

**Participant Experiences in Transforming
Chronic Pain and Chronic Fatigue Syndrome**

by

**Amy Barbara Lariviere
B.A., University of Victoria, 1993**

**A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of**

MASTER OF ARTS

in the Department of Educational Psychology and Leadership Studies

**© Amy Barbara Lariviere, 2004
University of Victoria**

**All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy
or other means, without the permission of the author.**

Supervisor: Dr. E. Anne Marshall

ABSTRACT

Chronic Pain and Chronic Fatigue Syndrome are conditions that often defy accurate diagnosis and effective medical treatment. This often leaves sufferers feeling hopeless and frustrated. Despite the fact that researchers and clinicians may be uncertain about etiology and treatment for these debilitating conditions, little research has been done to investigate the possibility that subjective awareness by sufferers may provide a source of wisdom and illumination regarding their illnesses.

In this qualitative study, eight participants of a residential, chronic pain program were interviewed pre- and post-program. Sufferers participated in a multi-modal, holistic treatment program incorporating acupuncture, psychotherapy, relaxation, biofeedback, Hellerwork massage, and psycho-educational group work. Findings suggest that patients can be excellent resources for understanding, integrating, and transforming these illnesses.

TABLE OF CONTENTS

Abstract	i
Table of Contents	iii
Acknowledgments	vii
Dedication	viii

CHAPTER ONE: INTRODUCTION

Introduction	1
Finding Resources	3

CHAPTER TWO: LITERATURE REVIEW

Overview of Literature Review	5
Chapter Introduction	6
Part 1: Chronic Fatigue Syndrome (CFS)	6
Chronic Fatigue Syndrome: General	6
Prevalence	7
History as it Relates to Chronic Fatigue Syndrome	8
Current Research in CFS	10
Problems with Diagnosing and Treating CFS: Implications for Patients	14
Clinical Counselling Concerns	15
Valuing a Patient's Own Knowingness, Wholeness and Ability to Heal	16
Including Patients' Knowingness in Health Research	17
Part 2: Chronic Pain	19
Researcher's Personal Experience	19
Types of Pain	21
Understanding Chronic Pain: Expansion of Definitions	22
Multidisciplinary Treatment of Chronic Pain	23
Complementary Alternative Medicine	25
Energy Medicine	26
Acupuncture and Traditional Chinese Medicine	27
Part 3: Rationale for the Present Study	29

CHAPTER THREE: METHOD

Overview of Method Section	31
Chapter Introduction	31
The Research Questions	33
Research Design: Qualitative Methodology	33
Chronology of Methodological Steps	34
Qualitative Research Methods that Informed This Study	36
Ethnography	36
Case Study Research	38
Phenomenology	40
Heuristic Research	41
Principles That Were Important to Me In Terms of Research Design	42
Elaboration on the Methodology	43
Setting of the Victoria Pain Clinic	43
Participants	44
Participant Screening and Selection	44
Meeting the Participants	45
Pre-Program Interviews	46
Reinforcing Confidentiality and the Right to Withdraw	46
Researcher's Role in the Program	47
Program Description	47
Post-Program Interviews	49
Steps and Stages of Data Analysis	50
Pre-Program Data Analysis: Procedure	51
Post-Program Data Analysis: Procedure	52
The Research Journal	54
Verification	55

CHAPTER FOUR: RESULTS

Overview of Results Section	60
Chapter Introduction	60

Data Analysis of Pre-Program Interviews	61
Participant Profiles: Philosophy and Construction	61
Pre-Program Participant Profiles and Post-Program Transformation Stories	63
Homer	
Pre-Program Profile	63
Post-Program Transformation Story	65
Researcher's Excerpt	77
Jade	
Pre-Program Profile	78
Post-Program Transformation Story	80
Researcher's Excerpt	85
Pierre	
Pre-Program Profile	86
Post-Program Transformation Story	88
Researcher's Excerpt	94
Arsinoe	
Pre-Program Profile	95
Researcher's Excerpt	98
Post-Program Transformation Story	98
Researcher's Excerpt	109
Juliann	
Pre-Program Profile	109
Post-Program Transformation Story	111
Researcher's Excerpts	118
Colette	
Pre-Program Profile	120
Post-Program Transformation Story	122
Researcher's Excerpts	132
Alexandra	
Pre-Program Profile	134
Post-Program Transformation Story	136
Researcher's Excerpts	144
Sage	
Pre-Program Profile	144
Post-Program Transformation Story	148
Researcher's Excerpt	157

CHAPTER FIVE: DISCUSSION

Overview of Discussion Section	158
Chapter Introduction	158
Summary of Findings	159
Outcomes	159
Discussion of Findings	160
Process of Transformation: Summary	177

CHAPTER SIX: IMPLICATIONS OF THE FINDINGS

Overview of Chapter Six	179
Answering the Research Questions	179
Implications of the Findings	180
For Sufferers of Chronic Pain and Chronic Fatigue Syndrome	180
Clinical Implications: General	182
Clinical Implications for Individual Work with Clients	183
The Findings as They Relate to Current Literature	193
Limitations of this Research Study	201
Suggestions for Future Research	203
Conclusion	205
References	206
Appendices	
Appendix A: Participant Recruitment Letter	215
Appendix B: Participant Consent Form	216
Appendix C: Interview Protocols	218
Appendix D: The Victoria Pain Clinic	220
Appendix E: Classification of Pain Facilities	223

ACKNOWLEDGMENTS

First of all, my thanks go to the participants of this study. You have given me gifts; much greater than you may realize.

Next I would like to acknowledge my supervisor, Dr. Anne Marshall, who has given of herself in a quiet and very caring way. Her instruction, guidance, and patience with this process have been heartwarming and very valuable. I thank my committee members, Dr. Norah Trace, and Dr. Antoinette Oberg for their expertise in certain areas which helped clarify and illumine new tracks of emergence in this writing.

My family including my Mom, Muriel Hendricks, Bruce and Helene Hendricks, Aunt Marilyn, and Uncle Bill Levy, Marion and Normond Ellis, Marion, Jenny, Annalise, Taleea, Kathy, Berte, and Ellen. You have all been inspirations and sources of support, love and strength; each in your own beautiful ways. I am truly blessed.

I thank my friends, Susan-Rose, Rowan, Alana, Linda, Jane, Willie, Jean, Jacqui, Catherine, Shaari, and Wendy for their unconditional friendship, support, and faith in me.

Thank you to Sam Wallace, Berte Marr, Moria McKechnie, and Wendy Koivisto for much appreciated, good-hearted, technical support.

And deep gratitude goes to the Victoria Pain Clinic staff for their dedication, and mentorship, in treating Chronic Pain and Chronic Fatigue Syndrome.

DEDICATION

This thesis is dedicated to opening doors of knowledge that alleviate human suffering.

CHAPTER ONE

Introduction

I have had the pleasure of writing this thesis over the past two years. I say pleasure, because to get to know such brave souls as those who went through the 10 day program at the Victoria Pain Clinic in as much detail as I have, has been a gift for which I am most grateful. Qualitative research methodology affords the researcher an opportunity to immerse in the data. And with this immersion comes a knowingness, not only of the one whose data I am analyzing, but also of myself.

For analysis of some of the latter transcripts, I had the added benefit of writing at a secluded, oceanfront home on Pender Island, B. C. Just myself, and Mustang (the Tom cat), occupied the space where the participants' words resounded. Mustang could not hear the words, but he still was a part of the research process. One cannot immerse in the qualitative research process without affecting all those around him/her. Qualitative research is demanding. It demanded my full presence. There were times when Mustang wanted to *bat the toy again*, but went out sulking because I was hit with an *Aha*, from engaging with one of my participant's data.

So what is this thesis about? It is about the experiences of eight people who went through a 10 day residential Pain program at the Victoria Pain Clinic in the summer of 2001. I interviewed these participants before and after their program. I also attended the full program myself as a co-participant. I attended all the group sessions, but did not have the individual treatments with practitioners.

Why did I conduct this research? What is the rationale for the present study?

Originally, my interest in the study was to develop a much greater understanding of Chronic Fatigue Syndrome (CFS). As a nurse, psychotherapist, and human being, this illness was capturing my attention. On a personal level, a friend and colleague of mine, had a busy private therapy practice. She ran the 43km (26 mile) marathon in October, and in May of the following year, had to give up her practice due to CFS. Suddenly she was ill, out of work, forced to sell her home, and was relocating. I found this sudden and dramatic change of life very hard to understand.

In my private practice also, I had several clients who had recently been diagnosed with CFS. I found it difficult to treat these clients. Although they desperately wanted to get better, they had very little energy with which to apply themselves to therapy. Their lives were consumed with repeated medical appointments in which they were looking for *answers* to help them. Mostly, they were *coming up dry*.

I conducted a vast, and yet focused, literature search of CFS to familiarize myself with the field, and to see what was being explored both psychologically, and medically. What emerged from the literature review was work that was being done which was largely focused on proposed causation, clinical course of the illness, and/or coping strategies for sufferers, as well as many drug trials which related to microbiological etiology or treatment. However, there was a void in terms of evidence of treatments that were showing any significant results for recovery from the illness. Although some minor successes were indicated in studies of cognitive behavioural therapy, researchers could not tout them as being statistically significant in terms of helping people with CFS to regain health. I wondered, "If I am beginning to feel *desperate* about hope for recovery

for people with CFS, how can sufferers cope when they are exhausted, and yet knocking on doors with no answers?

Finding Resources

Immediately after conducting the above literature review, I began a practicum as a student at the Victoria Pain Clinic. Quite skeptical at first, I assisted with a 10 day residential program. I took part in the group exercises, helped with some of the treatment modalities, and attended all the lectures given by practitioners. I learned new theories about illness, stress, emotions, and the body. Most significant to me was that I witnessed participants with CFS and Chronic Pain positively impact their illnesses over the course of the 10 days. Participants seemed to be engaged in an experience through which they appeared to be making inner connections regarding their illnesses. They were then using these insights toward their own growth and recovery.

I witnessed this through dialogues with participants, and within counselling sessions. Also, changes were visibly observed in participants, pre to post program. People with Chronic Fatigue Syndrome, who, at first, were barely able to do any of the exercises, had greater endurance and life energy toward the end of the program. Pain levels amongst group members generally declined dramatically. People in Chronic Pain were able to go without narcotics, or had greatly reduced the amount of pain medications used. Participants confirmed attitudinal and emotional shifts in regards to healing CFS. Although I didn't *quantify* these results (this statistical information is available from the Victoria Pain Clinic), I did observe them to be true among members of this group of participants.

My hopelessness changed to intrigue. I wondered: What was the growth process participants went through to be able to impact their illnesses in such a short period of time? Can this process be explained? If so, are there answers within the explanations that will also benefit others in Chronic Pain or with CFS? Can we as practitioners learn something about how to work with people with CFS and Chronic Pain more effectively based on what these participants' journeys can teach us? The above questions became the research questions for this study.

I began to get excited about conducting a study to track this process. My enthusiasm and quest for knowledge led me to meet with both the Medical Director and the Program Director at the Victoria Pain Clinic. At that time, I specifically wanted to conduct a study tracking the processes of participants for recovery from CFS. After this meeting, I decided to include participants with Chronic Pain and Chronic Fatigue Syndrome in the study (as discussed in Method Section). Therefore, the literature review which follows relates to studies in the areas of both Chronic Fatigue Syndrome, and Chronic Pain.

CHAPTER TWO: LITERATURE REVIEW

Overview of Literature Review

- Chapter Introduction
- Part 1: Chronic Fatigue Syndrome (CFS)
- Chronic Fatigue Syndrome: General
 - Prevalence
 - History as it Relates to CFS
 - Current Research in CFS
 - Problems with Diagnosing and Treating CFS: Implications for Patients
 - Clinical Counselling Concerns
 - Valuing a Patient's Own Knowingness, Wholeness and Ability to Heal
 - Including Patients' Own Knowingness in Health Research
- Part 2: Chronic Pain
 - Researcher's Personal Experience
 - Types of Pain
 - Understanding Chronic Pain: Expansion of Definitions
 - Multidisciplinary Treatment of Chronic Pain
 - Complementary Alternative Medicine
 - Energy Medicine
 - Acupuncture and Traditional Chinese Medicine
- Part 3: Rationale for the Present Study

Chapter Introduction

Multidisciplinary research in both Chronic Fatigue Syndrome and Chronic Pain is extensive. This selected literature review concerns itself with studies which have relevance to the rationale for this study, provide background information for the understanding of CFS and Chronic Pain, represent trends in diagnosis and treatment for people with CFS or Chronic Pain, and embrace the concept of a patient's own knowingness about his/her illness. The literature review is organized into three parts. Part 1 is about Chronic Fatigue Syndrome as organized in the previous overview. Part 2 is about Chronic Pain as per overview. And the final part concludes with a discussion of the rationale for the present study.

Part 1: Chronic Fatigue Syndrome

Chronic Fatigue Syndrome: General

Chronic fatigue syndrome is an illness that is characterized by severe, debilitating fatigue, and other symptoms including sleep disturbances, impaired concentration, musculoskeletal pain, and headaches.

In 1994, the Center for Disease Control developed overarching criteria for diagnosing CFS including: clinically evaluated, medically unexplained fatigue of at least six months duration, that is of new onset, not a result of ongoing exertion, not substantially alleviated by rest, and involves a substantial reduction in previous levels of activity. In addition, there is the occurrence of four or more of the following symptoms: subjective memory impairment, tender lymph nodes, muscle pain, joint pain, headache, unrefreshing sleep, post-exertional malaise > 24 hours; (continuous fatigue that does not disappear within the first 24 hours after exercise).

Exclusion criteria include:

active, unresolved, or suspected disease likely to cause fatigue; psychotic, melancholic or bipolar depression (but not uncomplicated major depression), psychotic disorders, dementia, anorexia or bulimia nervosa,

alcohol misuse or other substance misuse, severe obesity (Reid, Chalder, Cleare, Hotopf, & Wessely, 2000, p. 293).

Prevalence

Recent community and primary care based studies estimate the prevalence of CFS to range from 0.2 - 2.6% of the general population depending on criteria used (Wessely, et al., 1997). Systematic population surveys have found similar rates of the syndrome in people of different socioeconomic status, and in all ethnic groups (Lawrie & Pelosi, 1995; Steele, et al., 1998). Female sex is the only demographic risk factor; women are three times more likely than men to be diagnosed with the illness (Burke, 1992; Melamed, 1998).

Several researchers have speculated about the reasons for the increased prevalence of its diagnosis in women. Melamed (1998) believes it is due to the fact that women are more verbally expressive regarding their emotions, and may be more likely to seek treatment for the debilitating symptoms of CFS. Other researchers (Petrie, Austin, Cowley, & Helmcap, 1996) have suggested that European and North American cultures valorize the male body as the standard by which all other bodies are judged and thus, men in general are less apt to admit to bodily symptoms which are incongruent with this societal image. Abbey & Garfinkel (as cited in Friedberg, 1996) attribute the increased prevalence of CFS in women to socio-cultural causes. These researchers propose that:

Late 19th century neurasthenia, a CFS-like illness, and the modern CFS, have both occurred during social transformations in the role of women. To be more specific, the rapidly changing role of women over the past two decades may have created an impossible set of cultural expectations: to achieve in the workplace, to nurture a family, and to embrace social commitments (p. 36).

These authors further explain that “these cultural norms, although not consciously rejected by women, produce a debilitating psycho-physiological or conversion-like illness that releases them from an array of burdensome obligations” (Abbey & Garfinkel, as cited in Friedberg, 1996, p. 36). I believe that the socio-cultural link is an important link to investigate, but I am not in agreement with characterizing CFS as a conversion-like illness. Instead, my belief is that the majority of women are coping as best they can with their rapidly changing roles, and sets of impossible expectations. If women get sick, it is because over functioning in this way is not natural to the body (and their bodies are letting them know that). The fact that the prevalence of CFS in females is much greater; 70% of all cases (Albrecht & Wallace, 1998) brings many questions to mind from a socio-cultural gender perspective. These are outside of the domain of this present thesis, but will undoubtedly need exploration in other studies.

History as it Relates to Chronic Fatigue Syndrome

Researchers in Western medicine, psychology and socio-cultural disciplines have been investigating chronic fatigue since the 1860's. According to Friedberg and Jason, “In 1869, George Beard, an American neurologist was responsible for publicizing a disease he called neurasthenia: a disabling condition, which was an entirely organic illness of profound fatigability of the body, and mind” (1998, p. 6). Doctors at this time were prescribing a rest cure for these patients.

However, by World War I, the diagnosis of neurasthenia had become very unpopular as medical practitioners rejected the neurological basis of the disease, and instead considered neurasthenia as a psychological disorder (Wessely, Hotopf & Sharpe, 1998). “At this time, fatigue on the slightest exertion was decided to be a symptom of

anxiety, but prolonged fatigue was considered to be depression; perhaps minor, attenuated, atypical, masked, but always a form of anxious melancholia” (Ibid, p. 102).

“The diagnosis of neurasthenia was eventually discredited and became shameful for patients to confess.” Briggs & Levine (1994) explain that:

Between World War I and the 1980's, CFS was much less reported. This may have been due to the fact that physicians viewed these physical complaints in psychiatric terms. However, during this time period, two epidemics of fatiguing illnesses were reported. The first occurred in 1934, at a Los Angeles County hospital, and the second in 1955, at the Royal Free Hospital in England. Both epidemics involved medical staff rather than patients. Although researchers studied these epidemics, they could not explain what had occurred, and some of the affected remained chronically ill with fluctuating symptoms and significant functional impairment (as cited in Friedberg & Jason, 1998, p. 7).

“In the 1960's and 1970's, chronic brucellosis (a bacterial, infectious disease) was often cited as the cause of CFS, but patients with this diagnosis were typically viewed as having psychiatric conditions, usually depression” (Friedberg & Jason, 1998, p. 7). In the 1980's, CFS was explained as chronic Epstein-Barr virus syndrome, and viewed as a persistent viral illness. This etiology, however, was later discredited (H. Johnson, as cited in Friedberg & Jason, 1998). But, having created this viral link, CFS was beginning to be viewed as having a medical cause rather than a purely psychiatric origin.

Again in 1987, an epidemic of CFS broke out in Lake Tahoe, Nevada. Media attention to this epidemic invited an outpouring of reports of the same type of illness from both patients and physicians across the United States, Canada, the United Kingdom, and Australia. Presently, in terms of understanding the illness, patients are more likely to view the illness as having a medical cause (e.g. from an infectious agent), whereas many medical doctors are explaining it as a reversible psychiatric disorder, or simply a non-illness (Friedberg & Jason, 1998, p. 8).

The fact that CFS is difficult to diagnose and classify has important implications for its sufferers including stigmatization, feelings of hopelessness,

and frustration. (These will be discussed in a later section of this review about patient implications).

Current Research in CFS

CFS research has been undertaken in various disciplines including (but not limited to): anthropology, biochemistry, Western medical science, Eastern medical science, occupational health, nursing, psychology, psychiatry, sociology, social work, and women's studies. What follows is information from studies which have most bearing on this current study.

Studies in the literature to date have largely been quantitative, and focused on discovering etiological factors in the disease (Chaitow, 1998; Chubb et al., 1999; Scott, et al., 1999), or experimental studies of new drugs in the treatment of CFS (Goodnick & Jorge, 1999; Hickie, 1999; Natelson, et al., 1999; Reid, Chalder, Cleare, Hotopf, & Wessely, 2000; Scott & Dinan, 1999; Straus, McKenzie, & Demitrack, 1999; Vercoulen, Swanink, Zitman, Vreden, & Hoofs, 1996). Thus far, there has been nothing conclusive in terms of scientific evidence of particular biological/etiological factors at the root of CFS. Viral studies and immunological studies are inconclusive, and have produced inconsistent results (Lyall, Peakman & Wessely, 2003). Additionally, no effective drug treatment is available for CFS.

Treatments that showed some promise but overall provided inconclusive evidence include: hydrocortisone, reduced nicotinamide adenine dinucleotide, essential fatty acids, and immunoglobulin G (Erdman, 2003). A detailed review of pharmacological intervention in CFS may be found in Blondel-Hill & Shafran (1993).

Psychological research to date in the field of Chronic Fatigue Syndrome has mainly focused on: (a) sufferers' frustrations due to lack of a definitive diagnosis, (Beaulieu, 1995; Cohn, 1999; Friedberg & Jason, 1998; Hyden & Sacks, 1998; Melamed, 1998), (b) facets of their adjustment to the illness of CFS (Antoni, et al., 1994; Jason, Jordan, & Richmond, 1999; Lewis, Cooper, & Bennett, 1999), (c) coping and support strategies (Beaulieu, 1995; Folkman & Lazarus, 1980; Schaefer, 1995, 1997; Ware, 1999), and/or the use of cognitive behavioral therapies (Chubb, et al., 1999; David, Wessely, & Pelosi, 1991; Deale, Chalder, Marks, & Wessely 1997; Deale, Chalder, & Wessely, 1998; Friedberg, 1996; Friedberg & Jason, 1998; Jason, 1999; Sharpe et al., 1996, Sharpe, 1997).

In 1992, the National Institute for Mental Health (U.S.A.), and the National Institute for Allergy and Infectious Diseases jointly sponsored studies into six behavioral and psychosocial domains in CFS: fatigue, mood disturbance, functional status, sleep disturbance, global well being (i.e. psychological status), and pain. Studies in behavior coping and social support were also deemed important research areas for understanding and comprehensively evaluating CFS. The main focus of these joint studies were: (a) exploring better means of diagnosing CFS with clearer definitions of the symptoms of the illness, (b) refining the differences between CFS and depression, (c) developing a host of psychometric evaluation tools useful in standardizing research measures, and (d) publishing more rigorous treatment studies (randomized controlled trials), and outcome measures (Adapted from Friedberg & Jason, 1998).

CFS research is complicated for the following reasons: The symptoms for people with CFS overlap with other illnesses such as Chronic Pain, depression, anxiety disorder, Addison's disease, fibromyalgia, viral illness, and/or infectious illness (recurrent low-grade fever, lymphadenopathy). This overlap in symptoms precludes easy diagnosis (for screening purposes and subject selection), and it is also very difficult to determine

whether any treatment benefits for CFS alone might be obscured by the various, concurrent, diagnoses interfering with the success of the treatment.

The bulk of the published psychological treatment studies involve cognitive behavioural therapy (CBT) for sufferers of CFS:

CBT ... aims to facilitate recovery from illness by intervening in the cognitive component of the illness. The cognitive component is emphasized because of its presumed importance in illness perpetuation ... Change in the cognitive component is assumed to lead to more effective coping behavior, less emotional distress, and ... a reduction in biological disturbance (Sharpe, 1997, p. 357).

According to cognitive behavioral therapists, fatigue and its associated disability trigger illness related cognitive distortions including exaggerated catastrophic beliefs and self deprecating thoughts. These beliefs in turn elicit negative emotions such as anger, anxiety or discouragement. Additional fatigue is then associated with these emotions and the client is then caught up in an illness loop, generating greater distress. Cognitive behavior therapy which focuses on coping skills works to restructure the link between illness related disability, and its consequence of maladaptive cognitions and fatigue-related affect. Fatigue induced emotional stress and depression are treated with relaxation techniques and pleasant mood induction; maladaptive cognitions with cognitive coping skills and interpersonal support; and symptom fluctuations and disability with activity pacing, daily life restructuring and social assertiveness training (Friedberg & Jason, 1998, p. 140).

There have been minor successes reported with CBT in terms of helping clients cope with emotional stress through identification of triggers which exacerbate symptoms, or promote relapse (Sharpe, 1997), and in programs which teach activity pacing to sufferers of CFS (Deale, Chalder, & Wessely, 1998; Friedberg, 1995; Friedberg & Jason, 1998).

In discussing psychological treatment options, Friedberg (1996) suggests the following key elements of psychotherapeutic intervention in CFS:

1. An unequivocal empathic response to the patient's symptoms and disabilities;

2. Relaxation training to cope with stress and tension, to induce more restful sleep, and to generate a sense of well-being;
3. The use of cognitive-behavioral interventions to reduce symptoms of depression, anxiety, and depression-related fatigue;
4. Assessment based prescriptions for activity modification (“activity pacing,” Friedberg, 1995), and
5. Medications to manage depression/anxiety/sleep disturbance and pain.

As aforementioned, most of the psychological studies relating to CFS have been in cognitive behavioral therapy. These therapies are aimed at helping sufferers cope better with the illness, or avoid pitfalls of the cognitive illness loop as described above. The intent of this study, however, is to describe experiences, and processes which are part of pathways for healing the illness. Reber (1995, p. 330) defines healing as follows: 1. “to become healthy again, to make whole, to free from impairment, 2. providing assistance in the restorative process.” Taber (1977, H-9) also calls healing: “The restoration to a normal condition; to cure, to make whole, healthy.” To me, what stands out from these definitions is that healing is a restorative process. In other words, there is a normal, or natural state of health that exists within human beings, and that a healing process is one which allows this state to be restored.

This distinction is important in terms of the psychological research to date. Although it is important to be able to cope with what CFS presents in one’s life, discovering factors that may eventually bring about a full change of condition, can bring hope and encouragement for people with CFS, and provide direction and motivation on their life paths. This study is unique in the field of CFS research in that it bases its ideology on the premise that there can be a greater quality of life for people with CFS

beyond coping, and it considers patients as valuable resources in the discovery of that knowledge.

One of the areas that has been extensively researched, and written about concerns problems and frustrations CFS patients have in receiving a proper diagnosis, or discovering helpful treatment options (Beaulieu, 1995; Hyden & Sacks, 1998; Kantrowitz, Farrar, & Locke, 1995). I will discuss this next.

Problems with Diagnosing and Treating CFS: Implications for Patients

When CFS sufferers are on a path to health restoration, they are faced with numerous obstacles. When patients with CFS are trying to understand their illnesses, many are faced with a maze of possible causes, each with its own proposed medical, psychological or alternative treatment(s). Chaitow (1998) lists the following areas that come under investigation for sufferers of CFS:

Allergic and autoimmune conditions; neural and/or limbic malfunctions; infections including: bacterial, fungal, viral, and parasitic; genetically inherited tendencies; multiply occurring current symptoms: (pain, fatigue, insomnia, irritable bowel syndrome, digestive, and allergic, genito-urinary symptoms); possible nutrient deficiencies; acquired toxicity from pesticides, heavy metals, petrochemicals; iatrogenic influences; lifestyle factors such as: poor sleep patterns, inadequate or excessive exercise, alcohol, tobacco or drug usage, poor food choices, emotional distress; personality traits such as powerlessness, anxiety, depression; interpersonal issues; bowel dysfunction; organ dysfunction such as with liver or kidneys; endocrine imbalance; trauma, physical or psychological (p. 196).

The list of possible causes is extensive and overwhelming for sufferers. For CFS patients, a difficulty with deciphering this maze is not only the overwhelming number of possibilities, but also the lack of available energy with which to investigate them. The causes may also be mysterious and difficult to understand. The person may not be treated as an individual, but subjected to the latest remedy being tried in the medical,

psychological, or alternative fields. Friedberg & Jason (1998) state, “CFS patients, especially those who are severely disabled, may be desperate to try any potential treatment for their illness, even though newly touted therapies for the illness are often experimental at best, or entirely untested at worst. Hence, there is the potential for abuse, as CFS sufferers are desperate for a cure” (p. 124).

Some researchers suggest that there is a significant risk of suicide in long-lasting CFS cases, especially where there is a lack of sympathy or support from medical practitioners, family, and friends (Albrecht & Wallace, 1998), or that many CFS patients say they would rather have cancer than not know what was making them feel like they were dying (Melamed, 1998). In order to gain support and understanding, CFS sufferers are likely to turn to counsellors. The next scenario points out the general plight of sufferers when they come to counsellors for help. Gwenith Whitford (1995) describes living with CFS in this way:

Living with CFS is very difficult and definitely a challenge. My gradual decline into illness happened after a very stressful year. It intensified when I started a demanding new job in an air-tight office building in Halifax. The pain, exhaustion and depression were so debilitating that sometimes I wanted to die. Sleep was never restorative, as severe headaches would often keep me awake all night. I kept going because I denied the sickness within me. Fortunately I had the support and help of my husband ...The hardest part was the loss of a previously active professional and social life. My friendships suffered. As the months dragged on with no signs of improvement, the phone calls and visits from friends and colleagues eventually fizzled out. Added to this humiliation was the fact that I looked well, thereby making it difficult for all but the most loyal to believe there was truly something wrong with me (p. 20).

Clinical Counselling Concerns

Clinical issues relating to CFS which may present themselves to counsellors include some that are common to many clients with chronic disability such as:

depression, despair, pain, hopelessness, grief and loss issues relating to change of identity, loss of job, loss of significant relationships, attitudes toward one's body and illness, self blame attributions, marital problems, feelings of lack of control in life, financial issues, and the need for new coping strategies. However, CFS clients have some unique concerns based on the fact that the medical system has not, thus far, been able to find a known etiology or cure for the disease, nor has it been necessarily successful in its ability to diagnose the disease for its sufferers (Beaulieu, 1995; Friedberg & Jason, 1998; Hyden & Sacks, 1998). This is problematic in that many clients are disbelieved by their physicians, or told that the disease is in their heads, or psychosomatic (Henrikson, 1995; Melamed, 1998). Clients are then at a loss to explain their cluster of symptoms. They may, therefore, doubt themselves and/or develop a lack of faith in the medical profession, as well as express frustration/anger at doctors for lack of support, sympathy or cure (Friedberg & Jason, 1998). Doctors, may in fact, run a series of tests on patients only to come up with no answers or remedies for them (Kantrowitz, et al., 1995). Clients' complaints may be viewed as illegitimate by doctors, creating a marginalization of those with the disease as well as an emerging need for those who subjectively believe they have the disease (Ware, 1999), to rely more on their own resources to understand the syndrome (Cohn, 1999; Schaefer, 1995/1997).

Valuing a Patient's Own Knowingness, Wholeness and Ability to Heal

Qualitative studies relating to subjective experiences of people with CFS are difficult to find. Schaefer (1995/1997), however, conducted two qualitative studies of women with fibromyalgia. (Fibromyalgia is similar to CFS in that its sufferers, mostly female, have met with similar difficulties related to diagnosis, and treatment. CFS and

fibromyalgia have several overlapping symptoms including fatigue and muscle pain. Strategies used by those with fibromyalgia may also be useful to those suffering from CFS).

Schaefer's (1997) study identified six important themes. These included:

1. That the participants' experience of pain is both mental and physical and that the feeling of pain is exacerbated by the fact that participants don't feel there is anything they can do for themselves.
2. Fear of pain and discomfort interferes with ability to do things.
3. Suffering results from doing things out of the ordinary routine.
4. Knowing the self helps control the illness.
5. Stress affects how one feels.
6. Doing things that are pleasant and appealing helps to ease the discomfort (p. 568).

Schaefer included diary entries from her eight participants as part of her data base. She concluded that diaries "can help women to become more self aware, improve their inner strength, and awaken their inner healing powers" (Ibid). Schaefer's results imply that inner dialogue may somehow provide access to doorways for healing.

Including Patients' Own Knowingness in Health Research

In order to understand why there is a dearth of articles related to CFS sufferers own experiences in healing or recovery from CFS, Malterud (1993) states:

Power and knowledge are closely connected, and this is no less true for the medical profession than it is for any other sphere of life. Knowledge is constructed by voice. Unfortunately, women's voices are often silent in the factory where medical knowledge is produced.

Baron (1981) infers that the problem of patients' voices (male and female) being absent in the medical field is that:

Traditional medical views of illness systematically exclude intuitive knowledge from their description of disease and thus result in functionally impressive, but human ungrounded medicine. The ... experience of the sick person is ignored, in order to obtain an “objective” description of pathology.

This *objective* bias in science has led medical doctors and researchers away from studying patients’ subjective experiences as these experiences are not readily quantifiable and, therefore, it is argued that this is *not good science*. However, this rationale has serious implications for sufferers of CFS and Chronic Pain. One such implication is the disempowerment of people from believing in their own inner wisdom as a guide toward healing their illnesses. If doctors or medical scientists become authorities on health and illness, and only objective, quantifiable, studies constitute reliable knowledge about health, then a patient’s own reflexive, and/or intuitive knowledge is not valued, or even sought out as a resource. Neither the physician nor the patient looks to the patient’s own wisdom as a source for healing.

Dr. R. J. Baron (1985) states the following:

Our medical world view is rooted in an anatomicopathologic view of disease that precludes a rigorous understanding of the experience of illness. What we need to remedy this problem is not just the admonition to remember that our patients are people, but a radical restructuring of what we take disease to be (p. 606).

The choice to conduct this qualitative research study examining experiences of participants with CFS, I believe, employs a paradigm which may be empowering to those suffering from CFS. By looking for meaning within patients’ own experiences, the traditional paradigm of physician/psychiatrist as expert is turned on its head as patients themselves are viewed as sources of authority regarding their own health. This type of empowerment is particularly important in combating the helplessness experienced by

sufferers of CFS. I agree with Ivan Illich (1979) who argued that contemporary medicine has had a role in expropriating human health, and undermining the human being's ability to take responsibility for his/her own sicknesses" (as cited in Ashworth, Giorgi & Koning, 1986, p. 189).

The dearth of understanding, explanation, and treatment options for CFS from health professionals leaves sufferers desperate for a means of understanding their own illnesses. In Heijman's (1998) study of illness cognitions in patients with CFS it was discovered that patients who considered their illness to be a serious condition, who believed that they had no control over their illness, and saw little possibility for cure, reported higher levels of impairment in physical, and social functioning, and greater problems in mental health and vitality. It makes sense to me, therefore, that for sufferers with CFS, describing experiences which access their inner resources may be particularly empowering especially in view of the fact that cures are not available from outside experts.

Part 2: Chronic Pain

Researcher's Personal Experience

When I began this study, I was no stranger to pain. A serious car accident in 1984 on the Washington State Freeway, another accident in 1986 near Port Angeles, and a fall at home in 1999, all gave me first hand experience of pain (including body knowledge) and ways of treating it.

Also, during my undergraduate studies in the early 1990's, I went through a few years of severe migraine headaches. Pain medications had little effect. What helped me were some alternative therapies such as chiropractic, massage,

and cranio-sacral therapy (osteopathy), as well as years of body-oriented, psychotherapeutic work. I knew how debilitating Chronic Pain could be. I also knew about fatigue, and the interconnection between fatigue and pain. I knew how scared I felt some mornings when I was awakened by my alarm, at 5:25 a.m., for a nursing shift, and awoke in pain. Somehow, I ignored the pain while I worked, all the while attending to others in pain. Once in a while when an elderly patient in pain would look at me with a compassionate, loving eye, I knew that the server and served were one.

During my practicum at the Victoria Pain Clinic (VPC) in January 2001, I spent ten days with a group of 12 people. Eleven of them were in severe, Chronic Pain. The twelfth person had been diagnosed with CFS. It was then that I learned that there were ways of working with pain which were different from what I had learned in nursing school. In nursing school, pain theory was very practical and aimed at palliation, (relief), for the patient in pain. Pain was considered as, “an inevitable sensory response to tissue damage” (Loeser & Melzack, 1999, p. 1607), and the theory behind pain was called the *Gate Control Theory* (Melzack-Wall, 1965), which described the mechanisms of response in the brain and central nervous system which operate when a noxious stimulus is perceived by the brain. Apart from the physiological explanation of pain, I also learned (as regards patients themselves) that pain is whatever the patient says it is (McCaffery, 1997). I took this to mean that if a patient says he/she is in pain, believe him/her!

I spent many years caring for dying patients. I worked at Hospice, on the medical oncology ward of the Victoria General Hospital, in community nursing,

and in care homes. The approach was to allow patients to die as pain free as possible. That to me was merciful and compassionate care of them. In discussing Chronic Pain in this thesis, however, we are talking about a large number of people who are living in pain, and *not* imminently dying.

Types of Pain

Pain can be classified into three basic types. The first type is *transient pain* which occurs by activation of nosioceptors of the skin, or other tissues of the body, in the absence of any tissue damage (Loeser & Melzack, 1999). This type of pain subsides once the stimulus is removed e.g. pain during an injection.

The next type of pain is *acute pain*. In acute pain, substantial injury of body tissue activates nosioceptors at the site of the tissue damage:

The local injury does not overwhelm the body's reparative mechanisms. *Healing* can occur without medical intervention. The report of pain stops long before healing has been completed. However, medical interventions may be useful ... to prevent or reduce pain and to speed up the healing process by shortening the duration of the injury ... This type of pain is seen after trauma, surgery and some diseases. The healing process usually takes a few days or a few weeks (Loeser & Melzack, 1999, p. 1608).

The third type is *chronic pain*. "Chronic pain is defined by its length; more than six months, and by the fact that the body is unable to restore its physiological functions to normal homeostatic levels" (Loeser & Melzack, 1999, p.1608):

Unlike acute pain which is initially associated with specific autonomic and somatic reflexes, these disappear in patients with Chronic Pain. Many physicians and patients do not realize that pain can occur without nosioception: (The detection of tissue damage by special cells in tissue). The intensity of Chronic Pain frequently bears little or no relation to the extent of tissue injury or other quantifiable pathology (Ibid).

In chronic pain syndromes, the intensity of pain may be out of proportion to the original injury or tissue damage. Therefore, Chronic Pain sufferers often seek medical attention. “Chronic pain differs from acute pain because therapies that provide only transient pain relief do not resolve the underlying pathologic process. Chronic pain will continue when treatment stops” (Loeser & Melzack, 1999, p. 1608). Most common types of chronic pain include back pain, headaches, neck pain, musculoskeletal pain (e.g. shoulders, joints, soft tissue injuries), osteoarthritis, and fibromyalgia. Some researchers estimate that 40% of the general population suffers from chronic intractable benign pain (Verhaak, Kerssen, Dekker, Sorbi, & Bensing, 1998).

Understanding Chronic Pain: Expansion of Definitions

Chronic pain affects the quality of life for its sufferers. Current understandings of pain have advanced from a solely biological explanation to one in which pain is viewed as a multi-factorial, “biological, psychological, social, and existential phenomenon” (Bullington, Nordemar, R., Nordemar, K. & Sjostra-Flanagan, C., 2003, p. 325). According to Bendelow, “Pain lies at the intersection of biology and culture, and for that reason, emotional, psychological, socio-political, existential, and spiritual aspects of pain must be taken into account” (Bendelow, as cited in Bullington, Nordemar, R., Nordemar, K., & Sjostra-Flanagan, 2003, p. 325).

The International Association for the Study of Pain (IASP) “provides more, and more scientific evidence that Chronic Pain is a biopsychosocial event, and that its diagnosis, and treatment should be considered in a multidisciplinary frame” (Poppe, Devulder, Mariman & Mortier (2003, p. 92).

