

THE POWER WITHIN ILLNESS

Uncovering The Essence of Transformation Through The Experience Of Illness

by

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ABSTRACT

Research in the field of mind/body/spirit/mental connection is extensive. However very few studies have focused on the persons who have survived a life-threatening critical illness and the way in which they redefine beliefs, values and their world view. Recognition of the transformation that occurs following such a crisis is an important contribution toward understanding all facets of the connectedness that exists between our mind, our body, our spirit, our mental/emotional state and healing. This study will consider the question "What kind of transformation occurs for some who experience critical illness?"

Transformation means starting with one thing and ending up with another. This study reveals the inner world of eight participants (co-searchers) who experienced a medical crisis and found their inner world transformed. A clear view of the road taken by the participants is elucidated following a heuristic path requiring the researcher to interview to the point of saturation. The criterion for a heuristic study has been met.

Relevant literature pertaining to the changing worldview of professionals working within the area of wellness from Grecian times to the present is considered. Some qualitative methods available to researchers are explored.

This study can contribute to modification and/or expansion of existing health care programs to include the person in the situation. Credible evidence is presented to support the importance of acknowledging the positive aspects within illnesses that can be offered within a variety of health related disciplines: psychology, counseling, nursing, and religious studies, social work and health care providers.

The nature of heuristic research is to merge the participants and the investigator. The co-searchers and the investigator reveal their understanding of those things that existed only in an innate dimension prior to illness. As a result of their experience, the researcher and the co-searchers present a rich plethora of changed perspectives they identify as transformative revealing the power illness offers us to reevaluate our personal actions impacting those around us as our worldview expands. This study is not meant to query who lives and who dies, for death ultimately claims us all.

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My greatest debt of gratitude is to the participants in my study who shared their painful memories and their greatest joys to uncover the essence of their transformation that others would find hope and knowledge.

DEDICATION

I dedicate this volume of work to my eight granddaughters, Rebecca, Shannon, Gabrielle, Chelsea, Madeline, Mariah, Julianna Faith and Sandra. The words we have sung together so often will now have greater meaning:

Woman I Am. Spirit I Am.
I Am The Infinite Within My Soul.
I Have No Beginning And I Have No End.
All This I Am.

To my grandsons Aaron Stuart and Little Quinn, that they may see what can come from dedication to a Grande Passion.

To my great granddaughter Bailey and my great grandsons Christian And Daniel, that they may know all things can be believed into being, and to my dear and constant friends, Steve and Anne who never faltered in their belief in me.

CHAPTER 1

Introduction

When I was a child I was to be quiet, stay out of the way, and let the adults deal with the requirements of the ill. My mother was cloistered in her bedroom alone most of the time while the caregivers busied themselves with their preparations for her. I watched as windows were closed, blinds drawn, and saw my mother accepting the administrations of others. Her role was to lie quietly and respond to the directions she was given. My child's mind knew they were doing it "all wrong". They were contributing to a sense of helplessness, as though my mother had no involvement or participation in her illness.

I recall quietly entering her room when no one was watching me, opening up the blinds and letting the sun pour across my mother's bed. She opened her eyes with a smile and we spent the best part of an hour enjoying the light, the fresh air, and our laughter. Her eyes lit up and the color rose to her cheeks. She was enjoying herself. This experience stayed with me for a lifetime. My time with her did not change her physical health status but it did contribute to her sense of well being.

I had opportunity to put into practice what I had innately known as a child later in life. I was able to enter many a room bringing light, music and optimism working in a multi-level care facility during my undergraduate degree. Returning from holidays on one occasion, I found

a senior, who had been active and well when I left, lying in a comatose state. Greta was of German descent and was a musician in her younger years. Much of the time I had spent with her was at a piano in the music room. She did not consciously have a memory of music but I had only to place her hands upon the main C chord and the music of her favorite composers would fill the room. Her hands had stored what her mind could no longer remember.

The nurses told me the medical doctor had advised the family there was no hope for Greta's recovery. I requested permission to spend time with her. I took a tape recorder and some polka music to her room. I reminded her of the many happy hours we had spent together at the piano as the music filled the room. Her finger on top of the cover started to keep time to the beat of the music. I put a castanet in her hand; her eyes opened, and she smiled. Within two days she was again out of her bed and eating in the dining room. I saw this transformation and was, in turn, transformed.

She died a few months later and that was several years ago. I have permission, from her family, to show a visual of this amazing woman two days after she arose from her bed.

Greta With The Castanet I Placed in her Hand



While working in Wahta Mohawk Territory, I witnessed a healing that was facilitated by Mohawk Warrior drummers. The Mohawk drummers from Kanasatake, Quebec came to Josephs' home in Ontario to either ease his journey into the next world or contribute to his remaining here. Joseph was expected to die within 24 hours having had a massive stroke some days before he became comatose. After the drummers began to drum, Joseph's eyes opened. He was quite alert and aware. He miraculously recovered. Kalweit (1993) explains that, "Primeval medicine and primal healing methods travel the inner way, in a

quest for wholeness and health beyond the ego.” (p.4).

These healings were of the spirit, not of the body. Things of this nature may be seen as miracles however traditional medicine recognizes the concept of a universal energy. The Indians call this energy “Prana”, the Chinese call it “Chi”, the Japanese call it “Ki”, while others call it Universal Energy, Healing Energy, Life Force energy, etc. Great religious Masters like Jesus, Buddha, and others had healed the sick with their hands or simply with their thoughts (energy) and prayers. Secular healing masters such as Dr. Anton Mesmer healed thousands a day using a form of energy he called “animal magnetism”. This energy sounds mystical and implausible, but perhaps it only sounds this way because science has not yet developed proper tools to measure this energy. One variation of its use has been accepted by the medical realm: acupuncture. Even though conventional medicine still cannot “see” or “measure” this energy flow in acupuncture, the results of such use often are quantifiable. A short discussion of this energy flow is found later in this document connected to the discipline called psychoneuroimmunology.

These experiences and others cited in this paper were the impetus that led me to search for meaning and a sense of connection in a process of growth and transformation occurring as a result of exposure to the crisis of life-threatening illness. Transformation is a word used often in studies connected to the transpersonal domain, but for the

purpose of this study, it is used in the sense of a marked change, as in appearance or character, usually for the better.

Purpose and Rationale of the Study

The spark that lay quietly within me was fanned when my husband was diagnosed with a terminal illness and given a time frame of six months. I was privileged to take the journey with him from diagnosis to death. We experienced an amazing transition to a quality of life that had not previously existed for either of us during the years we had spent together. The prognosis was accurate however we both were transformed as a result of the crisis of illness that impacted our lives. On this journey I discovered an awareness that was previously unknown to me. Something that resided in an innate dimension that precluded my knowing until I allowed it into my consciousness. An expansion of my worldview occurred to include concepts vastly changed from the understanding I had prior to this experience. It was at this point I began to consider an inquiry into the essence of transformation that may occur for those who have transcended (survived) a serious illness. The purpose of this study is to explore that transformation in order that I understand this phenomenon at a deeper level and grow in self-awareness and self-knowledge. I am searching for an essential insight that will "throw a beginning light onto a human experience." (Moustakas, 1990.p.11).

My motivation has been my personal experiences. Illness has been one of the opportunities presented to me to uncover and discover both knowledge and wisdom. As a health care provider I saw medical personnel who applied their medical knowledge excluding the potential of the person who was ill from contributing to their own healing. As a University student I found few courses that opened up any understanding of the inner world of the person who was ill.

Krishnamurti (1956) posits that, "The approach to the problem is more important than the problem itself; the approach shapes the problem, not the end...how you regard the problem is of the greatest importance, because your attitude and prejudices, your fears and hopes will color it (p.99) Illness has the power to set us on a road of discovering new ways to perceive what society has considered as a bad thing. Finding positive ways to view illness creates a different perspective. If we can view disease through a lens that is different than the lens we have been taught to use, this transforms our world view of critical illness and leads to transformation in our lives. This progression in thought is the rationale for the basis of this study. My desire is to identify and/or uncover the essence of transformation through exploration of the roads taken by others who have journeyed through the world of critical illness.

To differentiate between my comments, and the research of others, the co-searchers words have been *italicized*. The actual names of the co-searchers have been replaced with pseudonyms.

Overview Of The Research Procedure

The Context

Doctor's offices and medical centers across North America are offering biofeedback, relaxation techniques and other alternative therapies to individuals who choose to either augment biomedical procedures, or seek other avenues to healing. British Columbia has been progressive in opening centers that support a holistic perspective pertaining to persons diagnosed with cancer. Dr. James Houston collaborated with colleagues to open the first clinic in Victoria, British Columbia, containing practitioners of many alternative therapies as well as medical doctors who support the patient in their individual choice of treatment. The Centre for Integrated Healing is now open in Vancouver providing an integrated approach to healing. The center encourages those that are ill to take control of their own healing and to participate with conventional medical treatment and alternative methods to improve their quality of life.

A crisis such as illness provides an opportunity to evaluate one's own criteria setting aside societal norms previously adhered to. People who have life long values they've lived by as long as they can remember may discover family, teachers, and others they admired instilled these values. An opportunity to explore one's personal and individual value systems is afforded. This opportunity exists, not only for the person who has the illness, but those who are a part of the life that is threatened.

My grandmother lay in a hospital bed. At the age of 99, the medical support staff was treating her in a palliative care manner. Night and day I sat by her side talking to her of our past pleasures, reminding her of the sun on the fall leaves at our cottage, the way her diamonds glittered as she held her hand up to enjoy the spectacle. The Doctor told me I was forcing her to stay when it might very well be her choice to go. I told him she may be ready but I was not yet prepared to face life without her. The deep raspy breathing of death began. Frantic, I looked around me. There was a picture of my daughter's newborn child – a child my grandmother had not seen. I grabbed the picture, held it up in front of her closed eyes and said, "LOOK, Nana LOOK at Lisa's new daughter!!" Her eyes flew open, and a slight smile crossed her face. I have no count of the number of times I used this ploy to hold her until I was ready for her to go.

Maintaining a link to the vital force of life was something I was practicing innately. The physiological factors all pointed to death. A 99-year-old woman lives on; a young vibrant teenager dies. We don't yet understand the complex reasons behind why some people survive and some don't apart from physiological grounds. Whether we are in the role of patient, caring family, physician, or researcher, we are all human beings trying to understand the essence of transformation that occurs after transcending a critical illness. Changes occur, not only for the person in the situation, but also for those that support them. As research

begins to consider individuals, new roads are created to understanding the transformative process.

