing sheet enclosed – appropriate style?		
7. Is an information sheet for participants enclosed? appropriate style?		
8. Does the information sheet contain contact details for the researcher and supervisor?		
9. Is the information sheet sufficiently informative about the study?		
10. Has Section 2 been completed by the researcher on the ethics form?		

11. Any parts of the study to be conducted outside the university? If so a Risk Assessment form must be attached – Is it?		
12. Any parts of the study to be conducted on another institution’s premises? If so a letter of acceptance by the institution must be obtained - Letters of acceptance by all external institutions are attached.		
13. Letter(s) of acceptance from external institutions have been requested and will be submitted to the PSY office ASAP.		
14. Has the student signed the form? If physical or electronic signatures are not available, an email endorsing the application must be attached.		
15. Is the proposal sufficiently informative about the study?		

Signatures of approval:

PSY OFFICE received

Supervisor: _____ date: _____

date:.....

Ethics Panel: _____ date: _____

date:.....

(signed pending approval of Risk Assessment form)

date:.....

If any of the following is required and not available when submitting this form, the Ethics Panel Reviewer will need to see them once they are received – please enclose with this form when they become available:

- letter of acceptance from other institution
- any other relevant document (e.g. ethical approval from other institution):

PSY OFFICE received

Required documents seen by Ethics Panel: _____ date: _____ date:.....

SECTION 4 (to be completed by the Psychology Ethics panel reviewers)

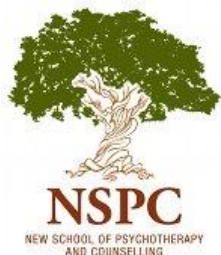
		Recommendations/comments
1. Is UG/PG module specified?		
2. If it is a resubmission, has this been specified and the original form enclosed here?		
3. Is the name(s) of student/ researcher(s) specified? If physical or electronic signatures are not available, has an email endorsing the application been attached?		
4. Is the name(s) of supervisor specified? If physical or electronic signatures are not available, has an email endorsing the application been attached?		
5. Is the consent form attached?		
6. Are debriefing procedures specified? If appropriate, is the debriefing sheet attached? Is this sufficiently informative?		
7. Is an information sheet for participants attached?		
8. Does the information sheet contain contact details for the researcher?		
9. Is the information sheet sufficiently informative about the study? Appropriate style?		
10. Has Section 2 (points 12-15) been ticked by the researcher on the ethics form?		
11. Any parts of the study to be conducted outside the university? If so a fully completed Risk Assessment form must be attached – is it?		

12. If any parts of the study are conducted on another institution/s premises, a letter of agreement by the institution/s must be produced. Are letter/s of acceptance by all external institution/s attached?		
13. Letter/s of acceptance by external institution/s has/have been requested.		
14. Has the applicant signed? If physical or electronic signatures are not available, an email endorsing the application must be attached.		
15. Is the proposal sufficiently informative about the study? Any clarity issues?		
16. Is anyone likely to be disadvantaged or harmed?		
17. If deception, protracted testing or sensitive aspects are involved, do the benefits of the study outweigh these undesirable aspects?		
18. Is this research raising any conflict of interest concerns?		

Appendix B: Information for research participants



**Middlesex
University**



Participant Information Sheet – Taking Part in Research

The Problem of Pain: Informing Treatment through Personal Experiences of Recovery from Chronic Lower Back Pain (approved following PAP viva)

Researcher: **Mr Christos Christophy**

This research is being undertaken as a requirement for a Doctorate in Counselling Psychology from NSPC and Middlesex University

This research is being supervised by Dr Rosemary Lodge and Professor Emmy van Deurzen

Mr Christos Christophy
NSPC Ltd
61-63 Fortune Green Rd
London NW6 1DR
0845 557 7752
Email: CC1232@live.mdx.ac.uk

Middlesex University
The Burroughs
London NW4 4BT

Invitation to take part in research

You are being invited to take part in a research study to help us learn more about recovery from chronic pain. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

What is the purpose of the research?