Multidisciplinary Treatment of Chronic Pain

Since the early 1970's, multidisciplinary pain clinics, or centers, developed to treat Chronic Pain patients. Pain treatment facilities developed for a number of reasons. Fishbain (2000) in a Meta-analysis of non-surgical pain treatments stated the following:

First, people in general put a very high value on living a pain-free life. Second, numerous epidemiological studies determined that a large percentage (40%) of the general population suffered from chronic intractable benign pain (Verhaak et al., 1998). And third, the experience of treating continuous severe pain of battle injured World War II soldiers determined that a coordinated team was required to manage the different types of pain. It was observed that a significant percentage of low-back pain and neck pain patients did not improve with traditional medical treatment but remained disabled. These patients demonstrated a host of behavioral and psychosocial problems in association with their chronic pain. These problems required the intervention of disciplines besides those of the neurosurgeon, orthopedic surgeon, and anesthesiologist. In addition, these patients required a concurrent highly integrated multidisciplinary treatment approach that would address all the patient's problems simultaneously (Rosomoff & Steele-Rosomoff, as cited in Fishbain, p. 173).

Chronic pain clinics generally include professionals from several disciplines working together. Multidisciplinary pain centers are generally supervised by an appropriately trained and licensed director, and staffed by a physician, psychologist, mental health counselor, occupational therapist, physical therapist, and registered nurse.

For example:

A physician and mental health counselor can work as a team to treat the physical, emotional, interpersonal, financial and spiritual problems some pain patients have. Counseling to cope with the various side effects that go with pain – irritability, stress, sexual and parenting problems, must be an integral part of any team approach. In most cases, counseling is extended to the family (Weiner, 1991, p. 79).

Multidisciplinary Pain Clinics often utilize a variety of treatments for chronic pain. Common treatments include: pharmacological interventions including over the

counter drugs such as aspirin, acetaminophen (Tylenol), and ibuprofen. Also, prescription medications such as narcotic, and non-narcotic analgesics, steroidal, and non-steroidal anti-inflammatory agents are used. Other treatments/therapies include injections for muscle spasms, physiotherapy, transcutaneous electric nerve stimulation (TENS), biofeedback, stretching exercises, relaxation exercises, imagery, and distraction.

Counselling approaches generally focus on “coping and adjusting ... The goal is to help an individual develop internal resources to make the pain manageable” (Weiner, 1991, p. 79). In the U.S. alone, there are approximately 1500 – 2000 Chronic Pain facilities (Rosomoff & Steele-Rosomoff, as cited in Fishbain, 2000). The IASP classifies pain facilities into four different types. (These descriptions can be found in Appendix E).

Before the year 2000, Meta-analyses addressing the efficacy of specific treatment interventions for Chronic Pain were not consistent (Aronoff, Evans, & Enders, 1982; Aronoff, McAlary, Witkower, & Berdell 1988; Bendix, T., Bendix, A. F., Bush, & Jordan, 1996; Koes, Assendelft & Geert, 1996; Large & Peters, 1991; Wells & Miles, 1991; White & Harth, 1996, as cited in Meta-analysis, Fishbain, 2000). However, in a more recent Meta-analysis, the following conclusions were reached:

Pain facility treatment is effective for the treatment of Chronic Pain. In addition, reference to specific treatments: capsaicin, antidepressants, physical therapy, topical NSAIDS, cognitive behavioral therapies, and perhaps anticonvulsants and educational approaches were shown to be effective. Thus, according to these results, an ideal pain facility treatment program should provide the following: physical therapy, cognitive and behavior therapy, and educational therapies. In addition, psychopharmacological options include antidepressants, topical NSAIDS, capsaicin, and perhaps anticonvulsants (Fishbain, 2000, p. 177).

Fishbain, Cutler, Rosomoff & Steele-Rosomoff (1999) go on to say that in reality pain facilities:

may or may not provide these treatments, or may provide a greater range of treatments. Pain facilities generally use multiple treatments simultaneously which are integrated into a treatment package. Thus it is impossible to say whether the positive meta-analysis results for pain facility treatment related to the fact that the specific treatments shown to be effective were provided, or that other hereto-untested treatments were utilized. This question awaits further research (as cited in Fishbain, 2000, p. 177).

Complementary Alternative Medicine

Over the past fifteen years there has been an increasing popularity in Complementary Alternative Medicines (CAM) for the treatment of Chronic Pain. In the year 2000, Kathryn P. White, a psychologist from University of California Los Angeles, conducted a comprehensive study of complementary and alternative medicines to provide the psychological community with thorough and accurate information about various alternative methods. White indicated that 42% of Americans were estimated to be seeking unconventional treatments, and had been collectively spending 21.2 *billion* annually (p. 671). In lay language, this is largely due to the fact that *pain hurts*. Sufferers want solutions, and are often disenchanted with options available to them from the Western medical profession. White believes that the alternative movement “was spawned as a reaction to the overly specialized piecemeal approach to examining and treating patients prevalent in Western Medicine” (p. 673). She describes alternative medicine as:

(a) A comprehensive medical system based on alternative paradigms for understanding health and illness other than Western orthodox medicine’s biomedical model, or, (b) if partially or wholly understood from a biomedical perspective, medical systems that provide alternative modes of treatment to those comprising standard medical or psychological practice. This definition highlights the fact that many forms of alternative medicine reflect multicultural views of health and illness yet also include such practices as hydrotherapy and nutritional medicine, in which the

methods are at least partially understood from a biomedical worldview (p. 673).

CAM treatments may be referred to as holistic, complementary, alternative, mind-body medicine, integrative medicine, and/or energy medicine. Most common include: massage therapy, chiropractic, acupuncture, hypnosis, Ayurveda, Reiki, therapeutic touch, cranio-sacral therapy, homeopathy, naturopathy, and herbal medicine.

Holistic medicine generally adopts a unitary view of the mind, body, and spirit, and relates to the whole person in terms of health, illness, or wellness. In doing so, holistic medicine challenges the notion of a split between mind and body referred to as Cartesian dualism (Greer, 2003, p. 5). Instead, mind, body and spirit are recognized as operating together in a cooperative fashion. Holistic treatments may be an adjunct to orthodox medicine, or patients may decide to solely rely on CAM's for Chronic Pain. "Integrative medicine refers to efforts to integrate orthodox and alternative medical practices" (White, 2000, p. 673).

Energy Medicine

Several CAM traditions incorporate the concept of energy into their healing paradigms. Energy is referred to as Prana, Qi, Chi, Life force, or vital force, depending on the system used. Inherent in this understanding of energy is the idea that humans are energetic beings with a natural energy flow.

Prana is said to become inactive or disturbed, disrupting the normal flow of energy through part or all of the body, before pathology is manifested as physical disease. According to energy medical traditions, people's thoughts and emotions directly influence their life force; increasing, decreasing, knotting up, or freeing the flow of energy throughout their bodies. Although the physical body, life force and mind may appear ... separate, energy medical traditions see them as interconnected and part of the same energetic whole (White, 2000, p. 673).

At the Victoria Pain Clinic, energy medicine is practiced in the form of acupuncture, body psychotherapy, and breathing. These therapies assist clients to re-establish balance by helping them access energy, become aware of energy, and open its flow. White (2000) draws our attention to the fact that many people practice energy medicine regularly without necessarily thinking of it as such when they do Yoga, Tai-Chi, Qi Gong, or several of the Martial Arts.

Acupuncture and Traditional Chinese Medicine.

In the broadest sense classical and Traditional Chinese Medicine:

constitutes a comprehensive system of medicine developed over at least 2,500 years that uses acupuncture, acupressure, massage, a chiropractic-like technique known as Tui Na, herbal medicine, nutritional programs, lifestyle counseling, meditation, and energetic practices such as Tai Chi and Qi Gong to promote health and ameliorate disease (White, 2000, p. 675).

Although these practices originated in China, and are still practiced there, they have become popular in the United States and Canada since the early 1970's. In many U.S. states and Canadian provinces, acupuncturists are licensed health care practitioners. Although the scope of Chinese medicine is much wider than acupuncture alone, many people think of Chinese medicine as *acupuncture*.

The Victoria Pain Clinic's philosophy re: acupuncture concurs with White's analysis which follows. In North American culture, practitioners:

often behave as if there were a split between psyche and soma, with psychologists typically overlooking the body and most medical doctors paying little attention to the mind. Chinese medicine, by contrast, seeks to understand and treat a person's body and mind from an integrated perspective ... Therapies affecting the body are recognized as having the capacity to influence the mind, and vice versa. The paradigms in Chinese medicine focus on the whole person, not the disease, and address energetic

imbalances. Whereas in orthodox medicine diagnosis is an attempt to name disease, in Traditional Chinese Medicine (TCM) the goal is to recognize and right patterns of disharmony (White, 2000, p. 676).

The Victoria Pain Clinic uses TCM incorporating *Five Element Theory*, which has its roots in the laws of nature, and changing seasons. Many studies have been done which substantiate the efficacy of acupuncture for the treatment of acute and Chronic Pain (see review of 37 clinical trials in Birch & Hammerschlag, 1996).

In terms of psychological areas, Lanza (1986) found that combining acupuncture with biofeedback was twice as effective as biofeedback alone in reducing anxiety, and muscle tension (as cited in White, 2000, p. 676). Guizhen, Yunjun, Linxiang, & Aizhen (1998) concluded that combining acupuncture with behavioral desensitization was clearly superior to and about twice as effective as either procedure alone in treating patients with anxiety disorder (as cited in White, 2000). Clinical trials have also supported acupuncture's effectiveness in the treatment of substance abuse (Brewington, Smith & Lipton, 1994; Bullock, Culliton, & Olander, 1989; Bullock, Umen, Culliton, & Olander, 1987; Clavel, Benhamou, Company-Huertas, & Flamant, 1985; Lipton, Brewington, & Smith, 1994; Margolin, Avants, Change & Kosten, 1993, as cited in White, 2000, p. 677). White suggests that future studies should use Western psychological, and East Asian diagnostic methods in assessing depression, anxiety, or other psychological disorders, and evaluating treatment effectiveness.

In this paper, the ideology about Chronic Pain and Chronic Fatigue Syndrome I employ resonates with that of Steen & Haugli (2000) which is based on:

Phenomenological epistemology ... Within the phenomenological frame of understanding, the body is viewed as a subject and carrier of meaning, and therefore, chronic pain can be interpreted as a rational reaction to the totality of a person's life situation.

My definition includes a bio-psychosocial model of illness formation, and treatment, as well as an *honouring of the body as a highly intelligent* conveyor of needs, feelings, and solutions which, in connection with the mind, and spirit, sustain overall well being.

Part 3: Rationale for the Present Study

When I was exploring ideas about CFS, I had the following thoughts: First, because valid explanations about CFS: proposed causes and cures, were not yet available from the Western medical profession, I began to consider the idea that perhaps there are answers within persons with CFS which might be accessed as resources for understanding of their own illnesses. A second thought also occurred to me and inspired the study. That conception revolved around the fact that I witnessed people with CFS, and Chronic Pain, impact their conditions at a previous 10 day residential Pain Program at the Victoria Pain Clinic. I didn't know how it happened, but there seemed to be quite a contrast between the lack of hope and answers available to sufferers from the *world at large*, and the changes I witnessed occurring through the Pain Program.

As previously stated, many researchers have recognized that CFS sufferers are desperate for an explanation for their disease (Albrecht & Wallace, 1998; Melamed, 1998), yet I am not aware of any studies that explore how patients own wisdom can provide a source of awareness and healing in CFS. This study aims at a description of such experiences. It is hoped that the insights shared by participants in these pages can shed light on the meaning of CFS for participants, as well as psychotherapeutic pathways toward recovery from the illness.

In terms of understanding Chronic Pain, Fishbain (2000), in his Meta-analysis of the effectiveness of treatments at Chronic Pain Clinics, states that further research is called for to determine exactly what treatments are most effective. He suggests that it is difficult to decipher whether a particular treatment is effective, or whether an other “hereto-untested treatment” may have accounted for beneficial results (p. 177). In my way of thinking, one of the components of a “here-to untested treatment” may be the patient him/herself. In other words, treatments work in combination with the people who have them, and a bio-psychosocial, and holistic model, must take into account the person within the treatment equation.

Therefore, this study is aimed at describing, and illuminating, a process that participants experienced during a 10 day residential pain program, in order to advance current research about the interweave of a patient’s own knowingness with various treatment modalities.

CHAPTER THREE: METHOD

Overview of Method Section

- Chapter Introduction
- The Research Questions
- Research Design: Qualitative Methodology
 - Chronology of Methodological Steps
 - Qualitative Research Methods that Informed This Study
 - Ethnography
 - Case Study Research
 - Phenomenology
 - Heuristic Research
 - Principles that were Important to Me in Terms of Research Design
 - Elaboration on the Methodology
 - Verification

Chapter Introduction

This study, of eight participants in a 10 day residential Pain Program at the Victoria Pain Clinic, is a qualitative study which uses pre and post-program semi-structured interviews to elicit the data needed to answer the research questions. The study has been informed, and most influenced by the qualitative research traditions of ethnography (Patton, 1980/1990); case study (Yin, 1994); and phenomenological inquiry (Giorgi, 1979; Moustakas, 1990/1994). For construction of the narratives, and sensing the permission to include my own writings (*as Researcher's Excerpts*), I drew upon the influence of Ely, Vinz, Downing, and Anzul (1997).

The Method Section flows chronologically, based on the development and evolution of the study. It begins by capturing the sense of inquiry that inspired the study, then states the research questions, and explicates the choice to use qualitative methodology to best answer the research questions.

Next, I include a chronology of the Methodological steps, which is an abbreviated version of the actual practices, procedures, and stages of analysis involved in the study. The chronology should help the reader better navigate and understand the next section: *Qualitative Traditions that Inform the Study*, by placing the traditions within the context, and timeline of the study.

A fuller, more narrative explanation of the methodological steps and procedures follows next. Chapter Three ends with thoughts in the process of verification of this research study.

Beginning the Research Journey

I begin the research journey with something that has called to me from within my life experience, something to which I have association and fleeting awarenesses but whose nature is largely unknown (adapted from Moustakas, 1990). This statement resonates with how I was feeling at the beginning of this inquiry. I had observed a phenomenon at the Victoria Pain Clinic that seemed transformative for participants with Chronic Pain and Chronic Fatigue Syndrome. Exactly what the phenomenon consisted of and what *sparked* it were unknown to me. I was curious to explore this further.

The Research Questions

I developed the following four research questions to guide the study:

1. What was the growth process participants went through to be able to impact their illnesses in such a short period of time?
2. Can this process be explained?
3. Are there answers within the explanations that will also benefit others in Chronic Pain or with CFS?
4. Can we, as practitioners, learn something about how to work with people with CFS and Chronic Pain more effectively based on what these participants' journeys can teach us?

Research Design: Qualitative Methodology

I asked myself what type of methodology best answers the questions? Because I wanted to carefully track the participants' growth processes in-depth, and gain understanding of participants' inner worlds,' qualitative methodology was the method to use. Qualitative methodology also gave me the advantage of conducting the research in a way that elicited the *least constrained* data. By this I mean that by using interview protocols which gave the participants latitude to fully express themselves, I would gain the richest, most informing data. This qualitative study is descriptive, and exploratory. The research design is eclectic in that it draws upon the strengths of several qualitative methodologies and utilizes them to best answer the research questions. These include: ethnography, case study, and phenomenology.

Chronology of Methodological Steps

Step 1: Conceptual Framework

- Define the nature of the problem under investigation
- Formulate questions for study
- Construct Research Questions
- Decide how to approach the problem to best answer the questions
- Apply to University of Victoria Ethics committee for approval to conduct study

Step 2: Initiating the Study

- Approach Victoria Pain Clinic about conducting Study
- Make decision to include Chronic Pain, and CFS Participants in Study
- Receive Consent from University of Victoria Ethics Committee to Proceed with Study

Step 3: Preparation

- Send out Participant Recruitment Letters (Appendix A)
- Prepare Informed Consent Forms for Participants (Appendix B)
- Meet with Pain Clinic staff to prepare for the study
- Create Pre-Program Participant Interview Protocol

Step 4: During the initial phase of the Program

- Meet participants at noon, before the start of the Pain Program
- Explain study to participants, answer questions, obtain signed informed consent forms from participants of the study (See Appendix B: Informed Consent)
- Conduct Pre-program interviews from 1:30 p.m. – 6 p.m., before program start (30 minutes each) (See Appendix C re: Pre-Program Interview Protocols)
- Clarify any participant questions or concerns
- Introduce myself as a researcher at Pain Program's first evening group, that night. Field questions about study. Explain that I will not be collecting any data during the Program, and that their participation is completely voluntary. They can withdraw at any time. Reiterate confidentiality, and the use of pseudonyms in the study. Explain that I will be part of the group sessions.

Step 5: During the next 9 days of the Program

- Write summaries of impressions, and initial main themes from pre-program interviews as soon after interviews as possible
- Participate in program as researcher, and group member. Attend stretching exercises, relaxation exercises, lectures, psycho-educational classes, and group experiences.
- Attend most meals with participants
- Keep my own research journal about my process, as well as the research process
- Listen to all pre-program interview tapes in order to prepare for post-program interviews
- Schedule and conduct individual practitioner interviews (See Appendix C)
- Create standard interview protocol for all eight participants as well as participant specific follow-up questions for Post-Program Interviews

Step 6: At Program End

- Schedule and conduct Post-Program interviews for participants: 45 minutes to 1½ hours each before participant leaves the Pain Clinic (See Appendix C)

Step 7: Within the first two weeks Post Program

- Listen to all eight Post-Program interview tapes
- Transcribe all the interview data including Pre-Program, Post-Program, and Practitioner interview tapes.
- Finish practitioner interviews of two staff members who were too busy during the Program, and transcribe. (These two interviews took place two weeks after Program end).

Step 8: (Details of exact data analysis methods follow next in the Exploration Section)

- Data Analysis of **Pre-Program** Interviews → **Participant Profiles** (in Chapter 4)
- Create Composite Pre-Program Story → *Life on a Postage Stamp* (in Chapter 4)

Step 9

- Data Analysis of **Post-Program Interviews** for each participant
- *Stage 1 Data Analysis* → Researcher holds the intention of describing the participant's journey as fully and clearly as possible; including salient themes. These narratives are called: **Post-Program Transformation Stories**

- *Stage 2 Data Analysis* → The researcher holds the intention of discovering from the data, what sparked his/her transformation? What was the process? What accounted for the insights/transformation? These are written as Stage 2 narratives at the end of the Transformation Stories.

Step 10: Across – Participant Analysis

- Conduct across participant data analysis of all Post-Program transformation stories → *Summary of Findings* (main themes across participants in Chapter Five)
- Discerning the components of the transformation process: Across participant composite of Stage 2 Data Analysis → *Process of Transformation: Summary* (in Chapter Five).

Step 11: Writing

Qualitative Research Methods that Informed This Study

A number of qualitative research methodologies were drawn upon in this study.

Emphases of certain traditions in different parts of the procedures, or analyses arose as part of a natural evolution of the study (what the study called forth). They were also rooted in conscious decisions I made at various points along the way regarding what I believed were the soundest ways of answering the research questions. The following section describes the contributions of the various schools to the overall methodology: ethnography, case study, phenomenology, and heuristics.

Ethnography

The “Culture” of the Pain Clinic

In ethnographic studies, researchers generally study cultures of people within their natural environments in order to examine some aspect(s) of cultural phenomena.

The goal is to describe that culture (or aspect of it) as indigenously as possible. To achieve this goal, ethnographers often spend considerable periods of time actually living

in the culture to best understand it, and to develop trusting relationships with people of the culture. This provides them with first hand experience of the culture, and the development of trusting relationships aids in obtaining optimal data for research purposes.

The present research has certain dimensions akin to an ethnographic study. The participants lived at the Victoria Pain Clinic for 10 or 11 days. The Pain Clinic has its own culture which consists of the setting, the program, the staff, and participants. The study was conducted within this co-relational atmosphere. The group setting was a type of *home base* for participants. Participants were away from their usual outside worlds, and temporarily free from worldly responsibilities and contacts. (A fuller description of the Victoria Pain Clinic is in Appendix D).

Researcher as Participant in the Culture

Although I didn't reside there, I was at the Pain Clinic for approximately 12 hours everyday, for the 10 days of the program. I immersed in the same culture with the participants, practitioners, cooks, and helpers. I was part of the group. I also experienced two acupuncture sessions on the insistence of one of the participants who felt that I wouldn't understand her experience without having these treatments. In this way she was acknowledging the value of the researcher's immersion in the culture. Patton (as cited in Moustakas, 1994) describes the value of the researcher being part of the group. He states:

By direct observation, the researcher is better able to understand the context in which the people live and share activities and their lives; first hand experience enables the researcher to be open to discover and deduce what is significant; ... The researcher can include his or her own

perceptions of what is essential in understanding the setting, its participants and staff (p. 3-4).

I certainly found that immersing myself in the group was of great benefit to the research. It gave me the opportunity to live the experience I was investigating to a much greater degree than might have happened if I had only met with participants for interviews before and after the program. It was also vitally important in building trust and rapport with participants, which was a great help in being able to reach the depths necessary in the post-program interviews.

Some of the other principles of ethnographic research, as described by Patton (1990) apply to this study. His suggestions follow, and have been implemented in the study:

1. Represent program participants in their own terms. Use quotations. Capture participants' views of their experiences in their own words.
2. Build trust and rapport at the entry stage. Remember that the evaluator-observer is also being observed and evaluated.
3. Be as involved as possible in experiencing the program as fully as possible while maintaining an analytical perspective (as cited in Moustakas, 1994, p. 3).

Case Study Research

I draw on the work of Yin (1994) as follows: (a) in designing the participant profiles from Pre-Program interview data, (b) in my decision to interview participants both Pre and Post program, (c) in my decision to interview each of the practitioners of the Victoria Pain Clinic, (d) in writing the Post-program Transformation Stories. In case study methodology, the life of the participant is the focus of study. One individual, or a group of individual cases, can be used to "illuminate a specific issue" (Creswell, 1998).

In this situation, the interview questions for participants pre-program were designed to create profiles which gave a *snapshot* of their multidimensional lives. I felt that it was particularly important to develop a portrait of the participants in as full a way as possible at the start of the program. This was due to the fact that this study was about learning from participants' journeys, and the fact that people with CFS and Chronic Pain are often dismissed by practitioners, or thought of only in terms of their illness or ailments alone which can be damaging for self esteem. Therefore, I believe that the participants deserved to be represented in as *whole* a fashion as possible.

The decision to conduct both pre and post-program interviews also relates to certain values inherent in case study research. In order to investigate the change process for participants during the program, it wasn't enough to study the phenomenon of change on its own. It is important to emphasize that it is the subject who is changing; the person has changed. One way of having that change process come alive was to center on the participant as he/she described his/her changes. Focusing on the participant meant describing his/her inner world; attitudes, emotions, pain/fatigue levels, as well as outer world (e.g. relationships with group members, and practitioners in the program), to create rich, and full descriptions of the participants.

Case study methodology calls for a description of the context in which the study takes place. This can be found in Appendix D which includes references to the history, philosophy, treatments, and daily schedules for participants of the Victoria Pain Clinic. Descriptions that relate to the Clinic and program have also been expressed in many of the Participant Post-Program Transformation Stories. So each participant case is

contextualized as part of a larger program, or setting, within which the participant operates.

Phenomenology

As well as describing the participants' experiences, Stage 2 of data analysis asks the questions, "How did this growth process happen? What accounted for the changes/transformation in participants? It was this curiosity in spirit of the original inquiry that inspired the study. To answer these questions I used a phenomenological data analysis process. I was investigating participant experiences of transformation. I wanted to know what sparked the transformation. I constructed the Post-Program interviews to probe into areas from which I hoped to elicit data that would provide "comprehensive descriptions ... of the essence of the experience" (Van Kaam, as cited in Moustakas, 1994, p. 13). The aim was to "determine what an experience means for the persons who have had the experience, and are able to provide a comprehensive description of it" (Moustakas, p.13).

During the Post-Program interviews, the skills I have as a counsellor allowed me to go *beneath* the questions themselves in order to carefully probe with participants about the process of transformation. Although participants could cite many examples of their changes, identifying the process for the changes was not as readily available to their conscious minds. One of the goals of phenomenology is to elucidate these hidden experiences and bring them into awareness. Another goal is to refine the data in such a way as to reveal the *essence* of the experience. To these ends, the data analysis procedure I employed for the post program transcripts was akin to Giorgi's (as cited in Moustakas, 1994):

1. The researcher reads the entire description of the experience straight through to get a sense of the whole.
2. Next, the researcher reads the same description more slowly and delineates each time that a transition in meaning is perceived with respect to the intention of discovering the meaning.
3. The researcher then eliminates redundancies and clarifies or elaborates to himself the meaning of the units he just constituted by relating them to each other and to the sense of the whole.
4. The researcher reflects on the given units, still expressed essentially in the concrete language of the subject, and comes up with the essence of that situation for the subject. Each unit is systematically interrogated for what it reveals. The researcher transforms each unit, when relevant, into the language of psychological science.
5. The researcher synthesizes and integrates the insights achieved into a consistent description of the structure ... of the experience (p. 14).

Heuristic Research

In heuristics, “The research participants remain visible in the examination of the data and especially in the individual portraits, they continue to be portrayed as whole persons” (Douglass & Moustakas, as cited in Moustakas, 1994, p. 19). In this study, this means that even when the process of transformation was the object of analysis, you don’t lose sight of the participant. The participant him/herself is the agent of transformation.

Heuristic research aims toward composite depictions that remain close to individual stories. The composite depiction of an experience is developed through a process of immersion into, study of, and concentration on the experience of the phenomenon as presented by each co-researcher. At some point in this process, the qualities, core themes, and essences that permeate the experience of the entire group of co-researchers are understood and a universal depiction is constructed (Moustakas, as cited in Moustakas, 1994, p. 20).

It was by multiple readings of the Post-Program Transformation Stories, and interviews with quality time for reflection, that I created the Summary of Findings, and

Summary of the Transformation Process (in Chapter Five), which synthesize core themes from all participant Post Program Transformation Stories.

Principles That Were Important to Me In Terms of Research Design

Osborne (1994) states that in qualitative methodology, “The emphasis is upon discovery, description and meaning, rather than the traditional natural science criteria of prediction, control and measurement” (p. 168). Because I had witnessed such an *alive* process of change at the Victoria Pain Clinic, I had an excited sense of discovery about the study. And it was important to me to keep this spirit of discovery alive. This meant that I kept the questions of the study in an *active sanctuary* inside of me where they were protected, and where they could give me impetus for the pursuit of knowledge about them, as well as joy in the discovery process.

A part of keeping the discovery alive meant taking an active interest in participants during the interviews and staying present for their feelings; whether they were feelings of joy, excitement, and enthusiastic self discovery; or feelings of sadness, fear, anger, or distress. I was highly cognizant of having utmost respect for participants. It was important to me to structure the interviews, conduct the analyses, and write the participant stories in ways that represented the participants’ experiences as closely, and as accurately, as possible. This was the reason I decided to use a data analysis procedure that was exacting, and required many steps (as described in the next section). I found that in the continual refinement of my understanding of the data, the meanings, processes, and intentions of participants became clearer and clearer. It was like removing the debris from a jewel buried in the earth to eventually uncover a shining diamond. The process

was hard work, but short cuts left the jewel disguised (and stopped me from getting a good night's sleep).

In order to reflect the participant's process and meanings accurately, I had to step aside, and yet let myself feel the data. This is much like the behavior of a counselor who is empathic, and engaged, yet distant enough to be perceptive to what is really being said, and intended by the client. Some of the data was harder for me to distance from. I have referred to these situations in some *Researcher's Excerpts that are included in italicized font in various parts of the Results Section*. My many years as a practicing meditator helped me to maintain an observing ego and compassionate distance.

The decision to paint a vivid, and detailed description of each participant, and to use his/her own words, and quotes, led to some longer Post-Program stories. I believe these give the reader the advantage of sensing more of the life worlds of participants, as well as filling in gaps about what it might be like to be a participant in such a program.

Elaboration on the Methodology

Setting of the Victoria Pain Clinic

The Victoria Pain Clinic (VPC) was selected as the site for the research because the aim of the study was to explore a phenomenon that I witnessed within their program, several months earlier. The Victoria Pain Clinic is located in a semi-rural setting just outside of Victoria, British Columbia, Canada. VPC has been operating since 1985, and states its philosophy as follows:

Recovery from Chronic Pain/stress must come from within our clients; it is not something that therapists can do for them. Our therapists are teachers who help the client create his or her own recovery process.

Specifically, their philosophy is based on:

1. The importance of the client assuming full responsibility for their own health and recovery process.
2. Treatment of the whole individual – mind, body, and spirit; and
3. An emphasis on natural healing processes rather than reliance on drugs and external aids (adapted from the Victoria Pain Clinic website: <http://www.vicpain.com>).

Participants

Participants include eight members of a 10 day program which took place in July of 2001. (The group consisted of nine members. One did not want to be in the study). All program participants were contacted ahead of their program by letter of recruitment (See Appendix A). Three consented to participation in the study by return mail ahead of the program start date. Another five participants agreed by signed consent on the day the program started. The participants include six females, and two males; six Canadians, and two Americans. Their ages range from 27 – 60. (Fuller descriptions of the participants at the start of the program can be found in Pre-Program Profiles, Chapter Four).

Participant Screening and Selection

At the inception of this study, I was only going to include people in the research study who were formally diagnosed with CFS. However, when I approached the Medical Director of the VPC with my ideas for the study, he suggested that I also include people with Chronic Pain in my participant sample. He argued that *labeling* a participant/person as someone with CFS, or Chronic Pain, was another form of disenfranchisement for the person in that the label tended to: (a) identify the person as the disease (thereby limiting the full scope of who the person is), (b) keep the person stuck (by denying the fluid nature, or ability to move out of the condition), and (c) keep the person stuck based on

the economics of illness (e.g. the patient is only funded when the diagnostic label defines him/her). We also discussed the fact that the symptomatology for both conditions overlaps quite significantly (very few people with Chronic Pain are not chronically fatigued, and many people with CFS also have Chronic Pain). There also was the problem of diagnostic uncertainty as regards screening of clients who *just have CFS*. Many people in Chronic Pain may have CFS without an official diagnosis. These arguments were worth considering.

I also pondered the following thoughts in terms of interviewing participants with both CFS and Chronic Pain for this study. Firstly, Chronic Pain and Chronic Fatigue Syndrome were both conditions which were not readily diagnosed, or treated successfully by the medical profession. Because I had witnessed a transformation in participants with CFS and Chronic Pain at a previous program at the Victoria Pain Clinic, I thought that understanding this process might benefit people with CFS and with Chronic Pain. I decided to investigate just how the process unfolds. Also, from the point of view of uncovering information which could help re-appropriate power back to the individual, it made sense to me to include people with both Chronic Pain and Chronic Fatigue Syndrome in my participant sample.

Meeting the Participants

I met the participants around noon of the first day of the program. They had just arrived at the Clinic. The program didn't start until 6:30 p.m. We sat out on the deck on that bright summer's day, and exchanged introductions. I located the participants who had already mailed in their consent for the study, and set up times for their Pre-Program interviews. While I was discussing the study with these participants, several of the other

participants became interested in the study and began asking me questions. The result was that the total number of participants in the study jumped from three to eight. (I had been prepared to conduct the study over two programs, if necessary, to have a total of six to eight participants. This was not necessary).

Pre-Program Interviews

Seven of the Pre-Program interviews were conducted at the VPC that afternoon, and the last Pre-Program interview was done the following morning, before the programmed activities started. The intention of the initial interview was to develop rapport between researcher and participant, to collect overall information regarding each participant; to *paint a portrait* of them at the start of the program, and to gain understanding of the nature of their illness, as well as hopes, and expectations participants brought to the program. (See Appendix C for Interview Questions).

Immediately following the Pre-program interviews, I wrote down any impressions I had of participants and any outstanding themes that *called out to me* from the interviews.

Reinforcing Confidentiality and the Right to Withdraw

That night, which was the first night of the Program, I introduced myself as a researcher, and explained to the participants that I would not be collecting any data, or taking any notes about them during the Pain program. The Post-Program interviews would be scheduled to fit their schedules on the last day of the Program. I reinforced the participant's right to withdraw from the study at any time. I believe this helped, in that it was important to establish the fact that I wasn't *watching*, or interfering with, any of the

participants during the Program. They needed complete privacy to establish safety for their own work in the program, and I respected that.

Researcher's Role in the Program

During the program I was a group member. I attended almost all of the group sessions. I also ate meals with the participants most of the time. I did not sleep at the Pain Clinic, yet I was generally at the Clinic for approximately 12 hours most every day. In group sessions I participated in small ways. I was quite aware of the importance of being sure that the participants each had all the quality time they required in, and from, the group. My needs were secondary to this. I socialized in limited ways with clients, and got to know them. Sometimes they relied on me to talk with when they were going through a particularly difficult time.

It was challenging for me to be both a researcher and a group participant. The full body stretching and relaxation exercises, which occurred first thing in the morning, would get me so deeply relaxed, it was hard to *come back* to more of a beta state of mind when I had to leave the Clinic. This was challenging in that I wanted to *immerse* in the program, to understand it fully, and yet I found it very difficult to make these *switches* in consciousness. The participants are meant to go very deep in these relaxations and meditations; to totally release tension. For me, moving in and out of these altered states, as rapidly and frequently as was necessary was tricky, and sometimes frightening.

Program Description

The program at the Victoria Pain Clinic involves participants in a variety of treatments, and self awareness activities daily from 0830 – 2100 hours. Participants are

busy with group sessions, or private treatments throughout the day and evening. (See daily schedule in Appendix D).

The program is conducted in a large residential home atmosphere, which is comfortable, warm, and non-pretentious. Rooms are generally semi-private. Private rooms can be requested. Attention is paid to creating a physical space that is safe for clients. All meals are provided. Sessions are not mandatory, but attendance is recommended by staff.

Over the 10 day period, each participant experiences five medically administered acupuncture treatments, five stretch and spray sessions with a registered nurse, five Biofeedback sessions, six individual psychotherapy sessions, three Hellerwork massages, and an average of 6 hours per day of group work which includes stretching, progressive muscle relaxation, autogenic training, guided visualizations, postural awareness exercises, self esteem, communication and interpersonal skill training, story telling, body awareness and expression exercises, group check-ins assessing pain and fatigue levels, and some process time. Group sessions are conducted using a psycho-educational model, and also include theories and lectures about stress, pain, and illness.

Staff consists of a Clinic Director, (Ph.D. Psychologist), Medical Director (Physician, and Acupuncturist), Registered Nurse; who helps with assessments, medications, Stretch and Spray, and Counselling; a Biofeedback practitioner, (Ph.D. Psychologist); a Hellerwork practitioner, (also an R.N.); a Registered Clinical Counsellor (M.A.) for private and group work; and an Experienced Assistant, who helps in the acupuncture room. Programs are run bi-monthly, and generally include 12 participants. Staff team meetings are conducted regularly to discuss participant cases. The team

approach is well orchestrated to create a harmonious and safe feeling for participants going from one practitioner session to another.

Post-Program Interviews

Some of the participants had come long distances to attend the VPC, and were catching flights out. This determined the Post-Program interview schedules. I conducted one of the Post-Program interviews on the last night of the Program. The other seven interviews were conducted on the morning of the final day of the program (See Appendix C for Interview Questions).

The Post-Program interview protocols were designed to answer the research questions. At first I wanted to get a general sense of the participant's experience of the program. Then I wanted to know what really *stood out* for them. The skills that I have as a counsellor allowed me to co-create an environment with the participant whereby we could go to the depths in exploring his/her experiences of the program, and process of change. Participants were generally motivated to tell me about their journeys. Most were enthusiastic, and some were verbose in telling me about the changes that had occurred. It took gentler probing to elicit data which related to how the change process actually came about.

Practitioner Interviews

I conducted individual interviews with each of the staff members, including the Program Director. These interviews were conducted largely for my own learning. The basic questions are in Appendix C. The interviews were designed to have an open style, so that practitioners could tell me what was most important to them from their years of

experience in working with people in Chronic Pain or CFS. Practitioners provided information to me about their overall visions for participants' healing processes. I also used this opportunity to ask the practitioners questions about any of the treatment modalities that were new to me. The interviews were interesting and evocative. They furnished me with many interesting perspectives on helping clients heal from CFS and Chronic Pain. Some of this interview data is included in relevant areas of the discussion section.

Steps and Stages of Data Analysis

Following the program, I was busy transcribing the Pre-program interviews, Post-Program Interviews, and the Practitioner interviews. I had a friend's help with transcribing about one third of the interview tapes. (All participants and practitioners had chosen pseudonyms).

After the interviews were transcribed, I mailed the transcripts to participants and practitioners. Participants received verbatim copies of both their Pre-Program and Post-Program interview transcripts. The practitioners also received verbatim copies of their interview transcripts. All participants and practitioners received a letter in their package which asked them to read the transcripts and verify the accuracy of them. They were asked to be certain that all the information was correct. They were also at liberty to ask for any parts to be removed, that they didn't want included in the thesis. I followed up with all of them to ask for feedback on the transcripts. I received information from all but one participant who I could not contact after several tries by phone, and e-mail. I made all the corrections to the transcripts that were requested by participants, and/or practitioners.

Pre-Program Data Analysis: Procedure

Based on the work of Moustakas (1990; heuristic research), and Yin (1994; case study research), pre-program transcripts were analyzed with the goal of giving the reader understanding of participants' life experiences, and recent historical background prior to the start of the program. From each individual's voiced depiction, "individual portraits were created that include the biographical information of the participant" (adapted from Moustakas, 1994), as well as hopes for the program. These are written as Pre-Program Profiles (in Chapter Four).

From these individual depictions and portraits, a composite depiction of the experience, representing the entire group of participants was developed. Moustakas, (1994) states: "On the basis of his or her study of all of the depictions and portraits and personal knowledge of the experience, the primary researcher develops a creative synthesis." This synthesis is a composite story of participants' experiences pre-program called, *Life on a Postage Stamp* (also in Chapter Four).

Data from the initial interviews were analyzed in the following manner:

- (a) All tapes listened to, and reviewed several times.
- (b) Transcripts were colour-coded based on:
 1. Demographic information such as age, gender, hometown, family situation, career, general personality characteristics, values
 2. History of illness
 3. Hopes for the pain program
 4. For two participants, who were *second timers* to the clinic, another category called: *Learning from the previous program* was created

5. Information and themes from within each category were then used to construct *Participant Profiles*.

Post-Program Data Analysis: Procedure

Data were analyzed using a phenomenological reduction method based on the works of Giorgi (1979; as outlined on page 41) and Moustakas (1990/1994). The aim of Stage 1 analysis was to identify and distill themes according to their meaning units, and then to contextualize these themes into a narrated story of each participant's journey. In order to achieve this, it was necessary for me to bracket my own biases, projections, or potential sources of distortion of the data, so that the essence of each individual's experience could emerge as distinctly as possible.