The co-searchers in this study found themselves in a place of radically reassessing their inner worlds. They discovered an internal richness never appreciated before. They found ways to empower themselves and to reach new realms of consciousness through uncovering their own set of values. They were transformed and others who participated in a support role found themselves in a process of transformation. The present medical prognosis of the co-searchers varies. This study is not meant to query who lives and who dies, for death ultimately claims us all. Healing is always in the present moment. The paradox is that we all have the terminal illness of mortality, so we are all on an upcoming "death as transformation" journey.

The Participants

A poster (see Appendix C) in a general practitioner's office requesting individuals who had transcended a life threatening illness to share transformations in their lives and word of mouth produced the participants in this study. Known as co-searchers, 8 persons between the ages of 32 and 70 shared their experiences from initial diagnosis to what they consider a state of wellness. Each of the interviews took place in the home of the participant at their request. That was where they felt most comfortable.

The metamorphosis that had taken place became more meaningful for the co-searchers as they read the transcription of their own story. Reading the written copy of our exchange and the summary of the data which included information gathered from all co-searchers, brought clarity of vision and a sense of validation to everyone. They were able to revisit and see new strengths and skills they had used in the context of their journey. The importance of both telling and hearing the stories of others in similar circumstances was revealed, substantiating the concept that story-telling has a valuable place in the healing process.

Rationale For Using Qualitative Research

Qualitative methodology involves questions about human lived experiences, and personal contact with individuals in their own environment is made. Descriptive data are generated in a heuristic study that helps us to understand people's experiences. To feel comfortable within a particular method of reporting, I had to take a step back and ask myself, "Who is my research for?"

- Is it for the academic community to have a fuller and more complete understanding of transformation through illness?
- Is it for the medical profession to witness the inner source that works to heal us when we are ill?

- Is it to be a testimony to be read by newly diagnosed victims of a serious and life-threatening illness?
- Is it satisfying my own need to generalize my personal experiences to a wider population?

Perhaps a little of all of the above. Going through this process of self-exploration brought me to a full realization that the passion necessary to proceed came primarily from my own desire to experience a transformative process. This process would move that which is innate within me to a conscious level. I have been searching to validate my own personal experiences and to find the words to express what was held in the tacit dimension. Gadamer (1986) suggests that we are transformed into a communion, in which we do not remain what we were in our position as researcher (p.103). I also have a passionate desire to reveal and illuminate the positive aspects of illness.

Why would the co-searchers want to share such a personal journey and for whom would they be offering to revisit their sometimes long and arduous trip? Each co-searcher revealed their reason for participating at some point during this process.

Erica feels the study offers an opportunity for others to witness how it has been for some who have transcended illness. *"You know, for people to have the gift of knowing that what has happened to them is not*

random – that they are co-creators with their illness. They have the opportunity here to co-create.”

Mavis used a quote from the Bible that reflected her hope. *“In second Corinthians Chapter 1: verses 3-4 “Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies, and God of all comforts, who comforts us in all our tribulation, that we may be able to comfort those who are in any trouble, with the comfort with which we ourselves are comforted by God.”*

William shared with me that, *“Having an opportunity to read the responses from the people you interviewed has given me new insight into an enemy that was trying to take control of my being, my soul and a clearer understanding of the gifts illness brought me.”*

Sandy wanted to participate so that people would understand some of the benefits of illness. She said, *“I just hope that people will see that there are lots of us that go “through” cancer and are well, happy and more content with ourselves as a result of this illness.”*

Joan told me, *“When I saw your request to participate in this study I had this sudden thought that what had happened to me might have a reason bigger than just me. I thought maybe I would understand what that was, if I called you.”*

When Donna responded to my request to review my research findings, she included a note that said, *“I felt I would get a better grip on my feelings if I were able to discuss them at length with someone who*

really cared to listen...you. I felt that if I was free to say whatever I wanted out loud to someone and get feedback from that person, then I would feel validated. And it worked, thank you my friend."

Janet participated because, *"I wanted people to know they can't just accept what medical people tell them. We have a core to our being...that is us...not the disease...and the medical profession need to know we have an inner strength that is a part of our healing."*

Betty told me, *"I thought your paper would be a perfect avenue to express how love, strength, support, belief and courage can make the difference when one is very ill."*

I chose a heuristic method as the tool to undertake this study because it is a method that arises from the ontological base of humanistic psychology. Heuristic research explores the meaning of human experiences surfacing from the personal questions, problems or challenges of the researcher (Parse, 1996, p.11). Heuristic research varies from the traditional expectations of a classic phenomenological study. Phenomenology in its pure form requires the researcher to explore and "bracket" their presuppositions. The concept of "bracketing" is changing as it is acknowledged that we may "bracket" our thoughts however they are always present within the researcher.

Moustakas's (1990) heuristic research method welcomes the presuppositions, experiences, and passionate interest of the researcher. Moustakas describes the path the investigator takes as, "A reaching

inward for tacit awareness and knowledge. Intuition runs freely, which in turn, elucidates the context from which the question takes form and significance” (p.27). The bridge between the explicit and the tacit is the realm of the between, or the intuitive (p.23)

In order to “intuit”, one must first immerse oneself in the literature and research that exists regarding a given topic. I have done this over the past three years. Intuition can only come when there is first a knowledge base to draw on.

There is no hypothesis required when undertaking a heuristic study. On the contrary, a hypothesis would establish a preconceived direction by the researcher. Heuristics offers a freedom of exploration and inquiry without bounds or operational definitions. In the final analysis, the co-searchers are part of the defining of essential and nonessential elements.

Throughout the study and prior to entering into dialogue with the participants, I engaged in a personal heuristic method of learning. This took place through many experiences of my own in which I discovered questions rather than answers. These questions became the basis of my study. My desire is to share my own personal experiences and record the experiences of others, whose worldview has been expanded and changed, as a result of an acute crisis that brought them to a place of inner transformation.

The method I used was to organize and analyze the data by gathering personal notes and observations, transcribing the tapes of the participant, keeping field notes made at the time of the interview, incorporating my own memoirs which led to identification of themes and patterns.

At certain points, I separated the text into meaningful units. This was an intuitive process that was guided by a tacit awareness of what was meaningful. Each interview was conducted in this manner, immersing myself with the co-searcher in identifying what was meaningful to me, cooperated by the co-searcher. Only when this felt complete, did I move forward to the next interview.

My inquiry was not meant to have a definite end point. I knew that the process of research data gathering and reflection would be complete when a repeated pattern emerged. After the eighth interview the journeys of the co-searchers were not producing new information and I knew my quest for discovery or "un-covery" had ended.

Polanyi (1969) notes that, "Having donned new glasses, we are ourselves transformed" (p.82). He states, "Having made a discovery, I shall never see the world again as before. My eyes have become different. I have made myself into a person seeing and thinking differently. I have crossed a gap, the heuristic gap, which lies between problem and discovery" (p.143).

Summary

It has been a recurring theme for me from early childhood to both benefit from, and witness the power illness has given me and others. We have discovered previously unknown strengths, uncovered core beliefs of our own and created change patterns in our behavior. I have experienced transformation through personal participation in the change that has occurred for myself, for friends and family, and witnessed what might be considered miracles.

In my meeting with the co-searchers, there were no specific questions asked. There was a natural opening and unfolding that occurred through a trust that grew as we shared our thoughts. We experienced a "knowing" that reflected the I/Thou relationship of Buber (1937). A communal flow occurred from the depth to and from myself and another self:

But where the dialogue is fulfilled in its being, between partners who have turned to one another in truth, who express themselves without reserve and are free of the desire for semblance, there is brought into being a memorable common fruitfulness which is to be found nowhere else. At such times, at each such time, the word arises in a substantial way between men [sic] who have been seized in their depths and opened out by the dynamic of an elemental togetherness. The interhuman opens out what otherwise remains unopened (Buber, 1937, p.86).

The co-searchers spoke of their present and their past, the before and after of life threatening illness. As a result of their journey through illness they perceived themselves and others differently. Laing (1969) declared that, "Unless we can see through it, we only see through it" (p.105).

The rational soul ... travels through the whole universe and the void that surrounds it ... it reaches out into the boundless extent of infinity, and it examines and contemplates the periodic rebirth of all things (Marcus Aurelius, Meditations, 11:1).

As a researcher, it is my responsibility to acknowledge the complexities of the human experience and to understand that there are no absolutes when it comes to felt lived experience. Hillman (1989) speaks of the "felt experience" in the following way:

We may imagine our deep hurts not merely as wounds to be healed, but as salt mines from which we gain a precious essence and without which the soul cannot live...the soul has a drive to remember...we make salt in our suffering and, by working through our sufferings, we gain salt, healing the soul of its deficiency (p.125)

Erica, one of the contributors to this study, explained the process she went through in this way: "*I started really working on my whole*

person, without splitting off the body mind heart and spirit. I had a sense of learning through pain but there was a time when I finally got it – that the stuff that happened to me, and the spiritual merged. After cancer they were no longer separate – they had simply merged. So now, everything seems purposeful, and no matter what happens, at any level, it is now seen as okay. This is something that I have to transform, or use, because it is significant to me in some way. It is not separate – it is a gift that is happening to me.”

A soul that is healed contributes to a sense of emotional, psychological and physiological well-being. According to recent research in the field of psychoneuroimmunology, this may bring us to a balance within our system that can contribute to healing from disease in some cases.

The following review of the literature shows the path taken by researchers in the western world. Advances in biomedical procedures combined with a renewal of interest in traditional healing methods have brought us full circle to a present day understanding of the interconnectedness of the personal and the transpersonal domains.

CHAPTER 2

Review of Relevant Literature

The Mind/Body/Spirit Relationship

In ancient Greece there were temples with rooms to which sick people could retreat to be healed by the gods and goddesses. The goal was not only physical healing. There was an understanding that illness is a sacred space providing an opportunity for a quiet time of introspection that could contribute to healing the core of our being. Being healthy encompassed all things – the mind, the body and the spirit. Healers were also Priests or Shamans who cared for the wellness of their people in all ways. Healing demands belief and the people trusted and believed in the Priests and Shamans. The place of the Shaman was multi faceted. It was understood that their place in society was not necessarily to heal from physical illness, but also to remove obstacles that prohibited wellness.