This study would like to hear from participants who have recovered from chronic lower back pain (CLBP) within the last 5 years. To take part in the study recovery would not have been due to surgery, drug therapy or any physical therapies such as physiotherapy or osteopathy. I am interested in learning about the recovery from chronic lower back pain and I hope to increase our understanding of CLBP.

What will happen to me if I take part?

You will be asked to share your experience about your personal recovery from CLBP. This will take place either in a face to face interview or a Skype interview. Both types of interviews are conducted by the researcher and should last no longer than 90 minutes.

The face to face interviews will take place in a dedicated space used for psychotherapy in the researcher's home (London, N1) ensuring that the space used to conduct the interview is quiet, comfortable and confidential. The interview will be semi-structured which means it will be based around some set interview questions (see below) but will allow you to talk openly and freely about what you think is relevant.

The Skype interviews will also be conducted from the same location by the researcher to ensure the same level of privacy. If you choose to be interviewed via Skype, you need to ensure that the interview will be held at a private location where you will not be interrupted. Any issues such as potential technical problems or anything else related to the Skype interview will be discussed via email prior to the interview. As with face to face interviews it is a good idea to keep all telephones switched off or on silent.

What will you do with the information that I provide?

Your data will all be kept confidential and anonymised so that you cannot be identified from the research. All interviews will be recorded so that they can be typed up and analysed. Once the interviews have been typed the recordings will be destroyed and the interview transcripts will be stored on a password protected computer in encrypted files.

The research methods used to analyse the data will be qualitative heuristic analysis. Qualitative means that the research will focus on a personal description of your recovery and heuristic means that the researcher has also had personal experience of CLBP. Any other information you give me will be stored in a locked filing cabinet. I will keep the key that links your details with the project code in a locked filing cabinet

The information will be kept at least until 6 months after I graduate, and will be treated as confidential. If my research is published, I will make sure that neither your name nor other identifying details are used.

What are the possible disadvantages of taking part?

The likelihood of any risk in taking part is extremely low. You may however want to bear in mind that by talking about your recovery from CLBP you may be reminded of some difficult experiences you may have had prior to recovery. A disadvantage will be a loss of your time to take part in the interview.

What are the possible benefits of taking part?

Being interviewed about your experience of recovery from pain has no direct benefit, although some people may find it an opportunity to reflect on their experience, and could find this beneficial.

Consent

You will be given a copy of this information sheet for your personal records, and if you agree to take part, you will be asked to sign the attached consent form before the study begins.

Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part you may withdraw at any time without giving a reason. (See specific guidelines for consent in a separate file)

Who is organising and funding the research?

This research is entirely self-funded and there are no conflicts of interest

Who has reviewed the study?

All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The NSPC research ethics sub-committee have approved this study

Thank you for reading this information sheet.

If you have any further questions, you can contact me at:

Christos Christophy
NSPC Ltd
61-63 Fortune Green Rd
London NW6 1DR
0845 557 7752
Email: CC1232@live.mdx.ac.uk

If you any concerns about the conduct of the study, you may contact my supervisor:

Dr Rosemary Lodge
NSPC Ltd
61-63 Fortune Green Rd
London NW6 1DR
0845 557 7752
Admin@nspc.org.uk

Or

The Principal
NSPC Ltd
61-63 Fortune Green Rd

London NW6 1DR
0845 557 7752
Admin@nspc.org.uk

Questions you will be asked during the interview

What attracted you to this study?

Thinking back can you describe your experience of pain?

Can you describe the process of your recovery from pain?

What were things like before the onset of pain?

What are things like now?

Written consent form



NSPC Ltd with Middlesex University

Doctorate in Counselling Psychology Program

Written Informed Consent

Title of study and academic year: **The Problem of Pain: A Heuristic and Structural Existential**

Analysis of Unexplained Physical Pain

Researcher: Christos Christophy_____

Supervisor (*only for students*): Dr Rosemary Lodge

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant.

I have been given contact details for the researcher in the information sheet.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur.

Print name

Sign Name

date: _____

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