The guiding principle for writing the narratives derived from heuristic research (Moustakas, 1994) in which "a comprehensive story is portrayed in vivid, alive, accurate, and meaningful language ... and where the depictions themselves achieve layers of depth and meaning." (p. 19). As Moustakas explains, the stories themselves are complete in their depiction of the participant's journey: "The depiction is complete in itself. Interpretation not only adds nothing to heuristic knowledge but removes the aliveness and vitality from the nature, roots, meanings and essences of experience" (Ibid). Hence, these stories, which arose from an exacting procedure of data analysis, stand fully representative of the phenomenon being investigated (e.g. the participant's journey; as close to the participant's own experience as possible).

Stage 2 analysis again, draws on principles of phenomenology (Moustakas, 1994) whereby data are analyzed to uncover the *essence* of the experience for participants. In this case, after participants' journeys were vividly depicted, transcripts were analyzed to

discern the essence of the transformation. In other words, “What was intrinsic to each individual to set the transformation in motion and sustain its existence? What was at the core of the experience that constituted its essence?”

Details of the exact analysis procedures follow:

Stage 1 Data Analysis:

1. The participant transcript was read in entirety for basic understanding.
2. Then, I asked the following question of the data: What was this participant’s journey like? What happened for this participant during the 10 day program?
3. The transcript was colour coded, and notes made on themes.
4. The Post-Program interview tape was again listened to in its entirety. Particular attention was paid to voice inflections, emotions expressed by the participant, general tone, energy levels, and other nuances that can best be *picked up* verbally to add significance to the written words.
5. An initial summary of the participant’s journey was then written.
6. Each transcript was then analyzed line by line in order to further refine, clarify, and expand comprehension of what the participant was saying, and meaning.
(This step was critically important for the refinement necessary for comprehensive, detailed, and accurate understanding).
7. Participant *Transformation Stories* were then written as the themes were refined, and meanings elucidated.

Stage 2 Data Analysis:

In Stage 2, I started with a clean interview transcript. I re-read the transcript while holding the intention of discerning from the data how each participant's process unfolded. The following questions were asked of the data, "How did this transformation take place? What accounted for the insights? What sparked this participant's transformation? Areas of the transcript that brought insight to the above questions were highlighted. Then, when a pattern emerged which gave comprehensive understanding, I wrote that, and studied it, to determine if the data supported the proposed interpretation. If so, that interpretation of the particular transformation process was written. These pieces of analysis are inserted just following each participant's Post-Program Transformation Story (in Chapter Four).

(Due to the nature of the data, it was impossible to keep findings from these stages of analysis completely separate at all times in the write-ups. So, there may, in fact, be some areas of overlap within the write ups).

The Summary of Findings, Discussion of Findings, and Summary of the Transformation Process (Chapter Five) were also derived from a phenomenological reduction method of data analysis (Moustakas, 1994), whereby an accurate description of participants' composite experiences was synthesized from Post-Program Transformation Stories and Stage 2 data analysis.

The Research Journal

Writing in my research journal was vital; especially during the program itself. The experience was intense, and I found myself needing to center on a regular basis.

Beyond my own process, I also wrote about the program, and included many insights that were illuminations for me during the program. In the months following the data collection, I wrote excerpts in my journal as they related to the part of the study in which I was engaged. *Some of these excerpts appear scattered throughout the Results section in italicized font. They are placed there because they refer to a process I was in with the participants' data. The data were speaking to me, and I was responding through the written excerpts. It was challenging to spend long hours immersed in data about pain, and fatigue. Although the stories are replete with triumphs; they are also replete with pain. I learned a lot about staying with pain and accepting it. I also experienced my own pain at deeper levels. For this I am grateful, because now I am in touch with "more of me."*

Verification

Creswell (1998) views verification in qualitative research, "as a process that occurs throughout the data collection, analysis, and report writing of a study" (p. 194). From this perspective, it behooves one to examine the study design and methods that are used to arrive at the findings. If these methods are sound, and scrupulously applied, then it stands to reason that the end product will also be of high quality. In this study, the following principles of verification apply:

1. The participant's voices were not silenced or misconstrued. They were given full voice. Their interviews were transcribed verbatim, and they had input into exactly what was to be included in the interview transcripts. The written accounts of their transformation stories also included many original participant quotes. They are heard, and well represented. In

keeping with this is the fact that the intention I held during data analysis was to accurately portray a participant, and his/her salient themes of the journey. This required discrimination, and a bracketing of my own thoughts in a separate journal.

2. In addition, in order to maintain lucidity and focus during the study, I regularly used meditative, cognitive, emotional, and spiritual practices to *clear my mind*, and handle any emotional *triggering* which could cloud the accuracy of data analysis.

I will also evaluate the study according to some principles delineated by Howe and Eisenhart (1990). Howe and Eisenhart: “assess a study by asking whether the research questions drive the data collection and analysis; rather than the reverse being the case” (p. 6). In this study, the interview questions were constructed specifically to elicit answers to the research questions.

Findings from data analysis Stage 1, answer the first research question: “What was the growth process participants went through to be able to impact their illnesses in such a short period of time?” Stage 2 of data analysis answers research question 2: “Can this process be explained?” Therefore, the data were analyzed specifically to answer the research questions.

Secondly, Howe and Eisenhart ask whether the, “data collection and analysis techniques are competently applied in a technical sense” (1990, p. 7). As a novice researcher, that is difficult to answer. However, although I am an amateur, I was determined to apply scrupulous standards to each of the steps of the study. My years of both nursing (21 years), and counselling experience (13 years), were a distinct advantage

to the quality of the data collected through the interviews. Knowing how to interview, and relate to people, produced data without a lot of extraneous material, and difficult questions were answered by participants in fairly direct ways. This generally made analysis more straightforward.

At times when interview transcripts were difficult to comprehend, I took many deep breaths, and returned to my critical thinking and counselling skills in order to understand participants' trends of thoughts, and meanings. (Some of the transcripts were more challenging due to cognitive impairments for participants based on trauma from previous accidents).

The third question that Howe and Eisenhart (1990) ask in relation to verifying qualitative research results is in regard to the subjective aspects of the researcher. They ask, "Are his/her assumptions made explicit" (p.7). To answer this question, I asked myself: "Does the fact that I observed participant changes in a previous program at the Pain Clinic bias me in any ways? If so, how?"

My bias is that there are changes to look for in the interviews, and in the written data, how ever small they might be. This bias was mostly beneficial in that it helped me probe participants in subtle ways to illuminate nuances of their change processes no matter how small. However, acknowledging my desire to uncover a process which can help people with CFS or Chronic Pain to change, or heal, is another matter to consider. How much was I invested in the outcomes? How does this investment affect the findings?

To answer these questions, I can only go back to the data, and the way I handled its analysis, and presentation. By this I mean that although I *wanted* to find a process that

would help in healing CFS and Chronic Pain, the continual checks on my self as a researcher, and the methods used, should have prevented my bias from distorting the results. My belief is that my analyses and findings represent the truth inherent in the data collected.

How does my bias toward, or against, conventional or CAM methods affect how I portray the results? In general, I think the fact that I have knowledge and experience of many CAM treatments is a resource for the study. I have tried to remain open minded, yet critical, in terms of how I view the emotional catharsis methods, and acupuncture methods at the Clinic. Again, if I am doing my job as an objective researcher with sound methodology, my biases will be used as a way to critically evaluate the study, and not to dominate the findings.

The final question I will address from Howe and Eisenhart (1990, p. 7) is: “Does the study have *value* both in informing, and improving practice, and in protecting confidentiality, privacy, and truth telling of participants?” Research questions three and four were specifically designed to discern whether the findings of this study can help sufferers of CFS and Chronic Pain, and/or add to the knowledge of practitioners in the field. There are many implications from this study that I believe will help to improve clinical and research practice in the fields of CFS and Chronic Pain. These are fully explained in Chapter 6.

The study has received approval from the University Ethics Committee, and has been conducted according to the guidelines in the Informed Consent Form (See Appendix B). There were no breaches of confidentiality or consent. Privacy has been respected by

the use of pseudonyms for all participants and practitioners. Any other information that could potentially identify a participant has been removed.

Verification by Outside Sources

Two participants' post-program interview transcripts were read, and analyzed, by two independent graduate students who were familiar with qualitative research methods. These students had no previous knowledge of the participants, or the data analysis methods I used. They each gave me written feedback on the participant's interview transcript. They wrote summaries, as well as conducting line by line analyses. When I compared their summaries, main themes, and line by line analyses per participant, I found the themes, and main details of the participants' journeys were similar to mine. Their wording was slightly different, but the meanings were the same. When there were any small discrepancies in meaning, I considered the difference, and analyzed that part of the transcript to determine the closest meaning intended by the participant. Having this cross check was another form of verification of the methods, and consequent findings of the study.

CHAPTER FOUR: RESULTS

Overview

- Chapter Introduction
- Data Analysis of Pre-Program Interviews
 - Participant Profiles: Philosophy and Construction
- Pre-Program Participant Profiles and Post-Program Transformation Stories
 - Homer
 - Jade
 - Pierre
 - Arsinoe
 - Juliann
 - Colette
 - Alexandra
 - Sage
- *Researcher's Excerpts*

Chapter Introduction

In this chapter, results of data analysis for each participant are presented. Pre-Program Participant Profiles are followed by Post-Program Transformation Stories, and Stage 2 data analysis results. There are also *Researcher's Excerpts juxtaposed in places where I was particularly engaged with participant data, or reflecting on concepts within this research process.*

Data Analysis of Pre-program Interviews

Participant Profiles: Philosophy and Construction

Pre-Program interviews were guided by the underlying principle of contextualizing each participant as a whole and unique person involved in a multidimensional life. These lives encompassed areas that participants described from individual, familial, career, social, medical, spiritual, and/or emotional perspectives. These people were suffering from Chronic Pain and/or CFS, amidst busy lives and broken dreams. The pre-program profiles include brief histories and hopes for each participant which I synthesized from the initial interviews in participants' own words.

First, a composite sketch follows which depicts what life was like for participants pre-program. One of the participants, Homer, referred to living a life with Chronic Pain/Fatigue as *Life on a Postage Stamp*. This is the title of the next piece.

Life on a Postage Stamp

Life on a postage stamp refers to the type of *shrunk* existence experienced by participants pre-program. *Life on a postage stamp* is characterized by a box-like existence induced by Chronic Pain, fatigue, and the inability to participate in a full life. Daily activity shrinks to be able to accommodate only one's barest survival needs. The postage stamp appears in monotone colours; reflecting the dullness of life. The participants not only viewed their own lives as dull, but also believed that they were viewed by others in this way. Participants with Chronic Pain generally felt that friends and family tended to either feel sorry for them, or distanced themselves. Numbers of friends had become vastly reduced with most times only one or two really old friends sticking by.

Chronic use of pain medication fostered the *postage-stamp* cycle, because instead of relieving pain and allowing expansion into life; participants felt that the medications created cycles of dependency for them, and did little more than temporarily remove the very rough edges, or moments of extreme pain. This was partly due to participants' dislike of taking pain pills, and dislike of thinking of themselves as someone who needs to take pills. This reluctance may have resulted in participants taking less than adequate doses, or else participants may have developed tolerance to medications due to persistent use over long periods.

Another part of the *postage stamp* existence involved the matrix of relationships where the world of the person in pain/fatigue revolved around the pursuit of medical or paramedical advice. In other words, the participant's available energy and time was taken up with appointments with doctors, and other medical practitioners, leaving no energy for social life, or previously enjoyed activities.

Life on a postage stamp was also often accompanied by depression as part of the pain/fatigue experience. Depression arose as the life world of participants shrank (as described above) and when options for relief also shrank. In these cases there really was no *light at the end of the tunnel*, and hope for recovery was dim, or lost. Several participants spoke of thoughts of suicide; their friends and family members realistically worried about it also.

The despair and suffering of participants which was reiterated through all the pre-program interviews was something I felt deeply during, and after the interviews, and took seriously. People entering the program looked *down* as evidenced by body language, voice tone, posture, and an overall lack of affect of any joy or gaiety.

What follows are Pre-Program profiles (based on data analysis from initial interviews) for each participant. (Please note: All ages of participants, and family members, and others mentioned in the write ups are accurate from the time of data collection, July 2001).

Following each individual's Pre-Program profile is his/her Post Program Transformation Story, encompassing two stages of data analysis. Some of the ways I was affected by the participant's data have evolved into *excerpts* or pieces of my own writing, which allow the reader to experience something of what my process was like as I was so closely absorbed in these creative beings lives for long time periods.

Pre-Program Participant Profiles and Post-Program Transformation Stories

Homer: Pre-Program Profile

Homer is 50 years old, and a father of two sons, ages 20 and 24. He lives in the Northwestern United States, and has been on his own since his boys left home; approximately two to three years prior to the program. Homer has been divorced since 1983. He describes his life with a disability as living *a pretty slow and isolated* life now, especially compared with his years of owning a highly successful audio-visual company.

Homer's life went through a drastic change as a result of a fall, which took place several years ago while he was vacationing in Costa Rica. He describes the incident as follows:

I was in Costa Rica on a pleasure trip, and on my second day there, one of the guides directed me to where he said there was a wonderful swimming hole. Another guy and I walked there. We split up at one point and I have no memory of anything that happened after that. But my friend said we were talking, and he was in the river, and I was about 80 or 90 feet up above, just talking, nothing wrong, and then at one point, I leaned over, and for some unknown reason, grabbed a branch that looked like it

wouldn't support me, and it didn't, and I came crashing down, and didn't even fall into the river. I fell onto the rock next to the river, and then slipped into the river; unconscious. So my friend had to do the lesser of two evils, of moving somebody with a broken back, or letting me down; so he pulled me out.

So, I spent a couple of days in a Costa Rican hospital, and then was flown back home, and it was a very critical situation. They told my family I wasn't going to live, and they told me I wasn't going to walk. And my opinion, or my attitude the whole time, was that they were crazy. I totally expected to fully recover, and it pretty much felt like that was happening all the way through all the major milestones.

I went through all those milestones, and got out of the hospital after three months. I was still in a wheelchair but after about three more months of physiotherapy, I was walking again. I was driving a car and everything seemed to be coming along as it should after such a major accident. This was true for one and a half to two years, but by the end of the second year, I had really developed a problem with the medication. And so, the whole issue of pain and pain medication has been pretty much my primary focus for the last two years.

Homer went on to describe his addiction to the narcotic, Oxycontin, and his difficulties getting off of it. Several times when he came off the medication, he was unable to function ... "in that much pain. It was just a horrendous pain as well as having no energy whatsoever, being literally unable to really get up, and do anything."

Beyond problems with addiction and pain, Homer described his life over the last four years, in a larger sense, as being pervaded by loss:

I wanted to numb out emotionally because I was so completely unhappy with my life. I sold my business, my kids have left home, I don't have any meaningful daily activity, I don't have an active circle of friends. I feel like my old friends stick around because they feel sorry for me. I feel like a dull person because all I have to talk about is my pain, and what's going wrong with me in my life. I'm distraught at being 50 years old, and basically having no discernable future other than, "How am I going to live with as little pain as possible." I'm pretty sure enough of my pain is emotionally based. In other words, I think it can be controlled through other means than taking drugs.

Hopes for the Program

1. To get off Oxycontin. “I want to be at a point where I don’t need it physically or emotionally. I’m more concerned about the ability to get to the point of not needing it emotionally vs. physically.
2. I am hopeful about this Clinic because it has a humane atmosphere to help me deal with my pain in a way other than with drugs. (Focus of the clinic is larger than just diminishing physical pain).
3. I want to start putting together a life that doesn’t have management of pain as the number one issue. That I can go on, and either do something in business, and /or have a relationship, and/or find anything meaningful to do other than what I've done for the last two years which is mess around with pain, and its side effects.

Homer: Post-Program Transformation Story

(N.B. Homer’s journey is detailed, in order to act as a prototype to aid in readers’ comprehension of VPC procedures and culture, as well as participants’ intrinsic processes).

The change in Homer from pre to post program appeared dramatic and obvious to me. In the post-program interview he looked *light*, with a broad and radiant smile. His shoulders were relaxed, and eyes shining. His face had a boyish *flush*, and there was no cane. Homer’s voice was full of animation, and I was continually lowering the volume on the tape, as he spoke with such enthusiasm.

Homer was completely satisfied with his experiences of the program. He states, “I’ve been given the opportunity to take my life back. I’ve been given certain tools, and certain insights, and certain experiences. I’m as close to a transformational change as I think I’m gonna get ever in seven days.” Homer attributes his transformation to

experiences in acupuncture, psychotherapy, new cognitive awarenesses, and the group.

Important themes from Homer's transformation follow:

Re-experiencing the Fall: An Excursion in Consciousness

The most amazing and powerful experience so far was, I believe it was the third acupuncture session I had, I re-experienced my fall in Costa Rica that I had several years ago, and I'm getting goose pimples just saying that right now.

This experience was powerful for Homer for several reasons. The first is that the re-experience gave him an opportunity to *fill in the blanks* as to what happened during the experience of falling. This amnesic piece had left him feeling very incomplete, and anxious. He explained that understanding his fall helped alleviate a lot of anxiety. "And I have absolutely no doubt that what I experienced was exactly what happened."

The second part of the experience that had tremendous value to him was what he called, *the emotional catharsis*, or release of many pent up feelings which had been stored in his body. This took place by re-experiencing the fall from an altered state, with observing ego. He believes this allowed him to directly release a great deal of pain.

The third part was a major revelation to him, and a sense of knowingness for him about *why he fell*, (in psychological terms), as relates to his ex-wife.

Homer described the experience of falling during acupuncture as follows:

I was in the air when I realized that I was falling. It wasn't like I tripped and I was, you know, holding onto something, and down I went. It was just like, all of a sudden I had this you know, searing realization that I'm falling backwards down this cliff, and the emotional part of that, ... you know, it was just like literally doing it except that there was enough of my ego there, my adult ego which knew, which knew that I was just re-experiencing it, and not really falling that I could stay with the experience. But it was just like falling. It was *fucking terrifying*. It was, I could feel the wind going by me. I could see the rock. I could, I was reaching for branches, I was, you know, I could feel myself hitting the

rock wall, and I don't know how long it went on. I know that it went on longer, well I don't know this, but I think this, that the re-experience went on a lot longer than the actual. I mean how long does it take to fall 90 feet? I mean six seconds, maybe. I was falling for a good minute or two in the room.

I asked Homer what was involved in going through an acupuncture experience like the one where he re-experienced his fall. He said:

Well, you're breathing deeply, and you're being stimulated in some way either directly with needles, or in the case when I re-experienced the fall, they used the tool that stimulates the acupuncture points in your ear. Which is really amazing, all they did was click this thing in my ear, and down I went. There was encouragement from Gabriel (the doctor) and Lily (his assistant) who guided me toward visualizing this little crevice of altered state of consciousness. And they, just as much as was necessary, kept encouraging me to be in it. But they didn't really need to much. I found myself with a high degree of trust when it happened.

Homer's trust and willingness to go into the experience was inspired by his motivation to get well. He believed that by going into the altered state, and re-experiencing the fall with emotional release and an observing ego, that he would revitalize his health. He said powerfully:

I wasn't ever reticent to go in there. I want to go in there. I want to find the black door. I want to get to the other side. I want to walk right again. I want to restore my nerve function in my legs. So that's my motivation.

Further describing the experience he stated:

It's very hard to explain the experience because you're in an altered state of consciousness, and yet your ego is watching it. But at any rate, there were all these different opinions happening. It was like, my ego is going, I'm falling, how great, this is fantastic; I can't believe it great, cool, far-out. And you know, the part of me that's re-experiencing it is going, what's happening, what's happening (fear in his voice), I'm falling, I can't ... believe it, I'm falling, oh my God, I'm falling, I'm falling, falling; just totally terror stricken.

Further describing the emotional process he said:

When Gabriel stimulated certain acupuncture points it was painful. But instead of resisting it, I would just breathe into it, and that would facilitate the start of the whole process. There would be shaking, and then this electrical energy going through me. In my case, since a lot of my injuries are in my left side, I would feel it going down from the bottom of my spine, and down my left leg, and out my foot. When I re-experienced hitting the rock when I landed, I landed on my left side; and you know I had an L1 burst fracture, and a punctured lung, and a flailed chest, and eight broken ribs, and it hurt. *It hurt a lot.*

And the only way to deal with that, at that point, was to scream and yell because it hurt so much. And I could feel my back break, and so much of this had to do with attitude, and willingness. Because you know, the ego part of me watching it, I suppose could have gotten scared, and pulled out at that point, but the ego part of me was going, *Let's do it all right.* And so, with either painful stuff that I was re-experiencing, or painful points that were being pushed on; I just breathed into it, and gave voice to whatever emotion it was, and I pretty much found that I don't think there was a single pain I couldn't take, that was too much (sounding calm and self-assured). As long as I could enter the experience and expel the energy, I was fine.

Another thing that happened when I was falling was that there was just a flash, just for a millisecond, of my ex-wife, Annette, as I was falling. And the meaning that I make of that, and I've thought about it, and felt it, the insight was that I've got unfinished business with her. And I feel like there's a lack of closure, and I can't at this point in time get that from her. And there's also a part of me that has this frozen desire, frozen need, that I wish we were back together again, and it's been something that I've worked on. But I think that part of the reason that I fell was to get her attention. This blows my mind, and I would have laughed that off with a sneer, eight, nine days ago. But based on my experience now, I believe that to be true. I also believe it to be true because that's what happened. I got that! When I was in hospital, she was there. She let down most of her defenses. She acted as if she were my wife. She stayed overnight in the hospital. She took care of me, especially one horrible night where I could hardly breathe. And it's kind of like; did I jump off this mountain just to get the attention of my ex-wife? I mean that's pretty mind-blowing if that's possible.

I questioned Homer as to how he came to know this as a truth for himself. He stated that although there could be other explanations for why he thought of his ex-wife while he was falling, what feels right to him is:

Part of the reason I fell was, (voice breaking with frustration), I've tried everything I can for the last ten years to get her attention and nothing has worked. O.K., I'm gonna jump off this rock. I mean that feels more right even though it sounds, may sound, totally ludicrous.

And with the work that he's done with Anon (counselling) he realizes how deep his feelings of "loss and sadness and anger are, so I can believe it. It makes it much more believable to me that there was a connection there."

He further went on to say:

When you're in that state, I mean it's amazing enough to me that it's possible to be in that state, but having been in that state I trust everything that I experienced as real, as totally real. I mean, I'm sure some people would say it's just some kind of illusion that your mind worked up, but that's just so *not* true.

Further Awareness Through the Counselling Exchange

The work that Homer did in counselling helped him see how many feelings remained unfinished from the ending of his marriage. He knows he needs to finish this work. He also takes the knowledge of the possibility of falling (as a cry for attention from Annette) as a signal of how important it is to do that work. He stated that although the fall, and his injury/illness brought him more closeness with Annette, "I'm not sure that in the big picture it was worth it ... It's all grist for the mill." Through the counselling experience, Homer was able to understand his emotional pain as being related to unfinished business/feelings about his ex-wife, and was aware that these feelings were reflecting in physical pain in his body. Working psychotherapeutically with the relationship issues would change the nature of his pain.

Oxycontin Free

The second important outcome of the program for Homer was his ability to come completely off the narcotic, Oxycontin, of which he was taking 12 – 15 pills per day pre-program. Although he had decided, in consultation with the R.N. at the clinic, to wean off the pills gradually over several days, he actually found himself coming off the medication *cold turkey*. He describes his experience as follows:

I had come to the point where I realized that the pills might be numbing the pain some, but they were numbing me out mentally, emotionally, completely; and also making any kind of spiritual connection totally impossible. I think they are; the use of those pills, are the reason that I've experienced my life as just contracting to the point of meaninglessness in the last few years.

After hearing one of Dr. Wolf's lectures, Homer became inspired:

I saw that there was nothing positive for me to ever take another of those pills, ever. And that was what I needed. I wanted to do it (come off the pills) for awhile, but I needed to feel really good about it from an intellectual, fully understandable, point of view. I wanted to do it as a free person making a choice, not as an addict.

So I gathered up my 120 Oxycontin pills, went into the bathroom, and at first, held eight of them out. I figured, I'll just have some tomorrow, you know, in case tomorrow morning's hard, you know (laughing). Then I dumped all of them in the bowl except for these eight, and I looked at the eight in my left hand and said, "Oh get out of here." And so I threw those in there and flushed them, and found out that they don't flush. So I went back there two hours later and there they were (laughing). "Goddamit, how many times do I have to go through this?" At that time I wasn't craving them or anything, but I was just at wits end, and I just flushed the toilet and took a cleaning brush, and just started jamming it down the toilet. "*Get the fuck out of here, get out of my life. (That actually was pretty cathartic,*" he said calmly).

By late afternoon of the next day, the pain was so bad it was like *dropping off the edge of the earth*. Homer described feeling like he had to leave his body, but instead he chose to consciously go through the withdrawal experience. He accomplished this by

nurturing himself in the hot tub, realizing he wasn't breathing and starting to breathe, and having contact with another group member who helped him laugh, and distracted him from the horrible panic he was feeling inside. He described the initial feelings of withdrawal as *disassembling* and accompanied by sharp feelings of panic and like, *I'm gonna die*. The contact, self nurturing, and breathing, allowed him to get over this stage. And that night he went to bed straight after the evening session for a long sleep.

The next two days were hard as well, but Homer stated that he went through a minimum of withdrawal symptoms. He also found it interesting that "it was the very first day that I was without pills that I had that powerful experience in acupuncture" (as previously described).

Cognitive shifts

Homer's transformation process and ability to move onto a different *track* in his life has been aided by certain shifts in cognition. One shift was in his new view of pain as a messenger, "not something to just keep pushing away, but my pain as a messenger for me to look at what's going on in my life. And that's just unbelievable ... I was on this spiritual quest when I was in my 30's, and very serious about it ... I'm back on track now."

When I inquired further as to what pain as a messenger means, Homer explained:

Well pain, as I now understand it, is energy. And the messenger part of it is the new way of looking at it which is the way out of the rabbit hole. If I keep looking at pain as a bad thing to avoid, and to run away from, then I stay stuck in the self definition of an addict ... or of a disabled person. And that's a position of weakness. And I'm not going to move out of that position with that attitude towards pain. So I guess my understanding is that if I want to have an improvement in the quality of my life, I'm going to need to change my perspective; 'cause it's all in your perspective on pain.

This doesn't mean that I'll never take another pain killer. But what I believe now is that through doing the kind of work we've been doing here for the last week, it's possible to discharge enough old emotional hurt which will then heal the physical hurt. It's the way out for me. And what I've seen is that my body holds memories of painful events that have happened, and it's possible to dissipate that pain through various means.

Homer's cognitive shifts seemed to derive from (a) what he learned in terms of new information, and paradigms about pain, (b) what he came to know experientially on a body and emotional level, and (c) what he gained from energetically transforming traumas which were contributing to his pain, confusion, and dependency.

Homer's sense of applying this concept of pain as messenger at home will mean:

1. Spending uninterrupted *quiet time* (taking sacred space)
2. Listening to what he needs, rather than pushing pain away. Viewing his pain as a way of looking at what's going on in his life, and
3. Discovering what its transformation looks like. Homer believes this is an on-going process that may take "years and years and years ... but it sure beats the hell out of living on a postage stamp."

Homer's happiness was evident during the interview when he said,

This whole paradigm allows me to just bypass the whole medical system, the traditional system, which delights me. I feel like I've been given a new way to look at things through the experiences I've had here, and that's the most precious thing I could have.

Transforming: The Group Experience

Homer stated:

At first, I could feel myself withholding (from the group members) and more than I usually do. I don't know why, but I was fighting the natural force that happens when people come together and share experiences.

And it finally caught up with me and now I'm feeling really comfortable with everybody in the group.

I think a huge part of the success (of the program) is that you go through this with other people, and you talk about it the whole time you're going through it.

Homer explained how powerful it is to watch people go through major ups and downs, and come out of it *netting something positive by a lot*. He described the value of the group experience as follows:

The group really helped. I don't think the experience/transformation would be as powerful if you came here alone. In the group you see other people's pain, and them working on their pain. You see other people who you thought you were pissed off at the other day, and now you're crying because they're just so eloquent - so amazing at what they're doing. And that kind of influence is really important in this work because you can't always be concentrating on yourself. You have to see what other people are doing to know it's not impossible for yourself, and also you have to be connected to other people. You can't just have it be all about you and your stuff.

When I asked Homer about particular experiences related to the group, he identified the following areas of importance:

1. The group was beautifully interwoven with the whole program. The whole process worked. Participants got into a *groove* with the exercises, breathing, relaxation, connecting with other members, and their experiences.
2. Being involved in exercises where you are relating directly to people "forces you to be human." Homer referred to one such instance where he was engaged in an exercise touching another's hands, and said, "I realized when I did that; I'd not touched a woman's hands tenderly in over 10 years. And it was just almost too much right there to keep going. But it forces you to be human. I had trained myself not to be human. I think it is very human for people who see other people

who are suffering, and especially if they're going through similar things, to really relate to them, and open up, and help them with their process.”

I asked him if any situation in particular helped him *warm up* to the group, and he cited one early morning (he wasn't feeling well), and a female group member was:

Just being very friendly and went and got me coffee. And it was just like, I live alone. I've lived alone for, I don't know, 15 years. People don't get me coffee. I do everything for myself. And I hurt a lot.

Homer described sharing a room with another male group member and the rough edges they encountered at first. However, he states:

I really developed a sense of heart for him. I could tell how badly he wants to go be a man and provide for his family and he's not sure if he's gonna be able to do it. And it just kills him not to be able to do it.

It was these *heart opening* situations, and the experience of going through such an in-depth process with others, that led Homer to say that he thinks “a huge part of the success is that you go through the experience with other people. I believe the strength of the group is directly proportional to how much you get out of the program.” The connectedness has really helped.

Moving into the Future

At the end of the program, Homer was reconnected to a track of self discovery he'd been on in his 30's. To me, this signified being in touch with himself again, in a deeper way. He explained that because of his time in the program, he feels like he's been “given the opportunity to live his life totally differently.” He has to honour the information and experience he's had, which has been very powerful. By viewing his pain as a messenger, he believes there is a way out of the cycle of being a person in pain, “though it may take years.” He has a choice now. He can go home, “and resume

everything he was doing before that wasn't working, or employ what he now knows from his new understandings of pain.”

What he's most fearful of, and feels most anxious about, in going home is:

I'm not good at doing things slowly, and implementing small changes over time. I'm an all or nothing kind of guy. However, I'm going to be as conscious as I can of doing only a certain number of things each day. In order to really reach a transformative space, it's going to take time.

Homer plans on:

1. Changing his perspective about pain (pain as a messenger)
2. Creating a space to tune into himself for twenty minutes, twice a day
3. Carrying on with Hellerwork, acupuncture, and counselling in his home town, and perhaps coming back to the clinic for *boosters* from time to time
4. And avoiding doctors who view pain as the enemy, or something to avoid.

He realizes that his unresolved issue with Annette is “probably the main thing standing in my way right now in terms of moving on in my life.” And his biggest challenges will be isolation, and negative self talk.

Stage 2 Data Analysis: What Accounted for the Transformation/Insights?

In reading Homer's transcript through the lens of capturing the essence of his transformation, I realize that he was involved in a deep process of discovery within himself. He credits acupuncture, bodywork, counselling, and the group, as the main players in his transformation. I believe these external factors were a big help to Homer. I also believe that Homer was a big help to himself in that he was determined to get well, and able to fully engage in what was offered. He also came to the program with clear goals to accomplish. He was willing to go into the energetic experiences in acupuncture;

facing any fears, and relaxing any resistances. All these factors contributed to his success.

When I think more specifically about Homer's transformation process, I believe the following portray the essence of his transformation:

1. I believe he had a willingness and trust to re-experience his fall, to go into the altered states, and to be present with energetic changes. He allowed himself to surrender to the process with awareness. He supported himself (as did the practitioners) in the process. He had an observing ego that could go through the experience, and support the parts that were scared or in pain. He was willing to embrace feelings and sensations no matter how painful. He seemed to believe that if he breathed into the pain, or feeling state, and gave voice to whatever emotion was there, the feelings would release and let go, and he would have less pain. And this was the case for him. His experience "after each session was always one of having just released something," allowing more *free flow* of energy. The way he re-experienced the fall allowed him to dispel held pain. He used the insights from the falling experience as fodder for his counselling sessions.
2. Cognitively, his belief system was ignited and aligned with the philosophy and thoughts of the Clinic. Because he found the Clinic's philosophies about pain *fully understandable*, shifts occurred in the way he perceived pain. These new pain paradigms opened up choices for him about how to perceive, and work with his pain. He experienced the new found ability to have these choices as liberating.

3. Knowingness: Homer didn't question the truths and insights he arrived at experientially. He trusted his experiences, and knew that what he experienced was true. This allowed him to move forward with these truths.
4. Homer saw himself as a pioneer who could help others by being brave. He believed in, and was brave about discharging feelings. He yelled, hurt, cried, got angry; and came through to the other side laughing and smiling. He felt he was an example to others. This leadership role gave him strength and purpose.
5. Homer journeyed into counselling sessions and learned more about the emotional connections to his pain. He also became aware of how much more work he will need to do to be healthy.
6. Homer realized that this work would not have been accomplished if he had come to the program on his own. He valued the group, and the sense of connection with others. There was support, and open heartedness there for him with others, and an alchemy as well as common residence in the womb-like chrysalis of pain. It was from within this chrysalis that transformation took place.
7. His determination and willingness, with strong, inner adult ego support, guided him through the changes. All of the above factors were interwoven into an alive fabric for change.

Researcher's Excerpt

"But if you will not know yourselves, then you dwell in poverty, and it is you who are that poverty" (Jesus).

But how difficult and treacherous the road of self discovery is at times. How much easier it seems to glean knowledge, medication, something from another, when I

am in pain. What can I learn from myself at these times? Aren't I impoverished when I am in pain? Or can pain be my teacher? Can I open into the arms of pain when the feelings are so intense? What allows me the safety and comfort of doing so? What allows me to trust enough to feel my pain, and to be safe in its arms?

Jade: Pre-Program Profile

Jade is a 27-year-old single woman who has lived in Northern Canada since age 9. She now lives in her family home with two cats, and a dog. She loves what the Northern lifestyle offers her. Her mom, dad, and brother all live in town. She is very interested in animals, and wrote a paper about Pet therapy called, *Relax Me*, referring to the importance of pets for seniors. Jade feels her cats and dog are an important source of comfort. "Animals respond no matter what. They don't care if you're having a bad day, or whatever. They're good all the time."

Jade worked as a nursing home attendant, and prior to her accident was planning on obtaining a bachelor's degree to further her nursing career. She describes herself as very independent; being out on her own since age 15. Although she loves her parents, it's hard for her to have had to move back home. She feels compassion towards her dad who is chronically ill with pain, cluster headaches, and "horrible arthritis." Her mother is the caregiver for both of them.

History of Present Illness

Jade was involved in a motor vehicle accident in 1997. Regarding her accident she states:

I got hit when I was on the passenger side of a car, and I turned my head just in time to see him hit us; which is why I have all neck damage (whiplash) and shoulder damage from the seatbelts. They have a hell of a

time with the shoulder damage because it's not the outside that hurts. It's in the joint, and they can't make that better.

Jade has had many different treatments since her car accident including four neurotomies, many hospitalizations, massage therapy, physiotherapy, acupuncture, cupping, laying on of hands, visualization, aromatherapy, and different diets. These were to treat various types of pain, headaches, and brain swelling. She also “tried just about every narcotic there is along with any other kind of drug for pain.” She states she’s “in pain 24/7” (all the time). Her pain comes down slightly, for short periods, but “doesn’t ever go away.” This on-going situation with pain, including repeated trips to emergency, and several hospitalizations, has left her with very few friends, and a feeling that she’s missed her twenties. Due to the desperation with her situation, doctors were afraid she would take her life. She admits to feeling suicidal. She said she would’ve been dead a long time ago, “if it weren’t for her cats needing her, or disappointing her parents.”

Hopes for the Program

Jade’s G.P. recommended that she come to the clinic, as other alternatives had not worked, and she was suicidal. She had multiple treatments, but nothing that was effective for the pain.

From the program she hopes to:

1. Be able to deal with people and be normal again. She expressed, “What if I can’t be normal again?” Although she wants to get better, she is also afraid she won’t know how to be better since she’s been isolated and in pain for so long. And she’s worried about relapse.
2. Learn some more coping techniques

3. Be able to talk with people “who understand you, who are in the same frame of mind.”
4. Most important is to learn how to run my own life again, and get away from everybody else doing it (e.g. medical practitioners, lawyers)
5. To learn to be more accepting of myself
6. To learn how to be a human being again instead of just a person who has Chronic Pain. “It would be nice to be known for my name, instead of my disease.”
7. Hopes to get better, and stay off drugs, all drugs. “I want to be able to get off everything, and not have to go to emergency anymore.”
8. To learn memory techniques. Jade feels that drugs taken over the past four years slowed her down, and caused memory loss. She wants her memory back!

Jade: Post-Program Transformation Story

Reflecting on Jade's process

She's saying she went from pain 24/7 (severe headaches), and feeling suicidal; to major pain only four times in 10 days, and wanting to live. How did it happen? How do I iterate this? I explain this by looking at what contributed to Jade's improvement in well-being. Although the climate and treatments at the clinic were conducive to her growth, the work was her own.

Jade describes her process at the Pain Clinic as one in which she *came out of her shell*. “When I got there, I was a complete hardass. And little by little they started chipping it off me” (the staff and group members). The main themes from Jade's transcript follow.

The Importance of the Group

“Since I came, I learned to be around people again, and not be frightened in their presence.” Jade realized the extent to which she had been feeling isolated at home. She described one of the benefits of the group as follows:

We’re all in the same boat which is nice. It’s very nice to have support like that ‘cause you don’t have to explain where you’re coming from. Everyone knows and completely understands which is great.” (This was especially true if you’re in a lot of pain).

The community she felt with the other group members was a large part of what allowed her to “open her heart again.” A pre-program goal was to be able to have some social contact. In this program she had that, and more. Her heart was touched. “My heart is open again.”

Opening to Her Feelings

Another part of her opening was an *opening to her feelings* in general. She states, “I was shut down from feelings before I came here. I shut down one little bit at a time (since the accident). Now I can feel stuff, even if it’s scary. It’s nice being able to feel stuff again. It’s nice to feel alive again. I learned how to cry again which I haven’t done in a really, really long time, unless I was forced into it. I don’t feel so weak anymore (about crying). And ranting and raving was really good for me, too.”

I asked her if she was surprised with how angry she felt. She replied, “Oh, I knew I had lots of that. I just didn’t think I had anything else. I figured the anger had pretty much terminated anything else in there, but apparently not.”

Handling Her Panic Attacks

Another milestone for Jade was her *new found ability to handle her panic attacks*. She learned to breathe through them, be aware of body sensations, apply positive self talk, and ask for support from another group member. In terms of receiving support she said, “It’s nice to have Pierre there during a panic attack ‘cause the terror is scary to be alone with.”