Western culture has assumed a separation between mind and body, between spirituality and science, since the rise of modern science. These dualisms have been incorporated into modern medicine. Dossey (1993) briefly demarcates three historical eras that embody fundamentally different approaches to the relationship of mind, body and spirit.

Era One: Although physical medicine was practiced long before the nineteenth century, it was in the late 1860's when disease was

identified as being either serious, which meant the patient might die, or chronic, which meant the patient would continue to be incapacitated by the disease. The ability to cure diseases that were previously incurable is a result of technology that has dramatically increased the success of medical interventions. These advancements in biomedicine have contributed to a new population of survivors that now require more than physical care. Researchers in such disciplines as nursing, sociology, medical anthropology, theology, and others have turned to new areas of study such as the impact of survivorship (Breaden, 1997; Croog & Levine, 1972; DeLaatet and Lampkin, 1992; Hassey, Dow, 1990, 1991; Leigh, 1992), hope (Carson Soeken & Grimm, 1988; Hall, 1990, 1994; Herth, 1989; Wilkinson, 1996) and coping (Halstead and Fernsler, 1994; Koenig, George and Siegler, 1988; Lazarus and Folkman, 1984; Pargament, Ensing et al, 1990). This new era of the mind-body connection thus becomes Dossey's Era Two.

Era Two: The era of mind-body medicine arising in the 1950's is still developing. There was an increase in the use of mind-body therapies such as hypnosis, biofeedback and relaxation techniques during this period. There are also many types of imagery, therapies and techniques that have received attention by scientific researchers in the last half of the present century such as intercessory prayer (praying for others at a distance) and psychosocial support (such as counselling using guided imagery and creative visualization). These techniques

connect the power of the mind with the power of the body to heal and cure (Davis, 1994). Dossey points out that Era One and Era Two are similar in as much as both adhere to a classical time-space framework, wherein the mind is seen as localized to points in space and time (i.e., the present moment) creating a complementary mind-body relationship. Dossey's Era Two developmental time frame may be considered to be inaccurate by some. For instance, Paracelsus referred to the other side or second half of human nature meaning that disease has an 'invisible' aetiology (Webster, 1995). Biomedicine is most often focused on individuation and autonomy, although this is a culture-bound notion that effectively disallows ethnopsychologies (psychology attributed to particular ethnic groups) that recognize as normative a multiplicity of selves, or self, as part of a universal whole (Sargeant & Johnson, 1996:46-60).

Era Three: Dossey tells us the era of nonlocal or transpersonal medicine is recognized and acknowledged in the 1990's. One must assume Dossey is referring only to biomedicine of the western world when he suggests that the area of nonlocal or transpersonal medicine is just now being recognized. For thousands of years, traditional medicine (meaning interventions other than biomedicine) has taken the view that mind can escape the confines of the body and the present moment and can become part of nonlocal time and space This suggests that mind is a factor that can affect healing between persons or as Davis (1994) tells

us, "We can receive healing and/or curing by some intervention that is beyond our present time and space"(p.35). In the Christian world several hundred years ago, St. Augustine said, "Without God, we cannot: without us, God will not" (Weatherhead, 1952, p.233). Augustine believed that intercessory prayer may be heard, which suggests that Dossey's nonlocal medicine or transpersonal medicine was recognized early in the Christian era.

Sweeping generalizations such as Dossey uses in his trilogy do not necessarily consider the experimental work of earlier researchers such as Frances Galton (1883) who produced what is probably the first epidemiological survey in the field of what is sometimes known as 'paranormal healing'. In 1883 Frances Galton compared the life-expectancy rates for prayerful people, such as divines, those of the monarchy, and materialistic people such as doctors and lawyers. Galton's conclusion was that sovereigns, whom he regarded as much prayed for, appeared to be the shortest-lived occupational group. He concluded that prayer did not seem to bring about temporal benefits. Joyce & Weldon (1965) assert, "(S)ome men[sic] possess the faculty of obtaining results over which they have little or no direct personal control, by means of devout and earnest prayer, while others doubt the truth of this assertion" (p.367).

Based on information offered by Wirth's studies (Wirth, 1993; Wirth & Cram, 1994) it would appear that the person who offers the

prayers shares in the responsibility of a successful intervention. This is not something that Galton considered at the time of his work in the area of transpersonal healing. Wirth's studies involved subjects that were unaware that a healing study was being conducted, which precluded the results being impacted by suggestion, expectation and the placebo effect. There was no contact or communication between the practitioner of Reiki and LeShan (both healing modalities that involve the focus of the practitioner on the person who is unwell without any physical contact being made) and the subjects in the study. This suggests that such social and physical factors are not necessary prerequisites for a distant healing effect. Reiki is based on ancient Sanskrit Buddhist writings that reveal the unified energy foundation of the universe. Similarly, LeShan was founded on a unified interconnectedness theory of healing which is analogous to many traditional native healing techniques.

In 1968, Jung presented his theory of the Collective Unconscious and several others hypothesized that humans possess a single mind (Carrington, 1947; Rhine, 1946; Tyrrell, 1946) suggesting that if we are of one mind, we are capable of impacting ourselves and others with creative visualization, guided imagery, prayer, meditation, Le Shan and Reiki (both involved in a transference of energy from the healer to the individual seeking balance) and other similar healing modalities (Baginski, 1988 p.94). These tools contribute to the creation of balance within us by impacting our central nervous system and our immune

system as they connect to the PS (psyche). There is clinical research supporting the concept of the transpersonal domain holding the ability to contribute to psychological and physiological healing. McGuire (1996) concludes that ritual practice may be effective in healing precisely because of its ability to metaphorically address and transform the unitary body/mind/self. McGuire found that religion promotes the total involvement and absorption of the body/mind/self through its use of emotions, imagination, memory, perception and sense (p.114). Abraham Maslow, after a massive heart attack, shared publicly that he felt gratitude for the experience because transformation occurred for him shifting his previous life patterns to include a serenity and calm he had not previously enjoyed. He saw this as emitting from the transpersonal domain, calling it a plateau experience (Cleary & Shapiro, p 5,1995). It is interesting to consider that prayer, meditation, and other physical practices like yoga contribute to the states we postulate are associated with healing, such as absorption in a single focus; the relaxation response; emotional catharsis; a humbling of the reasoning cortex; visualization; active imagination; coherent intention.

Faith Healing, Miracles and Inexplicable Remission

In a study of Anglo-Saxon medicine, faith healing is described as, "That dangerous field placed between theology and medicine, that no one has dared thoroughly to explore" (Bonser, p.125, 1963). The Catholic Church is well used to claims of faith healing and inexplicable

miraculous cure. A set of criteria to identify and authenticate miraculous cures was devised in 1735, modified in 1883, and identified at that time as the International Medical Committee of Lourdes (CMIL). Dowling (1984) claims that, "Since 1858, there have been approximately 6000 claims of miraculous healing at Lourdes. Only 64 have been acknowledged as miraculous healing through the procedures of the CMIL" (p.634). Since the beginning of the 19th century, there have been other miraculous cures reported as a result of a renewal within Christian denominations.

The Charismatic Movement And Miracles

The development of the charismatic movement, one of the most recent renewals of the Church, is assumed to have begun in Los Angeles in 1906. This movement emphasizes one of the gifts of the Holy Spirit evidenced at Pentecost; that of the gift of healing or charismata, which includes other gifts such as the ability to speak in and interpret tongues (glossolalia). This modern Pentecostal movement has spread into all the mainline denominations, notably within the Roman Catholic Church since 1967 (Ranaghan & Ranaghan, 1969). Within the charismatic movement, reports of physical healing are more rare than reports of inner healing that is emotional (Sequeira, 1994, pp.126-143). In 1974, a panel reported to the General Assembly of the Church of Scotland concluding that certain extraordinary phenomena do occur, such as speaking in tongues and divine healing - they have to be

accepted as facts (Church of Scotland, 1974). McGuire (1988) notes that the network support provided by membership in certain charismatic healing movements may influence a feeling of well-being and encourage healing of psychological trauma as well as contributing to a physical healing of minor ailments (p.79). Hahn and Kleinman (1983) state that beliefs and expectations heal. They conceptualized that mind and beliefs are literally embodied and conversely, the bodies of persons literally mindful (p.16). Looking at so-called miraculous healing, the religious among us might be inclined to say, "God did it." It then becomes incumbent on us to ask, "What is God?" Perhaps the spirit infusing a place? An extra biological energy? Selfless love of another? (McGuire, 1996).

The healing system is accessed along myriad pathways, "God" being one of those paths, depending on one's beliefs. A miracle will always be something of a mystery - not because science cannot draw progressively closer to understanding, but because each person's soul can never be plumbed, nor the mysteries of each heart completely fathomed (Hirschberg & Barasch, 1995).

O'Regan and Hirschberg (1993) have produced an annotated bibliography drawing heavily on a ten-year research program of the Institute of Noetic Sciences. Hundreds of cases are included. O'Regan discovered a site in Yugoslavia where an apparition of the Virgin Mary has been reported every day since June 24, 1981 in the village of

Medjugorje, north of Dubrovnik. There have been some 250 to 300 reports of healing in this place. One dramatic healing recorded the experience of a woman from Milan, Italy, who had been diagnosed with multiple sclerosis. She arrived in a wheelchair one evening to be in the room with the children who had the apparition experience. She felt a sudden movement through her body, and she stood up and walked. She has since been in good health and her case is being monitored in Italy. These cases are being sent to Lourdes for investigation by the CMIL. One would assume that these miracles reflect prayers to a Christian God; however, there was some consternation in Medjugorje when a Moslem boy was healed.

Their study concluded that there is a wide body of evidence suggesting that extraordinary healing, including regression of normally fatal tumors, takes place, with no known scientific explanation. This evidence implies the existence of a healing system, which appears to contain at least three components: a) a self-diagnostic system, b) a self-repair system, and c) a regenerative system. The evidence suggests that this kind of healing can be triggered by a variety of stimuli, diverse in nature, including signals, suggestions and guidance from the physical, mental and/or spiritual realms of every individual, and this unknown healing system is describable and researchable in a manner similar, but not identical to, the way other well-known control systems in the body became known – e.g. the nervous system and the immune system.