Jade became clear with just how to breathe during a panic attack. She explains, “Breathing really helps. I don’t do it too deep, or too fast, because then it brings on a panic attack.” She can actually recognize when an attack is coming, “My heart starts racing, racing, racing, and I start getting really hot.”

Along with this, she feels she learned many other techniques to “whip myself into shape physically, and emotionally, and try to get back into having some sort of life again ‘cause I see that it’s at least possible.”

Cognition

Jade found that even with several deep relaxation periods per day, she still had a lot of trouble sleeping. She described her left brain as being way too active – “It’s still yelling back there, I can hear it all the time’ piling it on – it’s all your fault, maybe it could be worse, etc. However, before, these thought processes used to just run over me. Now I can sort of slow them down enough, so I can see them when they go by, like watching a movie.”

She learned to employ positive self talk to counteract lots of self criticism. At the end of the program, she was concerned, “I don’t have self-esteem or anything like that. I’m hoping to try to have some now. A little bit.” She plans on “putting stuff she likes

about herself in the booklet” (handed out by the clinic) in order to work on developing her self-esteem.

Regarding her *memory*, she states, “*I have 10 days of memories*. I haven’t had any memories for about four years. It was all the drugs and stuff. It erases your mind.”

Pain

Jade described her pain as getting out of hand only four times really badly. Her pain cycle has changed. She also learned to handle her headaches differently. “Even if it doesn’t get better, at least I can deal better. Now I realize that I’m the one that’s burying myself.”

Desire to Live

“I was pretty much hanging on by my one finger when I came here. I was very suicidal. I think I’ll survive now. I’ll live. I want to run my own life. I keep telling myself I’ll survive, “Yes you will, yes you will, yes you will. I’m having a hard time believing, it but trying. *I want to survive because there’s a lot of stuff out there I’d like to see, and know; and I can see that that’s possible again, which is nice.*” She’s relying on continuing support from the group. “I still feel very supported by this place, and the people I’ve met here. So I’m hoping that with their help, I can do it.”

Data Analysis Stage 2: What Sparked Her Transformation?

Jade was able to come alive again in the environment at the Pain Clinic. “I don’t think I’ve ever been in a more supportive environment.” The strength of the environment for Jade encompassed the strengths of all the practitioners, and the other group members. “I don’t think that even the support of the staff would have been enough to get me to

come out of my shell again.” Yet staff’s own vulnerability contributed to her success with panic attacks. “Kate and Victoria, (practitioners), helped me with the panic stuff. I never would have thought that they had ever had anything like that happen to them, because they’re just so put together, and so on their path. I realized that I’m not the first, or only one, to have these experiences. I learned from watching others.”

From reading Jade’s transcript many times, I am struck by the strong sense of solidarity she felt with the other group members. It was as if they provided a platform, or springboard, from which she felt confident to leap into her own beingness. Jade says, “With their support I was able to *go into myself* which is strange for me, it’s a new place to go.”

Safety

The physical contact she had with group members like holding hands, just sitting near someone, or being hugged, provided much needed safety and support for her. She describes the program itself as “so safe and structured to take care of us, ‘cause we’ve forgotten how to take care of ourselves, and it’s nice to learn that stuff again.”

Her Experience in Acupuncture

In acupuncture, she relived her car accident. She had a sudden remembrance of it, and went with it after the needles were inserted. Although she was afraid, the therapist present helped her to scream through the fear, and to breathe slowly. This allowed a release and lessening of her overall pain, and the flow of energy achieved allowed her to be present for feelings other than pain and numbness. The acupuncture helped her open and let go. She felt supported to grow.

Counselling

In counselling she became aware of her inner child, and received support for her in sessions with Anon. Although she kept the details of these sessions private, my sense was that the counselling allowed her to reach into her younger parts and reconnect, which, combined with outside support, was very valuable to her.

Determination

Jade didn't quit although she wanted to at times. It seems her determination to *stick it out* came from not wanting to let other people down including her parents, doctor and group members at the Clinic. During the times she wanted to quit, she thought about them all, and knew they'd want her to try her best. The environment of the Clinic, including practitioners, group members and Jade, served as a type of *cocoon* within which Jade felt safety and support to grow, outgrow, release, learn new skills, and set transformation in motion. Jade's style was of an *autonomous learner*. She was aware of the intrinsic exchange of learning present in all situations; whether they were with other group members, practitioners, or on her own. Her ability to extract the learning from each situation was part of her own self awareness, pooled with her sense of inner gratitude. All the above components served Jade, and will continue to serve her in the future.

Researcher's Excerpt: 1984

It was on that fateful day, a bright, sunny summer's afternoon that the crash took place. Myself, my friend, Tess, my daughter, Jenny, all of us stricken head on by a pick-up truck. We were on the way to Tess' sister's wedding in Portland, when a drunk driver

cut us off at 70 mph. Our Toyota Tercel lift back, totaled. (Fortunately not on fire, but scrunched into an accordion shape). Now in 2003, I still feel the impact of that accident. That severe whiplash still plagues the tissues of my neck. As much as I like to deny/ignore the damage that remains, I cannot.

As recently as four days ago, I had to make a trip over the water from this secluded writing spot on Pender Island, in order to go to the chiropractor. My plans for writing that day, slashed. My feelings trashed; disappointed. Everything is ideal here; the sea, the quiet, my alone time for contemplation. How dare my body fag out at a time like this.

Staying in touch with the data from the pain program, and its participants, gets me talking to myself. "Pain is a messenger, not just theirs, but yours in this case. Go and get treatment for this pain, and return to your writing following." And so, the day went differently, but upon returning to my island, I could breathe again without grimacing. I was tired. I rested, yet again. I get frustrated with how much rest I seem to need. But who said we are machines that can keep producing and functioning at will? I work hard nursing, counselling. I need rest. And I shall rest when I am weary.

Pierre: Pre-Program Profile

Pierre lives in Western Canada, is 32 years old, married, and a father of three. He grew up in Quebec and is bilingual; reading and writing in both languages. He describes himself as *a contractor kid*. He worked in construction his whole life, gaining a lot of experience, and has run many crews. Pierre left home at age 14, and has lived all over Canada. His goal was to be a construction contractor.

He loves motorcycles and can understand the mechanics of most things. Pierre said, "I rode a lot of Harleys, spent time with a lot of bikers, partied hard, and worked hard. Now I have a family, three kids, and my wife. I know I can't just sit at home, and do nothing because I'll die. I won't be healthy anymore." He takes his role as provider for his family very seriously. His back injury has created a lot of financial uneasiness, and progressive downsizing which has been a difficult adjustment for Pierre and his family.

History of Present Illness

Pierre worked as a framer before his back injury. He explains, "I didn't really have an accident. We had a very rough week lifting really heavy things, and eventually my back just went." Previously he had physiotherapy a few times for his back, but was only down with the problem for a week or two. This time his back wouldn't come back. In April of 1997, he was diagnosed with bulging discs in his spine, but he was told there should be no pain involved. Pierre has been through several rehab programs as well as physiotherapy over the past four years. He feels worse now than before starting these programs.

He describes these programs by saying:

They just wanted to make you so miserable you'd go back to work. The exercises they made me do every day would make me bed bound, and I was unable to walk for the rest of the week. However, over the years, I did learn a few things, sometimes bringing my morale up. Most practitioners got impatient, gave up on me, or told me the pain was just in my head. I'm just lazy, and don't want to go back to work.

Pierre experiences his pain as quite severe, and consuming. WCB sent him to the Pain Clinic as a condition for their continued funding.

Hopes for the Program

Pierre feels that even if he can find one little thing to help make his back hurt less, then the program will be worthwhile. He hopes to gain any kind of knowledge along those lines to make his life work better. He believes that any small thing he learns could help him forever.

He is hopeful that this Pain Program will be about people, and not just pushing him to exercise. He is worried about the possibility of attending another program that could make his pain worse.

Pierre: Post-Program Transformation Story

Pierre's experience at the Pain Clinic was a delicate weave of subtle elements. I am going to describe some of these subtleties to inform the reader about his journey. Although Pierre felt that the effects of the Pain program were minimal in terms of immediate relief for his back pain, overall he feels that he benefited a great deal from the program. A description of themes of his journey follows.

Cognition: Brain and Attitude Changes

The first major change for Pierre involved a change in his attitude. "I feel much better in my head. I think they made my brain better so my attitude makes everything better altogether period. My attitude's way different." I questioned him, "How do you think *they* made your brain better?" Pierre: "Oh, I made my brain better myself but they helped me along." "Making his brain better," is illustrative of being calmer. He states, "It's not so frigging wild anymore; not so much going on in there. I can actually concentrate on a few things better."

In addition to his brain being calmer, he also has developed a new attitude surrounding his pain. “I think I might have learned here, when my back hurts really, really bad, how to bring it down in a shorter period of time. I’m talking days less, two to three days less than what I’m accustomed to doing.”

As an example, Pierre told this story:

Like you know, in the past, if my starter went on my van, I couldn’t afford to pay somebody to fix it for me because I didn’t have enough money (so I had to go and fix my car myself. And then I’d be in bed for 3 days after. Maybe now I’ll be in bed for just a day and a half.

I asked him, “What is it that you learned that will alter your time in pain?” He replied, “Instead of saying, No, it doesn’t hurt, keep doing it, you’ve gotta finish it, gotta finish it, I think maybe my attitude might be a little bit different where I’ll go finish it later when my brain doesn’t hurt so much, and I won’t bring myself to the point of crawling on my hands and knees to get to the bathroom.”

On this same topic he said, “In the past, I would stay up until three in the morning because I promised I’d have something done, or whatever, to finish it. (I used to perform best under pressure. I always put myself in those situations on purpose). So now, with my back pain, those situations are maybe a little bit too much to handle. I learned that maybe I won’t make those promises anymore, so that might help.”

Another attitudinal change for Pierre involved his ability to be patient, and understanding. He believes he has gained patience which will “make everybody around me happier, ‘cause I’m not very patient. I get pissed off quite easily when things don’t go ... when somebody does a mistake I find stupid; I have no tolerance for it. I think I’ll be more understanding. So I think my kids will like me a little bit better; my wife, too, probably.”

And, (in terms of himself), “one of the most important things to me is, instead of hating that my back hurts so much, try to deal with it instead. Quit getting mad all the time about it. That’s a hard one. I need to work at making my recovery better. I have to change how I live.”

Understanding His Back Pain

Pierre’s Post-Program interview is replete with statements of frustration, and disappointment with previous rehab programs, medical doctors, and specialists. He describes previous programs as *meat markets*. “They run you through their program. If you’re not better by the end, they’re all pissed off at you.” In addition to being frustrated with treatment programs, he has also been frustrated with what he felt was the lack of ability on the part of medical practitioners to answer questions about his pain, and give him plausible explanations. Regarding his pain he states:

Well, it’s kind of tough, because I don’t know where and why it’s there. I haven’t been able to locate it in me, and mechanically, as somebody who knows how to do things with their hands like build houses, and fix cars, and build motorcycles, and rebuild lawn mowers ... taking something apart and putting it back together again so it’s fixed right, with that attitude in my brain, not knowing why I’m sore pisses me off a lot.

During the program, Pierre had an experience with David (Hellerwork) where they looked at a drawing of the human body, and “David pointed to places, and things that could have happened to me that might be why it’s hurting. He explained it the best that I had it explained to me so far.” David’s explanation corresponded with Pierre’s own knowingness – “It comes from the bones, for sure. It might be my fascia that’s attached to the bone or whatever, but you know it’s coming from that location.” Pierre felt that the explanations given at the Clinic about pain and stress made sense to him. This was

very important for him. “Everything medical that I’ve been shown from people who work here makes sense to me, whereas before it was all bullshit.” (Previous explanations made no sense to him).

Sense of Connection

Pierre had very positive experiences in the acupuncture room. He connected strongly with both Dr. Wolf, and Lily. He describes Dr. Wolf as a man who “doesn’t have time to waste, doesn’t take crap, and is a straight shooter. I could relate big time.”

He found Lily very knowledgeable. Pierre states:

I think the most important thing that happened to me in acupuncture is; I was O.K. to talk to somebody about things that I never talked to anybody about before, and react to certain things that I usually keep to myself.

He describes crying so hard with Lily that, “I had to use half a box of Kleenex. I felt like a little kid. I couldn’t control myself. I bawled. I was sore.”

What seemed a turning point in developing Pierre’s confidence with the program occurred during his first acupuncture treatment:

He had some pins in, and I started shaking a little bit, and he put his hand here (points to his chest near his heart) and I felt like ... like an alien movie where they put their hand on your chest, and they heal you there; like those people that heal dead animals or whatever. It felt like that to me. I thought it was pretty cool. That was a rude awakening. It was like telling me aliens do exist. It was kind of a cool thing that opened my mind up really good to start paying attention to everybody else around here, and everything they’re saying, and listen. I still have my judgments about some things but a lot of the stuff made sense to me. But if I hadn’t gone through that with Dr. Wolf, the first day, I probably would have hated being here the whole time.

In terms of the overall importance of his connection with Dr. Wolf, he stated,

So if Dr. Wolf wasn’t here, it wouldn’t have worked, done any good for me to be here; I don’t think. I would have just walked around, “I don’t

want to talk about this to anybody. I don't want to do this, don't want to participate in the group. It's none of their business.

Another experience in acupuncture increased his trust:

He had some acupuncture needles in my back where it hurts, and I felt like I had a meat hook stuck in my back, and I was lifted off the floor (a few feet) ... I was trying to grab the bed to pull myself down, but I couldn't. I kept saying to Dr. Wolf, "Get your damned thumb out of my back," but he was sitting across the room with Homer. He wasn't even touching me. I thought it was cool (that his treatment could have such an impact on me).

Pierre was relieved by this experience. He construed it to mean that these practitioners found him simple to help; (a contrast to his previous experiences). "You're simply buddy – it's like you've been in a million times. There's just nothing to it, you're not that complicated." Pierre states, "I was enlightened there pretty good." And after spending the past four years moving from one therapy to another, being treated easily and effectively was of major importance to him.

Relationships with Practitioners at the Pain Clinic

In Pierre's mind, there is a poignant difference between practitioners at the Victoria Pain Clinic, and other programs he attended:

I've never been to a place where there are so many people in one place that are good, and feel like they want to make you better, and they care about what's gonna happen to you. I found that most of the other places I had been were trying to make you so miserable that you'd do anything to get away from there; and you'd go back to work, and WCB or whatever insurance company you were there for wouldn't have to pay you anymore.

Further to this, he adds:

Previous practitioners tried to pump it in, but the way they sent it out was not good for my brain to understand. People here are pretty caring, so you tend to listen to them, and pay attention to them, because I think they are pretty wise and smart. So they have something to show me. So I was interested in learning. So I paid attention more.

Pierre has the following advice for practitioners:

Calm down and treat people how you'd like to be treated if you were hurt; not asking them to pump it out all the time like on a production line. That kind of pressure makes them mad at you. It's going too far for people who are really, really sore. If you'd treat people better, they'd probably listen to you better.

Group

Pierre felt uncomfortable in the group. "I didn't enjoy sitting in group because I was always uncomfortable, even on mats on the floor or whatever. The group just made me feel sad." However, he said, "to talk to all these people, and see I'm not the only one like that in the world helped." And seeing people worse off than he was helped him feel a bit better about himself.

Stage 2 Data Analysis: Sparks of Transformation

I see Pierre's transformation as an on-going process that he will further post program. He knows there is a great deal of information to integrate from the program, as well as lifestyle changes to make regarding his pain levels. He also knows it will take time to integrate and implement these changes.

I believe that his motivation toward recovery at the end of the program is an outcome of the level of trust he was able to reach in the program. It seems that the trust he had for practitioners enabled him to experience deeper trust for his own body, and its signals around pain, as well as needs for rest, and recovery.

I believe that the aforementioned experiences in acupuncture, including connections with Dr. Wolf and Lily, acted as a rudder steering him clearly into the program, and allowing him to open to the possibilities for healing that were available. He

admits himself that without these connections, the program wouldn't have worked for him at all.

The safety and trust he experienced with Dr. Wolf, and Lily, allowed him to talk about things he never talked to anybody about before (things he usually kept to himself). This safety promoted a release of long held emotions, especially sadness.

The fact that he perceived the practitioners as finding him *simple* to treat added to his confidence with the program; its theories and methods. Because the explanations made sense, he was willing to engage with the treatments, and apply the methods as instructed.

Although Pierre downplays the value of the group, the fact that others were hurting, too, (some worse than he was), may have added to his ability to *get off his own back* as he realized that, "I'm not the only one in the world" (who hurts). Experiences in the group, and with practitioners, helped him face the fact that he *hurts*. This was an important piece for him. Potentially it will allow him to stop and pay attention to the pain, rather than pushing on, or getting mad at himself for being in so much pain.

Researcher's Excerpt

Stuck

I was stuck ... for days ... what is going on? Why the delay? My energy is lying deep. Nothing is moving. I cannot write. I don't want to read the transcripts or analyze right now. What is happening?

What I think is happening within me is that I am feeling a participant's pain; sensing the size of it (from car accidents one after another). I am compassionate, and

sad. I am also acknowledging the collective pain of all the participants. Pain is, and pain hurts. Sometimes it hurts, and hurts. All my participants are hurting. I feel sad when I think about the pain they carry: the repeated car accidents, serious falls, and serious bodily injuries. Pain hurts. And it is O.K. for me to go down into this, to acknowledge it, and to feel it.

Mostly my self; like a hopeful child, wants to look beyond the struggle. But this morning, I awaken early to a dark room in the height of winter. In the depths of my being there is pain, for the suffering of others, and for my own suffering. I understand the gravity of pain, but then I stay with it, and it shifts, and is gone. And this is true of life: if we observe, the pain passes, too. And so it is.

Arsinoe: Pre-Program Profile

Arsinoe is a 29 year old, married, woman, who was born and raised in B.C. She now lives in the interior, in a new home, with her husband, and two dogs. She has one sister and two *wonderful parents*. When asked about her career, she describes herself as an energetic, robust, manager for a resort company which is part of a mid-sized hotel chain. She very much enjoys her career, and views her work as very important to her. She frequently works long hours, and has goals of advancing through to the higher echelons of the company. She left home at 18, and describes herself as a very independent person. "I stand on my own two feet." She has a lot of compassion for people and enjoys the social aspects of her work.

History of Present Illness

Arsinoe had four motor vehicle accidents over the course of the past ten years, resulting in multiple injuries. In the first accident, she was a passenger who was rear-ended. This resulted in a whiplash that she felt was “no big deal.” In the second accident, she was once again rear-ended in her Jeep. She had problems recovering from this accident including “really bad, constant headaches.” She finally sought the help of a chiropractor, and was able to be headache free for an entire month. However, upon leaving the chiropractor’s office, she was rear-ended again (as a passenger while her husband was driving her home from the appointment). This resulted in whiplash, neck problems, head problems, lower, and mid-back problems. At this point she was still working.

She describes herself as “soldiering on since my career was very important to me. So I worked with the pain, lived with the pain. It was getting to the point where I was taking 20 Ibuprofen (pain killers) a day, and just insane headaches.”

After about two and a half years, Arsinoe began seeking alternative therapies because, “I was really having trouble balancing my life with the pain.” Then in July of 2000, she had another accident. “I was driving down the highway, and some idiot talking on a cell phone ran a red light, and I t-boned him, and totaled my car. And from there, things just got worse.” After each accident, it took longer and longer to recover. She stopped working after the fourth accident, describing her life as being in a downward spiral with pain, and depression. Discussing the pain, she says, “You know I’ve had to sit down in the middle of the supermarket aisle, and hold my head and cry because it hurts so much. It’s humiliating.”

Regarding the depression, she says she has no social life. "I don't go out because I never know when the pain's going to hit. Why bother answering the phone since you have nothing to talk about." Referring to the downhill spiral she says, "I know that the more depressed you get, the worse the pain feels, and the more frustrated, and stressed out you get. The more frustrated and stressed out you get, the less you can do, the more depressed you get. I work so hard to take one step forward, and then it's two steps back when the pain hits again, really bad. I need help to get out of that rut, that downward spiral." The pain and depression have had a strong, negative impact on her marital relationship. "We can't be a sociable couple anymore, and I feel like a failure in terms of my part of the marriage. The old me, just isn't there."

Hopes for the Program

When asked what she would like to gain from the program, she expressed the following concerns:

1. Feeling lost in terms of understanding her illness (feels picked on/punished). She wants to know what the lesson is she is supposed to be learning (accidents keep happening).
2. Wants to go beyond just coping with the pain, or accepting that she may have to manage it for the rest of her life. "Because to me that means I'm giving up, and never curing it. It makes me very angry when somebody tells me I have to learn how to cope with it. If I don't believe I'm going back to my job full time, I have nothing to look forward to. I can't accept that this is who I'm gonna be forever."
3. "It's hard to be weak, and not be able to fix yourself, when you're used to being able to do it. That's what I'm looking for most."

4. “My marriage and my career are the two most important things to me, and they’re both not working. I want to feel better so my career and marriage are both back on track.”

Researcher’s Excerpt

After 1st re-read of Arsinoe’s Post-Program transcript:

I’m feeling overwhelmed about writing up Arsinoe. Her experience was so profound. What if I don’t do it right? What if I miss something? I feel like just putting her whole transcript in, verbatim. Anything else feels like a mistake. Her words are the clearest way to express what she experienced. Anything else will miss a beat; misconstrue her meanings. Her words are better than mine will be.

Perhaps if I tell her story in the way she did, people won’t believe it. They’ll say I’ve exaggerated. The task feels daunting.

Arsinoe: Post-Program Transformation Story

She sat before me. At times I felt as if we were outdoors; with the sun shining lightly, yet softly and directly upon me. But, in fact, we were sitting across from one another in a windowless room, taping our post-program interview. Her smile beautifully lit the room. I felt comforted in her calmness.

In describing some of her changes, Arsinoe said, “I knew that we have this wonderful energy and light within us, so to speak. And I hadn’t lost all ability to see it in others, but I certainly lost all ability to see it in me.” I asked, “Now can you see it in you?” *Arsinoe:* Yes, I can see it in me. And it’s a wonderful feeling.” I asked her,

“How do you suppose you’ve come to experience this?” *Arsinoe*: “If there is light, it’s because I believe so much in what I’ve learned here.”

Her response sounded somewhat evangelical to me. I probed. “Please explain what you mean by that comment:”

It’s not that one word here is taken as gospel ... that’s what I liked about the way everything was presented here. It wasn’t told to you it’s this way, and if you don’t believe it’s this way, we’re going to make you believe it’s this way.” Instead, whatever way is right for you is the way that they will support. It’s more about me and *empowerment*. It’s about *believing in me*. And it’s about *the whole energy thing, too...like me being able to control my own energy, and me being able to feel my own energy*. It’s about me being able to manage my pain. About having confidence and being able to live again; in a new way, even with pain.

Arsinoe’s transformation was profound. I reflected on her transcript for many hours, trying to decipher the best way to present her transformation story. Pre to post program changes surfaced repeatedly throughout her data. Her story had a rhythm. She answered the interview questions by telling me about what her experience was like before the program, and what her experience is like now.

The main areas of change are reflected in the following categories:

1. Moving from hopelessness to hope
2. Regaining confidence
3. Reconnecting with her body
4. Managing pain
5. Discovering her self and her knowingness
6. Relating with others also in pain
7. Making healthy choices about her career
8. Re-socializing/decreasing isolation

9. Rekindling her marriage
10. Being empowered in her own choices.

Moving From Hopelessness to Hope

Arsinoe's hope derives from having learned many new tools, and ways of thinking, which have given her a feeling of confidence toward the future. When she first arrived she was feeling very hopeless, "My pain had taken control of my life." Now she is confident there is hope. "There are a lot of options available to me, and my pain is no longer in charge of me. I'm back in charge."

Confidence

This hopefulness also derived from feeling much more confident in herself. "I'm much more confident in looking in me, and finding out what I need." She described that, pre-program, her confidence:

had just gone away. I tried everything that I knew how to do to fix my problem, and still came up dry; no answers. And nothing worked and everybody was telling me that it should be working. Normally I can fix things on my own, and I couldn't. And my confidence level was shot. And that really flowed into many other areas of my life.

Being in the group atmosphere and having the support of ten other people going through the same issues, or similar, were key factors in her ability to rebuild confidence. She described the group as having "so much openness, so much honesty, so much support, and so much love that you couldn't not be touched by that. They couldn't not boost your self-esteem, and your confidence."

She also felt that the practitioners were all so open, honest, and supportive. And, "I can't think of any other medical practitioner that's ever listened in the way that they

listen. Each and every one of them was willing to go down whatever road it took to help each of us get to where we wanted to be.”

Reconnecting with her body was a large factor in boosting her confidence in being able to handle her pain. She described her experiences in acupuncture as amazing in that they put her in touch with the power of her body, and the power of her energy.

And I had lost complete touch with that. So that’s really given me a whole new insight into what’s going on in my body, and how to listen to my body. And how to nurture my body, not just feed it a bunch of drugs, and if I’m in pain, just shut down completely. There’s still, at that point, some things that I personally can do to help myself. I learned about the energy you carry in your body, and how to create a healthy energy flow, and why energy isn’t flowing properly. I have the basic handles on it now.

I asked her, could you actually get a sense of where your energy was flowing, and where it was blocking?”

Arsinoe: “Completely. I know that I store sadness, and fear, and anger in my body. Anger is the one that I didn’t understand. I wasn’t expecting that to be there at all. And the specific areas in me, I carried so much of it in my shoulders, and my abdomen, and my low back, which are key areas to where I’ve had so much pain.”

Managing Pain

Arsinoe:

Between the acupuncture and the breathing exercises, I’ve come to realize that approximately 25% of my physical pain is pain that I have the capability of controlling or lessening, if I’m paying attention to my body. And if I can control 25% ... , as I do that, the core pieces that I can’t get to are then going to be able to heal themselves a little better ‘cause I’m freeing up more space in there. And that’s what I’m going to work towards.

Arsinoe came to a whole new understanding of managing her pain. When she first came to the program, she *didn’t want to manage her pain*.

To me that meant that I was giving in. The accident wasn't my fault, why should I have to do the work? Why should I have to manage it? Manage it to me meant I was giving up on ever finding a cure.

And now, managing it to me means that I'm back in charge and just because I have pain doesn't mean that I can't still have a life.

She learned to listen to her body and what her pain is telling her. "Not to just mask it with drugs, or with a drink, or with complaints. Now I don't need to block out what my body is telling me. I'm comfortable listening to it." She stated that she doesn't need crutches of booze, drugs, and medications. She knows she may, in fact, go through "crazy pain" again. But instead of reacting previously with "absolute, complete dread, that, oh my God, this pain hurts so much I'm gonna die, and why am I being punished?" Now she will face it by "going, O.K., there's something wrong in my body, and I need to sit down, and figure out what it is. It's really quite simple."

Discovering Her Self and Her Knowingness

Several times in the interview, Arsinoe referred to having reawakened a sense of her own knowingness in regards to healing her pain. Referring to her insight process she said, "When I finally got it, and a light bulb went off, it didn't feel to me like somebody was shoving something down my throat. It felt to me like, *I knew that. On some level I knew all that, and for some reason it had just all been disregarded, or hidden so far deep, because it wasn't what everybody else was telling me I needed.*"

This knowingness is also evident in her attunement with her body. She can listen to her body, and what it is telling her. I asked her how she was certain of what her body was saying. She answered, "I am in touch with going places in my mind and body such that I just know, and it feels good." When I asked her how she does this, she answered:

“I’m just being there. (And if you had told me 10 days ago that this is how I’d feel, I’d have said you were out to lunch, but this is where I am now). I’m comfortable listening to my body.”

Pre-program, she described herself as spending a lot of time alone, and being lonely. Now she’s not scared to go home and be alone anymore, “Because I won’t be lonely because *I’m there*, and I’m pretty great to be with.”

Relating with Others also in Pain

This was important to Arsinoe for several reasons. First, because other people were also in pain, and they could all relate on this level, she felt that she wasn’t the only one. She wasn’t the only one who “felt betrayed by fate.” By having a commonality of feelings with others, she came to understand that her own feelings “weren’t silly or useless. They were just feelings, and surprisingly enough other people had them, too.” These experiences helped her feel like she wasn’t alone. This was valuable to her because:

I’d spent so much time alone in the past year, I figured I had to find my way out on my own, and my way out wasn’t working, and I don’t think that I could have, (where I was ten days ago), I wouldn’t have been capable of getting out on my own. I needed the boost of the group to reaffirm my abilities to do it.

She knows now that she has the tools to do it on her own (deal with her pain), and that it’s “not gonna be easy.” However, she is confident she is on the right track, and expects to rely on on-going support from group members if she falls back into old patterns. She states, “If I keep at it, there’s no way I won’t get life back.”

Making Healthy Choices About Her Career

In the group work, Arsinoe focused quite a bit on her career and previous work patterns. She described herself as a *workaholic* and that work was extremely important to her. It is still important to her now, but no longer important that the work, “has to be the same thing.” At the start of the program she believed she would be a failure if she couldn’t go back to her 12-14 hour per day job. She had very high standards for herself about work. She characterized the time she was off work as follows: “Every day I was away from work was another nail in my coffin so far as my career went, and that’s where I was focusing.” She had great difficulty giving herself time to heal. Now she can appreciate:

that if something happens to your body to cause pain, it’s O.K. to take the time to heal, and you want to heal correctly ... I can always see that in somebody else... If there’s something wrong with my staff, and they need time off work, I would never say (if they broke their arm for example), get back to work the day the cast comes off, and do 110%. But for some reason, I expected that of myself. Now I see that the pain was a gift to help open my eyes to how before the accident, it was not a healthy way of being. I’m fortunate to be young enough, just going on 30; to catch it, instead of catching it at 50.

Instead of feeling like a failure if she couldn’t go back to work full time straight off the bat, she now has the confidence to know that:

It’s just not possible, when you’ve been off work so long and are living with Chronic Pain, to jump back into a 12-14 hour/day job, and not have setbacks, and some pretty huge setbacks if I had jumped back into the 12-14 hour day job, and had not been successful right away, and had to leave work again. That probably would have shot me back another 10 steps. I was a workaholic, and I don’t need to judge myself by those unhealthy standards that I was holding myself to before.

Her goal for her career is that at the end of three months, she will work into gradual re-integration to work; “maybe starting with two days part time mornings, and

working up from there. So that I'm setting myself up for success this time; and checking in with my body twice a day."

Re-socializing, Decreasing Isolation

In the past, Arsinoe's pain greatly affected her social life. "I knew that at some point the pain, the extreme pain, would hit whenever I went out. Therefore, I didn't go out, because I didn't want to appear weak; and I didn't want to have to leave. Also, I had little confidence. I felt that because I spent so much time home alone, and my concentration was lacking (I barely even read the paper and it was just me, and my pain), I didn't know what to talk about. I'm used to talking about my work. That's where I get most of my stories from). But now I have had this wonderful reaffirmation that I can not only be in a group setting and contribute, I can make friends, and have lasting connections as well."

Her plan is to go out, and meet people, and contribute. "If the pain hits, that's O.K. I can go home, or find a way to deal with it. Leaving is not a sign of weakness. It's a sign that my body is telling me that I need to stop now. And at least I will have had, say three hours of fun and being with people, and friendship, as opposed to nothing."

Rekindling Her Relationship with Her Husband

Pre-program, she experienced communication issues, and lack of libido (on her part), in her marriage. She believes her ability to communicate was affected because, "I didn't know how to deal with what was happening to my body, and I was shutting down so much due to pain." She describes her husband as a good communicator. She said:

“I’ve been given so many amazing tools for communication, and my husband is open to start with,” so their communication will be a lot better.

In terms of their sexual relationship, she portrays it as a big part of their relationship, and that they both enjoy it. The last year was a real change for her. “I just didn’t want it anymore.” This was a real struggle for her husband. She is now very happy to say that she feels her sex drive coming back. “Unfortunately now he’s not home for eight weeks, so he’s going to get quite a shock when he does get home!”

Being Empowered in Her Own Choices

“I thought I was taking charge before of the way things were going, but I realize it wasn’t necessarily in a way that benefited me to the max. And so, I’m going to be readdressing that.” She feels confident that she can make her own decisions. “It’s not just up to someone else to tell me to do this, and to try that, and well if this doesn’t work then it’s game over.”

I asked her, “If a medical practitioner were to say to you, “Well, we’ll try this, and if it doesn’t work, then there is nothing more we can do. What do you think you would say? She replied, “My response now would be, there may be nothing more you can do, but there’s lots more that I can do. I feel empowered, and that is probably the most important tool I’m taking out of here.”

She feels confident in her ability to think clearly about what is best for her and make sound decisions. “Now I can see options. I know there are many options, whether it be medical treatment, my future career, or my relationship with my husband. There are tons of them. I don’t know why I couldn’t see them for a while. But I see a

huge light at the end of the tunnel, and the tunnel is not nearly as long as it looked before, and that is a very peaceful feeling.”

Stage 2 Data Analysis

Arsinoe’s post program interview is replete with significant insights. In this, the second stage of data analysis, I tracked her insight process to ascertain just how she may have been afforded, or come upon, these insights. What stands out to me is not just one avenue which opened these doors of insight. Rather, she herself stated, “Everything in particular had its place.”

Although Arsinoe admits some skepticism toward the healing team at first, (“I indulged the healing team at first”), the approach of these practitioners, the group, and the “non-clinical setting” in which the program took place helped her to feel safe enough to open up, and “explore places I hadn’t been in a long time.” Her feelings of safety were greatly augmented by, what she termed, “the group atmosphere; having the support of 10 other people going through the same or similar issues” to hers. These were people who could relate. Being related to, and being able to relate to others exactly as she was, helped boost her confidence immensely. Instead of feeling like she was somehow lacking, due to being a person in pain, she began to feel that she was someone with something to contribute.

Arsinoe credits the many tools she learned as a source of renewed independence and confidence for her. She learned ways of managing pain through acupuncture (increased body awareness), counselling, stretching, and relaxation classes, and in group sessions. In addition, during several of the group exercises, she focused on her work life. She *chipped away*, sometimes with difficulty, at her old image of herself as a successful

businesswoman working 12-14 hours per day. In the end she held realistic viewpoints regarding her future career, and was content with these points of view:

I need to go ahead and discover what my new life is going to be. And I'm confident that I can do that. If I choose not to go back to working the way I was working before, because the price is too high for my body, that's a healthy choice to me. And I can accept that now, whereas I couldn't accept that 10 days ago.

Her ability to come into her own power was a product of several forces: (a) feeling safe in the environment as described above with group and staff, (b) trusting, and liking the practitioners, (c) feeling affirmed by her experiences in the group, (d) opening herself in the acupuncture sessions to her own energy flow, and becoming well attuned to her body, (e) trusting her body's wisdom (what her body was telling her), (f) deciding to use the tools she learned at the clinic into the future, (g) desiring to be empowered, and in charge of her own life; simultaneous with listening to her body.

Because she describes herself as a person who is *independent* and *confidence driven*; pre-program, when she couldn't *fix her problem* (e.g. her Chronic Pain), she felt hopeless. This sense of her own ineffectuality pervaded, and she was depressed. Now, "having had those qualities re-ignited" she is feeling empowered, and "less and less like I need the help of antidepressants." She will seek her GP's advice about weaning off these when she gets home.

With renewed agency, she plans on becoming more consistent with the tools she's "taking home from here." This will take "practice, setting up her own daily routine of stretches, a space for her, and time for her just to reflect, talk to her body, and find out what's going on. She also plans on re-approaching some of her current practitioners."

She knows she has many options, and now has the confidence to explore those that feel right to her.

Researcher's Excerpt

My data is my teacher. When I immerse, I learn. I am in a dialogue with Arsinoe; her words repeating in the quiet recesses of my mind. Lessons learned, shared with me. How fortunate I am. The message of listening to your body: a gift. My body speaks to me, and like a mother attuning to her first born child, I listen, and I hear, and I know. The sounds of my own body telling me I'm alive, to the rhythm, the sounds of creation as they express themselves through me.

There is an exchange with my data. It feeds me as I live in it, and then enter into an alchemy: a metamorphosis through which words, concepts, spring forth; and take their life: a new creation. We are one, and yet I am distinct, but encircled by her story. I breathe in, ask to receive the gifts, then let go, and move on.

Juliann: Pre-Program Profile

Juliann, now living in the mid-western United States, is a 51-year-old widow, and mother of two teenagers. Her husband passed away nine years ago, at the age of 46. She described their marriage as *wonderful*. “We absolutely adored each other. I thought my husband was my reward for having to live such a difficult life. Many of my friends said we had a marriage everybody envied, and wished they had.” She has a very close relationship with her son and daughter, who she has raised alone since ages 8 and 10.

Juliann originally grew up on the West Coast, in what she described as a *rather dysfunctional family*. “Ultimately my sister and my father committed suicide, leaving

only my mother” (who she describes as *toxic*). Her present relationship with her mother is distant. She has no other family, but does have one close friend. However, this friend recently lost her son in a “freak car accident.”

She has been very successful career-wise. She started out as a librarian when in college, and then worked in the television industry in production. She also had her own business on the side, and when her TV show was cancelled, she went into the personnel temp industry. Juliann and her husband opened their own temporary help company, which became quite a large company. After her husband died, she “doubled the business in the two years after he died.” Although the business was successful, Juliann felt that it was taking away from the children, so she sold it, and moved to the mid west with her kids. At her new destination, she bought a theatre that was closing down, and made it a non-profit community theatre. Recently, she has had to get out of this due to back surgery and scoliosis.

History of Present Illness

Juliann has had scoliosis since her teenage years but she was able to live with it, doing a lot of exercise until the birth of her daughter. After a difficult birth, the worst of her back pain started. She received successful treatment for this for years from a Chinese acupuncturist who then had to return to China. After that, practitioners became anxious, and felt something had to be done to help her nerves. Her lower back “kind of collapsed” because of lack of response of those nerves, and she was losing feeling in her legs.

Therefore, she had two surgeries on her back. Fourteen vertebrae were fused in her back in the first surgery, and then in her most recent surgery, (5 months ago); she had

“slices of cadavers’ femur bones replace her discs to make the fusion more solid.” Since then, she hasn’t been able to stand up straight, and is in serious pain, 24/7. She hasn’t been able to work at all over the past year, and can only do about 2 – 3 hours of any activity per day. She has also been hospitalized for depression “because of all I was through with my back.” Juliann felt that her surgeon was, “a good technician, but really had no empathy for, or understanding of my pain.”

Hopes for the Program

1. “If we can’t get the pain to improve, I want to learn how to live with it.”
2. “I want to have a more functional life, and become the person I was before. “I think that’s been the most upsetting for me; that I’m not the person I was before, and there are a lot of years ahead of me, and that frightens me.”
3. “I want to be able to still do things, and still travel, and do things with my kids, and grandkids.”
4. “I’ve been as close to being suicidal as I’ve ever been, and if it weren’t for my kids, I’d be gone. But I could never put my kids through that. All I have are my kids; that’s all. But on the same token, all my kids have is me.”

Juliann: Post-Program Transformation Story

It’s the final day of the program and Juliann is tired during the post program interview. Yet despite her fatigue, a very strong and centered woman is sitting with me. Relaxed, and in touch with her new found self, Juliann speaks with decisiveness, and hopefulness, about her future. She is clearly empowered by sensing that she has the tools to manage her pain, and to handle her relationships in ways that are life-giving for her.

When we reflected upon what made for a successful program, she indicated the following:

1. Her work in counselling with Anon
2. Her Hellerwork massages with David
3. Insights and interpersonal awarenesses she received through her experiences in acupuncture
4. The ability to practice new behaviours in a safe place, and with safe people (e.g. other group members)
5. Feeling permission to put herself first
6. Feeling that her needs were listened to, acknowledged, accepted, and accommodated.

Juliann's description of what happened in each of the above areas will be explicated next.

Counselling Work

Juliann did not find her acupuncture sessions helpful, "as what was being dredged up in acupuncture were issues I'd already worked on." However, when she talked with Anon, "her conversations were much more successful at reaching into certain avenues of my life that I hadn't touched upon, and for some reason she was able to elicit those so quickly." And Juliann worked on these. She states that counselling was where she got most of her work done.

One example was a session with Anon when she brought Juliann's attention to something she had idly said at the lunch table:

She brought an interpretation of what she thought I said, and asked, "Tell me if I'm way off base." And it was just right on the money, but I hadn't seen it. I just hadn't seen it that way. And when I did make the

connection, (to the situation and people), I was in touch with my anger. And I was able to do some work which was screaming, and pounding pillows, and yelling at them, and telling them, (the perpetrators), exactly what I thought of them, and how they had lied, and cheated me ... and waited till I had gone into the hospital to do those things. And how much it had cost me, not only financially, but in trust, and in every other way. And how much that it hurt.

And with Anon, “We got to the core of issues. And I cried, and got to the base of my feelings, and I howled, and cried, and worked things through, and screamed, and hollered, and did all the work that I think a lot of people got done in the acupuncture room. I did it through Anon. So I guess it doesn’t matter how it works itself out as long as it happens.”

Hellerwork Massages

Juliann made a decision to forego her final acupuncture session, and have an additional massage with David instead. She states, “That was far more effective, and better for me in the long run. I went and had something done that was productive for me.” Juliann characterizes those massages as very effective for her pain. “He really was able to move some things around.” She also found the cranio-sacral sessions with Kate, helpful.

Interpersonal Awarenesses Through Acupuncture

Juliann states that:

One of my biggest problems in the acupuncture room is that I don’t do well with distraction, with somebody else being there. And the person who was my partner, talked constantly, and that was a big distraction for me...She never stopped talking, even as they were doing different procedures on her. She just kept talk, talk, talk, talk, talking, and that was driving me crazy ... the non-sensical, incessant, chattering going on was just making me furious. And they encouraged me to go into that, and get

really mad, but I didn't think that was accomplishing what I wanted to accomplish in terms of getting any work done.

(So she didn't do it). Toward the end of the program, Juliann was encouraged to bring this up to her acupuncture partner. She didn't want to. "I didn't want to make somebody feel uncomfortable, and bad, at the end of the session. It was not a good, or fair thing to do."

But before the end, Dr. Wolf made room for them all to talk. Juliann was able to:

say one of those things from the heart. I was able to bring up that the reason I was getting a massage (instead of an acupuncture session) was purely out of issues of my own; that there were reminders of my mother coming up like crazy. When she would talk and talk and talk and talk, and I was not able to settle in, they were purely my issues, and not hers at all, but it brought up an issue from my mother that I hadn't dealt with. With my mother, when she calls, there is just this incessant rambling. I mean literally you can put the phone down, go clean the house, and come back, and Aha, kind of come down, and mow the lawn, come back, really ... " (while mom's still talking).

Being able to confront this group member was monumentally important:

I never would have done this in a million years before (e.g. voice her concerns, and complain). My mother would have made me completely wrong. I would have to pay for things that I said that were anything contrary to her opinion.

About the group member, she went on to say,

"She has given me a genuine gift. I was able to compliment her for the gift she gave me. I was grateful, and thanked her for bringing that issue up for me."

Practicing New Behaviours in Safety

Juliann gained a lot from the group sessions taught by Anon. These included a variety of communication skills and self awareness skills; allowing group members to practice tools for building self esteem, and self assertion.

I've read about a lot of these things in the past, but here, you're in a safe environment where you can practice some of these things, and I think that's what helps. And being given the phrases, and being given the tools to help, and practicing them on real people. Practicing them on safe people is very helpful.

Giving Herself Permission to Put Herself First

This is a new found skill that she is beginning to integrate. She had come to the program feeling suicidal, but states that, "as compared with having 0-3% desire to live pre-program, her desire to live now has moved to about 50%; and that's half way up. So the more I can develop, and nurture all I've learned, the more it's gonna improve, and grow."

When I asked her why she no longer feels suicidal, she stated:

I think giving myself permission to put myself first, over all the other people that I seem to put first, even ahead of my children; that ability to put myself first above everybody else, and the fact that that was good, and that was right, was a real relief to me. 'Cause I tend to put everybody else ahead of me, and it just wears me down to where I just can't continue on. And knowing that I wouldn't be shunned, or considered selfish has really helped.

When I asked her how she will live this new philosophy, she stated:

"Just say, No."

When she goes home:

The first thing I'm going to do is write a letter of resignation from the Board of Directors of the Housing Association I'm involved in (even though they are full of flattery of me ... we need your business mind, etc.), and refuse the nomination.

That is a way of putting herself first. And in terms of her desire to lead a more functional, fun life, she stated:

I need to set boundaries. And that's the saying, "No." And just putting up boundaries of what I will do, and not do. And not saying, "Yes," when I

mean, “No;” and being willing to say *No*, when that’s what I really mean. That’s the hardest thing to do.

Acknowledging Her Needs

Juliann really appreciated the fact that *her* needs were heard, listened to, and acknowledged. She describes herself as someone who normally concedes. “I will always bow out to avoid any confrontation. I’m a strong person. I can do without. They’re not as strong, so let them go ahead, and have their way.”

However, in this situation, her right to experience her own needs was promoted by staff, and group members, to the point where she felt safe enough, and respected enough to express them. This was gratifying for her, and such a new experience that she was shocked at being able to express her own truth.

Stage 2: How the Process Unfolded. What Sparked Her Transformation?

At the beginning of the program, Juliann wanted to pack her bags and go home. She felt betrayed regarding the way the acupuncture was practiced at the Clinic. She felt it was misrepresented to her in the literature she received. However, after talking with her daughter by phone, who said, “You owe it to yourself to stay, and give it some time to see if it is worthwhile or not,” she felt supported, and decided to give it more time.

It seems that from that point on, Juliann was determined to, “make her experience her own,” in terms of getting what she came for. And, in the end, she felt she had benefited very much from the Program.

Getting the most benefit for herself seemed to derive from: (a) feeling safe in the atmosphere of the Pain Clinic, (b) her connection with Anon, and the work she did in counselling, (c) choosing extra Hellerwork, and taking advantage of these sessions which

were really helping her pain, (d) recognizing the transference she had regarding her acupuncture partner, and using this process to learn a great deal about how she related interpersonally, and (e) using the group sessions to re-pattern her behaviours, in terms of communication and assertiveness, which gave her confidence to use these skills in the world. In effect, she used the microcosmic, safe, world of the Pain Clinic to sharpen skills to use in the macrocosm.

In addition, Juliann became much more internally focused. Through the repeated relaxations, and stretching exercises, she became more aware of her body. She learned to pay attention to her body. When she was resting, instead of distracting herself with T.V. or a magazine, she would meditate, and use oral chanting (a new technique that she learned). She found this form of internal focusing very healing, especially when certain sounds reverberated at her solar plexus. She was recently post-operative, and required a lot of rest. She mentioned that she and Anon had a counselling session in her room, as she was too tired to go out. And that was good for her.

In terms of her body, she speaks with much more of her own authority about herself. "Right now, if it feels like I'm tired, and I need to rest, then I'll honour that. And if I can go and do something, then I will." Pre-program, Juliann was confused. "Doctors didn't agree about why she was in pain, or whether she *should be* in pain".

I was frightened by the fact that I was bedridden. I didn't understand, wasn't sure why. One doctor said, "Oh, you should be fine," and another doctor was going, "You've got six pounds of hardware inside of you, you should be in pain." I used to stay in bed, and watch movies all day because I didn't feel like getting up, and I was frightened. Now, I know I need to rest periodically (the pain in my lower back tells me). I need to rest at least every two hours. I need to flatten out for a little bit, and if I've put heat on it, I only have to rest for 10-15 minutes, and then I'm up, and raring to go.

The work she did with Anon was emotionally cathartic. Although she didn't express her feelings in the acupuncture room, she did have four sessions of acupuncture whereby her energy would have been stimulated to move, as well as moving in her counselling sessions. Juliann described her pain as being greatly reduced; to the point where, several times, she forgot to take her pain medication. "I just didn't even think about taking them. My-gosh, it's night time. Well I don't need any now, so."

Perhaps the safety of the group, as well as feeling permission to express herself, and put herself first, also allowed her to experience the right to care for herself in ways that she needed. She admits, "I was starting to take the time out for myself, knowing that I needed to do that!" From the act of having her needs respected by others, she, in turn, felt right in respecting her own needs.

Because she wasn't *pushed* to confront her acupuncture partner, but given the space for same, she was successful in doing so; in her own time, and own way. It was important for her to *come from the heart*, and the fact that she was received so well brought great fulfillment (and surprise) to her.

In summary, Juliann's insights were a product of her ability to work hard, and to use the program in ways that suited her. Her connections, particularly with Anon, David, Kate, and group members, brought her great safety within an environment where she felt free to experience, express, and explore more of who she is.

Researcher's Excerpts

Standing Up For the Self

What an important lesson I am learning from Juliann! I learned that not being able to stand up for oneself, or not being able to put one self first, is enough to cause one

to feel suicidal. This raises a red flag for me. It sounds so simple, but it is not. If we put ourselves aside enough, life becomes pointless. It leads to depression, loss of self, which leads to suicide.

This is a gift to me. To remind me of the all importance of standing up for myself and my own needs.

Immersing in the Data

I am affected by the data. I am not immune. I question the immersion process in qualitative research. When I immerse into the topic of Chronic Pain, I feel very vulnerable. I seem to have to be willing to risk immersing myself in another's pain. To understand immersion I look up the definition:

Immerse: (Oxford Dictionary, 2000, p. 397)

- 1. Put completely into water or other liquid*
- 2. Absorb or involve deeply in thought or business, etc.*
- 3. Embed (fix firmly in a surrounding mass).*

My thoughts go to, "Maybe if I set a boundary:"

Boundary (p. 92): A line that marks a limit.

Immerse: (Oxford's thesaurus, 1997, p. 216)

- 1. plunge, sink, submerge, dip, dunk, duck, inundate.*

Antonym. Raise.

- 2. plunge, sink, submerge, bury, absorb, engross, engage, occupy, involve. I immersed myself in my work and never noticed the time.*

Antonym. Disinvolve, disengage.

Immersion: immersing, being immersed.

an I plunge into the participant's data on pain, and submerge, immerse, and then raise out of it without losing the flavours, textures, meanings; the spice of the mixture of the data?

I am engaged, engrossed, occupied, involved. I immerse myself in my work and never notice the time! Can I immerse, embed, involve myself deeply, and also disengage so I don't absorb the pain?

Can I set a boundary (a line that marks a limit)? Or are we too connected for this to be possible? I notice that I feel her pain as my own. We are embedded. I live with it, learn from it, and let go.

Colette: Pre-Program Profile

Colette is a 39 year-old entrepreneur from the interior of B.C. She and her husband own three businesses. She describes herself as a driven, dynamic, person who has always been a very active, career-minded, individual. She's done a tremendous amount career wise, including being a marketing and advertising manager for a very large company; traveling and lecturing at some of the largest international trade shows in the world. She comes from a very active family, "a really dynamic, go get it, you've got a goal, go for it, kind of stock."

Colette is part of a blended family with husband, and two sons; one in elementary school, and the other in college. At the time of the interview, she was involved in selling one of her companies so that she could pursue a change of direction in order to "upgrade into something less stressful." Presently, with owning three companies, she is working weekends, nights; "you name it." Colette feels that she, "wants to contribute a little bit more in an area that has more importance for her." Her plans include going back to university to become a professor.

History of Illness

Colette had an accident four years ago at a trade show. “The stairs collapsed underneath me, and I fell through and injured myself.” She suffers from pain in her left shoulder, neck, jaw, head, lower back, groin, and knees from the fall. Colette said,

After the accident happened, I went into survival mode. There was so much going on, and I was physically unable to keep up with it. My energy levels have plummeted, and literally my world came crashing in after that. And for four years, I’ve been saying I’m going to get better. I mean it’s just, it’s soft tissue, it’s gonna get better, and so far it’s not, even though I’m still trying to maintain that same level of go, go, go. I’ve glossed over the amount of pain I’ve had to go through. I’m good at hiding pain, but it’s been tremendous. I mean it’s depressing. I got to the point where I wanted to die. I wanted to kill myself. I was so frustrated.

Although Colette has been going to doctors to get painkillers, she stated, “I don’t want to do just painkillers. I’m not that kind of a person. I believe in the power of the mind, and I believe in my ability to work toward healing myself.”

Hopes for the Program

That is why I am here ... to take some time to heal myself. I want to have the tools and things in place to do the things I want to with my life for the next 30 – 40 years. The accident and the pain have caused me to stop and back away, and figure out what I want to do with the rest of my life. I’m asking myself what’s important in life. Is it having another car, or buying another house, or owning a bigger business or, dot, dot, dot? I am good at things, I can make things happen, but what do I want to make happen? You can gain the whole world, and lose your soul or lose your contact with a God.

“The Pain Clinic program will allow me:

1. More time for reflection
2. I’m looking for tools to help deal with the pain and stress.
3. I’m hoping to do some deep work with massage to break down some of the soft tissue damage.

4. I'm looking to deal with some issues just bubbling inside that are saying, *O.K. deal with me now*. I can feel them there like a knot in my throat. I want to deal with some of those emotional issues, to help deal with the pain.
5. I firmly believe that your mind and body are interconnected, and you can change your thinking, and transform attitudes. I'm hoping to improve my thinking.
6. I don't see this program as a miracle, or *you fix me*. It's going to be a lot of work on my behalf.
7. So, I'm here to further my spiritual evolution and transformation. I've seen glimpses of the power that's available to me. I want to be able to choose a life that actively embraces this power."

Colette: Post-Program Transformation Story

When she spoke, I sensed the seriousness of purpose behind her words. Her program was successful, but she would, "only move forward if she continues to use the tools she learned." Her experience of the program had been meaningful. Her messages, said softly, penetrated my beingness with their gifts of grace, and an open heart. What did she say? What were the unique elements we discussed that characterized Colette's journey?

Colette began by saying she found the program very full, and very intense; "a tremendous learning experience." She discussed how the various clinical practices were interwoven such that the program worked on many different levels. For Colette, "The plethora of experience was more than she anticipated." Colette's experience also unfolded on many levels.

To explain Colette's journey, I have divided her experiences into the following themes: (a) Her experiences in Hellerwork, (b) Her experiences in acupuncture, (c) Her

experiences with the group, (d) Her self esteem, (e) Energy and spirituality, (f) Tools for the future.

Experiences in Hellerwork

Colette described her pain as being, “down about 25-35% at the end of the program.” She felt that the Hellerwork was of great benefit. It provided her with a, “tremendous amount of relief.” She stated that although lay people don’t think pain relief is worthwhile unless the pain is stopped, for her, “to take the edge down like that is very significant, and very meaningful, pain relief.” Besides what she described as, “David’s magic hands,” the process that was going on during the Hellerwork sessions is worth conveying. During the treatments, Colette was communicating back and forth with David:

I would say, hold off, or wait a second, let me breathe into that spot ‘cause it hurts. And so we had a really clear communication, therapist to patient, which I think really helped. I was able to go into the physical pain and breathe through it, and allow it to happen, working my way through it that way.

I asked Colette what enabled her to work with the pain in this way? She described her process as follows:

I think I had tremendous success because I was willing to let go, relax, feel the pain, watch my edge, breathe. I said, O.K. to this process, and made a contract with myself that I was going to work with this to the absolute best of my abilities. So I played a role in my willingness. I think I was a very willing participant. You know, I’m very open to it; which can be difficult; and breathing, lots of good breathing. That was a very important part of it. I would feel it, and actually work my way through it. Push through it. Not even push through it, but allow it to happen, allow it, and relax, instead of fighting it. I mean I’ve spent years fighting my pain, and to actually feel it, and to let my body go with the pain, as opposed to fighting it. I think that’s the biggest lesson I’ve learned here, too, is to just stop fighting it; and work with it, you know.

Colette also derived new hope about her recovery from the success of the Hellerwork treatments. She said that she had been going to massage therapists, and chiropractors, and physiotherapists for years without pain relief, and consequently she was in a state of fear in terms of her abilities to recover. With David's treatments, after just a few sessions she was able to move, "her shoulder in ways she never thought possible again." This gave her hope, "for correction of some of the physical problems," she had endured for years.

In terms of letting go and relaxing in the sessions, she proclaimed, "I worked very hard to relax!" She knew she had to, "do the work" (e.g. relax). And this was not easy for a driven business person and mother, like herself. However, she came to make changes, and to take responsibility. "I'm not a victim personality. I'm not the kind of person who says, "Oh fix me." I recognize that I've got to do the work. I worked very hard in this program, and consequently I've had success, and I've seen success."

Experiences in Acupuncture

"I found the acupuncture room more threatening physically. Interestingly, abuse issues came up." I asked Colette if she was frightened in there. She said, "No, I was never frightened in there. I was working through some fear, you bet. But in terms of on a conscious level, I was never frightened in there. I felt safe enough to be able to actually experience experiences that I was too frightened to experience at the time."

Colette had one experience of what she called a *body memory*.

At one point, I was being strangled. I mean my tongue came right out of my mouth, my neck; a red mark across my neck actually formed, and I was choking like I was there. But you still have that piece of consciousness that says I'm not really choking, but just kind of reliving that memory. That's something that will stay with me for a long time.

In that experience she learned to “let energy flow.”

I see a relationship between pain, and energy, and energy blockages, and letting it out ... Since the neck thing, I can breathe more clearly. Now, to me, on a left brain, intellectual perspective it seems almost bizarre, flaky. On the other hand, it happened. I mean that’s what the reality is; that I went through this experience in there.

I tried to probe a little more into the meaning of this experience for her. She said, “You know, you could psychoanalyze this stuff to death, but I don’t think it’s necessary. The energy has been released, and I feel better. So why go into the whole analysis?” Colette feels she experienced a very big learning in relating her physical pain to blocked energy. This is a fairly new concept to her which she now can relate to both somatically and intellectually.

Apart from the experiential component of acupuncture, the theory also made sense to her. For Colette, it was very important that the theories of the clinic were reasonable, sensible, and based on science. She was not interested in a “New Age program that is flaky,” in any way. Even though the program involved acupuncture (Chinese medicine), visualization, energy work, and body work, to Colette, all these treatments had a strong scientific grounding which was explained by various practitioners. These scientific theories made sense to her. “On an intellectual, mental level, I think there was a tremendous amount of food there.”

On an emotional level, Colette was able to reach tremendous depths. “I had experiences I found almost shocking, surreal, and emotionally just tremendously charged. And releasing them, and working with them has just been a wonderful experience.” The pain clinic is, “a very safe environment that allows for that emotional stuff to come out. And some really good support went with it.”

Experiences with the Group

Colette found the group setting, “very touching.” She felt she learned, “an awful lot from every member of the group with their sharing, their insights, their *aha*’s, and their pain; and their courage, and their ability; their tenacity, to move on. Seeing other people work through their stuff was very touching.” She found this to be a wonderful part of the program.

Self esteem

Personal work, group work, body awarenesses, and energy awarenesses, all helped Colette discover some key pieces related to her self esteem.

I think the biggest thing I’ve noticed is that I need to be gentler with myself. I need to be softer and easier on myself. In order to survive the rest of my life, I need to be nicer to me. You know, inside physically, and just dealing with issues, and not holding onto them. Self esteem means looking out for me. I mean, I’m a typical mom; I’ve been giving for 20 years. I still have kids to give to, but you know, there’s a sanctioning out, and pulling some time for me, and I think then I’ll be able to even give more.

Energy and Spirituality

Colette views pain as blocked energy. Traditional medicine deals with pain by blocking it out. She thinks you need to let it flow; that it’s good if the energy is flowing. In her body work sessions, she experienced the connectedness of her body. When David was pushing around her diaphragm area, she was feeling it right down her psoas muscle and into her leg.

We’re connected, you know, and energy can get tied up, or even fascia can get tied up. I think I’ve got a lot of tied up fascia that’s kind of hinged on itself. So getting that to move smoothly again is important. I think there are different components. There’s the physical component but there’s also

an energy component, and obviously there's got to be a spark or something that keeps us from being a corpse. So, I choose to call that *energy*.

Colette further explains, "At the Clinic, we dealt with a lot of real spiritual issues without the imposition of belief systems on top of that." There were no superimposed, "You've got to believe this." Colette believes that, "We're energy beings, and from a spiritual perspective, I think that's tying into your god within, or whatever you want to call it. But you know, none of that was imposed on you. You were totally allowed to go, spiritually, whichever road you wanted to go on, and that I really appreciated."

Tools for the Future

Because Colette lives in rural B. C., where support is minimal, she has some apprehension about going home:

A lot of personal responsibility is going to be required ... It's going to be up to me. My expectations of the traditional medical profession have diminished dramatically. I don't think they have the skills; the capabilities (to handle stress and pain). Our system isn't set up for it. They're set up to set a broken leg. They're not set up to deal with the emotional issues that may have caused, or brought together the events that would make that (illness/accident) happen.

I asked her about the role of self reliance in healing from Chronic Pain. She replied:

You've got to take responsibility, but you need some leadership. I can be as self reliant as I want to be, but if I don't know where a light switch is in the wall, how can I turn it on? Or if I don't know what a light switch is, how can I turn the light on?

The tools she learned at the Pain Clinic have taught her where the light switches are, and how to turn them on. She plans to use the various tools she's been given including, "the stretching, visualizations, Hellerwork, even the myoclonic shaking, or the

willingness to let my body do what it wants to do, when it wants to do it, or at least making a contract that we'll do it later, O.K.? ... shedding those tears, maybe not exactly in that business meeting, but you know going and honouring myself.”

Colette says:

Spiritually speaking, even from a Christian's perspective we are taught, your body is the temple of God ... How much clearer can it be? Take care of it; honour yourself. If you can take care of yourself, then it's much easier to take care of others.

Colette feels that her recovery has been unequivocally helped by this program. However, she also knows that “The proof will be in the pudding, and the proof will also be in how much work I put into it when I leave here.” Applying the tools she has learned will keep the momentum of recovery alive. Although Colette believes she has had some phenomenal attitudinal changes, the harder part is yet to come. “It's easy to change attitudes, but it's hard to create the habits that make them stick. But I've been given some good tools.” At this point she appears very determined to apply these newly learned tools. “I've recognized a need to change my life for awhile. You know either that, or just die, or collapse, or face some very, very serious illness that kind of wipes me out. That's part of the reason why I came to the program.” She now has both the desire, and the tools to make those changes.

Data Analysis Stage 2: What Sparked Colette's Transformation?

All of the aforementioned components were vital to Colette's transformation. But what exactly sparked her transformation? What accounted for her insights? Colette's transformation was a product of many factors. These factors will be described next.

Determination

In herself, she was determined. She stated that she felt “desperate” when she first came to the program. She knew that her lifestyle was not serving her, and that if she continued to live in the same way, she would become seriously ill. Her pain had not been relieved by the variety of practitioners she had been seeing. So her motivation was high to learn something new at the program, for her benefit.

A Keen Learner

Colette made the most of the learning environment she was in. She quickly recognized that the program had scope for many learnings and she was eager. She found the science behind the overall experiences to be very plausible, and logical. “The logic is very, very clear ... So philosophically, scientifically, intellectually, I felt very, very good about it.” Because it made sense to her, she felt very much at ease to apply what she was learning to her work during the program. Her learning was from the practitioners, as well as from other group members who she admired and respected.

Working Hard

Colette wasted no time in applying the theories she was learning to her actual treatment sessions. Because she knew that she was coming to the program to work hard, she worked with the practitioners in her treatments. The practices taught by Anon, of breathing into the pain, relaxing, letting go, going to the edge of the pain, were practices she adopted during both Hellerwork and acupuncture sessions.

Willingness to Go Into the Pain

It took bravery on Colette's part to let go, relax, and feel the pain. Even though it was difficult to feel her pain, she made a contract with herself to do so, and to work with it to the absolute best of her abilities. Instead of fighting it, she decided to relax into it. During the acupuncture sessions, despite some fear based on trauma from abuse, she was still willing to let go, and go into the *body memories*. This was accomplished by the presence, in her, of a strong *observer part* who knew that the trauma wasn't, in fact, happening in the present time, and that the fear was just *clearing*.

Safety of the Environment at the Clinic

She was able to reach tremendous emotional depths because she found the Pain Clinic, "a very safe place to do it, and with some really good support that went with it." For people to feel safe enough to release deep, traumatic memories, high levels of safety are extremely important. Because of the safe environment that is established by all practitioners (and group members) together at the Clinic, participants are *held in a womb of safety* which embraces them with feelings of trust and respect. This environment makes releasing of emotions easier.

Emotional Release

For Colette, the ability to emotionally release long held body memories was very valuable. She said, "Certainly, the combination of elements here, I think made it a lot easier to deal, specifically, with a lot of emotional stuff that would have taken a lot more processing on my own behalf had I determined to do it through more traditional venues; you know counselor, or whatever the case." She described herself as a person who

“traditionally has stuffed a lot of emotional trauma, as well as physical trauma ... so, just even letting that out,” was transformative.

Body Awareness

Colette was aware of both body sensations, and energy flowing in her body. She began to sense where energy blockages existed within her body; and she could employ breathing, and relaxing, to help these blockages move. Her awareness allowed her to dialogue about her needs in the Hellerwork sessions. Her body was very responsive to the Hellerwork. She found these sessions transformative in terms of allowing for a greater energy flow, and for much needed pain relief. Possibly, because she had not had pain relief for so long, finally experiencing relief may have added to her determination to heal in the program. She certainly feels that it added a new found hope to her life.

Spiritual Awareness

Colette equated energy, with the spark of light, or life, within each of us. This is the same spark that to her, represents the god within each of us. Her spiritual beliefs added conviction and purpose to her work at the Pain Clinic. Believing that we are *energy beings* allowed her awareness to go to ways of removing energy blockages so that she could *flow* better. When her energy is flowing, her overall pain levels are reduced, and energy levels are increased. Perceiving energy as spiritual light in the body may consequently allow greater respect for this creation. As she said, “The body is the temple of god. How much clearer can it be? Take care of it.” And she is now in the process of honouring herself, and her own needs, too.

Researcher's Excerpts

Facing Fatigue

“Honour your body. Take care of yourself.” These statements of Colette’s sound so simple, but are they? There is often a conflict of interest between what the body wants and what else is going on. For example, today I am deadbeat tired. All I really want to do is sleep. I am also on some sort of a deadline as regards finishing this degree. I want to write, and make use of the environment on Pender to finish Colette’s analysis, and perhaps write some of the discussion section while I am “in the depths” of the data in myself.

My body seems to have different needs...largely, to sleep. Even though I went back to sleep, mid morning, for about two hours, that doesn’t seem to be enough. The other day after completely finishing a participant’s write up, I slept on and off for almost 24 hours!

Is this cause for alarm? Or is this just me “letting down” after more than three weeks of quiet. The ocean stretches out before me. So does the cat. Why not I? If I really stay with this letting down process, will I come out the other side with renewed energy?

I can see why people with Chronic Fatigue Syndrome get frightened. The world doesn’t make room for that extent of fatigue. People are called lazy, slow. If people have no reserves of money saved, they push on; despite fatigue. In my opinion, people in Canadian and American cultures do not live in harmony with their bodies. The emphasis is almost totally on doing, achieving; at the expense of resting, relaxing. Apart from the

seven or eight hours of sleep per night, which is acceptable for most people, very little emphasis is placed on the importance of revitalizing through rest and relaxation.

When Colette said, "It's hard work to relax," that struck a chord with me. For me, it's not hard work to relax, I just forget about doing so. 21 years of nursing, raising children, three university degrees, weren't those activities relaxing and restorative? They were productive activities. They give me pride in accomplishment. Products show from previous labours that I know are worthwhile. But what about me?

Take care of myself; such a simple statement. And yes, it does take self esteem and also, know how. I have to know what is best for me, and be able to give that to myself. It is divine when I do. When I'm so tired, it's hard to summon up strength to do it all. But, I am trusting that if I "go with the flow" of my own body and tiredness, and pay attention, that I will replenish over time. I'd say I'm worth it.

Pender Island Darkness

It seems impossible to immerse in the transcripts without going through my own emotional releases. Feelings well up. Are they mine or theirs? Does it matter? Today I was on an emotional roller coaster. It's less than two weeks before Christmas, no moon, no ferries on the ocean (due to strike); just darkness.

I took a long night's walk. I'm remembering all the Christmases we spent as a family (17 of them). This year I'm on my own. Somehow Colette's method for experiencing feelings helps ease my pain. I practice it without even thinking. I breathe. I let myself feel the pain, the loss. A friend phones and reminds me: "Christmas is still how you create it in your thoughts." I don't want to hear this. I just want to be with the feelings; to be down.

But on my walk I remember her words. My mind fills with some happier possibilities for how Christmas might be. The emotional bog within becomes like tide breaking away. The fear of aloneness trickles in open concentric circles away from me. I breathe life into the circles. The bubbles burst – away. I observe. How much control of all this (consciousness wise) do I have? If not me, who else?

Alexandra: Pre-Program Profile

Alexandra, who lives in British Columbia, is 60 years old, and a mother of two grown children; ages 30, and 32. She has been divorced twice, and has been living alone for the past 17 years. She describes herself as a private person; liking her own space, but not liking being alone all the time. She was a psychiatric nurse who worked in Crisis Intervention. Alexandra was forced to leave her career 13 years ago due to health problems, unable to meet her goals for advancing her education, and further work.

History of Illness

Alexandra has had bipolar depression for the past 30 years. In 1993, she had a serious depressive episode, and has since suffered from severe fatigue, Chronic Pain, and depression. She doesn't respond well to medications; antidepressants or mood stabilizers of any sort. Her children are concerned for her, but "they don't understand why I'm not more active, even though they know I'm depressed, and I have fatigue and pain. They think that I'm just not trying hard enough; so that's very stressful." Being in so much pain has caused her to withdraw, as she hasn't been able to, "get out there and be with people."

Over the past 15 months, Alexandra has been very ill with a manic episode, and then very severe depression, making her pain and fatigue even worse. She has chronic insomnia, getting just a few hours of sleep each night. This in turn affects her mental functioning, and it's hard for her to concentrate. Over the years she has been thought of as having multiple sclerosis and/or Chronic Fatigue Syndrome.

Alexandra finished a program at the Victoria Pain Clinic in April of 2000. She described the program as “absolutely wonderful. I went home convinced I could change my life, you know, by applying what I learned.” However, within two weeks, she was in a manic episode, and became hospitalized with depression, and a gall bladder attack. Post hospital discharge she tried to implement what she learned at the Pain Clinic including relaxation exercises, and meditation, but found it hard to remain consistent due to depression. Not being able to meet her goal of consistently applying what she learned has been discouraging for Alexandra. She now states, “I don’t have any goals in life because nothing seems possible anymore. Quite frankly, my life seems totally pointless, and I’ve been quite suicidal in recent weeks.” Her pain and fatigue are severe with little remission.

Learning from Previous Program

When asked specifically what she gained from the last program, she said,

I believe that illness is a message, although I don’t know what my message is supposed to be, to me. But I know I have a lot of sadness. The other thing is that change comes from within; and meditation and bodywork are important to me.

Hopes for the Program

In terms of what she hopes to gain from this next program, she stated:

1. "I hope that I'll come to a better understanding of what my illnesses are about, and be able to reconcile with so many losses.
2. I also need to be able to surrender to my feelings – sort of give in to something without giving up. I don't know how to do that, and
3. For me there's the thought that there's no possibility of rebuilding anymore. I've always had hope that I would somehow do something. But that's all but gone. So I guess I've come here for hope."

Alexandra: Post-Program Transformation Story

Alexandra experienced a major transformation during the program. Her experiences were somewhat different from the previous participants' accounts, as she completed the program for a second time. Her enthusiasm, joy, and gleaming expression were evident during our post program interview. And yet her expectations of herself, and her life post program, were tempered with doses of realism. Referring to this program she stated:

It's been a holiday. We go away, and get restored, and then we go back to our lives and don't expect day to day life to be like that. I take everything that happened here and has changed me, and I take that back with me.

Alexandra has suffered from depression for 30 years, and Chronic Pain and Chronic Fatigue Syndrome since 1993. She knows that when she goes home, she's "not suddenly going to have a lot of energy." Instead of trying to go home, "expecting to change my life like I did after the first program, this time I'm not going to put myself under pressure. If I put myself under pressure, I feel overwhelmed. I'm trying to keep my focus and intent, (on the changes I want to make), but be flexible with it."

What was Alexandra's transformation about? Main themes can be categorized as follows:

1. Shifting from despair to hopefulness; the art of the possible as opposed to the impossible
2. Letting go of physical tension, which in turn reduced her pain
3. Giving voice to her feelings and releasing
4. Changing her pattern of "trying really hard"
5. The importance of connection (with group members, practitioners, and with herself, spiritually)
6. Changing her relationship to her depression, body pain, and fatigue; breaking out of the pain, fatigue, depression, and fear cycle
7. Bringing purpose to her life.

Shifting from Despair to Hopefulness

Despite her fatigue, there was an enthusiasm about Alexandra during the post-program interview. The despair and despondency I saw during the pre-program interview had vanished. She described it as follows:

I was in just incredible despair when I came here. And now I believe I have a chance at a life; whereas I really didn't think that was possible, the way I felt when I came. And that's very difficult to put in words, because words, you know, language, really isn't adequate to the situation. I just have to say I'm transformed on all levels. Pre-program, I didn't have any hope. That was the awful thing. Through all the years of difficulty, I've always been able to hang on to a little hope that I'll just get through a particular patch. You know, things will go on; I'll have a breather or something. I was beyond that, which was incredibly frightening.

I asked her to tell me more about being *transformed on all levels*. She began with the physical changes.

Letting go of Tension and Pain

Alexandra attributes her ability to let go of physical tension to being able to breathe more fully, and being able to let go with coaching. “Physically, all of that tension I was carrying is gone, and that was clearly a lot of what was involved in my pain. I was always holding my breath, and along with that, muscle tension. I’m aware of having a deeper, more even breathing. I am breathing all the time, rather than holding my breath, by and large.”

She uses breathing as a tool to let go and, “to get into my body.” At the clinic, with coaching (from practitioners), she’s been able to breathe, and get a release of held energy. She has been able to shake and let go. Alexandra feels she needs the support to do this. “Not permission or anything, the coaching just facilitates it (the process). Alexandra learned how to let go by “really getting into the breathing.”

Changing Her Pattern of “Trying Really Hard”

For her to be successful, she knows she needs to stop trying so hard. She realizes that her pattern of *trying too hard* is antithetical to relaxing and letting go:

I feel really clear about having the intention (of letting go) and allowing something to happen. Trying too hard has been the way I get along in life, and this is the sort of thing that doesn’t work. It’s not a matter of studying hard, or putting in more hours, or those usual kinds of things we do in achieving in an outer world.

To her, that’s not what letting go of pain and fatigue are about.

Giving Voice to Her Feelings and Releasing

Alexandra found that the pre-program interview she had for this research helped her to feel understood, and to *land* into a place of safety in the program. This was

followed up next by an acupuncture session when “a great deal more sadness came out. I had this incredible scream. I’ve never had that before in my life ... open throated scream, and I yelled, *Help, Help me*. I came to the program knowing I had a voice inside saying, *I need help*. And to externalize it so totally, just the fact that I could, that I had that much feeling inside, and that I could externalize it (and others heard me). That was the remarkable thing. My mood changed dramatically after that.” She had a “normal” sort of mood for the past seven days which was a complete change from the shadow of depression she’s lived in.

Breaking Out of the Pain, Fatigue, Depression, and Fear Cycle

Alexandra described her years of depression as follows:

Depression is many things. It’s a whole shadowing of my view of life which becomes this feeling of impossibility, of blackness. There’s grief in there; of a losing of my intellect; of losing my ability to relate to those people most important to me; of losing my desire to be in the world.

The depression affects her physically:

It gets to be one of those circular things. The depression makes me tireder. It triggers pain. It triggers more fatigue, which in turn influences the depression. And then there’s fear within the blackness of the depression. And I couldn’t figure out how to break through into that. And that’s what coming to the clinic here was about for me, and, of course, it’s happened.

Alexandra felt that this year she really, “heard it at a much deeper level, to go into it – and that’s really important for me, particularly with the depression. It’s been very, very deep of late, and I just want to get away from it, away from myself.” She describes what *going into it* means:

Well, ultimately, it’s a leaning into it; a going toward it. I’ve tried that during sessions here, just allowing myself to experience the full impact of the depression. And there is some change in the quality of it, it lightens a

little bit. It's not that it goes away. But if I do that, I take out the fear factor (by letting go into it as well) ... and that's been a big thing for me.

When she wasn't able to "lean into it," she felt stuck.

It's impossible, a totally impossible situation. So I was suicidal. Suicide was the only thing that seemed a way out ... I was at considerable risk. Now my feelings have changed totally. I've been given a reprieve. I've been given a whole new experience of life.

Interpersonal and Spiritual Connection

"I wasn't able to break through the depression-pain-fatigue cycle at home because I knew I couldn't do it alone." Alexandra credits many facets of the pain program as helping her break through. "It's not one single thing. Acupuncture produces some dramatic things, and that in one way felt key, but all the group work, the counselling, the bodywork, my being with all the other clients. And just all the times we sat on the porch and just talked. Just being there with others and receiving all of this. It's nurturing."

Alexandra's transition from isolation and loneliness at home, to feeling included, nurtured, and recognized by group members was paramount to the positive nature of her journey. Referring to the group, she said, "Well, it gave me what I needed at the time I needed it ... It's a unique experience in what it's given to me." Alexandra found the total environment very supportive. Group members were able to provide positive feedback to her about her changes, and she benefited greatly from this reflection. Although she felt the changes very deeply, she was still pleased that others noticed them, too.

"Spiritually I feel in touch with myself and the rest of the world. Whereas, I felt just cut off, and isolated, and alone, and lonely."