Dowling (1984) noted that, "It is very difficult for many doctors to accept a cure as scientifically inexplicable, let alone miraculous (201). This western view has changed since Dowling made this statement. In 1996 at a meeting of the American Academy of Family Physicians, a survey of 296 doctors indicated that nearly all of them felt a person's faith could help the physical healing process, and 75% said they thought the prayers of others might help as well. Astin Harkness and Ernst (2000) conducted a systematic review of the efficacy of any form of distant healing as treatment for any medical condition. A total of 23 trials involving 2774 patients met the inclusion criteria and were analyzed. Heterogeneity of the studies precluded a formal meta-analysis. Of the trials, 5 examined prayer as the distant healing intervention, 11 assessed non-contact Therapeutic Touch, and 7 examined other forms of distant healing. Of the 23 studies, 13 (57%) yielded statistically significant treatment effects, 9 showed no effect over control interventions, and 1 showed a negative effect. The methodological limitations of several studies make it difficult to draw definitive conclusions about the efficacy of distant healing. However, given that approximately 57% of trials showed a positive treatment effect, the evidence thus far merits further study.

To the faithful, a miraculous cure is a sign of the power of God, a joy and a wonder. Some, like the Church authorities, are anxious to see a medical imprimatur, whilst others are impatient of these long-winded

procedures. Some skeptics start from the premise that miracles are impossible, therefore, they do not happen in Lourdes (or anywhere else) and in between are all manner of gradations. The one immutable is the impossibility of satisfying everyone. There has been some criticism of the CMIL in that they do not accept claims of cure from psychiatric illness (Gardner, 1983) however, claims of physical healings are sent to Lourdes for investigation by the CMIL.

The Spiritual Realm

Those patients who survived serious life threatening illness were rarely considered in the area of clinical research until recently. With the advancement of biomedical procedures there is a growing body of research that is paying attention to such things as survivorship, hope, and coping (see Era 1 in previous section) in relationship to transpersonal experiences. For instance, Reed (1986) compared terminally ill and healthy adults in terms of religiousness and sense of well-being and found no significant relationship in the terminally ill group in her first study, and yet a later work (Reed, 1987) resulted in findings that indicated a low but significant positive correlation between spirituality and well-being for the terminally ill, hospitalized adult group. The findings varied because of her changed definition of concepts. In her first study, the holding of religious conviction and religious practices were used as a measure according to the Religious Perspective Scale which was adapted from King and Hunt (1975). In the second study Reed

defined spirituality as a broader concept than religion or religiosity. She theorized that a key point to the empirical nature of spirituality as a multidimensional phenomenon is the epistemological assumption that spirituality can be empirically investigated and ultimately applied in practice, using methods of science and praxis. Berger (1974) contradicts Reed's theory with the argument that, "Spirituality is not measurable any more than would be such concepts as physicality, emotionality, or wholeness. Investigators should be reluctant to measure spirituality as a variable in and of itself. Components of spirituality cross traditional science boundaries such that the spiritual cannot be distinguished necessarily from what has been labeled as the social, psychological or physical parts of a human being... It has been suggested that a strong dose of humility is required to study spirituality, for the gods are not available to the scientist but only through the contents of human consciousness (p.28).

Frankl (1969) explored his experiences as a prisoner in a Nazi concentration camp during World War 11. There was little vestige of humanity left within many of the prisoners. They had been stripped of goals, desires, wishes, hope and yet, something contributed to their continuing will to live. Something as simple and/or as complex as a breathe of fresh air wafting through their cell, a sunrise, or a sunset they managed to see, created meaning and renewed their will to live. They derived the fortitude to continue to breathe and live, which led Frankl to

view people as spiritual beings. Frankl claimed that the lack of a sense of meaning is in itself a health problem (Steeves & Kahn, 1987). These experiences contributed to Frankl's musing (1971), "Is it not conceivable that there is another dimension possible, a world beyond man's world; a world in which the question of an ultimate meaning of human suffering would find an answer?" (p.89). Rogers (1990) concluded that the human field extends beyond the physical aspects of the human being, delimited only by our personal, self-imposed, multidimensional boundaries (p.7). These boundaries seem needed to organize our experiences.

Boundaries

An account of the transitions experienced by some individuals that no longer require boundaries to make meaning in their lives has been recorded through the contributions of the co-searchers in this study. The boundaries I speak of are self-imposed boundaries put in place as a result of our cultural orientation. Boundaries may differ in each culture however; they are created within us as we learn appropriate behavior within our culture. When faced with our mortality some have broken through that which held them captive. They have reached back to a time prior to learned behaviors to see through the boundaries they previously allowed to another level of understanding. At the present time there are no studies or research that can explain just where we hold this knowledge and the understanding that comes forward when we are faced with a major crisis in our lives. Perhaps the concept of innate

intelligence is archetypal. Our boundaries and behaviors are learned according to our cultural orientation, which leads to innumerable difficulties to be considered in general population studies. For example, the specifics of the individual's particular belief system may contribute to the outcome of the measurement. This is a factor making validity and reliability extremely difficult to attain.

Many researchers in a variety of disciplines have considered the influence of spiritual, religious, or philosophical beliefs on the outcome of acute physical illness empirically. Croog & Levine (1972) found, in a study of 324 men who recovered from a heart attack crisis that the conceptions of the etiology were strongly secular in orientation. Bearon (1990) considered religious cognitions and the use of prayer in health and illness. Her research findings showed that religious beliefs were intertwined with older adults' beliefs about their health and physical symptoms. King, Speck & Thomas (1994) considered the possible influence of religious, spiritual and philosophical beliefs on illness, finding that those with a good outcome felt that without God they would not have come through their crisis. These researchers saw many shortcomings in their quantitative research tools and concurred that a revised version of their work was warranted. These findings were reflective of other researchers work (Kass, Friedman, Lerserman, Zuttermeister & Benson, 1995; Reed, 1987; Spilka, Spanger & Nelson, 1983). One researcher has called the term spirituality a fuzzy concept that embraces obscurity

with passion (Spilka, 1993, p.1). What is seen as spiritual in one culture may be called something else in another culture.

Principe (1983) offers a definition in terms that could be considered by some as a universal application:

The way in which a person understands and lives within his or her historical context that aspect of his or her religion, philosophy or ethic that is viewed as the loftiest, the noblest, the most calculated to lead to the fullness of the ideal or perfection being sought. (p. 136)

I believe Principe's definition honors individuality of thought. Whatever beliefs, religions, spiritual understandings, particular dogma, creed or perspective one holds, we do the best we know how within that context at any given moment.

Through A Philosophical Lens

"Philosophical" is meant to imply the philosophical system which is composed of principles for conduct of life (e.g. serenity, calmness) - The word "philosophical" has its roots in the Greek *philo* - to love, *philos* friend, and *sophia* - wisdom. "Belief" has its roots in the word *lief* meaning gladly, willingly. In this context, philosophical belief is meant to convey the concept of those individuals who gladly and willingly immerse themselves in the principles for conduct of life that are part of their cultural and genetic make up.

This definition seems more applicable to Eastern culture than to

Western culture. In Eastern cultures, belief encompasses all aspects of life. The food eaten, exercise regimes, and the celebration of spirit are an integral part of daily living. In Western culture, our philosophical beliefs are sometimes compromised in favor of agreeing for the sake of maintaining relationships, establishing business connections, keeping peace between our children and ourselves and avoiding confrontation with others.

The principles of holism and balance reflected in eastern cultures can temper perceptions. Western culture has largely given way to the analytic urge in our recent history (Sargeant & Johnson, 1996). The Buddhist philosopher, Suzuki (1960, p.3) contrasts biomedical and traditional aesthetics and attitudes toward nature by comparing two poems: a seventeenth-century Japanese haiku and a nineteenth-century poem by Alfred Tennyson. The Japanese poet wrote:

When I look carefully

I see the nazuna blooming

By the hedge!

In contrast, Tennyson wrote:

Flower in the crannied wall,

I pluck you out of the crannies.

I hold you here, root and all, in my hand,

Little flower - but if I could understand

What you are, root and all, and all in all,
I should know what God and man is.

The Eastern poet does not pluck the nazuna but is content to admire it from a respectful distance; his feelings are, "too full, too deep, and he has no desire to conceptualize it" (p.3). Tennyson, in contrast, is active and analytical. He rips the plant by its roots, destroying it in the very act of admiring it. He does not apparently care for its destiny. His curiosity must be satisfied. "As some medical scientists do, he would vivisect the flower" (p.3). The analytic urge in biomedicine has been profound and sometimes destructive.

Biomedicine has been mistrustful of non-cognitive apprehension and non-linear, non-rational ways of knowing; accordingly, in recent times, emotion has had no place in scientific discourse (Jagger & Bordo, 1989, pp. 145-171; Lutz & Abu-Lughod, 1990, pp. 69-91).

Anthropological studies of health and healing in diverse cultures show that, "Health is a cultural ideal and varies widely over time and from culture to culture" (McGuire, 1993, 146).

A Canada-Thailand interdisciplinary research team under the auspices of the Centre For Studies In Religion And Society at the University of Victoria has undertaken a study of health care ethics. Medical scientists, sociologists, anthropologists, psychologists, philosophers and nursing professionals, law and religious studies scholars, were members of a team composed of Christian, secular and

Buddhist believers. One of their basic findings was that modern biomedicine is not in a neutral position from which to relate itself sensitively to other cultures. Rather, biomedicine *is* itself a culture alongside the other cultures - Muslim, Buddhist, Hindu, Chinese, etc. carrying with it its own particular philosophies and beliefs (Coward & Ratanakul, 1999). A report from a medical doctor first trained in biomedicine, and then spending twelve years in China in order to gain understanding of the traditional healing process experienced there, presents a simplistic outline of traditional healing:

I think the entire Chinese culture is based on the notion that there is a correct way to live, and that how you live ultimately influences your health. It's not just diet or exercise, it's also a spiritual or emotional balance that comes from the way you treat other people and the way you treat yourself. That has always been the highest goal of living in all the Taoist and Confucian traditions. And since that's the basis of their culture, it spills over into their medicine (Eisenberg, 1993, p.224).