Bringing Purpose to Her Life

Pre-program, Alexandra was in despair. There was the, “day-to-day holding on, gritting my teeth and feeling that I wasn’t going anywhere; that there was no point.” For her now, “it’s the art of the possible, as opposed to the impossible. It’s a connectedness, a joy; yes, a transcendence of the ordinary.”

Although she knows that hers is a hard road ahead with ongoing pain, fatigue, and depression; she also feels that she can bring some purpose to her life. “I don’t *know* what the purpose is, but at least I can move toward it. I mean, how does one know that one is moving toward something?” In the midst of her process, she’s sensing, and “assuming that’s part of what’s now happening for me. And that is my intention.”

Facing the Future

Alexandra knows that recovery is, “going to be a slow process, because I’m not suddenly going to have a lot of energy.” She was experiencing fear about going home, but is presently feeling more confident. She knows her edge (re: overextending and incurring pain and fatigue). She also has received energy, and nurturing, which have helped her restore, and feel more confident. She plans on using the breathing as a tool to let go, as well as continuing with relaxation exercises, and meditation. She plans on taking space daily to practice some of the new tools she’s learned (or had reinforced from her previous program).

I need to take the space which I’ve been doing ... and accept my life as it is now. And I’m assuming that if I’m changing my relationship to my depression, and my body pain, then what needs to happen will happen. I should, hopefully, get some relief from the fatigue, and the pain.

Stage 2 Data Analysis

What was her process? What accounted for the insights? Alexandra described herself as despairing when she came to the program. There was no light, or space in her, of joy. She described herself as “stuck” in a cycle of depression, fatigue, pain and fear, and this hopelessness caused her to feel suicidal.

Her process at the Pain Program unfolded from the first day’s interview where she felt *listened to* by me about her life with depression, CFS, and Chronic Pain. The next day, in acupuncture, she was able to cry out for help. She was not alone. She was coached; facilitated in her expression. Once again, she was heard. Her pain was allowed a voice. She began to allow her process without pushing it; without *forcing* it. She shed tension through the various therapies; the bodywork, counselling, acupuncture. As the physical tension lessened, so did her pain, and with less pain came less fatigue. As these lightened, her depression lightened as well, and she experienced a place to breathe within it; a place where it was O.K. for her to lean into the depression and fear, and by becoming aware of her breathing, she breathed deeper, and more evenly. And she was able to let go (of pain, fatigue, fear).

This all took place in an environment in which Alexandra felt safe and nurtured.

She felt respected as a person in pain and fatigue:

We’re seen as whole from the very start. Just that we have something difficult to deal with. We’re not only seen as whole, but that our incapacity, whether it’s an injury, or for me, what I’m dealing with, is seen as a significant thing ... that it’s meaningful, in that it’s a message. And not only that, it’s very much, it’s a part of the whole at the moment, and that we should embrace that illness, or injury, and take it with us.

Seeing herself in this way allowed Alexandra to *get the person back* whom she knew of as herself, when she identified with herself other than in a sick role. Group

members and practitioners were very supportive, and mirrored possibility for her. Through positive feedback when she made changes, she felt reinforced, validated, and seen in her growth process. This warmed her, and spurred her on.

Alexandra credits the residential nature and set up of the program as being part of what really helped. "Coming here, I was able to totally leave my life and receive nurturing, and knowledge, and experience ... I think it would be difficult to achieve all that while trying to live my day to day life."

So, despite what was *crippling depression*, Alexandra was able to move and grow. Her initial fear of "not getting through on an energy basis" was unfounded, as she "received energy from the ability to release feelings, and the support of everyone...the total environment." At home, she had been alone. The isolation grew large. Her psychiatrist only had new drugs to recommend. She prefers not to use drugs on an ongoing basis. She believes that the nurturing she received from others helped her more than drugs can:

I've tried just about every drug going over the last 16 or 17 years. But I haven't been happy. So this has reinforced for me how important environment is. I know it's important. And this is a unique environment. I know I'm not going to have this out in my day to day life.

But what she does have is a lightening of her depression, pain and fatigue; a sense of the importance of intention; and the use of the tools she now has. Through the creation of a practice space in her daily life, Alexandra plans to move along in a new relationship with her depression, pain, and chronic fatigue. This will be facilitated by breathing, letting go, asking for help, relaxing, meditating, and reducing social isolation.

And when she looks in the mirror, an increase in her self esteem will be reflected; a product of the nurturing received combined with her bravery.

Researcher's Excerpt: Research Process

There's no skimping on this qualitative research process. It seems to have a mind of its own; its own timing. Just when I think I'm finished a piece, e.g. a participant's post program story and analysis, something more beckons to be written. Something is just not quite right. And so I go into a reverie, or kind of deep meditative state, and it is in the working out from this space that the answers come to me about what is wrong with what has been written. It just didn't quite capture the essence of what the participant was saying, or really going through. It doesn't quite capture the discovery process as it was. There's a "felt sense, an energetic sense that something is not right yet."

Then I go through it, re-write, and bring a new energy to it. My spark matches the spark that is in the participant's transcript, and there is peace. I feel a sense of completion with the transcript. There may be more thoughts that come up for me in the future in relation to the transcript, but this piece feels right, and I can relax now.

Sage: Pre-Program Profile

Sage is an independent, 50-year-old construction worker from Alberta who owned her own company prior to her accident in 1997. She accomplished a lot of things including painting, decorating, lawn maintenance, welding, and general construction.

Sage now lives by herself, as it was too difficult for her to live with her daughter. Since her accident, she suffers from tremors, spasms, mood swings, and forgets things around the house. She has difficulty eating due to spilling, and considers her physical state unreliable, and potentially dangerous. For safety reasons she gave up her fridge and stove. She states, "I can't rely on me, and that bothers me because I was the leader of

things (in my own company); putting everybody together, and they could trust me. Now, it's don't count on me; – I'm the one who's liable to throw you off the scaffold out of whatever you did to scare me, and the one backflashing. Loud noises really throw me.”

Sage comes from a large family, being the youngest of six sisters, and one brother. She has one grown daughter, who she describes as a hard working woman, like herself. Sage's father died when she was only two, and her mother worked hard all her life to raise and support all the kids. She describes most of the family relationships as strained since her accident. “My family's all upset; everybody's out of balance. They'd sooner stay away because I'm just too much to handle, or I don't want them to see me like this. My family want me back the way I was before, not the way I am now, so I've detached.”

History of Illness

I was at work. I was making skid shacks for the oil rigs, and I went into work, and was hooking up my nailing gun, and I was underneath the steel diamond staircase, and two inches below the T bar, the air line blew up, and it threw me into the staircase, and that's where the accident happened. I haven't really worked ever since. I haven't done much since 1997. Everything just kind of collapsed where my own personal business went to an all time halt. I sold off cars, and a lot of assets, in order to make it 'cause WCB wouldn't kick in, and they made my life miserable.

I saw doctors all the time, and was finally diagnosed with Reflexive Sympathetic Disorder (RSD). I also have conversion disorder, CFS, and Post-traumatic Stress Disorder (PTSD). I've been trying to make sense of the whole thing for the last four years.

The accident resulted in physical changes, which she refers to as:

taking away all my choices, all my freedom, my hopes, and my dreams. It's just gone, and there's no way to make up for those lost years. I'll never go back to what I was doing before: baseball, vacations, loving somebody. I'll never have a relationship. It won't happen.

About her physical symptoms she said:

Something's over firing in my brain. My right arm is spastic, and also it affects my neck, back, and sometimes my legs. I have fatigue because I can't sleep from pain in the arm, and my brain overfiring. If somebody scares me unexpectedly; it's not a normal scare. This is a very traumatic scare, and totally upsets me, and I can't sleep. My sleep cycle in all is very irregular. Sometimes I sleep long periods (for days) and other times only an hour or two at a time. I had a life before the accident, and now with the accident, I really don't have a life.

Learning From Her Previous Program

This is Sage's second program at the Pain Clinic. She participated in her first program four months ago. Describing her experience, she says:

They teach you different things, and their methods are what everybody needs in life other than doctors. And no pills. It's a natural thing, and I'm that type of person. They're not feeding you drugs to shut you up. They're really here to listen to what your needs are. The last program reminded me from before the accident of who, and what, I was; learning through nature, stuff like that, and I can apply that. But I still need to get more. I'm soul searching, backtracking, maybe the accident, or my whole life, and trying to put it together.

I asked Sage what she feels she got out of the last program. She said,

1. "Understanding about what I believe; that it's O.K. to stick to my guns whether anybody likes it or not.
2. A sense of spiritual oneness; of wholeness
3. About my body: "What your body tells you, it's 100% right to listen to it, and really listen to it with a fine tooth comb, and follow what it has to say, and your healing becomes a little easier to understand.
4. I'm still suicidal at times, but I come out of it a little bit better now.

5. I learned it's O.K. to cry, kick and scream when you're feeling sick ... The release gives me more insight about my needs, and I'm a little bit more stable to understand certain things.
6. I've learned relaxation; to do it at my own pace, my own exercise, and meditation, at my own pace. Whatever amount I can do is still an accomplishment, and I need to pat myself on my own back for what I'm able to do.
7. Individuality, and listening to yourself, is very important in Chronic Pain.
8. I truly believed all my life, even before I came to the Pain Clinic that meditation, and knowing oneself, and knowing your roads, are where it's going to get you even further; but you need guidance, and the Pain Clinic can do that.
9. This Pain Clinic really opens up your mind to do research about what your own body's trying to tell you. It gives you a new avenue. You have the right to that information. And the medical field or people of authority are not going to allow you to do that. But if you can be strong and follow that road, you'll be better off.
10. It's soothing, and where you can go back, and then bring your life up to date, and perhaps get away from drug dependency.
11. Drugs are not gonna cure the pain.
12. And the acupuncture brings you in a different field altogether – what they do in the acupuncture room allows you to get in touch with what's in your memory. And if it comes out, it's a process of elimination, a release of pressure, and negative energies.”

Hopes for the Program

1. “To get a little further from where I left off last time. There’s basically unfinished business that we have to finish up, so I can go further. I want more, in depth.
2. To get away from the city, and be with people I can trust. “It’s not some place that is going to expose me to other people. This is a place where I can cry, and scream, but I still have to do my job, and move on, and go through the program. There’s no getting off the hook here. The discipline is very good. And your reward is really good food.
3. Hopefully this time we can wrap things up, so I can let it go. And if this is the life that I’m gonna be stuck with, make the best of it. Comfort me, kind of. But that’s about it. (I wish everybody could come here that’s in an accident, or any emotional stress).”

Sage: Post-Program Transformation Story

Sage’s program was over, and yet there was an intensity about her. She was still deep in process? She also had a deeply quiet presence that spoke volumes in terms of self understanding. I wasn’t sure what her interview would reveal, but I was eager to find out. After a lengthy data analysis, I have chosen the following themes as a way of telling the story of Sage’s journey through the Pain program:

1. Seriousness of purpose, and learning what she needed to know
2. Learning to express, and let go
3. Listening, attuning to, and following her body
4. Learning how to manage and reduce her pain

5. Her relationship with the group
6. Her continuous process of recovering from pain and fatigue.

Seriousness of Purpose

Sage calls herself a “second timer” in terms of this being her second time experiencing a 10 day program at the Victoria Pain Clinic. Her last program ended four months prior to this program. Sage has a strong commitment to her healing journey. Her journey is characterized by what she calls, “focus and discipline.” She had difficulty with the “1st timers,” when she felt that they weren’t taking the program seriously, or fully appreciating the staff for what is offered. To Sage, the healing journey she is on is important, and there is no time to waste. “Every minute counts. You waste it; what a waste. You know, it’s short term that we’re here. I want to get better.” Sage believes that she no longer needs the Victoria Pain Clinic. “The first time I needed it, and also thought that I needed it the second time, which I did, but to learn that I didn’t need it anymore.” Sage has a way of knowing exactly what she needs (and doesn’t). The fact that she says that she no longer needs the Victoria Pain Clinic, is her way of saying that the group work no longer serves her. She feels she’s outgrown the need for group support, and now needs more personal, individual support.

She also feels that the fact that she no longer needs the Victoria Pain Clinic is a positive thing. It means that the clinic has “done its job,” and she has “done her job,” in attending the treatments, applying herself, etc. In fact, they have done their jobs so well that she now has the tools, and knows exactly what she needs, to carry on her complete healing. Specifically, she knows that she still needs to learn not to fight her feelings. She

needs to stay with her feelings, and also “get back in tune with herself ... just by letting go and relaxing.” She feels complete now that she knows what she needs to do to grow.

Expressing and Letting Go

Sage experienced letting go: “once in her session with Anon, once with massage, and in acupuncture, “which is a “continuous letting go all the time,” and once or twice by herself, where, “I just broke, through somebody else’s feelings. They were talking, it hit a sore spot in me, so I could let go.” Being able to let go is a growing edge for her, especially as regards her anger, and learning to cry. She also knows she needs to practice expressing herself to people who hurt her. “Do my expression, instead of holding it in.” She feels she now has the tools for letting go. She described this as follows:

When I know something is bothering me, or I remember about something say my daughter had done, and it’s still pissing me off, I can deal with that by getting the frustration out. Then there is a process of elimination, one by one, of what’s hurting me inside.

She learned to yell, scream, cry, kick, hit, or throw pillows at the wall. This seemed to really help her. She described that after getting the feelings out, “it just fills you up with all this happiness...the more you can get out, the better, happier, and balanced that I feel that I am. It also shows in my self esteem, and every time that I’m doing it in these two weeks, the more I do it, the more I find I’m being freer, and freer, and freer.”

When I asked her just how she lets go, she explained: “Heavy breathing, meditation, really focusing, and discipline. And I put a little bit of out of body exercise, Tai-chi, and the deep relaxation. I combine them ... and I work through it.” To explain, *out of body exercise* she said:

You get so relaxed that you just go out there. You're so relaxed that you leave your body, and go out there. You kind of look at you in a different perspective. Out there I'm observing what I'm doing, and then I can kind of correct it.

She continued:

But then I have to go through the process of feeling ... So you have to relax yourself in order to get to the feeling to cry, or scream, and yell. And then after you've done all that, you may be all wound up and ... so you have to kind of meditate, get in tune to relax your body down (to get the spasms out); to balance; to get back in balance, and in tune.

According to Sage, going through these processes makes her stronger.

It makes you stronger, but not as in the fight of wanting to go and hurt somebody, or beat them up. It makes you stronger to go through all these processes. And your spirituality becomes more and more alive. You are, you're just so filled with good, until the next process comes that you have to deal with. And then you deal with that one, too. And each time you do it, the wholeness of yourself becomes stronger, and stronger, and better and you become better, and all of a sudden there's just nothing wrong with you. There's nothing. Right now I'm full.

Following Her Body

For Sage, listening to her body is paramount in her healing. "The answers are there. They're right there, if we just pay attention. If you can just follow your body, whether it would be Tai Chi, or relaxation, whatever comes to me, I do that, and then it just flows. One thing leads to another ... If you go with it, it just brings you all over, like everything, and anywhere. It might even tell you to get in your car and just go for a ride...or if you want to dance, you dance. You go with the flow. And then if you get a feeling that you think you're going crazy; analyze, why do I think I'm going crazy?...You analyze those things, and you find it's always in you."

During our interview, Sage had keen body awareness. At one point when we were talking, she said:

O.K., I feel a spasm right here, coming, and it's just starting, so I'd like to exercise it out, or even take a breath ... just try to breathe and calm it down. Get the arm down because she's gonna go full blown right off the Richter scale (with pain), if I don't catch it soon.

And with that mindfulness and breathing, she said, "See, it's gone, you can actually feel it. Something stressed that in a split second, and now it's gone."

Managing and Reducing Pain

Information from her Hellerwork sessions with David brought new revelations about her pain reduction. He was able to locate some trigger points at a muscle in her armpit which greatly reduced her arm pain, hand pain, and spasms. Together they found three or four points. She plans on finding a massage therapist at home to get muscle work done on that area to release the spasms. She feels that she will make a lot of progress. "It's almost a pin-point down. We're getting all the pieces to almost fit together" (in terms of her pain release).

She is able to pay attention to her pain, and take care of it. She can bring the pain down herself to a nice level, where she can tolerate it. "I can bring it down, but it does sidetrack me, so I have to work on that, too. I'm still very sensitive but I'm more aware of how much sensitivity there is in my body." For example, if a plane or train goes by, the noise really bothers her. She reacts with tremors. "I can practice at this point, just go into the tremor and say, "O.K., this train just went by, it really bothered me ... I'm all spazzed out here. I want to work with that now ... identify that it's just a train. It can't hurt me. Then do the concentration for bringing my own self down, the pain level down, the tremors down into a zone where it's comfortable. It still hurts, and I get really fatigued, but if I follow my body, I'll go lay down, if that's what I need is some sleep, or

if I need to exercise, or stretch it out, just go with that flow. I feel like I know what I have to do ... And hopefully it won't be there ever. It won't be in my life. I'll eliminate it all together. That's my goal."

She is aware of the connection between emotions and her body. Emotions are her teacher.

There's ways of getting better if you listen. But you really have to learn to get in tune with your body. I'm still going to have many years of learning to get more in tune and balanced. For example, if you're feeling depressed, it's inevitable something's bothering you. You just have to definitely deal with it. It's not gonna go away. You can shove it, you know, down to your feet. You're just not gonna walk right until you take care of it.

Her Relationship with the Group

Sage had certain expectations of the group based on her experiences of the first group. By comparison, she felt that this group *came up short*. She expressed at numerous times, throughout the interview, how difficult it was for her to be in this group. "With the group, with them being first (timers), they were frustrating me." She also found herself triggered by the group. She was aware that she didn't:

want to be around these first timers because they're flicking my mick in my body. So the awareness of that ...their effect on me to make me spaz ... For me, panic attacks, or getting excited will cost me dearly. So I had to go away from these people ... It's not them individually. It's just part of the process that I had to learn.

It's part of her learning, "to stay away from stress, and if I'm involved in the stress, which I *will* be going back home, and back out in the real world, I just have to deal with it a little bit better. And that's what they taught me here; this first time group."

In one group session toward the end, Sage, *exploded* and expressed her feelings, and thoughts about the group. "And all of a sudden it was just a turn around, even for

them.” She was pleasantly surprised with the outcome. She felt that following this *clearing session*, “everybody kind of changed in a little way. Each and every one of them changed, and so did I.”

She resisted confronting the group, but eventually realized she had to express herself. “I couldn’t deal with these people. I didn’t want any part of it. But then I had to deal with that. You have to be a part of that. I had to bring myself back; to be a part of it, because that’s where my learning was.” She also had to tell herself, “just because I blew up, that doesn’t mean I can stop my exercise, my program, because that’s what I’m here for.” She made progress by detaching from them, but still doing her program.

After awhile, that argument became a “real gift” to her. It got her “away from the group in order for her to expand on her own.” And realizing that her expression of anger had a positive impact, was very meaningful for her to experience. “This turned out a little different from just blowing up here.” In the end, she said, “We all came together. The puzzle finally fit together. We’re all friends; not close friends, but we all came together. We’re finding our way back.”

Recovery as a Process

When I told Sage that I was pleasantly surprised with the changes I witnessed in her from start to end of this program, she was quick to respond:

It’s not just within these ten days. It takes time. I came here in March for 10 or 13 days. I left. I started putting my program together when I went back home, and it’s been continuing from that time, to right up to this time. And when I leave here again, it will still continue at home. It’s not a 10 day program. It’s a continuous, every day, every day. Everything I learnt here I will take home once again with me and do it. It won’t stop once I walk out this door.

Sage believes that recovery takes time and practice, as well as knowing what to keep in her program, and what to eliminate. She eliminates those parts that no longer serve her, so that she makes time, and room, for treatments, and activities that do enhance her recovery. She calls it a “process of elimination” whereby she lets go of programs or treatments that she has outgrown, to make room for new avenues. At present, at home, she will continue with massage therapy, counselling, chiropractic, and will add acupuncture. She will keep them up, “until I no longer need them, too ... that I can do the whole course on my own.” Now that she has learned what she feels she has needed to know, she can eliminate the Victoria Pain Clinic, and move on.

She’s very excited about going home and continuing on with her healing journey. She’s almost impatient; with not a moment of healing time to waste. She believes her healing work is individual, and that she wouldn’t get far depending on someone else. “It’s your road. Take it with somebody else, and misery likes company. You get what you deserve. You get the road you took. You made the choice, you know.”

Stage 2 Data Analysis: What Accounted for Her Insights?

Sage has been highly motivated in her healing journey since her last program. She has worked diligently with the tools she has learned since last March. She has also employed the help of practitioners to support her, and used techniques for her healing. In this program, she applied herself seriously, and fully. She called it, “focus and discipline.” Despite the fact that she had so many contentious issues with the group, she moved in her own rhythm, following her body towards her own healing. She has a way of trusting herself; her own inner truth about what is best for her.

Perhaps being a second timer brought her a type of mature, no-nonsense, approach to her work at the Clinic. She had no tolerance for the “misery likes company” part of the program (as she saw it amongst group members). She wanted to get on with her work. I believe that the practitioners encouraged her to use her new found social skills of expression of her frustrations, and anger, in the group. Because she met with success doing this in this microcosmic setting, she has gained confidence to apply this type of expression in the outside world.

Sage was willing to learn to let go despite her fear of expressing her anger or feeling her sadness. This may have been based on the combination of trust in herself, (following her body, her own flow) as well as trust in the practitioners (her second time knowing and working with them). This safe combination allowed her to learn to open up her feelings more, and to give expression to them. She found this a very valuable tool for release of held emotions and physical pain.

The specialized work she did with David (Hellerwork) allowed her a more precise release of tension, and pain, based on specific trigger points. This type of knowledge and the fact that David gave her this treatment information to take home, will allow her to advance further with healing her most painful areas: shoulder, arm, and hand. She was ready to receive this information to target her healing as directly as possible.

Although Sage saw her confrontation with the group as an “explosion,” my sense was that it was also a reaching out on her part. She was concerned that the group members were *squandering* the opportunities for growth and healing available in the 10 day program, and wanted to make sure they all got the most out of their programs. She saw the negativity expressed about the program by certain group members as destructive

to the whole group, as well as sabotaging their own possibilities for healing. From this perspective, her being a “second timer,” she played the part of a *big sister* who didn’t want to let the “first timers” (little sisters and brothers) fritter their time away. To me this was a loving act. And she learned just how to express her anger and frustration in ways that were growthful for all. It was her heart of love that brought this about.

Researcher’s Excerpt:

Letting Go?

Why is it that I’d rather run from myself than feel my feelings? Go here, go there, run here, run there. If only I can get away.

But now I am home, and there is no place to go. The grief comes up in strong waves. I am scared, and don’t want to feel the feelings. Why not? I had no examples for this as a child. Examples were just to succeed and carry on. But I do feel. And when in the sanctity of my own arms, and in my own room, I cry. The tears are warm.

Sometimes I fluctuate between tears and fear again. I want to stop the feelings when I’m afraid. Then I do let go. I remember Sage’s bravery and allow myself to go through it. I cry from a deep place in me and the pain in my neck lessens. Ah - there is an emotional connection. My neck softens, as I release. My body is relieved. I also understand what Sage means by, “The process brings strength.” I am stronger because I am facing my feelings. I am going through it. And from being with myself, I know I have “me” to fall back on. Having myself, for myself, is very strengthening. Having my self is strength.

CHAPTER FIVE: DISCUSSION

Overview

- Chapter Introduction
- Summary of Findings
 - Outcomes
- Discussion of Findings
- Process of Transformation: Summary

Chapter Introduction

I found the process of summarizing the findings difficult because one runs the risk, through summary, of condensing the individual experiences in ways that may distort or minimize their original meanings. (That is why the results were first presented as individual Post-Program Transformation Stories, and summarized within each participant). Hence, in order to assure that the Summary of Findings was participant focused, I have included many of their original statements, or quotes, in the Discussion of Findings, which immediately follows the summary.

The Summary of Findings encapsulates key themes across participants, and the outcomes of these themes. The summary is a product of data analysis of all eight Post-Program transformation stories indicating themes which were both *salient, and frequently occurring*. Key elements of the transformation process across participants can inform both sufferers and practitioners in the field about what participants found particularly important in transforming Chronic Pain and Chronic Fatigue Syndrome.

This section ends with a Summary of the Transformation Process which is a composite of Stage 2 data analysis for all eight participants.

Summary of Findings

The following key themes arose from the Post-Program Transformation Stories:

1. Participants perceived the environment of the Victoria Pain Clinic as safe, supportive and empowering. High levels of trust were apparent in their relationships with practitioners.
2. Participants highly valued the group experience as supportive and intrinsic to their transformation processes.
3. Energetic experiences in acupuncture were key to emotional release; body awareness; reduction in pain and fatigue; and subsequent cognitive shifts.
4. There was internal consistency for participants between their own beliefs, and those of the clinic as regards theory, and science behind healing CFS and Chronic Pain. This congruity supported the transformation process.
5. Participants' accomplishments were a reflection of their abilities to work hard; go into the experiences; trust their bodies; and their own knowingness.

A coalescence of the above factors was intrinsic to the healing process and allowed participants to engage in a process whereby textures and meanings of their illnesses emerged and made sense in the fabric of their lives.

Outcomes

Participant synthesis of the above factors resulted in the following outcomes:

1. Pain relief
2. Decreased fatigue
3. Body re-connection
4. Spiritual connection

5. Shifts in global well being from: hopelessness to hopefulness; helplessness to confidence; from feeling suicidal to desiring to live; from a box-like existence to believing they now have many options and choices; moving from impossibility to possibility
6. A determination to apply their newly learned tools into the future in order to move forward with their growth processes.

These findings and outcomes will be elaborated upon next.

Discussion of Findings

Participants Perceptions of the Environment of the Victoria Pain Clinic as Safe, Supportive and Empowering

All participants found the safe and supportive environment of the Clinic to be vitally important. Participants found that the practitioners ... “had so much openness, so much honesty, so much support, and so much love, that you couldn’t not be touched by that” (Arsinoe). “I don’t think I’ve ever been in a more supportive environment” (Jade). “I’ve never been to a place where there are so many people in one place that are good and want to make you better, and they care about what is gonna happen to you” (Pierre). And, “I wasn’t able to break out of the depression/pain/fatigue cycle at home because I knew I couldn’t do it alone” (Alexandra).

Victoria Pain Clinic’s philosophy is to create safety and support for participants, as well as empowerment. Anon, (psychotherapist and group leader) explains:

I have a deep belief through my experience with the 20 years of working with people in this way, that with them exploring themselves in a safe and supportive environment, physically, mentally, emotionally; and increasing their own awareness of themselves at all of those levels, that they can find healing within themselves. The structure that we use as the framework has been something that we’ve developed over the last 15 years, and I

have a lot of trust that it supports this kind of process ... I trust that as people start to go into the experiences, that whatever needs to arise will arise with them. And it's creating the openness, and the safety, and supporting people as the things start to emerge; so that they can allow a fuller exploration of themselves.

In my interview with Anon, she was quick to say that it is not the framework of the Program itself that *causes* insights to arise for participants. Rather, she said:

I believe that each one of us inside ourselves wants to be who we potentially are, in the best sense ... I believe that each one of us is whole, and complete, and, in fact, knows it all, at our deepest levels. It's the conditioning from the past ... it's adverse circumstances, etc., that prevent some of these things from coming forward. And, the other level of it that supports this emergence is the sense that it is safe.

Many people comment ... that they can feel the caring, and they can feel the sense of safety ... Many have said that this is maybe the safest place that they've ever experienced, because they don't have to be anything in particular to be accepted. And they're not going to be criticized, or judged, or whatever ... that there's a genuine desire to help people, both move through and beyond the symptoms that they have, and discover more of the fullness of themselves (personal communication with Anon, 2001).

I am emphasizing these points, because it would not be possible, (or safe), for participants to work at the depths they did, without such a high level of safety and support being established. Also, in my experience, people in Chronic Pain and with CFS seem to have an *instinct* for authenticity. In other words, because they're sensitive and generally in a vulnerable state, they know when a practitioner is truly caring. Undoubtedly, they felt safe and supported in the environment of the Victoria Pain Clinic. And, because the practitioners held participants as already whole and complete, despite disabling symptoms, this reflection was available for them to mirror in relation to how they saw themselves.

The Power, Support and Value of the Group Experience

Another part of what constituted feelings of safety and support for most participants was their experience of the group. “With their support, I was able to go into myself” (Jade). “I think a huge part of the success (of the program) is that you go through this with other people, and you talk about it the whole time you’re going through it” (Homer). “I found the group very touching. Seeing other people working their stuff was very touching” (Colette). “All the group work ... just all the times we sat on the porch and just talked. Just being there with others and receiving all this. It’s nurturing” (Alexandra). Also Jade’s reference to Pierre being there to support her through a panic attack; and Homer’s support by a group member when he was withdrawing from narcotics, are poignant examples of the value of the support received from other group members.

Homer stated, “The group was beautifully interwoven with the whole program. The whole process worked. Participants got into a *groove* with the exercises, breathing, relaxation, and connection with other members, and their experiences. Being involved in exercises where you are relating directly to people forces you to be human.” And, for people with CFS and Chronic Pain, inclusion and connection with group members is in sharp contrast to the feelings of isolation they felt at home; as their social lives were limited by the constraints imposed by pain, and fatigue.

The group was a place to *come home to* for participants after a long day of treatments and processes. It was also a place for learning self assertion, and communication skills; providing a microcosm for exploring these tools in preparation for their macrocosmic use in the world. Having this *rehearsal* was particularly strengthening

for some of the participants (Juliann, Sage) and inextricably linked to their success in transformation of pain/fatigue. In other words, their pain/fatigue problems were compounded by lack of assertion, or fear of expression of anger or conflict in family, or interpersonal situations. Therefore, employing such skills in a safe and supportive atmosphere was a step in learning a new way of being in the world. Standing up for the self was critical for Juliann in terms of healing patterns that were keeping her from moving beyond the pain/fatigue cycle.

Energetic Experiences in Acupuncture

One of the ways that this study differentiates itself from other research in the field of CFS and Chronic Pain is the fact that it explores the use of acupuncture as part of a multi-modal residential program for releasing Chronic Pain, and recovering from CFS. The acupuncture, which uses a Five Element theory, also combines much intuitive, and experiential knowledge on the part of the practitioners re: characteristics of pain, holdings in the body, and release. In addition to the insertion of the acupuncture needles, the environment is set up to support emotional release. At least one co-therapist is present to support, and nurture the client, to feel safe enough to let go. Clients are instructed to breathe through the experiences, to allow themselves to shake or feel the *vibrations* (sensations) of their bodies, and to release out loud, if they wish, through yelling, screaming, crying, sobbing. Clients can also debrief, and be supported for these experiences in later sessions with the counsellor, or other practitioner.

Clients can often re-experience accidents or traumas (Homer, Jade, Colette), that were instrumental in their pain conditions, and use the re-experiencing to release the traumas. Participants use breathing, acceptance of the feelings, an observing ego, and a

willingness to go into (move toward the feelings, rather than away). Many report they are in an altered state during acupuncture treatments. Sage said, “The acupuncture brings you into a different field altogether.” “It’s very hard to explain the experience because you’re in an altered state of consciousness, and yet your ego is watching it” (Homer).

The acupuncture experience, additionally gives participants direct experience of their own energy. “I learned about the energy you carry in your body and how to create a healthy energy flow, and why energy isn’t flowing properly” (Arsinoe). Colette recognizes the physical components of pain as blocked energy. “There’s also an energy component. Obviously there’s got to be a spark, or something that keeps us from being a corpse. I choose to call that energy.”

Colette had the experience of what she called a *body memory*. In that experience she learned to “let energy flow.” She states that she sees a relationship “between pain, and energy, and energy blockages, and letting it out.” She has been relieved of pain since reliving, and releasing trauma on an energetic level from a body memory of a strangling.

Emotional Release

Almost all participants referred to the benefit of letting go in acupuncture through emotional release. (Juliann referred to having had her emotional releases through counselling). Alexandra described this, “incredible, open throated scream. I’ve never had that before in my life ... that I could externalize it was the remarkable thing.” And as a sufferer of CFS, this opening and release of fear (in a safe and supportive environment) contributed to her having increased energy following. Alex described the emotional release process as “allowing something to happen.”

Sage was able to let go despite her fear of expressing her anger, or feeling her sadness. She knows she needs to feel, in order to release pain and fatigue. After getting the feelings out, she described feeling happiness – “It just fills you up with happiness and brings you back to balance.” Arsinoe was able to make a connection between somatically stored feelings and Chronic Pain. “I know that I store sadness, and fear, and anger in my body; and the specific areas in me. I carried so much of it in my shoulders, abdomen, and low back, which are key areas to where I’ve had so much pain. Arsinoe refers to creating a healthy energy flow by releasing blocked emotions. When she can do this she is, “freeing up more space in there.”

When I interviewed Dr. Wolf of the Victoria Pain Clinic, we discussed the emotional letting go that takes place in the acupuncture (and therapy) sessions at the Clinic. He stated the following:

The transformation that takes place involves transforming the shadow. If you don’t explore the shadow, you don’t get the transformation. It’s as simple as that. It’s not that it’s impossible. Obviously the framework here is not the only way you could do it ... but if you have a relationship where nobody’s willing to explore the shadow, then no transformation occurs.

I asked Dr. Wolf about the experience of participants reliving their traumas and about body memories. He said the following:

The memory’s right there in their bodies all the time, and that is the tension that they’re carrying. And if they start to move towards the pain, and they let the body speak, then the memory is right there because that’s where it is. So all I do is say, O.K., let your body speak, make sound, if it’s there, cry if you feel like it. I try to frame it in a really free way. I don’t say, do this, do that. Rather, just let your body speak as we move towards the pain, and quite frequently, if they’ve had a major trauma, it’s right there. I mean it’s not like you have to look very far for it (personal communication, July, 2001).

Emotional Release Leading To Awareness of Spiritual Connection

Several participants indicated that once they *let go* emotionally, there seemed to be room inside to feel their own *light*. With enhanced energy flow and body awareness, along with letting go, there seemed to be a sense of spiritual connection for participants. When I asked Arsinoe about this she referred to the fact that before the program she had lost a sense of her own *spark*, or light, but, “Now I can see the light within me, and it’s a wonderful feeling.” Sage said, “After the processes you are stronger. And your spirituality becomes more, and more alive. You’re just so filled with good. Each time you release, the wholeness of yourself becomes stronger.” Alexandra said, “Spiritually, I feel in touch with myself and the rest of the world. Whereas, I felt so cut off and isolated” (before the program). Colette explained, “From a spiritual perspective, we’re energy beings.” She equates this energy with the spark of light, or life, within each of us. There appears to be something about the process of inner focused awareness, flowing with one’s energy, letting go, and releasing energies from the “shadow,” that allows for recognition of spiritual light within.

Reduction in Pain and Fatigue

Along with this type of awareness, participants also reported significant reduction in pain levels, and increases in energy levels (reduced fatigue) as a result of acupuncture treatments received. The openings that they experienced and the letting go allowed them to feel much more empowered in their lives. My sense is that this occurred for several reasons.

Firstly, the reduction in tension and dropping away of pain and fatigue was a great relief. With less pain and fatigue, there was naturally more ability to focus on the

positive. Secondly, the fact that participants could *do something* about their pain/fatigue was very empowering. After spending so much time *coming up dry* with ways of impacting their chronic illnesses, it was very empowering for them to actually be involved in a process whereby there were significant changes in their lives. The Clinic does not *take credit* for the changes, or growth experiences of participants. Therefore, participants *own* the experiences, and identify very much with being the *author* of the experiences for their own growth. Thirdly, the process of growth was one that had meaning for participants. By being so closely in touch with themselves energetically, physically, emotionally and spiritually, they could understand what the letting go signified in their lives, as well as what reconstruction of their lives is based on. Having this self knowledge is empowering. The illness no longer stands separate from the participant as something to *get rid of* but informs the participant about him/herself. The illness is contextualized as part of one's life; it fits in, and is a meaningful part of what makes one whole. In this way, the pain/fatigue is a gift.

Anon said,

In the past, I think the program was much more oriented toward helping people not be in pain; so more symptom oriented. But I've been doing this now, for over 20 years, so the symptoms seem to be less important. If people can engage the process within themselves, they can continue on after the program with that, and it can take them wherever they need to go. And the symptoms, I now believe, may be a necessary part of that process. Because without the symptoms, people don't do any, or very little, of the interior work that they may need to do. They remain caught up in their outer orientation, other oriented, and functioning, and doing out there in the world, and don't do the looking inside (which is critical) (personal communication, July, 2001).

There Was Internal Consistency for Participants Between Their Own Beliefs and Those of the Clinic As Regards Theory and Science behind Healing CFS and Chronic Pain

All of the participants came to the Clinic with a high frustration level regarding their interactions with medical professionals regarding their problems related to CFS and Chronic Pain. They were frustrated with the lack of explanations regarding their illnesses. Many were led down various medical paths in order to find out what was *wrong with them*. This was tiring for participants, and also contributed to feelings of hopelessness, and helplessness regarding getting well. At the Clinic, theories are taught in the group sessions which are easy for participants to understand. The theories are generally about the effects of stress and tension on the body. There are lectures about deleterious effects of maintaining high levels of stress over a continuous period of time, and what happens when stress either skyrockets, or is chronically maintained at an overly high level for an individual. Diagrams are shown of the effects, on the body, of elevated stress leading to tension and pain. Participants also attend Biofeedback sessions where they learn about their own stress levels, and how they can reduce the stress in their bodies. In Hellerwork, David teaches about the fascial (body tissues and muscle) components of pain, and about posture. There are many teachings that the Clinic offers including at least one daily practitioner lecture.

Several participants stated that they found the lectures and scientific explanations very useful. Some felt that their conditions were finally understood. This had the dual impact of: Allowing participants to relax because they felt that practitioners knew how to help them, e.g. Pierre, “you’re simple buddy.” And (because they believed in the teachings of the Clinic), they had a focus for their minds to grasp while they were going

through the processes. In other words, by understanding about the connections between stress, tension, emotions and the body, they could apply the theory and “make contracts with themselves” (Colette) to follow the guidelines for releasing stress, pain, and held emotions. The data support the fact that because the participants found the program logical, and scientifically sound, their facility with transformation was enhanced.

Participants' Accomplishments Were a Reflection of their Abilities to Work Hard, Go Into the Experiences, Trust Their Bodies, and Their Own Knowingness

As illustrated in the transformation stories, there were numerous examples of participants' eagerness to work hard. Every participant applied him/herself fully. Some examples that come to mind are: Colette making a contract with herself to work hard, and not breaking it. She said, “I need to allow the process to happen instead of fighting it.” Homer, being determined to re-live his accident in an altered state, in order to understand, and heal his trauma. Sage, “There's no time to waste” (in this healing process). For some, (Sage, Juliann) not letting down family members, or family doctors, acted as inspirations for them to keep going in the program. I was surprised, and impressed by the strength of the program participants, particularly as they seemed so low, and desperate pre-program. Several admitted to being suicidal, pre-program. However, *being at the end of the line*, in terms of having no other options that helped them, somehow seemed to be a plus in this situation. I puzzled over this.

Dr. Wolf had one interesting way of explaining this phenomenon.

He stated:

People are usually at this point when they come to see us. And actually we're not really interested in working with them until they've reached that point. And it takes quite a long time for people to realize that. They have to go through all the testing, all the co-dependent relationships (e.g. with

doctors), the pills and potions and drugs. They have to try them all, and when they get to the point where they realize that their symptoms are not going away, that all they're doing is shooting the messenger (e.g. the pain) on a daily basis. Then the sadhana is complete. Then they've gone through the psychic preparation for the transformation.

He believes that an important key to participants' transformations is that "They were *ripe, and ready* ... All we had to do was just create the context in which the transformation could occur. And to make the people feel safe enough and then it happens."

Additional explanation is that these people suffered so much, and in this supportive environment, with unconditional acceptance they felt encouraged to *really go to bat for themselves*. Because all outside methods had failed to help them, they were more willing to try *interior* journeying. When they were in touch with their bodies, or had experiences in acupuncture that may have seemed far fetched to others, they somehow knew that these experiences were still true for them. Following this inner knowingness was also empowering for these participants. Their knowingness reinforced a sense of their own authority and wisdom about their bodies, and meanings of experiences in the context of their own lives.

Listening to and Following Their Bodies

In Pierre's transcript, he described several examples of how he can now "deal with his pain better." Many of these methods rely upon listening to his body. In other words, when he decides to stop working on a project, it will be because his back is starting to hurt, and he now knows that if he *pushes it*, he will wind up crawling on hands and knees from bed to bathroom. Sage cited many examples of the importance of following her body, and its needs. "If you can just follow your body ... then it just flows.

One thing leads to another if you go with it.” To her this means resting when she is tired, moving when she needs to move, expressing her feelings when they need expression. Arsinoe has developed a new found desire to listen to her body; “not just mask it with drugs, or with a drink, or with complaints.” She described, “Now I don’t need to block out what my body is telling me.” She wants to nurture her body, and is comfortable following her body. Participants were able to attune well to their bodies. This was likely a product of the many *body focused* sessions of the program including stretching, deep relaxation, and body work treatments. Rather than avoiding their physical pain, participants were facing it. Through this process they gained respect for the guidance their bodies gave them, and developed relationships with their bodies to inform them of their needs.

Pain Relief

All but one participant (Pierre) stated that his/her pain was significantly reduced by the end of the program. Although participants still experienced pain, the duration (amount of hours per day of occurrence) was less. The frequency of occurrence per day, or week, was less. And the intensity was less. Homer was able to completely come off narcotics. Other participants had forgotten about taking their analgesics (Juliann). Complaints of fatigue that were present in all of the pre-program interviews were hardly voiced in the post program transcripts. (Alexandra and Juliann did voice continuing fatigue, but with more confidence about its management).

Most remarkable was the fact that participants felt empowered to handle their pain and fatigue with the tools they now were beginning to command from the program at the Victoria Pain Clinic. Pierre said, “I still have the pain but I know much more how to

handle it. Instead of getting mad at his back when it hurts, he will take that as a sign to rest. Sage is able to pay attention to her pain as soon as it starts, and take care of it. She can now bring her pain down to a level where she can tolerate it. Arsinoe is willing to go out to parties, (instead of remaining socially isolated), and if the pain hits, she will come home. “Leaving is not a sign of weakness. It’s a sign that my body is telling me that I need to stop now.”

Apart from learning new ways of managing pain and fatigue, participants also commented on receiving direct pain relief from some of the treatments experienced at the Clinic. Particular mention was made of the benefits of Hellerwork and “David’s magic hands (Colette).” Several participants expressed great relief both from the Hellerwork treatments, and the sense of being *understood* by the practitioner. As was previously stated, David had a way of explaining about participants’ sources of pain, and treatment thereof, which made their conditions and treatment plans much more understandable. Participants found this depth of understanding rare, and were relieved (Colette, Sage, Juliann, Pierre).

The philosophy of the Clinic towards pain is that *pain is a messenger*. This means that a person’s body is giving him/her a signal of pain to indicate that something is amiss. If we listen to the pain by tuning into our bodies, we can avoid worse illnesses. From this perspective, pain is a gift because it actually signals us to pay attention before things get worse. Participants remarked about their own recognition of this truth for themselves. The more they tuned into their bodies, the more they seemed to accept what the pain and fatigue were telling them. By listening, paying attention, and following their

bodies, participants were able to live more harmoniously within themselves with less pain and fatigue.

Shifts in Global Well Being

The shifts in well being that I witnessed in all participants pre-to-post program would ordinarily have seemed incredulous. Had I not been there for the entire program, and seen the process from start to finish, I would not have believed that such changes were possible.

Some of the participants' animated examples of changes in well being follow:

Alexandra: "I was in just incredible despair when I came here. And now I believe I have a chance at life; whereas I really didn't think that was possible ... I just have to say, I'm transformed on all levels. I have been given a whole new life." Arsinoe, "If I keep at it, there's no way I won't get my life back. I'm there, and I'm pretty great to be with."

Homer: "It's possible to discharge enough old emotional hurt, which will then heal the physical hurt. It's the way out for me. I'm ... a whole lot happier, and in a much better space. Where I'm at now is pretty close to, as close to a transformational change as I think I'm gonna get ever in seven days." Jade, "When I came, I was ... at the end of my rope, and I was starting to let go of it. I was suicidal. Now, I realize that I'm the one that's burying myself. I think I'll survive now. I'll live ... because there's a lot of stuff out there I'd like to see, and know. And I can see that that's possible again, which is nice." Colette: From a personal perspective, it's been phenomenal. I've had lots of changed attitudes ... I mean it's easy to change attitudes, but it's hard to create the habits to make them stick. So I've been given some good tools ... key pieces, self esteem wise. I think the biggest thing I've noticed is that I need to be gentler with myself. I need to be

softer and easier on myself. In order to survive the rest of my life, I need to be nicer to me.” Sage: “After getting the feelings out, it just fills you up with all this happiness ... the more you can get out, the better, happier, and balanced, I feel that I am. The answers are there. They’re right there, if we just pay attention. If you can just follow your body, then it just flows.” Pierre: “I feel much better in my head ... so my attitude makes everything better altogether, period. So my attitude’s way different.” Juliann: “When I came, my hope for recovery was very low. I was at 0%, in terms of how I felt about living. And I’ve moved to about a 50% and that’s half way up, so the more I can develop and nurture all the tools that I’ve learned, the more it’s gonna improve, and grow.”

I believe these shifts in well-being were a by-product of the aforementioned key themes. Participants’ pain/fatigue was respected. They were treated as whole beings. They were given tools and therapies to become empowered, and to release held emotions. The group support, tools for improving self esteem and communication, all helped increase participants’ confidence and optimism for the future.

Applying the Tools They Learned into the Future

Again, this theme came up in all transcripts. Participants were wise in terms of realizing that although they had made such gains in their sense of *global well being*, “The proof is in the pudding”, as Colette stated. In other words, if they can apply the practices they learned once at home, they would continue on the road to further recovery. In order to apply these tools, each person was determined to create a *sacred* space for him/herself to go to at least twice daily. In this space, time would be spent: attuning to their bodies, applying some of the practices such as stretching, relaxation, meditation. Taking the time out to *tune into themselves* in order to know how they are feeling, and what they are

needing; and just taking time out from worldly demands such as parenting, relationship issues, business concerns, other financial issues, etc. Many participants were excited about the new types of meditations they had learned, and planned on pursuing this. Also, many were planning to incorporate specific healing techniques learned at the Clinic into their regularly scheduled appointments with practitioners at home, such as massage therapists, etc.

Many also expressed new found strength in relation to how they would approach medical practitioners. The pre-program transcripts were replete with examples of participants' frustrations with dealings with medical practitioners. At the end of the program, when I questioned participants about their expectations for future relationships with doctors, they were more assertive and definite with their answers. Arsinoe said, "I thought I was taking charge of my life before, the way things were going. But now I realize it wasn't necessarily in a way that benefited me to the max. It's not just up to someone else to tell me to do this, and to try that, and well if this doesn't work then it's game over." She has much more of a sense of herself and what is right for her, and she will apply this in her dealings with medical professionals. Homer was very relieved about feeling "on his own path" again. He feels informed, and in touch about his own condition, and will use this knowledge to guide further treatments.

Because participants found a place of hope inside, they can use this to move them toward appropriate treatments on the road to recovery. Prior, to the program, without hope, desperation ensued which clouded judgment toward appropriate possibilities for healing.

Decreased Fatigue

Of the sample of eight participants in this study, all were experiencing fatigue concomitant with pain. Because their pain had carried on for so long, the resultant fatigue was great amongst participants. There was very little energy to live life, along with attendant depression. Probably only two (Sage and Alexandra), had been officially diagnosed as having CFS. However, more than four of the symptoms (markers for CFS): muscle pain, joint pain, headache, subjective memory impairment, un-refreshing sleep, ongoing fatigue, were present in all participants. More important than *classifying* these participants as having CFS, (or not), is the determination about whether the findings of these journeys can be useful to people with CFS.

One way of answering this question is by asking just what changes in fatigue were indicated by participants post-program. The following are indicated (from the post program data analysis):

1. All participants indicated increased energy levels post program. They felt more energetic, happier, and able to handle life.
2. Because they had made inroads in connecting with, and learning to listen to their bodies, they were able to use this knowledge to take better care of themselves. This included resting more, knowing their limits re: activities undertaken, and sleeping. This attunement to their bodies resulted in decreased fatigue.
3. For some, what was most important was learning how to stand up for themselves, assert themselves, and apply this to their lifestyles. The act of *putting themselves first; and of self nurturing*, was part of a process which reduced stress, tension and consequently, fatigue.

4. Being able to change *deadlines* (Pierre) for work projects; deciding to work less (Arsinoe, Colette), or creating work schedules that were realistic; and in alignment with the needs of their bodies, were also ways of reducing fatigue.
5. Reduction in their overall pain; having relief from the pain cycle, afforded the participants less struggle, and less fatigue.

Process of Transformation: Summary

The process of transformation across participants can best be summarized as follows:

1. Participants having the intention, and desire to get well, as well as fostering personal empowerment
2. Trusting, feeling safe, and supported, in the environment with staff, and group members of the program (or learning to successfully confront their dissatisfactions)
3. Being willing to let go into their experiences in acupuncture, counselling, and Hellerwork with highly qualified practitioners
4. Having confidence, and understanding the science behind the program
5. Applying the tools they learned within sessions: moving towards the pain with deep breathing; and emotional release with observing ego, to their healing process
6. Following their bodies in terms of needs for rest, movement, contact, alone time
7. Trusting their own inner wisdom, and/or experiences of knowingness (a product of an inter-weave of somatic, psychological, cognitive, and spiritual experience)
8. Being committed to using the tools learned at the Clinic once at home including the development of a *sacred space* to do their daily practices.

The findings indicate that when clients with CFS and Chronic Pain are engaged in a residential, multi-modal program that values their inner knowingness; is supportive, participant focused, and compassionate; with highly trained practitioners in psychotherapy, stress reduction, and energetic release, transformation of these conditions can take place. The findings also indicate that combining the body focused therapies of the VPC, with a patient's own willingness to grow, can elicit access to one's inner wisdom to help guide the healing process. Findings also show that researching sufferers' inner change processes can be fruitful in uncovering healing methods which may benefit others.

CHAPTER SIX: IMPLICATIONS OF THE FINDINGS

Overview

- Answering the Research Questions
- Implications of the Findings
 - For Sufferers of Chronic Pain and Chronic Fatigue Syndrome
 - Clinical Implications: General
 - Clinical Implications for Individual Work with Clients
 - The Findings as They Relate to Current Literature
- Limitations of the Study
- Suggestions for Future Research
- Conclusion

Answering the Research Questions

At the beginning of the study, I asked the following questions:

1. What was the growth process participants went through to be able to impact their illnesses in such a short period time?
2. Can this process be explained?
3. Are there answers within the explanations that will also benefit others in Chronic Pain or with Chronic Fatigue Syndrome?
4. Can we, as practitioners, learn something about how to work with people with CFS and Chronic Pain more effectively based on what these participants' journeys can teach us?

Have these questions been answered? I believe that the Post Program Transformation Stories, Stage 2 data analysis write ups, plus the Summary and Discussion of Findings, adequately answer questions one and two. Questions three and four will be answered in the next section.

Implications of the Findings

How May This Study Benefit People With Chronic Pain and Chronic Fatigue Syndrome?

To answer this question, I have created a Composite of significant ideas from the analyses of Participant Post-Program transcripts (in lay language). These ideas are a culmination of some of what the Post-Program transformation stories have taught me.

To People with Chronic Pain and Chronic Fatigue Syndrome

There is hope. There are ways of breaking out of the pain and fatigue cycle. There is nobody to *fix it* but there can be many changes made by your self over time. Healing from CFS and Chronic Pain is a process involving self responsibility. One needs to have courage to take steps on his/her own behalf. It is wise to seek practitioners who are willing to listen, and have knowledge re: CFS and /or Chronic Pain.

What to practice: 20 Practical Suggestions

1. Honour your body and what your pain/fatigue is showing you. (How to honour your body? Just be there with your body).
2. Breathe deeply. Stop and take 7 deep breaths whenever you think of it.
3. Practice deep relaxation often. (There are many tapes/CD's on progressive muscle relaxation, autogenics, etc. Find ones you like, and use them to stop building tension, and reduce the tension you already feel).

4. Stretch daily, and /or start gentle movement exercises.
5. Apply positive self talk. Get off your own back. You can do it. Find ways to build your own self esteem. Think of your good qualities. Be kind and gentle with yourself.
6. Lean into; move toward, or with, the pain/fatigue. Accept that's what you're experiencing in the moment. Breathe with it. Be present with and/or voice the feelings that come up. Observe yourself doing this; sense your body, and stay with the process. Give yourself credit for handling the pain/fatigue, again.
7. Adopt a form of meditation, or inner focusing. Practicing this will help to center yourself, develop your observer part, quiet your mind, reduce panic and anxiety, and increase peacefulness.
8. Ask for, and receive, physical contact, hugs, and affection from others, as you like.
9. Ask for explanations that you can understand from practitioners, and work with those who will listen to you as well. Set up clear communication back and forth with all your practitioners.
10. If you can, do something a little more active, and sense the energy of your body following. Where are the blocks? Where is the energy moving? What can you do to help your energy flow?
11. You may try acupuncture, acupressure, Hellerwork, chiropractic, physiotherapy, massage, cranio-sacral, or other body work therapies. Find out which body work therapies work for you. Stay with treatments that help your pain/fatigue, and eliminate those that don't. If necessary, see if practitioners will come to you.

12. Become very good at caring for yourself in the ways you need.
13. Direct any extra energy you have, beyond the basics, to *healing yourself*.
14. Don't try too hard, or pressure yourself. You'll do better if you learn to relax.
15. Remember, you are still whole when you're a person in pain or chronic fatigue; a whole person with something difficult to deal with.
16. Spend some time socializing; even for very short periods. Don't isolate.
17. Healing requires focus and discipline. Stick to your way, whether others like it, or agree with it, or not.
18. You have a right to understand your own body, and consent to what you think are the best treatments.
19. Get the help and support you need.
20. You have every right to heal.

Clinical Implications: General

Residential Format

The data indicate that there are definite benefits to using a residential modality for Chronic Pain and Chronic Fatigue recovery programs. (a) The continuous contact with practitioners, and other group members, over a 10 day period is advantageous for building the high levels of safety and trust necessary for clients to work at the depths that are needed to effect change in their illnesses. And, (b) a residential setting offers participants the opportunity to step away from their everyday lives. This affords them freedom from day to day life responsibilities; issues, relationships with family members and/or significant *others*, and the world at large. Certainly, to do the work at the emotional depths that these participants achieved, and to enter into the altered states

which can help transform consciousness, and consequently Chronic Pain and Chronic Fatigue Syndrome, a residential set up is most conducive.

However, the costs may be prohibitive to participants who are not funded by insurance companies, or otherwise have the means to pay for such an intensive therapy program. On an outpatient basis, there are many transferable skills that are indicated by the findings of this study that may benefit clients with CFS and Chronic Pain, as we work with them in private practice on an individual basis, or in group work.

Clinical Implications for Individual Work with Clients

When I reviewed the findings, and asked myself about clinical implications, the first voice I heard was Pierre's. "Tell them to treat people in pain, the way they'd want to be treated if they were in pain." This comment certainly provides a guidepost for how to treat clients in Chronic Pain and with CFS. Participants need to feel that practitioners are empathetic to their suffering. They need to feel that practitioners truly care about them. To this end, practitioners need to examine their own attitudes, and opinions, about people in Chronic Pain or with CFS, and determine what biases they carry and why. Are these biases in any way helpful to clients? There are stigmas attached to these illnesses which are prevalent in the culture. People who complain about pain, or CFS symptoms, are seen as weak, or malingerers, by many practitioners. Since clients with CFS and Chronic Pain tend to be very sensitive about how they're being treated, particularly whether they're believed or not, it behooves us to develop an attitude of caring and compassion for clients' chronic illnesses right from the start. If this is difficult, we need only think of the times we've had headaches, backaches, toothaches, extreme exhaustion, or flu-like illnesses, ourselves. What did we want from others at these times? It is important to

begin with a large amount of empathy. Having empathy is the first step toward helping the client move through CFS or Chronic Pain. Then, the task is to build as much safety, and trust as we can.

Establishing Safety and Trust

I believe it is important for therapists to *slow down* and recognize that working with clients with Chronic Pain and Chronic Fatigue Syndrome is a process that will take time, and unfold over time. Building trust in the therapeutic relationship and establishing safety, are the two most critical facets of the first stage of therapy with these clients. This is not different from the usual initial stage with any client, but is critically important because in order to work at the levels where healing and growth can be effected, clients need to have very high levels of trust, and feelings of safety; both in the therapist, and in their own process.

Having Knowledge of, and Communicating an Understandable Treatment Plan

Part of the process of building trust also involves having a *game plan* for how you may be able to help a client. This is best created in conjunction with the client based on his/her goals and desires, but should also reflect your knowledge in the field, and give the client some indication of what you think might be helpful. Although the plan needs to be flexible, and may change as the therapy goes along, the findings indicate that it is vitally important for therapists to have sound knowledge of ways to help people with CFS and Chronic Pain, and that knowledge needs to be communicated, and explained in ways that are understandable to the client. The client needs to have an opportunity to *weigh* the

explanations, and ask questions, in order to be able to trust in the logic behind the treatment plans.

Viewing Pain and Fatigue

The findings indicate that participants really benefited from the Clinic's view of them as whole and complete people who were facing something difficult, e.g. Chronic Pain, and Chronic Fatigue Syndrome. It's important to relate to the pain and fatigue clients are experiencing as a part of their wholeness; as a part of their lives, and as an expression of some aspects of themselves. Therefore we endeavour to understand the client as a whole person, and look for what his/her pain/fatigue may be telling us. How does the theme of pain/fatigue weave into the client's life?

Helping Clients Enhance Access to Their Own Knowingness

We can engage clients in a process whereby they can have greater access to their own knowingness. There may be several ways of doing this.

1. Respecting that each client *has* this inner sense of knowingness. By creating a respectful atmosphere and relationship with our clients, there is room and trust for a client's knowingness to surface. As therapists, we walk a tricky line between being some kind of an authority (as described in the section on therapist's own knowledge base), and yet not being *the* authority. In other words, the client is his/her own authority on his/her illness. We are just knowledgeable about how to best help elicit that knowingness.
2. It is vital to be a very good listener in order to make appropriate pain/fatigue assessments as clients may be suicidal, or depressed, or may need other referrals.

And listening helps in understanding the lived world of the client. We must listen in order to *get* what the pain and fatigue may mean in relation to the client's world.

Encouraging Clients to Discover Their Own Meanings Regarding Pain/Fatigue

There may be several steps to this: (a) Check out some of your hypotheses about possible meanings with clients and see if they concur. This may lead them to disagree with you, and *find their own truth*. (b) Help clients to discover, and articulate about their inner worlds. What are the client's resources? How does he/she solve everyday issues? What resources does the client use within him/herself *when the chips are down*? What helps a client get in touch with him/herself (e.g. journaling, meditation, prayer, jogging, body sensing, Yoga, etc.). Can any of these resources help them in understanding, and healing their Chronic Pain, and/or CFS? (c) Body psychotherapy can be very helpful in giving clients a sense of their bodies, and movement of energy. This awareness can involve postural knowledge such as afforded by physiotherapy, Feldenkrais, Alexander work. Body psychotherapy can also teach clients about how their energy is flowing (or isn't), how much support they feel inside their bodies for handling their lives, and illnesses, whether they are actually grounded, and *in their bodies*, or may have become dissociated due to shock/trauma/ abuse, or illness. Therapies such as Bioenergetics (A. Lowen, 1975), or Somatic Experiencing (P. Levine, 1997), are good therapies for creating body awareness, and reducing stress and trauma. Bioenergetics can also help clients who have difficulty expressing emotions, and/or are feeling very resistant to moving along energetically. Cognitive behavioral therapies such as progressive relaxation, autogenic training, guided visualizations, inner child meditations, and other

forms of meditation, can all help a client be in touch with his/her body in a more aware way, as well as reduce stress, tension, pain, and fatigue.

Energetic Views of Pain

Body psychotherapies can lead clients to greater awareness of their energy, how it is flowing, and blockages to flow. Viewing pain as blocked energy carries with it the benefit of both the client, and therapist, realizing that pain is not something fixed, solid, and permanent, but rather moving, changing, and impermanent. This does not mean that a client's pain is going to disappear right after his/her session with you, but it does mean that with continual progress, the pain can move, and change, and the client can get well. Working with energetic blocks in safe, and skilled ways can move them. Releasing energetic blocks can help release pain.

The Victoria Pain Clinic's model for emotional release can be useful to clients provided that care is taken to:

1. Assess client safety levels, and ability to experience deep, and charged feelings
2. Establish a safe space (e.g. you, your office space, and a safe space within the client)
3. Provide reassurance, and support that it's O.K. for clients to feel their feelings, and express them (instead of hiding, fighting, or denying them)
4. Let the client know that you will be there to support them when feelings come up
5. Work with clients to develop a strong observing ego (adult part) to help them go through emotional processes.

In order for therapists to be effective in helping clients work with charged, suppressed, emotions, therapists need to feel comfortable with same. This means that a

therapist needs to be comfortable with his/her own shadow sides, and deep feelings. It requires preparation on the part of the therapist for the sessions which include his/her own relaxation/meditation time, willingness to come present, and understanding that in order for the client to heal, he/she may need to express deep feelings to unravel the web of somatization.

Because somatization is a type of *defense* mechanism, therapists need to take great care in assessing the clients' strengths, and readiness for this type of work. Because resistance may logically occur to the dismantling of these defenses, therapists need to be trained in how to best engage the client's support in working with the resistances. Parts work, such as R. Schwartz (1995) *Internal Family Systems* work, can be useful in identifying, and working with, those parts of the client's self that may be sabotaging his/her efforts to get well. Gestalt therapy (Perls, 1988) is another method for working with parts that might be capable (or already involved in) sabotaging the healing process. These parts need to be viewed as serving a protective function for the client, however, no longer useful when their form of protection is actually sabotaging, or hurting the client's efforts at wellness. It may be very difficult for clients to grasp these concepts. As Dr. Wolf said, the shadow parts are very powerful, and need to be approached with respect. Because of the power of the shadow parts, clients may often identify strongly with them, and be very uncertain, or even hostile about *giving them up*, or learning to live more strongly in other parts of the self. This is all *grist for the mill* in terms of working with clients to help them heal from CFS and Chronic Pain.

The Value of Matched Intentions

Another valuable part of the therapeutic process involves the intentions of both client, and therapist. In order for transformation to occur, clients and therapists need to intend for this to happen. Clients need to be able to remain open to the possibility of a transformation in their situations. This means that they take a larger view of the therapy. The intent of the therapy becomes more than just suppression of symptoms (the pain and/or fatigue). Although symptoms may change, the goal is the exploration of the client situation, and gaining access to realms through which healing can take place. The therapist, intends for this transformation, and is comfortable and skilled in providing the space for this to occur.

Dr. M. T. Greenwood (1999) believes that this state of alignment of intention between client and therapist is vital for the transformation process. He states:

It is one thing for the practitioner to have cultivated a healing intent, but quite another to engender a similar intent in the patient. Yet without a shift in their intent, patients remain passive victims of their illness, waiting for us to perform some kind of miracle that will *fix* things for them. That attitude is unrealistic and needs to change ... One practical solution is to engage the patient actively in the therapeutic process as quickly as possible. Ideally, the practitioner ... becomes less active while the patient ... becomes more active (p. 18).

Dr. Greenwood talks about healing, transformation, and physical death this way:

Ultimately, we cannot avoid passage, although we can certainly delay it until we physically die. The challenge of healing is to pass through the gate while still alive creating a more authentic sense of self in the process. We want to help patients negotiate the passage. The difficulty is that for patients to pass through the gate, the patient-physician dyad must intend it without reservation. It is almost as if we *were* going to die, although obviously it is only psychic death being contemplated, not physical.

He further states:

The principle of intention is very simple, and passage through the gap is essentially automatic once the impediments to intention have been removed. The principles are: moving toward, silence, transformation, and manifestation:

1. Moving toward ... the directional vector that represents symptom exploration
2. Silence ... a state of quiet witnessing.
3. Transformation ... the automatic shifting dynamics of the gap.
4. Manifestation ... the subjective reality that emerges from the gap. (Greenwood, 1999, p. 20).

When we work with aligned intentions of both therapist, and client, parts that may come up to sabotage the therapy can be viewed as part of the whole, and allowed a voice within the gap where transformation occurs.

Reminding clients of their intentions toward wellness also has the advantage of helping clients have a sense of ownership for their growth processes, (since the intention represents the clients' wishes). Reminding clients of their conscious intentions can help elicit clients' motivation to get well.

Eliciting a Client's Motivation to Get Well

This is undoubtedly a challenging aspect of therapy with clients with CFS and Chronic Pain. Clients may be very down, depressed, fatigued, betrodnen, frustrated, angry, or overwhelmed at the prospect of getting well. They may also worry about what will happen financially; if they are dependent on a disability income. They may not know how to live again in the *world*. All these fears, frustrations, feelings of helplessness, and illness itself, can interfere with motivation. However, the findings from this study clearly show that motivation, and a clear sense of wanting to get well were

major themes (factors) in the post program successes of participants. Therefore, we can empower clients to stand within their own motivations for getting well, while we keep our empathy always as a backdrop for their explorations.

CFS Clients: Special Concerns

CFS clients present special concerns based on the fact that their energy is so low. This impacts their abilities to engage in the therapeutic process. It also warrants some new directions for treatment. In Chinese medicine, most CFS clients would be presenting with *deficient chi* (very low energy levels). Practitioners of Chinese Medicine, therefore, would undertake a process of helping the client to rebuild chi. This would generally be done with moxibustion (as even acupuncture needles might further deplete the energy of CFS patients). In this case, CFS sufferers would be able to relax, receive treatments on a regular basis, and over a period of time, energy would gradually be rebuilt.

This kind of treatment would go hand in hand with recommendations by counsellors for adequate rest, decreased stress and worry; balanced diet, and activity pacing. If, through psychological assessment, the client's energy is too low to engage in a therapeutic process, then counsellor support, and guidance for how to reduce energy demands, and rebuild vital energy is important. Problem solving about persistent stressors for the client, and helping the client restructure his/her life with a reduction of same, will also help.

It is also important to consider whether the client's energy may be being *funneled* into inner psychic domains that are *wearing the client out*. For example, if parts work is done (R. Schwartz, 1995), it can become clearer whether the client has a heavy *inner critic part* that is unrelenting and *on his/her back*, or a saboteur. In these cases, too much

energy is being spent continually meeting up to the expectations of these critical or sabotaging parts. Understanding how certain parts of the self, or aspects of a client's psyche may drive him/her to overwork, perfectionism, subservience, covert defiance, or lack of self assertion can also be fruitful pieces of work in client therapy for CFS.

Stresses from interpersonal relationships need consideration as well. It is most important to determine what the *client* senses as providing high degrees of inner stress/constraint, rather than assume that what you believe is stressful is also experienced that way by the client.

The Value of Group Work

Certainly, the post program transcripts are replete with examples of participants' profound enthusiasm with group support. Particularly for clients in Chronic Pain and with CFS, group work may be very useful as an antidote to the isolation they otherwise experience in their lives. However, for some, group work is just too much. People with CFS or Chronic Pain may be too sensitive to light, sound, or may just not be able to handle the demands of interaction with so many people (Sage, Pierre).

Group work has the value of providing a psycho-educational format whereby clients can be taught in groups about pain, stress, tension, fatigue cycles, etc. It also provides a *laboratory* like experience for learning skills related to self esteem, assertiveness, and interpersonal interactions that may effect the ways they handle pain, stress, fatigue. Certainly, one of the benefits for people with CFS, or Chronic Pain, of being in a group is the *all in the same boat phenomena* which was mentioned by every participant as very important to their healing process. There was something about that first night of the Program, when each person checked in and said, "I am a person in

pain/fatigue,” and was allowed to express what that experience was like. The camaraderie, sense of inclusion, and “*O.K. I am normal,*” sigh of relief that went through the room, was palpable.

Summary

As per the findings of the study, all of the above mentioned areas were key aspects to include in therapeutic encounters with people with CFS and Chronic Pain. If practitioners are not comfortable with, or don't agree with all aspects, even implementing some will likely enhance the experience of clients with CFS and Chronic Pain.

The Findings as They Relate to Current Literature

In this section, I will discuss how the findings of this study relate to trends in current literature in the following three areas:

1. The findings as they relate to studies in Cognitive Behavioural Therapy (CBT)
2. The findings as they relate to valuing a patient's own knowingness
3. The findings as they relate to the practice of holism in CFS and Chronic Pain treatment; (mind-body medicine).

I have chosen these areas because they represent focus areas of new research in the treatment of CFS and Chronic Pain, and because the findings are in juxtaposition to these research areas.

The Findings as They Relate to Cognitive Behavioural Therapy (CBT)

Cognitive behavioral therapists have published many studies which assess the effectiveness of CBT for people with “functional somatic syndromes” (David, Wessely & Pelosi, 1991; Deale, Chalder, Marks & Wessely, 1997; Deale, Chalder & Wessely, 1998;

Friedberg, 1996; Friedberg & Jason, 1998; Heijmans, 1998; Moss-Morris & Chalder, 2003; Pincus & Morley, 2001; Sharpe, 1997; Sharpe, Hawton, Simkin, Surawy, Hackmann, & Klimas, 1996). Functional somatic syndromes are described as syndromes which are disabling to individuals but, “in many cases, no disease can be found” (Sharpe, 1997, p. 356). The term, functional somatic syndrome, has generally replaced what was commonly called somatization, or psychosomatic disorder. As explained in the literature review, applied cognitive behavioral therapy aims at intervening in the cognitive component of illness, “because of its presumed importance in illness perpetuation. Change in the cognitive component is assumed to lead to more effective coping behavior, less emotional distress, and consequently to a reduction in the biological disturbance” (Sharpe, 1997, p. 357).

The findings of this current study concur with CBT studies in the following ways:

Cognitive behavioral therapies are used fairly extensively in the VPC for participants of the 10 day program. These include: stretching exercises, instruction in breathing, progressive relaxation, autogenic training, visualization, guided imagery, plus psycho-educational tools such as work with self esteem. Participants are also involved in training about the effects of stress on the body, and the relationship between stress, pain and fatigue. Because this study was not designed to evaluate the efficacy of these cognitive behavioral treatments with participants, we can only say that they were a part of the overall program and have had a part to play in the positive results of the study.

We can also say that the findings of this study suggest that when participants adopt a way of *reformulating* their understanding of their Chronic Pain, or Chronic

Fatigue Syndrome in ways that makes sense and bring confidence to them, the result is positive in terms of their healing process.

I believe the findings of this study also differ from other studies about CBT.

Sharpe (1997) describes the cognitive behavioral therapeutic approach for functional symptoms as follows:

The therapist and patient work together to: 1) systematically identify beliefs that the patient may hold about themselves, their illness, and other people and the world, 2) generate alternatives to those beliefs, and 3) choose between these alternative beliefs on the basis of best available evidence. This evidence will include both information provided by the therapist and the results of so-called behavioral experiments performed by the patient. In this way, the patient is helped to select and then to apply the most accurate and helpful ways of thinking about their predicament (p. 357).

Further thought along these lines is shown in studies of negative illness perceptions, or illness attributions in patients with CFS and Chronic Pain (Deale, Chalder & Wessely, 1998; Moss-Morris & Chalder, 2003; Pincus & Morley, 2001).

In these studies, people with CFS and Chronic Pain are held accountable for their “illness cognitions” and the relationship of these cognitions to the perpetuation of their illnesses.

Turk and Rudy (1992) describe this as follows:

Patients with chronic pain are viewed as active processors of information. They have negative expectations about their own ability and responsibility over their pain. Moreover they often view themselves as helpless. Such negative, maladaptive appraisals about their personal efficacy may reinforce the experience of demoralization, inactivity, and over reaction to nosioceptive stimulus appraisals and expectations are postulated as having an effect on behavior, leading to reduced effort and activity and psychological distress (as cited in Pincus & Morley, 2001, p. 600).

Morris and Chalder (2002) state the following:

Although the symptoms of CFS are largely medically unexplained, CFS patients have more negative views about their symptoms and the impact that these have had on their lives than do patients with a clearly defined

and potentially disabling medical condition. The data support the cognitive behavioural models of CFS that emphasize the importance of patients' illness perceptions in perpetuating this disorder (p. 305).

These studies have been used to illustrate that the emphasis in cognitive behavioral therapies for people with CFS and Chronic Pain is largely on coping, mental components, and taking responsibility for changing thoughts which perpetuate or intensify CFS and Chronic Pain. These goals are worthy, but may be cumbersome for patients, and insufficient for healing.

Findings from this study at the VPC suggest that a safe and supportive therapeutic environment, in which patients can energetically process somatic experiences, leads in itself to the cognitive restructuring of illness. In other words, once sufferers release traumas held in the body; release tension, pain, fatigue, and grasp the meaning(s) behind these situations; cognitive changes result. To me, it only makes sense that when the "load" on a person psychologically, emotionally, and physically is "lifted" then shifts in global well being will occur. To expect people who subjectively are feeling very ill to change cognitions is burdensome.

And, considering that 70% of CFS sufferers are female, from a feminist point of view, it behooves us to look at the implications of why scientists and researchers choose to extensively pursue research into CFS and Chronic Pain as psychosomatically induced. Perhaps, as described by E. Shorter (1991) the depiction of women as, "hysterical females with lack of real symptoms has endured since earliest times" (as cited in Friedberg & Jason, p. ix).

The psycho-educational component of the VPC teaches about stress and its relationship to pain and fatigue. A constructive way to apply CBT would be to help

sufferers in reducing and managing stress. Friedberg (1995) concurs that “stress appears to play an important role in CFS symptoms exacerbation and increased disability” (as cited in Friedberg, 1996).

Valuing Subjective Knowingness and the Patient/Practitioner Relationship

Findings from this study indicate that participants generally felt very supported by the practitioners at the Victoria Pain Clinic, especially as regards being seen by practitioners as whole and capable. This likely helped them feel more confident in accessing and expressing their own knowingness. VPC’s philosophy states:

We strongly believe that recovery from Chronic Pain/stress must come from within our clients. It is not something that therapists can do for them. ... Our philosophy is based on the importance of the client assuming full responsibility for their own health and recovery process.

As Colette (participant) said in her Post-program interview, although self responsibility is important in healing, one needs to be guided by practitioners experienced in *helping you turn on the light*. As such, the client and therapist embark on a collaborative and mutually respectful healing journey. This trend toward mutual respect and collaboration between practitioner and client is reflected in the current medical and psychological literature on Chronic Pain and CFS. E. S. More (1996) argues for the:

centrality of empathy in the doctor-patient relationship – as a core of ethically sound, responsible therapeutics ... and intends empathy to be an explicitly hermeneutic practice informed by a reflexive understanding of patient and self (p. 243).

More’s philosophy goes beyond a solely biological model of illness whereby the doctor behaves in an *expert* role, and the patient’s knowingness is disregarded. Lingardi and Grieco (1999) explore the fact that Western medicine’s choice of attending to the “body-object as its investigative starting point, while in actual fact it is dealing with

subjects. They refer to, and recommend “Gadamer’s model of medicine as the art of understanding and dialogue” ... and Plato’s concept of physician as a “master of the living totality; someone who is capable of activating the patient’s self healing capacity” (p. 413).

K. Malterud (1993/2000) addresses the issues of empowering practices in health care of patients with CFS and Chronic Pain. In her 1993 article, she argues for “sensitive and sensible research from women’s voices” (p. 365). These studies would need to use “methodology that preserves women’s messages and transforms them into medical knowledge ... a medical knowledge that reflects women’s reality” (Ibid). In order to help physicians working with people with CFS and Chronic Pain, Malterud (2000) teaches other physicians about the importance of valuing “extensive subjective symptoms as a source of knowledge for medically unexplained disorders which are mostly occurring in women” (p. 603).

In terms of the *doctor-patient* relationship, clients are often impressed with the services they receive from CAM practitioners (Whitford, 1995) because “they are often willing to spend more time with patients.” Whitford believes that “part of the holistic credo is to encourage patients to help themselves get better” (p. 22). In a 1995 book review of : *The Fatigue Artist*, by Lynne Sharon, (an autobiographical novel about her experiences of living with CFS), she states that after CFS took over her life, a turning point in her recovery came when a “herbal healer seemed to be truly interested in how she felt” (adapted from Butterbaugh, 1995). Hence, valuing subjective meanings, feelings, and accounts of illness is viewed as an important part of recovery from CFS and has recently been recognized as such in the research literature.

I believe that the following statement by Nordenfelt (1995) underscores the reason for valuing subjectivity in new illness paradigms. He states:

We need as much intellectual penetration and rigorous analysis in order to clarify the nature of suffering as for any other scientific investigation ... There are good reasons to direct much more of our attention to this humanistic aspect of medicine. We ought to remember that the existence of suffering is one of the main motives, if indeed not the most important motive, for undertaking the medical enterprise (p. 277).

Findings as they Relate to the Reciprocal Relationship of Body and Mind

An important finding and contribution of this study concerns concepts aforementioned by participants in relation to the body. Not only are the body and mind viewed as part of what constitute wholeness of being; but the body is also viewed as an intelligent conveyor of meanings and signals toward one's wellness. In other words, pain and fatigue are signals as part of an elaborate system by which humans *get to know, and care for, themselves*. Therefore, the way to wellness involves respecting one's body, and learning to develop a relationship with it whereby the wisdom of the body can be resourced, and best utilized.