In Traditional Chinese Medicine (TCM), disease is seen as the result of disharmony and energy blockage. The concept of Qi, or energy, derives from the traditional philosophy of TCM called Tao. Qi flows within the universe and within each person, creating wholeness with the environment and within and between persons. (Hall & Allan, 1994;

p.110). There is total and complete integration between the mind, body, spirit, and environment. This philosophy focuses on health and prevention. The person does not wait for illness to ensue before becoming concerned about health. The body is maintained in a cleansed state by means of nutrition, herbs, meditation and exercise. Hall and Allan (1994) state that Chinese medical practitioners are paid only when one is healthy. When one becomes ill, payment stops for the practitioner's efforts have not been effective.

Data gathered by King and Bushwick (1994) support this concept. They found that the hospitalized patient needed to know that their physician acknowledges and respects their religious and spiritual beliefs: Physicians seldom question patients about their religious beliefs... most of the emphasis in medical journals has been on ethical and humanistic rather than religious issues. Religion is rarely mentioned in medical school classes, and medical students are generally taught that a discussion of patients' religious and spiritual beliefs is inappropriate (p.349).

Exploring definitions and beliefs that are related to traditional curing and healing and biomedical curing and healing allows us to enter the world of cultural understandings of what curing and healing mean to the individual with the illness. This person may have a philosophical belief

rather than a religious or spiritual frame of reference or a belief in something that will aid them in acquiring a healthy perspective:

Although what may be called the Cartesian-Newtonian-Marxist paradigm, based on an incurable dichotomy between matter and mind has been shown to be inadequate by the astounding scientific developments that have taken place over the last four decades, the new science of the latter part of this century in the Western world seems to be approaching the ancient insights of seers and mystics from all the great traditions of humanity.

(Sheikh & Sheikh, 1989: foreword)

Jung (1968) was perhaps the first major figure in the West to grasp the deeper implications of traditional thought for the study and practice of psychology: that is, that the mental state of the patient can vastly affect the behavior of the body, that the mind exercises a subtle sovereignty over hormonal and other bodily functions, that the power of thought can often achieve what can only be described as miraculous results and that the mind and the body form one indivisible unit. These are insights shared by all the great spiritual teachings of the past, whether Hindu or Greek, Buddhist or Arab. Since Jung's awareness of the connection between the mental, physical and psychological functions previously isolated in Western thought, researchers have expressed diverse opinions regarding religiousness, spirituality, and philosophical beliefs

and the way this connection may enrich our understanding and expression of their constructs. The inconsistency in their definitions can also have some negative implications for social scientific research: First, without a clearer conception of what the terms mean, it is difficult to know what researchers and participants attribute to these terms. Second, a lack of consistency in defining the terms impairs communication within the social scientific study of religion and across other disciplines interested in the two concepts [such as health]. Third, without common definitions within social scientific research it becomes difficult to draw general conclusions from various studies (Zinnbauer et al., 1997, p.04).

A common language and a common perspective are needed to develop criteria that can apply in a pluralist society. A state of plurality (maintaining one's own cultural understanding while integrating the beliefs of others) must be the goal of researchers if research instruments are to reflect the beliefs of general populations, regardless of their ethnic and cultural background. Only in this way will biomedicine truly meet criteria of integrating mind, body and spiritual needs in order to offer holistic support to the individual who is ill. We live in a time of conceptual revolution. The search for universal concepts is having an impact in all spheres of biomedical and psychotherapeutic intervention. Philosophy, science and medicine continue to seek a common view that will offer a

culturally undistorted perspective. The state of plurality sought by these disciplines may not be possible until such time as; a) A common language across disciplines is developed and b) Western medicine embraces traditional methods and even then, the person with the illness will have their individual beliefs impacting their whole being. The idea of creating a paradigm that is culturally undistorted is almost unimaginable. In 1975, Rossner posed a question that addresses this very issue: Does the efficacy of prayer have to be scientifically proved? For what purpose? Will the majority of [hu]mankind change its praying habits on the basis of the results (positive or negative) of such a study? (p. 298)

It appears that the efficacy of prayer does have to be scientifically proven in order to change the habits of those biomedical practitioners desiring to impact disease of the body and of the mind. Perhaps reports, research, and studies of faith healing, miraculous curing, and inexplicable spontaneous remission, may succeed in impacting the perspective of medical practitioners who rely totally on biomedical intervention, setting aside the belief and power of the person to whom treatment is offered. The participants in this study commented on their practitioner's prognosis as having little impact on their own belief or philosophy.

The scientific explorations cited do not necessarily refer exclusively to the spiritual dimension however, if we consider prayer or intercessory

prayer (at a distance) as a 'self-directed guided imagery', and if guided imagery impacts cells as some researchers have reported (Zachariae, Jinquan, Petersen, Simonsen, Zachariae, Hansen, Andersen & Thestrup-Pedersen, 1994; Zachariae et al., 1990), then prayer or philosophical outlook can impact our physiology. This would contribute to healing and curing. I have spoken with Dr. Zachariae who concurs that our beliefs and our potential to access an innate dimension we possess may have an impact on healing from a serious illness. The contribution made to this study by the co-searchers involved substantiates much of this previous research.

Hahn and Kleinman (1983) suggest it is only in an anthropological framework that these phenomena will be comprehended (p.48). I would suggest that cross cultural and cross disciplinary studies that blend traditional and biomedical theories and treatment methods may be the vehicles that eventually bring us to a partnership model. Research that contributes to the creation of a conceptual framework that contains language that is common across disciplines and cultures is needed in order to explore and meet the needs of individuals with life threatening illness. King and Speck (1994) note that, "The lack of good quality work in this area of study is largely related to a lack of understanding of the language, research methods and concepts being used by epidemiologists, medical sociologists, theologians and various healthcare workers "(p.632). Lukoff (1992) concurs, stating that, "There

needs to be greater inter-disciplinary co-operation in undertaking such studies, in order to address the linguistic difficulties and different conceptual bases, so that a more productive alliance can result” (pp.673-682). Turton (1997) conducted a number of ethnographic research projects with Ojibwe people to investigate health promotion beliefs and behaviors. She concludes that, “Foundational inquiries examining the nature of cultural beliefs within particular cultures of various ethnic groups are imperative” (p.35).

In With The Old – Out With The New

A new paradigm of healing and curing that includes mind, body and spirit, crosses cultural boundaries, and reflects a pluralist perspective rather than a strictly Eurocentric position is being created. When historians look back at the twentieth century, they may conclude that two of the most important breakthroughs in Western psychology [and medicine] were not discoveries of new knowledge, but recognition of old wisdom (Walsh & Vaughan, 1993). The term “traditional medicine” is meant to encompass the old wisdoms such as Chinese medical thought, Buddhist thought and North American Indian belief, which have always affirmed the interconnectedness of all things. Karagulla & Kunz (1989) concur with this thinking – that our relationship with all the parts of ourselves, each other and all things in the universe, is the influence that impacts our health and our healing. The science of Ayurveda, Yoga, Tibetan medicine, Sufism, Shamanism and Japanese approaches to

healing also contain the concept that the absolute division between self and other is a false division, just as biomedicine now often acknowledges that the division between mind and body and spirit is false.

In 1993, the National Institutes of Health (NIH) established an Office for the Study of Unconventional Medical Practices to investigate a wide range of treatments. That beginning in 1993 expanded to be named the Office Of Alternative Medicine, and most recently, the National Centre for Complementary and Alternative Medicine. It now funds it's own research to the tune of millions of dollars annually. Harvard Medical School now offers a course on unorthodox medicine; Georgetown University, the University of Louisville, the University of Arizona and the University of Massachusetts in Worcester offer similar courses and lectures to medical students. Doctor's offices and medical centers across North America often offer biofeedback, relaxation techniques and other alternative therapies.

A study that measured the use of unconventional, complementary, and alternative therapy in the United States was reported in the New England Journal of Medicine (Eisenberg et al., 1993, p.246). In 1990, Americans made an estimated 425 million visits to providers of unconventional therapy (unconventional therapy means treatment by other than a physician registered with the College of Physicians and Surgeons). This number exceeds the number of visits to

all U.S. primary care physicians (388 million) during the same time period. Many of these therapies were offered by traditional healers (meaning those practicing Eastern methods of health, healing and curing). Many of these healers have a religious, spiritual or philosophical component within their work. People are using these methods to impact serious life threatening illness as well as to maintain health, suggesting that biomedical culture now more than ever before appreciates traditional values and beliefs regarding holistic health regimes (Dines, 1994; Engebretson, 1992, 1996; Hufford, 1986; McGuire, 1988).

There are those who believe that the integration of mind-body-spirit techniques used for so many thousands of years in traditional healing, combined with biomedical expertise, may someday be ranked with the discovery of antibiotics (Polakoff; 1993; p.36). Many researchers have suggested that research into lay health belief should be expanded in a systematic way in order that nurse practitioners, physicians and those who set health care policy have a clearer understanding of the needs of the person with the illness. This study provides some clarity of these personal needs. They are not only physical care (body), but include psychological (mind) support, and a respect and acceptance of the beliefs of the individual that may contain religious, spiritual or philosophical concepts. Fryback (1993) found that all of the interviews she did contained aspects of each domain the mental/emotional, the spiritual, and the physical (p.148), Moch (1989) considered health within

illness. She found the notion of measurement might in itself be inappropriate as measurement implies quantity or degree, whereas quality or variability is a more generalized response. Variability may include spiritual enlightenment, increased awareness of environment and self, and connectedness with the whole as well as the physical and emotional realms. O'Connor (1995) found healing can encompass such matters as comfort, care, family and community relationships, quality of life, peace of mind, restoration of dignity, acceptance, spiritual growth, and even ultimate salvation (p.28). Peteet (1985) researched the religious issues presented by cancer patients seen in psychiatric consultation. He found few of his clients had discussed their concerns other than medical queries with other members of the hospital staff suggesting more comprehensive care was required (p.53). Similar concerns arose in other research indicating the person with the illness needs to be heard by biomedical practitioners (Stacey & Homans, 1978; Williams, 1983). My research, and future qualitative studies building upon these research findings that express the felt lived experience of the individual with the life threatening illness will contribute to the changing perspective of health care in Western society.