Findings of this study also suggest that there is a reciprocal exchange between mind and body in healing CFS and Chronic Pain. Participants constructed relationships within mind and body such that their bodies became sources of knowledge and guidance to them which related to ways of healing. Participants in the study, sometimes let their minds *take a back seat* to their bodies when sensations such as pain signaled them to slow down or stop. At other times, when bodily sensations or feelings became too intense, a participant's mind, or observing ego, would step in to provide a healthy distance from

which to go through an experience. In this way, there was reciprocity, respect, and holism of mind and body in the healing approach.

The holistic approach is becoming more widely recognized in the current literature. Sommer (1996) states:

During the past 15 years there has been a birth of a new science -- the science of mind-body and holistic medicine, which is reminding us of the ancient principles upon which good health and medical care have been based. As expensive technological medicine continues to grow and stretch the health budgets of modern society, this new area is providing an important counterbalance and reminder of the value of a caring therapeutic relationship and simple lifestyle and support measures (p. 1233).

M. D. Gilbert (2003) comments about holism in the following way:

In the past century, the medical profession has taken pride in the rapid and often effective advancement of diagnostic technology, surgical interventions, and pharmaceutical remedies. However, it has also witnessed the unraveling of the woven connection among mind, body, and the human soul (p. 563).

Somehow, illnesses like CFS and Chronic Pain, which defy readily accessible Western medical classification and treatment, may be part of a movement which brings humankind back to wholeness. K. P. White (2000) stated (in literature review) that more and more people are turning to CAM's because of discouragement with the piecemeal approach to health in conventional Western medicine. This desire for holism is reflected in the multidimensional way in which Chronic Pain is now being viewed; as a phenomena encompassing physiological, emotional, psychological, socio-political, existential, and spiritual processes (adapted from Bullington, Nordemar, R., Nordemar, K., Sjostran-Flanagan, 2003, p. 325). In this example, mind and body are seen to be responding within the context of all the above spheres of life.

At the Victoria Pain Clinic, participants focused many hours per day on their bodies through stretching exercises, progressive and autogenic relaxations, bodywork sessions, acupuncture, biofeedback, etc. Interestingly, this level of attunement to one's body also seemed to help participants enter into levels of consciousness where body and mind are one, and consciousness becomes the fertile soil from which illumined awarenesses can germinate, sprout, and flourish.

The philosophy of holism in medicine and psychology has birthed new treatment approaches which honour human experience and health as being a product of many forces, with the human being as the central organizer of his/her unitary holistic experience. Shimura, Nagata, Hatakeyanu, Nishiyanu & Sugiura (2003), in an abstract of an article written in Japanese entitled, *The medicine of nurturing life energy – health creation and self organization*, refer to the vital role we all play in creating happy lives by accessing, working with, and organizing, dynamic life energy itself.

Limitations of this Research Study

1. Firstly, because the Victoria Pain Clinic provides such a unique and specialized program, it would be very difficult to replicate this study in another setting.
2. Secondly, the program at the Victoria Pain Clinic is expensive, and if a person with Chronic Pain or CFS is not insured, or cannot carry the costs, he/she cannot benefit from the service. In other words, just how available is this treatment program for people in Chronic Pain and with CFS?
3. In order to collect detailed data, the researcher was also a program participant. This meant many hours of involvement in the program phase of this work, in

addition to all the other phases. The time necessary for, and desire to immerse in such a program may not be possible or desirable for other researchers.

4. The findings indicate that the participants in this program were engaged in a process by which they were able to undergo transformation in relation to their pain and fatigue. Their healing processes were highly individual. Components of the recovery process cannot be easily *dissected* to fit a quantitative model, whereby particular treatment components are isolated as beneficial (or not) for recovery. The participant needs to be looked at as a whole being. This raises many questions in terms of needs for research funding outside of the *mainstream* treatment-evaluative models.
5. Because the Victoria Pain Clinic operates with highly experienced practitioners, practitioners are willing to go with participants into some very emotionally charged places of consciousness. A great amount of care and experience is necessary for this kind of work to be safe for clients. Therefore, this type of study should only be undertaken if professionals, well trained in body psychotherapy and safe emotional release work, are involved with participants in the study. There is a great deal of training required for psychotherapists, and doctors to be successful with this type of therapy, and short cuts to this learning are not ethically acceptable.
6. Although these participants provided conscientiously documented transformations in their Chronic Pain and CFS, there has not been a follow up qualitative study to determine whether the changes have been lasting, or not. Certainly a longitudinal study which follows participants at 6 months post-program, 1 year post-program,

2 years, 3 years, etc., would be useful to determine whether participants were continuing with the practices they learned at the program as they intended, and what the effects were.

7. It is also unknown whether participants are, in fact, able to remember, and apply the tools and concepts from the Victoria Pain Clinic into their futures. Are they strong enough, and equipped enough to carry forward what they have learned? If not, why not? What can we learn from this?

Suggestions for Future Research

1. Another study like this one could be done at the Victoria Pain Clinic which also included follow up with participants, as aforementioned, to assess long term effects.
2. A questionnaire could go out to participants from this study to assess how they are at this time (2-3 years post program). The questionnaire could be participant specific, based on issues from the transcripts, transformation stories, and also designed to give general participant feedback as regards gains from the program. There could be blank areas to fill in regarding on-going strengths, as well as challenges encountered by participants post-program.
3. Future research studies which incorporate the idea of a patient's own knowingness as valuable are critical to studies about CFS and Chronic Pain. Because answers are not readily available in terms of diagnosis, and treatment for these illnesses, studying ways that patients can develop, and use their own knowingness for healing themselves can be very useful. This also involves a paradigm shift from physician as expert; to a more collaborative process whereby

the expertise of the practitioner is combined with the expertise of the client to bring greatest illumination to any given health question.

4. The concepts in this study open the door to further investigations of the mind-body connection in health, particularly as regards the value of one's body connection in terms of understanding (informing) a person re: healing of disease. Further studies could investigate how communication with one's body, and interpretation of body messages, can inform sound health practices. If we do, in fact, have signals from our body which are there to point in the direction of balance and health, what methods are there for restoring one's ability to sense and hear these messages, and interpret them in healthy ways?
5. I think that further studies which combine acupuncture with psychotherapy would be useful in terms of evaluating this combination's effectiveness in reduction of both Chronic Pain, and Chronic Fatigue Syndrome.
6. Further studies by practitioners of energy medicine(s) would be very useful to help other practitioners who are working with people with CFS and Chronic Pain gain understanding of the best ways of utilizing this dimension.
7. The role of counselling which explores the lived worlds of people with CFS and Chronic Pain with the intention of transforming, and healing of these illnesses would be useful to explore in future studies. Elements of the therapy model, described in the Clinical Implications section, can be studied to determine the model's efficacy in helping clients recover from CFS and Chronic Pain.

8. Studies which explore the relationship between emotional release, pain, and fatigue levels would be useful to conduct. What happens physiologically when traumas or emotional energies are released in terms of pain/fatigue levels?

Conclusion

My interest in this study was sparked by wanting to understand how people who were chronically ill with Chronic Pain, or Chronic Fatigue Syndrome, who were depressed and *down* (both in affect and physically) at the start of the Victoria Pain Program, could, in fact, appear relaxed, whole, happy and positive, at the end of 10 days. I wanted to delineate what this process for change was on an individual basis, and to use some of the collective realizations to inform counselling practice and help sufferers. I believe the findings of this study, and the participants' stories themselves, can be rich sources of information, and inspiration, on the path of healing Chronic Pain and Chronic Fatigue Syndrome.

Future studies which engage, and value, a process of *Patient Knowingness*, and successfully respect and combine Energy medicine, Psychotherapy, Western Medicine, and Complementary Alternative Therapies, should prove fruitful in continuing to uncover important concepts to provide direction for recovery from Chronic Fatigue Syndrome, and Chronic Pain.

References

- *References marked with an asterisk indicate studies included in a meta-analysis edited by Fishbain, 2000.
- Albrecht, F., & Wallace, M. (1998). Detecting chronic fatigue syndrome: The role of counselors. *Journal of Counseling & Development, 76*, 183-189.
- Antoni, M. H., Brickman, A., Lutgendorf, S., Klimas, N., Imia-Fins, A., & Ironson, G., et al. (1994). Psychosocial correlates of illness burden in chronic fatigue syndrome. *Clinical Infectious Diseases, 18*, (Suppl 1), S 73-S 78.
- *Aronoff, G. M., Evans, W. O., & Enders, P. L. (1982). A review of follow-up studies of multidisciplinary pain units. *Pain, 16*, 1-11.
- *Aronoff, G. M., McAlary, P. W., Witkower, A., & Berdell, M. S. (1988). Pain treatment programs: Do they return workers to the workplace? *Occupational Medicine, 3*, 123-136.
- Ashworth, P. D., Giorgi, A., & deKoning, A. (1996). *Qualitative Research in Psychology*, Pittsburgh, PA: Duquesne University Press
- Baron, R. J. (1981). Bridging clinical distance: An empathic rediscovery of the known. *Journal of Medical Philosophy, Feb 6* (1), 5-23. Abstract retrieved February 1, 2004, from PubMed database.
- Baron, R. J. (1985). An introduction to medical phenomenology: I can't hear you while I'm listening. *Annals of Internal Medicine, Oct, 103*(4) 606-11. Abstract retrieved February 1, 2004, from PubMed database.
- Beaulieu, M. C. (1995). *Meanings of chronic fatigue syndrome to friends and families of sufferers*. Paper presented at the American Sociological Association .
- *Bendix, T., Bendix, A. F., Bush, E., & Jordan, A. (1996). Functional restoration in chronic low back pain. *Scandinavian Journal of Medical Science in Sports, 6*, 88-97.
- Birch, S., & Hammerschlag, R. (1996). *Acupuncture efficacy: A Compendium of controlled clinical studies*. Terrytown, NY: National Academy of Acupuncture and Oriental Medicine.
- Blondel-Hill, E., & Shafran, S. D. (1993). Treatment of the chronic fatigue syndrome. A review and practical guide. *Drugs, 46*, 639-651.

- Briggs, N. D., & Levine, P. H. (1994). A comparative review of systemic and neurological symptomatology in 12 outbreaks collectively described as chronic fatigue syndrome, epidemic neuromyasthenia and myalgic encephalomyelitis. *Clinical Infectious Diseases*, 18, Suppl. 1, S 32-S 42.
- Bullington, J., Nordemar, R., Nordemar, K., & Sjostrom-Flanagan, C. (2003). Meaning out of chaos: A way to *understand Chronic Pain*. *Scandinavian Journal of Caring Sciences*, 17(4), 325-331.
- Burke, S. (1992). Chronic fatigue syndrome: Can therapy help? *Social Work*, 37(1), 35-39.
- Butterbaugh, L. (1995). [Review of the book *The Fatigue Artist*]. *Off Our Backs*. xxv, Oct (9)17. Retrieved January 26, 2004, Contemporary Women's Issues database.
- Chaitow, L. (1998). Fibromyalgia: osteopathic-naturopathic approach. *Journal of Bodywork and Movement Therapies*, 2(4), 195-199.
- Chubb, H. L., Jones, I., Hillier, J., Moyle, C., Sadler, S., & Cole, T., et al. (1999). Chronic fatigue syndrome: Personality and attributional styles of patients in comparison to healthy controls and depressed individuals. *Journal of Mental Health-U.K.*, Aug., 8(4), 351-359.
- Cohn, S. (1999). Taking time to smell the roses: Accounts of people with chronic fatigue syndrome and their struggle with legitimization. *Anthropology & Medicine*, 6(2), 195-216.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.
- David, A. S., Wessely, S., & Pelosi, A. J. (1991). Chronic fatigue syndrome: Signs of a new approach. *British Journal of Hospital Medicine*, 45, 158-163.
- Deale, A., Chalder T., Marks, I., & Wessely, S. (1997). Cognitive behavior therapy for chronic fatigue syndrome: A randomized controlled trial. *American Journal of Psychiatry*, 154, 408-414.
- Deale, A., Chalder, T., & Wessely, S. (1998). Illness beliefs and treatment outcome in chronic fatigue syndrome. *Journal of Psychosomatic Research*, 45(1), 77-83.
- Douglass, B., & Moustakas, C. (1985). Heuristic inquiry: The internal search to know. *Journal of Humanistic Psychology*, 25(3), 39-55.
- Ely, M., Vinz, R., Downing, M., & Anzul, M. (1997). *On writing qualitative research: Living by words*. Washington, DC: The Falmer Press.

- Erdman, K. (2003). A review of treatment options for chronic fatigue syndrome. *Physician Assistant, 27*(5), 16-28. Retrieved February 26, 2004, from Health Source: Nursing/Academic Edition database.
- *Fishbain, D. A., Cutler, R. B., Rosomoff, H. L., & Steele-Rosomoff, R. (1999). Pain facility treatment outcome for failed back surgery syndrome. *Current review of Pain, 3*(1), 10-17.
- Fishbain, D. (Ed.). (2000). Meta-Analysis: Non-surgical Chronic Pain treatment outcome: A review. *International Review of Psychiatry, 12*(2), 170-181. Retrieved February 7, 2004, from PubMed database.
- Folkman, S., & Lazarus, R. (1980). An analysis of coping in a middle aged community sample. *Journal of Health and Social Behaviour, 21*, 219-239.
- Friedberg, F. (1995). *Coping with chronic fatigue syndrome: Nine things you can do*. Oakland, CA: New Harbinger.
- Friedberg, F. (1996). Chronic fatigue syndrome: A New application. *Professional Psychology: Research and Practice, 27*(5) 487-494. Retrieved January 2, 2004, from PsycARTICLES database.
- Freidberg, F., & Jason, L. (1998). *Understanding chronic fatigue syndrome*. Washington, DC: American Psychological Association.
- Gilbert, M. D. (2003). Weaving medicine back together: Mind-body medicine in the twenty-first century. *Journal of Alternative Complementary Medicine, Aug, 9*(4), 563-70. Abstract retrieved February 2, 2004, from PubMed database.
- Giorgi, A., Knowles, R. & Smith, D. L. (Eds.). (1979). *Duquesne studies in phenomenological psychology (Vol. 3)*. Pittsburgh: Duquesne University Press.
- Goodnick, P. J., & Jorge, C. M. (1999). Treatment of chronic fatigue syndrome with nefazadone. *American Journal of Psychology, May, 156*(5), 797-798.
- Greenwood, M. T. (1999). Acupuncture and intention: Needling without needles. *Medical Acupuncture, Spring/Summer, 17*(L1), 17-23.
- Greer, S. (2003). Healing the mind/body split: Bringing the patient back into oncology. *Integrated Cancer Therapies, Mar, 2*(1), 5-12. Retrieved February 2, 2004, from PubMed database.
- Guizhen, L., Yunjun, Z., Linxiang, G., & Aizhen, L. (1998). Comparative study of acupuncture combined with behavioral desensitization for treatment of anxiety neuroses. *American Journal of Acupuncture, 26* (2/3), 117-120.

- Heijmans, M. J. W. M. (1998). Coping and adaptive outcome in chronic fatigue syndrome: Importance of illness cognitions. *Journal of Psychosomatic Research*, Vol. 45(1), 39-51.
- Henriksson, C. M. (1995). Living with continuous muscular pain: Patient perspectives. Part I: Encounters and consequences. *Journal of Caring Sciences*, 9(2), 67-76.
- Hickie, I. (1999). Nefazadone for patients with chronic fatigue syndrome. *Australian and New Zealand Journal of Psychiatry*, Apr. 33(2), 278-280.
- Howe, K., & Eisenhart, M. (1990). Standards for qualitative (and quantitative) research: A prolegomenon. *Educational Researcher*, 19(4), 2-9.
- Hyden, L. C., & Sacks, L. (1998). Suffering, hope and diagnosis: On the negotiation of chronic fatigue syndrome. *Health*. Abstract retrieved March 12, 2000, Academic Search Elite (EBSCO Host) database.
- Jason, L. A., Jordan, K. M., & Richman, J. A. (1999). A community-based study of prolonged fatigue and chronic fatigue. *Journal of Health Psychology*, Vol 4(1), 9-26.
- Jason, L. A., King, C. P., Frankenberry, E. L., Jordan, K. M., Tryon-Warren, W., & Rademaker, F., et al. (1999). Chronic fatigue syndrome: Assessing symptoms and activity level. *Journal of Clinical Psychology*, Apr, 55(4) 411-424.
- Johnson, H. (1995). Osler's web. *Inside the labyrinth of chronic fatigue syndrome epidemic*. New York: Crown.
- Kantrowitz, F., Farrar, D. J., & Locke, S. E. (1995). Chronic fatigue syndrome: Treatment and future research. *Behavioral Medicine*, 21(1) 17-24.
- *Koes, B. W., Assendelft, W. J. J., & Geert, J. M. G. (1996). Spinal manipulation for low back pain: An updated systematic review of randomized clinical trials. *Spine*, 21, 2860-2873.
- Lanza, V. (1986). The contribution of acupuncture to clinical psychotherapy by means of biofeedback training. *International Journal of Acupuncture and Electro-Therapeutics Research*, 11(1), 53-57.
- *Large, R., & Peters, J. (1991). A critical appraisal of outcome of multidisciplinary pain clinic treatments. In: M. R. Bond, J. E. Charlton & C. J. Woolf (Eds.), *Proceedings of the VIth World Congress on Pain*, 1417-1425. Amsterdam: Elsevier.
- Lawrie, S. M., & Pelosi, A. J. (1995). Chronic fatigue syndrome in the community: Prevalence and associations. *British Journal of Psychiatry*, 166, 793-797.

- Levine, P. A. (1997). *Waking the Tiger: Healing trauma: The innate capacity to transform overwhelming experiences*. Berkeley, CA: North Atlantic Books.
- Lewis, S., Cooper, C. L., & Bennett, D. (1999). Psychosocial factors and chronic fatigue syndrome. *Psychological Medicine*, *24*, 661-671.
- Lingiardi, V., & Grieco, A. (1999). Hermeneutics and the philosophy of medicine. Hans-Georg Gadamer's platonic metaphor. *Theoretical Medical Bioethics*. *Sept*, *20*(5), 413-22. Abstract retrieved February 2, 2004, from PubMed database.
- Loeser, J. D., & Melzack, R. (1999). Pain: An overview. *The Lancet*, *Vol 353*, Issue 9164, 8 May, 1607-1609. Retrieved February 1, 2004, from Science Direct database.
- Lowen, A. (1975). *Bioenergetics*, New York: Penguin Books.
- Lyall, M., Peakmann, M., & Wessely, S. (2003). A systematic review and critical evaluation of the immunology of chronic fatigue syndrome. *Journal of Psychosomatic Research*, *55*(2), 79-90.
- Malterud, K. (1993). Strategies for empowering women's voices in the medical culture. *Health Care Women International*, *July-Aug*; *14*(4), 365-73. Abstract retrieved February 1, 2004, from PubMed database.
- Malterud, K. (2000). Symptoms as a source of medical knowledge: Understanding medically unexplained disorders in women. *Family Medicine*, *Oct*; *32*(9), 603-11. Abstract retrieved February 1, 2004, from PubMed database.
- McCaffery, M., & Ferrell, B. R. (1997). Nurses' knowledge of pain assessment and management: How much progress have we made? *Journal of Pain and Symptom Management*, *14*(3), 175-188. Abstract retrieved February 17, 2004, from Science Direct (Elsevier) database.
- Melamed, B. G. (1998). Unrecognized illness: Who suffers? What can be done? In F. Friedberg, F. & L. Jason, *Understanding chronic fatigue syndrome*, (pp.vii-xii). Washington, DC: American Psychological Association.
- Melzack, R., & Wall, P. D. (1965). Pain mechanisms: A new theory. *Science* *150*, 971-979. Abstract retrieved February 1, 2004, from Science Direct (Elsevier) database.
- More, E. S. (1996). Empathy as a hermeneutic practice. *Theoretical Medicine*, *Sep*; *17*(3), 243-54. Abstract retrieved February 1, 2004 from PubMed database.

- Moss-Morris, R., & Chalder, T. (2003). Illness perceptions and levels of disability in patients with chronic fatigue syndrome and rheumatoid arthritis. *Journal of Psychosomatic Research*, 55(4), 305-308.
- Moustakas, C. M. (1990). *Heuristic research: Design, methodology and applications*. Newbury Park, CA: Sage Publications.
- Moustakas, C. M. (1994). *Phenomenological research methods*. London: Thousand Oaks.
- Natelson, B. H., Denny, T., Zhou, X. D., La Manca, J., Ottenweller, J., & Tiersky, L., et al. (1999). Is depression associated with immune activation? *Journal of affective disorders*, 53(2), 179-184.
- Nordenfelt, L. (1995). On chronic illness and quality of life: A conceptual framework. *Health Care Analysis*, Nov, 3(4) 290-8. Abstract retrieved February 1, 2004, from PubMed database.
- Osborne, J. W. (1994). Some similarities and differences among phenomenological and other methods of psychological qualitative research. *Canadian Psychology* 35(2), 167-189.
- Patton, M. (1980). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage Publications.
- Perls, F. (1988). *Gestalt therapy verbatim*. Highland, NY: Center for Gestalt Development.
- Petrie, T. A., Austin, L. J., Cowley, B. J., & Helmcap, A. (1996). Sociocultural expectations of attractiveness for males. *Sex Roles*, Nov, 35, 9-10, 581-602.
- Pincus, T., & Morley, S. (2001). Cognitive-processing bias in Chronic Pain: A review and integration. *Psychological Bulletin*, 127(5), 599-617.
- Pollard, E. (Ed). (1994). *Oxford paperback dictionary*. New York: Oxford University Press.
- Poppe, C., Devulder, J., Mariman, A., & Mortier, E. (2003). Chronic pain therapy: An evolution from solo-interventions to a holistic interdisciplinary patient approach. *Acta Clin Belg*, 58(2), 92-97. Abstract retrieved February 2, 2004, from PubMed database.
- Reber, A. S. (Ed.). (1995). *Dictionary of psychology*, (6th ed.), New York: Penguin Group.

- Reid, S., Chalder, T., Cleare, A., Hotopf, M., & Wessely, S. (2000). Clinical review: Extracts from chronic fatigue syndrome clinical evidence. *British Medical Journal*, 320, 292-296.
- *Rosomoff, H. L. & Steele-Rosomoff, R. (1991). Comprehensive multidisciplinary pain center approach to the treatment of low back pain. *Neurosurgical Clinics of North America*, 2, 877-890.
- Schaefer, K. M. (1995). Struggling to maintain balance: A study of women living with fibromyalgia. *Journal of Advanced Nursing*, 21, 95-102.
- Schaefer, K. M. (1997). Health patterns of women with fibromyalgia. *Journal of Advanced nursing*, 26, 565-571.
- Schwartz, R. C. (1995). *Internal family systems*. New York: Guilford Press.
- Scott, L. V., & Dinan, T. G. (1999). The neuroendocrinology of chronic fatigue syndrome: Focus on the hypothalamic-pituitary-adrenal axis. *Functional Neurology: New Trends in Adaptive & Behavioral Disorders*, Jan-Mar, 14, 3-11.
- Scott, L.V., Teh, J., Resnek, R., Martin, A., Sohaib, A., & Dinan, T. G. (1999). Small adrenal glands in chronic fatigue syndrome: A preliminary computer tomography study. *Psychoneuroendocrinology*, Oct, 29(7), 759-768.
- Sharpe, M. A., Hawton, K., Simkin, S., Surawy, C., Hackmann, A., & Klimas, I. (1996). Cognitive behavior therapy for the chronic fatigue syndrome: A randomized controlled trial. *British Medical Journal*, 312, 22-26.
- Sharpe, M. A. (1997). Cognitive behavior therapy for functional somatic complaints. The example of chronic fatigue syndrome. *Psychosomatics*, 38, 356-362.
- Shimura, N., Nagata, K., Hatakeyama T., Nishiyama Y., & Sugiura, T. (2003). The medicine of nurturing life energy – health creation and self-organization. *Seishin Shinkeigaku Zasshi*, 105(4), 448-58. Abstract retrieved March 2, 2004 from PubMed database.
- Sommer, S. J. (1996). Mind-body medicine and holistic approaches: The scientific evidence. *Australian Family Physician*, Aug. 25(8), 1233-7, 1240-1, 1244. Abstract retrieved February 3, 2004, from PubMed database.
- Steele, L., Dobbins, J. G., Fukuda, K., Reyes, M., Randall, B., & Koppelman, M. (1998). The epidemiology of chronic fatigue in San Francisco. *American Journal of Medicine*, 105, (Suppl. 3A), 83-90.

- Steen, E., & Haugli, L. (2000). Generalized chronic musculoskeletal pain as a rational reaction to a life situation? *Theoretical Medical Bioethics*, *Nov*, 21(6), 581-99. Abstract retrieved February 1, 2004, from PubMed database.
- Straus, S. E., McKenzie, R., & Demitrack, M. A. (1999). Low dose hydrocortisone for treatment of chronic fatigue syndrome. *Journal of the American Medical Association*, (May), 281(20), 1888-1889.
- Thomas, C. L. (Ed.). (1980). *Taber's cyclopedic medical dictionary*. Philadelphia: Davis.
- Urdang, L. (Ed.). (1997). *The Oxford thesaurus* (2nd Ed.). New York: Oxford.
- Vercoulen, J. H., Swanink, C., Zitman, F., Vreden, G., & Hoofs, M. (1996). Randomized, double-blind, placebo-controlled study of fluoxetine in chronic fatigue syndrome. *The Lancet*, 347, 858-862.
- *Verhaak, P. F. M., Kerssens, J. J., Dekker, J., Sorbi, M. J., & Bensing, J. M. (1998). Prevalence of chronic benign disorder among adults: A review of the literature. *Pain*, 77, 231-239.
- Ware, N. C. (1999). Toward a model of social course in chronic illness: The example of chronic fatigue syndrome. *Culture, Medicine, Psychiatry*, Sep, 23(3), 303-331.
- Weiner, R. S. (1991). Team approach to pain relief. *Accent on Living*, 35(4), 79-81. Retrieved January 14, 2004, from Health Source: Nursing/Academic Edition database.
- *Wells, J. C. D. & Miles, J. B. (1991). Pain clinics and pain clinic treatment. *British Medical Bulletin*, 47, 762-785.
- Wessely, S., Chalder, T., Hirsch, S., Wallace, P., & Wright, D. (1997). The prevalence and morbidity of chronic fatigue syndrome: A prospective primary care study. *American Journal of Public Health*, 87, 1449-1445.
- Wessely, S., Hotopf, M., & Sharpe, M. (1998). *Chronic fatigue and its syndromes*. New York: Oxford University Press.
- White, K. P. (2000). Psychology and complementary and alternative medicine. *Professional Psychology Research and Practice*, 31(6), 671-681.
- *White, K. P., & Harth, M. (1996). An analytic review of 24 controlled clinical trials for fibromyalgia syndrome (FMS). *Pain*, 64, 211-219.
- Whitford, G. (1995). Putting together the pieces. *Herizons*, 9(5), 19-21. Retrieved January 26, 2004, from Contemporary Women's Issues database.

Yin, R. K. (1994). *Case study research: Design and methods*. Thousand Oaks, CA: Sage Publications.

Appendix A: Participant Recruitment Letter

Dear Pain Program Participant,

My name is Amy Lariviere and I am a graduate student in Counselling Psychology at the University of Victoria. I am conducting research about the relationship between people's experiences during the Victoria Pain Program and their understanding of chronic illness (e.g. Chronic Pain, chronic fatigue syndrome, fibromyalgia). This research is important because it will help validate the contribution that patients can make toward understanding their own illnesses and moving toward recovery.

I will be interviewing people from the next program at the Pain Clinic. If you choose to participate, your participation will include a brief interview (approximately 30 – 45 minutes) immediately before the start of the program, and another interview, (approximately one hour) after program completion.

The potential benefits of your participation include: (a) time with the researcher to discuss how you are in relation to Chronic Pain, fatigue/fibromyalgia, before starting the program, as well as (b) further time to “debrief” your experiences at the end of the program. There are no known or anticipated risks to you through participating in this research study. Participation is completely voluntary.

If you are interested in participating, please complete the bottom portion of this sheet and return it to me in the stamped envelope. Upon receipt of your consent, I will contact you to schedule the interviews.

If you have any questions, please contact Amy Lariviere at (250) 727 – 9836 or alariv@uvic.ca. You may also contact Anne Marshall, my University supervisor at (250) 721 – 7815 or amarshal@uvic.ca.

I am interested in participating in the study entitled, “Lived Experiences as they relate to understanding chronic illness.”

Name _____

Address _____

Phone Number _____ Fax _____

E-mail _____

Signature of participant

Appendix B: Participant Consent Form

Consent Form for Participation in the Study Entitled, “Lived Experiences as They Relate to Understanding Chronic Illness.”

Dear Pain Program Participant:

You are being invited to participate in a study entitled, “Lived Experiences as They Relate to Understanding Chronic Illness” that is being conducted by Amy Lariviere. Amy is a graduate counselling student in the Department of Educational Psychology at the University of Victoria. You may contact her if you have further questions by calling 250 727 9836 or by e-mail at alariv@uvic.ca. As a graduate student, this research is part of the requirements for a Master of Arts degree and it is being conducted under the supervision of Dr. Anne Marshall, Ph.D. You may contact Dr. Marshall at 250 727 7815 or by e-mail at amarshal@uvic.ca.

The purpose of this research project is to explore how your realizations, learnings, and awarenesses during the pain program can act as a guide toward understanding your illness.

Research of this type is important because illnesses such as Chronic Fatigue Syndrome, Fibromyalgia, and Chronic Pain often leave sufferers to their own devices in terms of getting well. The study aims at examining what your inner experiences can teach you about healing from chronic illness. The stories you tell, and the connections you make may help others gain understanding of these illnesses, and may also help counselors learn about how they can best facilitate clients’ growth.

You are being asked to participate in this study because as a participant at the Victoria Pain Clinic you will be involved in a process of inner focusing that may help you make connections regarding your illness (pain, fatigue). This process of understanding is valuable to study.

If you agree to voluntarily participate in this research, your participation will include a short interview of approximately 30 to 45 minutes before the 10 day program starts, and another interview of approximately one hour at the very end of the program. The purpose of the first interview will be to understand how you are in relation to pain/fatigue/illness at the start of the program, and to answer any questions you may have about the research. The focus of the second interview will be about your experiences during the program and how they may be contributing to understanding of your Chronic Pain/fatigue/illness.

Although there are no known or anticipated risks to you by participating in this research, the researcher will provide you with referrals to counselling services if requested. The potential benefits of your participation in this research include private time with the researcher before, and after, the Pain Program where you can discuss how you are, and explore your experience(s) of the Pain Program.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time, or refuse to answer certain questions without any consequences or explanation. In the event that you do withdraw from the study, your tape(s) will be erased, and any transcript(s) destroyed.

In terms of protecting your anonymity, your name will not be recorded on the transcribed data, on the interview tapes, or in the reports of the research results. A code number, or pseudonym will be assigned and used in place of your name. The key to the coded names will be kept separately from the interview data. Signed consent letters will also be stored separately from any data.

Your confidentiality and the confidentiality of the data will be protected by storing interview audiotapes and the transcribed data in a locked filing cabinet. Only the researcher will have access to the data. The audio-tapes from your interview, the transcribed data, and any notes taken during the interviews will be destroyed within five years.

After the second interview is completed, your transcripts will be sent to you by mail. I will ask you to review the transcripts for accuracy, make corrections, and add any information you think is important. This will take about 20 minutes.

A final copy of the research report will be given to you upon request. Research findings may be communicated anonymously in the form of lectures and workshops by the researcher to other sufferers of Chronic Fatigue Syndrome, Fibromyalgia, Chronic Pain and/or to counsellors working in the field. The results of this study may also be published in peer-review journals and presented at professional conferences.

In addition to being able to contact the researcher and the supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice President of Research at the University of Victoria 250 721 7968.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

PARTICIPANT SIGNATURE _____ DATE _____

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix C: Interview Protocols

Participant Pre-Program

1. Tell me about yourself (age, living circumstances, family situation, job/career).
2. Tell me about your history with chronic illness.
3. Why did you come to the Pain Clinic?
4. What do you hope for from the Pain Program?

Participant Post-Program

1. Can you describe your overall experience of the Pain Program.
2. Were there any particular insights or valuable experiences?
3. How did you arrive at them? What was the process?
4. (Questions were posed that were specific to each individual based on themes from pre-program interviews)
5. Has your recovery been helped?
6. What will you take into the future from what you've learned?
7. Anything additional to add?

Practitioner Interview Protocol

1. Set rapport and discuss what it is like for the interviewee; (the experience of being a practitioner at the Victoria Pain Clinic).
2. Please tell me a bit about your background in the field.

3. Please tell me about your philosophy, and vision for healing Chronic Pain/CFS.
4. Please explain your particular specialty as part of the overall Pain Program.
5. Questions to the Program Director regarding history, philosophy, and structure of the Victoria Pain Clinic.

Appendix D: The Victoria Pain Clinic

The Victoria Pain Clinic is a proven residential treatment centre serving clients who suffer from Chronic Pain and/or chronic stress. It is most suited for those who have not responded well to conventional therapy or wish to explore an alternative to drugs or surgery. A large portion of our clients have had accidents or surgery and are still in pain after the normal healing period has elapsed (more than 3 - 6 months).

Background and Philosophy

The origins of the Victoria Pain Clinic go back to 1980 when it operated solely as an outpatient facility. As the clinic encountered more severe cases over time, the need arose for more intensive forms of treatment, and in 1985, residential accommodations were added. The addition of a residential program allowed the clinic to provide more in depth therapies and extend its services to people over a much broader geographical area. Since 1980, over 4,000 clients from Canada, the U.S., Europe and Asia have been helped.

We strongly believe that recovery from Chronic Pain/stress must come from within our clients; it is not something that therapists can do for them. Our therapists are teachers who help the client create his or her own recovery process. Specifically, our philosophy is based on:

1. the importance of the client assuming full responsibility for their own health and recovery process;
2. treatment of the whole individual - mind, body, and spirit; and,
3. an emphasis on natural healing processes rather than reliance on drugs and external aids.

We do not emphasize any particular therapy or treatment theory. We provide a wide range of therapies around which the client can build a personal healing process.

The following are the therapies offered or available in our Residential Programs. Please keep in mind that the experience clients have with these therapies in a residential, group, multidisciplinary setting are often very different than what is usually experienced in an outpatient setting.

Individual Therapies

- *Stretch and Spray* is a hands on physical therapy to help clients achieve a relaxation and stretch of muscles beyond that which they are able to do on their own. A vapocoolant (Fluori-Methane, feels cold) is sprayed on the skin over the affected muscle. The therapist then gently helps the client stretch the muscle. After the stretch the area is covered with a moist heat pad. The therapy was

developed by Drs. Janet Travell and D. G. Simons and is well documented in *Myofascial Pain and Dysfunction: The Trigger Point Manual*.

- Individual Counselling is well understood. As practised at the Clinic it is integrated with breathing and can be integrated with bodywork.
- *Biofeedback* is the use of instrumentation to mirror psychophysiological processes of which the individual is not normally aware and which may be brought under voluntary control. This means giving a person immediate information about their own biological conditions, such as: muscle tension, skin surface temperature, brain wave activity, galvanic skin response, blood rate and heart rate. This feedback enables the individual to become an active participant in the process of health maintenance.
- *Acupuncture*, as practised in the residential Programs at the Victoria Pain Clinic, is in the style of Traditional Acupuncture. Traditional Acupuncture originated in China about 5,000 years ago and only recently is it becoming well understood in North America. Following an examination and diagnosis, acupuncture points are treated with some combination of heat, needles, and pressure. The focus is to restore the body's natural balance and energy flow.
- *Hellerwork* is a form of structural body-work designed for the purpose of realigning and rebalancing the body. The work was founded by Joseph Heller in the USA in 1978 and involves a form of deep tissue hands on therapy that helps the client release chronic tension and stress and produce a more relaxed youthful state.

Other individual therapies that may be included are hydrotherapy, *craniosacral therapy*, massage, integrated body psychotherapy (IBP), *Therapeutic Touch*, and *Myofascial Release Treatment*.

Group Therapies:

- Stretching Exercise (yoga based)
- Relaxation Class (autogenic training, progressive muscle relaxation, guided imagery, and visualization)
- Lecture/demonstration topics include: stress-pain cycle, message of pain, posture and movement, personal stress patterns, musculo-skeletal armouring, acupressure, art therapy, secondary gain, mind-body interaction, etc.
- Plus a great deal of informal discussion with the staff and the other clients.

Ten Day Residential Program Schedule

Group activity:

8:30 - 9:00 Stretching exercise (yoga based)

9:00 - 9:30 Relaxation (autogenic and progressive muscle)

*Individual therapy: **

9:30 - 10:30 Deep Muscle Work/Hellerwork

10:30 - 11:30 Biofeedback/relaxation/posture

11:30 - 12:30 Stretch and Spray

12:30 - 1:30 Lunch

1:30 - 2:30 Acupuncture

Group activity:

2:30 - 3:30 Lecture/demonstration (stress-pain cycle, message of pain, posture and movement, personal stress patterns, musculoskeletal armouring, acupressure, secondary gain, mind-body interaction)

3:30 - 4:00 Stretching (same as 8:30)

4:00 - 4:30 Relaxation (same as 9:00)

4:30 - 6:30 Dinner

6:30 - 8:45 Evening Discussion (introduction, self responsibility, structural vs. non-structural causes of pain, art therapy, communications, visualization, relationships, functional and dysfunctional attitudes, self talk, self esteem)

* sample day, other days would have counselling in lieu of one of these therapies.

(adapted from the Victoria Pain Clinic website: <http://www.vicpain.com>)

Appendix E: Classification of Pain Facilities

Modality-oriented clinic

Provides specific type of treatment, e.g. nerve blocks, transcutaneous nerve stimulation, acupuncture, biofeedback

May have one or more health care disciplines

Does not provide an integrated, comprehensive approach

Pain Clinic

Focuses on the diagnosis and management of patients with Chronic Pain or may

Specialize in specific diagnoses or pain related to a specific region of the body

Does not provide comprehensive assessment or treatment

Institution offering appropriate consultative and therapeutic services would qualify but never an isolated solo practitioner

Multi-disciplinary pain clinic

Specializes in the multi-disciplinary diagnosis and management of patients with Chronic Pain or may specialize in specific diagnoses or pain related to a specific region of the body

Staffed by physicians of different specialties and other health care providers

Differs from a multi-disciplinary pain center only because it does not include research and teaching

Multi-disciplinary pain center

Organization of health care professionals and basic scientists that includes research, teaching, and patient care in acute and Chronic Pain

Typically a component of a medical school or a teaching hospital

Clinical programs supervised by an appropriately trained and licensed director

Staffed by a minimum of physician, psychologist, occupational therapist, physical therapist, and registered nurse

Services provided integrated and based on interdisciplinary assessment and management

Offers both inpatient and outpatient program

(Adapted from Loeser, as cited in Fishbain, 2000).