Fryback (1993) felt it would be useful to determine how people living with varying forms of adversity and find meaning in their experiences (p.158). The Institute of Noetic Sciences (INS) was founded in 1973 with a mission statement that encompassed the concept of

universal change patterns and included the role of alternative medicine in Western society. Its purpose was to develop, articulate, and publicize ideas that were not widely accepted at that time. It is now solidly established with a reputation for solid research into the inner world of consciousness. Killoran, Schlitz and Lewis (2002) turned their attention to the impact of an individual's personal beliefs on survival of cancer. They focused on detailed study of the patient's life histories and personal meaning systems. This involved the development of a research agenda aimed at understanding how and why some individuals experience a better outcome than others when challenged with life-threatening illness. The study revealed the participants framed their unusual recoveries as being largely unremarkable. The researchers credited this finding to North American cultural values, which normalize adversity. The participants believed that one can have control over one's health and can even resist a recurrence of cancer (p.208).

There is presently more awareness that the individuals diagnosed with a critical disease have a great contribution to make in our quest to uncover the mind/body/spirit connectedness that contributes to healing and wellness. Hall (1986) explored crisis as an opportunity for spiritual growth. One of her conclusions was that, recovery from crises can have far reaching constructive effects on quality of life. She suggests that this association of crisis and opportunity needs to be documented in other research so that clinical and pastoral training programs might begin to

address ways in which individuals and families can be assisted to make transitions in their daily living as a result of the transformation that occurs when one faces a crisis situation (p.15). King & Bushwick (1994) explored the beliefs and attitudes of hospital in-patients about faith, prayer and healing. They concluded that their research needed to be broadened to other areas of the country to further determine the needs of those who are ill and hospitalized. Moch (1989) concluded in her study of health within illness that determination of the experience of the illness and positive outcomes have to be made on a very subjective basis rather than on an objective basis by those fighting the illness on behalf of the person in the situation (p.49). O'Connor, 1995; Quinn, 1997; Scherer, 1996; Turton, 1997; and Wendler, 1996 expressed similar views regarding the importance of qualitative research focusing on personal and subjective perspectives. Much research focus has been directed toward cancer remission (Yates, Chalmer, St. James, Follansbee & McKegney, 1981; p.123) and this focus continues into the present century. Has the transpersonal domain or some other awareness contributed to the survival of these victims of disease? The co-searchers in this study have validated this possibility.

Biomedicine deals with the disease and the individual with the disease deals with the illness. Researchers such as Dossey, 1984, Hannay, 1980, Kestenbaum, 1982 and Kleinman, 1988; May, 1991 have concurred that the diagnosis and prognosis is only one piece of the

whole. The contribution to wellness that is made by the individual who has the disease has to be amalgamated into the potential outcome. As a result of individuals who have begun to participate actively in extrapolating positive considerations from the illness they have and present day biomedical procedures, many times the prognosis is inaccurate and the patient continues to live an active and healthy life . Frank (1991) assigns this type of survival to the “ranks of the remission society” and identifies this community as one of being “chronically critical” (p.139).

The Language Of Disease

Definitions of health and disease by researchers often do not include the transpersonal domain or belief dimension. The philosophical outlook of the individual with the illness may provide metaphors that are unique. For instance, Frank (1991) has this to say about the metaphors used by biomedical practitioners when referring to cancer:

People with other disease are just plain sick; those with cancer “fight” it. During my heart trouble, no one suggested I “fight” my heart, but one of the first things I was told about cancer was, “You have to fight” Read any set of obituaries. People die of cancer after a “valiant battle” or a “long bout”. Government research programs are “wars” on cancer. Newspaper stories that refer to poverty, crime, and drug abuse as “cancer” reflect society’s attitude toward cancer as

“the dreaded other”. Against this other, combat is the only appropriate response. But I do not believe illness should be lived as a fight (p.83).

The ill themselves have had little to say, or else no one has listened (Frank, 1991; p.115). Some of the co-searchers agreed with Frank. Rather than “fighting”, they embraced their diagnosis eventually feeling a sense of being grateful for the opportunity illness gave them to reconsider their personal and worldview of the meaning within life. Notice the clear concise statements of some of the individuals with the illness.

Erica said, *“I do know that this (illness) is not random. It is purposeful – everything is purposeful.”*

Donna said, *“People are co-creators with their illness. They have the opportunity here to co-create”.*

Sandy said, *“I have come to feel honored that I have been entrusted with this illness. I needed that kind of heavy duty wake up so I could get on with growth”.*

It would appear that writers, researchers and our society see cancer in one way: the person with the illness very often has a very different perspective seeing cancer as quite adamantly “other” than the definitions used by those whose bodies are not involved with the disease.

The physician's biomedical perspective is offered to the individual with the life threatening illness: however each of the co-searchers in this study has a truth of his or her own. The physician's perspective did not necessarily reflect in the patient's own understanding and did not always impact the individual's beliefs. The reality of the person in the situation was often not the reality of the practitioner nor was it a reality that can be reported as a statistic. The approach used by some of the medical practitioners seemed to the co-searchers unnecessarily negative and cryptic.

Erica said, *"I remember him saying to me, "This cancer is so aggressive, I can see the cells multiplying under the microscope." And he said something about 3 months and I was in shock."*

Sandy said, *"The gynaecologist said, "You have to have a hysterectomy. You have cancer." I thought that was too harsh, too confrontative. If I were he, I would have tried to be more reassuring."*

Betty said, *"The doctor said, "You have cancer." I was so shocked with no preparation I just got up and walked out of the office."*

Janet said, *"This Doctor said to me, "Yah, your report looks good, but what are you going to do, if it's not good next time?" And I said, "You know, that is so shitty....why would you even say that? Like, you know I'm all clear....right now I'm clear..." and she said, "Well, yes, that's really good news, WE are winning the battle" and I thought, "OH, screw you. You've really got a problem lady."*

Donna said, *“After I had the ECG, all I can remember him saying was, “The stroke that’s headed your way is going to be so massive, you’ll be lucky if you die.” And when the cardiologist said that to me, I didn’t hear another word he said.”*

Joan said, *“After the examination, my doctor said, “I would guess the cancer is back. We may not be so lucky this time.”*

Only two of the physicians attended by the co-searchers in this study encouraged alternative or traditional methods as well as biomedical procedures to contribute towards a feeling of well being for the patient.

Donna considered herself fortunate. *“I’m lucky – I have a young doctor – he’s easy to talk to – he actually listens to his patients, and tries to work with them and I was very lucky – together, we have come up with what seems to be something that is going to work for me – and slowly, he’s introducing new things to make me even better.”*

Williams doctor told him, *“You have choices here. Do some research and together, we’ll look at what will feel most comfortable for you.”*

Changing Perspectives

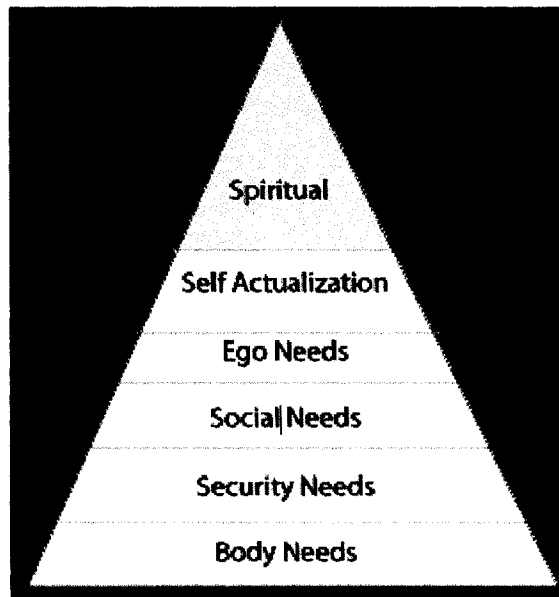
The thematic analysis and interpretation of the co-searchers’ changing worldview that developed following diagnosis of a life threatening illness is offered in this study from the perspective of the co-searchers’ epiphanies. The impetus for fundamental change in the worldview of our

Western society (meaning the values that define our lives and work) will be nourished by glimpses of expanded thought by individuals such as the co-searchers.

The transition from a paradigm in crisis to a new one ... is far from a cumulative process, one achieved by an articulation or extension of the old paradigm. Rather it is a reconstruction of the field from new fundamentals, a reconstruction that changes some of the field's most elementary theoretical generalizations... When the transition is complete, the profession will have changed its view of the field, its methods, and its goals. (Thomas S. Kuhn, 1963, p.76)

Researchers across disciplines have vastly different conceptualizations of religion, spirituality, and philosophical beliefs as reported in this paper. Individuals faced with their mortality due to life threatening illness may conceptualize in quite different and unique ways. The last century began a movement away from the limitations of professionally centered biomedical intervention and treatment. This century, our worldview is expanding to include the ill in their own healing process. Treatment facilities are becoming healing centers, focusing on empowering individuals in the pursuit of their own healing. Modern science is being integrated into a larger worldview. Creating a new vision of our future, a new paradigm in healing and wellness.

Abraham Maslow (1962:1968:1969:1970) presented a hierarchy of needs taught in the helping professions as a road to self-actualization. Maslow's research was grounded in a positive framework relating to what creates a successful life contrary to his peers of the time, who generally explored people with psychological problems



Maslow theorized that each level of need had to be at least partially met before moving on to the next level. The level showing as spiritual above was not dependant upon the lower levels being met. It was meant to reflect a movement to something greater than our physical emotional and psychological needs identified in the original hierarchical cone.

Following a serious heart attack Maslow acknowledged his hierarchy of basic needs for survival of humanity was incomplete in

secreted by the nerves when stress and anxiety are present can shut down or disturb the normal functioning of the immune system cells and that relieving the nervous system and immune system cells of this responsibility with a change of thinking and feeling allows the body's immune system and nervous system to focus on the problem at hand – healing the body.

Although many studies have shown the importance of positive mental states and feelings in the process of healing, no satisfactory experimental design exists that can answer how changed moods, behaviors or feelings and emotions influence the onset or cure of disease. Even though experiments using psychotherapy, meditation, and positive thinking increase immune functions, nobody can yet measure individual internal thinking or feelings. Klazien Matter-Walstra (1999) posits that, "PNI research offers an opportunity to integrate a mindless body medicine (biomedicine) with a bodiless mind medicine (the power of Palmer's innate) and might offer answers to the varied reactions of humans on obviously similar situations in health and disease." (p.2) Loving ourselves brought together all aspects of our being, which contributed to less stress, and less anxiety in our lives, leaving the CNS and the IS free to focus on healing. Nobody can measure individual internal thinking or feelings at this point so the relationship remains unsolved. My research contributes a small flame

toward identifying how conscious and/or unconscious processes can influence our health.

This chapter has examined relevant literature that encompasses historical constructs moving from the holistic perspective that existed prior to DesCartes to present day research that brings us full circle to an understanding and acceptance of ourselves as multi-faceted creatures with equal weight given to sociological, psychological, neurological, and physiological forces impacting the human experience of illness. Polakoff (1993) observed that, "There are those who believe that integration of mind-body-spirit techniques used for so many thousands of years in traditional healing combined with the biomedical expertise of the western world, may someday be ranked with the discovery of antibiotics." (p.36)

CHAPTER 3

Research Background

Life can only be understood backwards: but it must be lived forwards.

(Kierkegaard)

Looking backward has been a necessary process in order to move forward in putting voice to concepts and ideas that I believe were innately alive within me. Webster's definition of "innate" is, "Something inborn, natural, originating in the mind." Looking for synonyms, one finds "connate, deep, deep-seated, hereditary, immanent, inborn, inbred, indigenous, ingrained, inherent, instinctive, internal, intrinsic, intuitive, native, natural, untaught". Quite a plethora to attempt description of "innate". My personal experience with serious illness allowed me to experience emotions, thoughts, and feelings that impacted my beliefs and world-view tangibly. I suspect these changes were not new creations, but changes that existed innately prior to my connection to transcending illness.

The Concept Of Innate

D.D. Palmer, founder of the practice of chiropractic, presented his belief in an undivided fifth force he named "innate intelligence" in 1914. (Morgan, 1998; p.35). Palmer envisioned "Innate Intelligence" as a vague metaphysical force that permeated all living things. Palmer believed he could influence this fifth force to cooperate in repairing the physical body. His son followed his father's intuitive hunches suggesting that this innate

intelligence was carried from the brain to the periphery by direct mental impulses. In a time when purgatives and bloodletting were the cures used by most medical practitioners, Palmer's intuition was a refreshing possibility. Intuition is subject to error and cannot be substantiated. However, with the kind of experiments presently under study within the field of psychoneuroimmunology Palmer's intuition may yet be validated.

I use this reference not to challenge Palmer's hypothesis in anyway, but to illustrate the many faces of 'innate' and to illustrate the potential for a new paradigm resulting from intuitive thinking. Kuhn (1963) would remind us that a new paradigm might be weaker at first than the old one until the new paradigm has made enough successful predictions. A new paradigm is not necessarily of a higher order as we can see as we view the circular understanding of moving from integration of the interaction between our mind, our body, our emotions, and our mental capabilities which existed thousands of years ago to the separation of treating the body in isolation, and then back to integration in our present era. This process of movement occurred as the result of changing paradigms.

Lawrence (1991) posits that, "There is no way to verify the existence of innate. It must be accepted as a matter of faith, and faith will always remain suprarreal." (p.25). The context of each person's life determines at least part of what he or she knows innately to be true. All

co-searchers reported that they had absolute faith that they would overcome illness even though the medical prognosis suggested the impossibility of this happening. This serves to build upon the idea that some things reside in an innate capacity expressing as intuition. An explanation of concepts that move from an innate capacity may result from scientific studies within the field of psychoneuroimmunology in the future.

Initial engagement with the crisis of discovering one is no longer in good health but afflicted with critical illness impacts the individual in a deep-seated manner. Tolstoy (1920) expressed the experience of losing what was familiar to him in the following way. "I felt that what I had been standing on had collapsed and that I had nothing left under my feet. What I had lived on no longer existed and there was nothing left." (p.9) The co-searchers had a variety of reactions when they received a startling prognosis from their physicians.

Joan said, *"Nothing left of "old thinking" provided the opening to a new way of perceiving well-being and wholeness."*

Betty said, *"It was actually wonderful, because I probably wouldn't have taken the steps I took if it had not been pointed out by my physician that there was no hope for my recovery."*

Sandy said, *"I had to take control of my own destiny – there was nobody else including the doctor that had answers. I knew I would be guided back to wellness if I paid attention to my inner voice."*

Erica said, *"This isn't a disease – this has come to make me healthier"*.

O'Regan and Hirschberg (1995) organized a research system around the hypothesis that perhaps we all possess an innate healing system on the premise that mind, brain, and spirit act in concert when healing occurs. Their findings were reported after considering thousands of cases of apparent spontaneous remissions that they recorded in an annotated bibliography. My personal experiences and those of the co-searchers recorded in this study shed light on our potential to go within our being and uncover/discover what we require to contribute to our own state of well being. Polanyi (1958) remarked that there is a distinction between, "What we can know and prove and what we know and cannot prove" (p.266).

The Study

This study explores the experience of 8 persons who consulted their physician and received a diagnosis and prognosis revealing to them their body was coping with a serious illness. A request for participants who had transcended a serious life-threatening illness was posted in a general physician's office (see Appendix C). The request invited those wishing to participate to contact me via telephone or email. The criteria for participation had no particular diagnosis in mind; however only two of the persons who contacted me were not diagnosed with a cancer. I

honored the request to participate made by each applicant and the study took on a life and direction of its own.

The only question I asked initially in our interviews was, *“What changes occurred for you as a result of the journey through illness you have taken?”* In order to move from explanatory mode (talking about the disease) to a level of feeling, I used what is known in counselling as reflective listening. “What I hear you saying is... or, “It sounds like...”. For example: “When you were having this treatment, holding your teddy bear and listening to your own music, what was going on in your head?” and, “When you were telling me you felt removed from your body in some way when you came home and your body felt like a stranger, how did you feel about that?” and, “So, you were separating from the actual surgery. Can you say more about that?”

I completed each interview, transcribed the tape that was made and returned it to the co-searcher to validate the accuracy of the transcription. I affirmed they were free to delete or add to anything they felt was incomplete or that they were uncomfortable with. Only one query was made and that was to ascertain that the names of the medical people involved would not be viewed by anyone else. The co-searchers read through the transcription of our interview and responded. These responses also contributed data to be used in this study.

My Experience As Researcher

There were some unexpected experiences and challenges for me while gathering this data. I had not given consideration to the emotional stress involved in the interview process or my own inner empathic feelings as I recorded the stories of the co-searchers. The co-searchers were often visibly shaken by their vivid memories as they relived their experiences. My instinct to comfort was strong but my intuition was that they were revisiting a very painful and confusing time in their lives. It was not my place to comfort unless they indicated that was something they wanted. There were times when the picture the co-searcher was seeing caused an abrupt stop to their story. When this happened, I stopped the tape and we sat quietly together in communion and comfort. The feeling of "at-one-ment" created by the gentle rain of healing tears was as a baptism – a joining at a level beyond the reality of which we were a part. We joined in that moment at a soul level and our souls healed together. At times the co-searchers chose to carry on when they were reliving a particular time in their story. They chose not to break the continuity of their thoughts and feelings. In transcribing the interviews I was often overwhelmed by the material and had to leave the transcribing until I felt strong enough to continue.

I took the opportunity to return to daily living when the completed transcription was given to the co-searchers. This was a period of incubation. My mind would return to the actual taping sessions and some

particular detail would suddenly appear. Often in the middle of the night I found particular phrases and experiences that had not impacted me at the time coming forward in my thoughts. I kept a journal of these moments to be used when I would begin formulating patterns from the interviews. I found myself isolated from my friends and family having little in common with their day to day activities. It was difficult to remove myself from the emotional journey I had been on and return to what seemed to be a mundane existence outside of my research.

The Co-Searchers Experience

For most of the co-searchers the interviews were the first telling of their entire journey. Five of the eight participants reported that reading the transcription was a healing time for them. Betty's thoughts regarding her participation sum up what the other co-searchers felt in varying degrees:

"As I mentioned to you I tend to talk things through in my life. This was my opportunity to talk about my illness, my treatment, my recovery and my transformations, with a wonderful listener. This has been very healing and at times a painful time for me as I relived some unpleasant times and made sure I will be able view them through positive eyes in the future. I may need to draw on myself again in hard times."

One participant had not assimilated exactly what had contributed to her surviving and transcending cancer. She expressed such deep

appreciation for the opportunity this study had given her to see, with clarity, the unfolding from critical illness to well being.

"I read the whole of the transcribed interview you sent me over and over. I saw things I said to you that I hadn't really seen until I read it. I told you about things that happened and when I read the words, I couldn't believe I'd even remembered some of it. It was like reading about somebody else, and I can't thank you enough for listening to me. Telling my story to you seems to have taken away the nightmares I've often had since the surgery."

We must close our eyes and invoke a new manner of seeing...A wakefulness that is the birthright of us all, though few put it to use (Plotinus, 260AD)

Seeing in print their strengths, their experiences, the changes that had occurred for them, and the coping mechanisms they had used contributed to closure for them. The value of story telling as a therapeutic tool has been validated within this study. Responses from the co-searchers support the importance of this means of therapeutic intervention in cases of Post Traumatic Stress Disorder. I completed each interview before moving forward to a new participant. Moustakas's (1990) criteria outlining procedures for analysis of data in a heuristic study require an individual depiction of each research participant and identification of individual themes prior to moving forward to explore universal qualities and themes (p.2).

The Co-Searchers (pseudonyms used)

(1) Donna is a middle-aged lady living in British Columbia. She was told she did not have the life expectancy of others. Her immediate thought as she listened to her physician was an urgent need to create a happy and satisfying life for herself. Within days she left her husband of over twenty years, a decision she had been trying to make for a long time. Committed to the expectations of her children, her parents, and her friends, she had been living in a physical and mentally abusive relationship for a very long time. Almost immediately she felt no need to please others. Her concern was focused on making herself happy. She realized that was her job rather than taking on the responsibility of making and/or keeping others happy. She now felt that quality of life was of prime importance because the quantity had become unpredictable.

(2) William is a retired engineer living in California. He was diagnosed with prostate cancer three years ago. He was certain the lab and the doctor had made a mistake. He experienced deep-seated anger at life, at God, feeling he did not deserve to have cancer so soon after retiring. He began to research on his own and came to the conclusion cancer was not a part of him.

(3) Sandy, a retired widow living in British Columbia was experiencing some bleeding. Following a D & C, her general practitioner told her, "You have cancer and I'm arranging for you to have a hysterectomy." She felt the doctor was "unkind", talking in a medical

voice in a very confrontative manner. She was unable to ask any questions because of his manner. She got up, thanked him, and left his office.

(4) Janet in her late 40's lives in British Columbia. A housewife and mother, she was on a weight loss program, exercising regularly, when she began to notice what she thought was an erratic heartbeat. A diabetic, she initially thought that the racing heart, the feeling of faintness and the sweating would be corrected by insulin adjustment. She went to the emergency room to try to establish cause. Nothing seemed out of the ordinary however a chest x-ray was taken as a safe guard. The attending doctor told her he could see a shadow on her lung. She questioned what a "shadow" meant, suspecting it was bronchitis or pleurisy. His response was, "*No, it's a mass of some kind.*" That was Janet's introduction to a clinical diagnosis of adnio carcinoma media stynum given to her following a bronchoscope. The physician told Janet they could not do surgery. She had, at best, six months to take care of her affairs.

(5) Erica lives in British Columbia. She is a wife, mother and business executive. She was involved in a car accident. The impact caused sprains in her back. She was unable to work and found herself feeling there was something that was not healing properly. She was scheduled for surgery and as she was recovering from the anesthetic she remembers the doctor saying to her, "This cancer is so aggressive,

the lump is just huge. I could see the cells multiplying under the microscope.” Then she remembers something about 3 months. She had a friend with her. After the doctor left, she asked her friend what he had said. She was told the doctor had basically said, “Get your affairs in order —no one in British Columbia has survived this kind of breast cancer. You have perhaps only days to live”. Everything was hopeless — nothing was possible.

(6) Joan is in her mid 50's and is living in Alberta. She had been diagnosed with cancer. Following a hysterectomy she was declared healthy and continued to enjoy her busy life in the arts community. Five years later she was again diagnosed with cancer. This time her physician told her there was nothing that could be done for her. Shocked at this sudden reversal in her health status she found herself sitting in her living room with no awareness of having left the doctor's office.

(7) Betty, a wife mother and professional, lives in British Columbia. She had a little bit of blood on the toilet tissue and having had children she attributed it to haemorrhoids. She joked with friends bringing up colon cancer in a joking way prior to having any tests at all. When the diagnosis was confirmed she viewed the situation as a simple procedure to correct a bothersome situation. When a friend expressed admiration for her strength in facing her mortality she was deeply offended and angry. Never had she considered death as a possibility or

even considered what this disease meant in terms of her mortality. It was simply a medical problem that needed to be corrected.

(8) Mavis lives on her own in Ontario. Fifteen years ago, she was diagnosed with Multiple Sclerosis. She was told she needed to accept the fact that she would be in a wheelchair for the rest of her life. She was eleven years in a wheel chair. Through the power of prayer and biomedicine she is now free of the wheelchair and in her opinion, “*A walking miracle to the power of intercessory prayer*”.

These are the co-searchers who have shared their journeys with me that we might better understand their inner world and the process that led to what they consider to be transformation in their lives.

CHAPTER FOUR

Methodological Structure

Choosing A Method Of Inquiry

The choice of methodology results from considering the nature of the inquiry. Qualitative methodology involves questions about human lived experiences and personal contact with individuals is made in their own environment. Rich descriptive data are generated that help us understand people's experiences. Quantitative research quantifies or measures phenomena in numerical ways using statistical procedures to describe phenomena or to identify relationships between them.

An exploration of the following methods within the field of qualitative inquiry revealed heuristic methodology as the best fit for myself in the role of researcher and the method that would best fit to reveal and illuminate the experience of transformation that can occur when a person has experienced a critical illness.

Grounded Theory Methodology Grounded theory requires that the researcher have a great deal of objectivity. Glaser's (1978) procedural directions explicitly lead the researcher toward the ideal state of objectivity necessary to become a successful grounded theorist (p.8). I had no sense of objectivity regarding the study I was about to undertake. I was passionately involved with the subject matter and was searching for others who had similar experiences to my own. As stated earlier, there were many reasons to undertake this study; one of them

being my own need to bring my personal experiences into the study.

Glaser further explains that the grounded theory method should be able to explain what happened, predict what will happen, and interpret what is happening in an area of substantive or formal inquiry (p.4). It was not my goal to explain the experience of the co-searchers nor to predict what will happen, but to produce a common thread. Grounded theory's main goal is to yield hypotheses. A heuristic inquiry yields no hypothesis but rather a subjective concept validated by the participants in the study.

The individuals involved in the data gathering in a grounded theory study are left behind in favor of, "A research product that constitutes a theoretical formulation or integrated set of conceptual hypotheses about the substantive area under study." (Glaser 1992: p.10). Glaser & Strauss (1967) developed grounded theory originally, in part, to support the active role of persons in shaping the worlds they live in through the processes of symbolic interaction (Glaser, 1992: p.15).

Symbolic Interactionism - This is a sociologically grounded psychology whose lineage includes epistemological roots from philosophy, education, psychology and sociology (Tourigny S.C. 1994: p.165). This method is grounded in a constructivist worldview - that individuals are shaped by and in turn create elements of social structure. Denzin (1969) posits that symbolic interactionism takes as a fundamental concern the relationship between individual conduct and forms of social organization (p.922). This method could be appropriate for me, for example, if my

study were to consider the lived experience of individuals with a serious illness and their relationship to biomedicine. My study is concerned with the transpersonal dimension of the co-searcher (respondent). Moustakas (1990) speaks of the symbolic growth experience (SGE) meaning, "A sudden dramatic shift in perception, belief, or understanding that alters one's frame of reference or world view (p.99). Frick (1990) defined symbolic growth as, "A conscious perception of the symbolic-metaphorical dimension of immediate experience leading to heightened awareness, the creation of meaning, and personal growth (p.68). The individual experiences of the participants in this study create a base that could be used and expanded if a researcher, for example, chose to explore their altered worldview as it relates to the workplace.

Ethnography This method requires that in order to achieve reliability and validity there must be an analysis of the data and avoidance of observer bias. My premise that I wish to join the co-searcher in moving our lived experience away from the tacit dimension to a place where people can speak and understand each other would not meet the criteria required by ethnography. Ethnography has, as it's main concern, the routine productions of persons in social organizations. Studies that range from analysis of mental health clinics, hospitals police departments, juvenile courts, etc. to analysis of individuals living within a particular culture have been undertaken using this method.

Grounded theory, symbolic interactionism and ethnography all provide a similar view of the interaction and socialization process. They would possibly be methods to consider for further research regarding the lived experience of individuals who have experienced transformation after the crisis of illness in their lives, and their connection to some aspect of this experience.

Phenomenology Max van Manen (1997) states that a good phenomenological text has the effect of making us suddenly 'see' something in a manner that enriches our understanding of everyday life experience (p.345). He suggests this 'seeing' is not just a cognitive understanding but also an insight that speaks to our cognitive and non-cognitive sensibilities. The challenge within phenomenology is to make explicit meaning that is felt and grasped at the core of our being. At times, phenomenologists use pieces of literature, poetry, anecdotal portrayals, and images in an attempt to adequately express that which cannot be understood in any other way. There are essences that words cannot fully conceptualize, for example; that which is created within us when we view a sunset that we might say brought peace to our soul. To fully articulate what that sunset meant to us is not always possible because it is a sense that is 'felt' rather than intellectualized. It is this 'felt' meaning that phenomenology attempts to express in order that we may better understand a dimension of our wholeness. This dimension may be of a transcendental nature as presented in the previous example.

Phenomenology therefore is the method of choice of some researchers who wish to explore a human experience in order to produce an insightful study of concrete human phenomena that can enrich our perceptiveness and our reflective understandings (van Manen: 1997. p.348). A heuristic study falls under the umbrella of phenomenology. A researcher using a phenomenological method desires to evoke an epiphany or transformative effect on the reader. "When this happens", says Gadamer, (1975), "then language touches us in the soul." The image has touched the depths before it stirs the surface of our being or self. And this is also true of a simple experience of reading. The image offered us by reading the poem or viewing a piece of art now becomes really our own. It takes roots in us. It has been given us by another, but we begin to have the impression that we could have created it, that we should have created it. It becomes a new being in our language, expressing us by making us what it expresses: in other words, it is at once a becoming of expression, and a becoming of our being. Here expression creates being (Bachelard, 1964: found in van Manen, 1997, p.xix).

Heuristic Research

Surrounded with phenomenological journal articles and research papers, one small book suddenly provides the poof of air needed to reawaken the dying flame within me. When the night is the darkest and there seems no hope that light will, I often rise, like a phoenix, to a

brighter and more promising day. Clarke Moustakas's (1990) heuristic research theory presented to me the tool I knew was right for my proposed undertaking.

The word "heuristic" is derived from the Greek "heuriskein," which is defined as "to discover"; it may also share the root for another English term for discovery, "Eureka!" (Patton, 1990). Like other qualitative methods, the heuristic approach allows the researcher to study an issue in depth and detail, unconstrained by the predetermined categories and standardized measures of most other qualitative methods. This concept offers me a way to proceed that has a design, a methodology, and an application that offers an approach to human science research that fits with my beliefs, my values, and my worldview. An approach that requires a passionate and discerning personal involvement and a burning desire to know the essence of some aspect of life through the internal pathways of the self.

The experience of the co-searchers was transcribed, returned to the co-searcher for their approval – a time they could remove, or add to what had been recorded. I then identified themes, and similar feelings and thoughts again returning my insight to the participants, asking them for their input. This is the heart of how qualitative heuristic research differs from statistical analysis. The interpretation is inevitably mine. I present the data, support my analysis, and in the end, it is my interpretation that is offered to the co-searchers in an attempt to produce

consensus regarding the explication of material from the interviews that clearly describes, individually and collectively, the transformation that occurred through the experience of transcending serious illness. Together, we sorted through and identified the essential and non-essential aspects of transformation as we had experienced it. If I had, in isolation, made a distinction between essential and nonessential elements contained in the experience of transformation that would be a bias on my part. It became a mutual choice. I may have identified something as nonessential that was a focus for someone else had I attempted this independently. It is a strength of heuristic research that the participants are a part of the whole up to and including validation of the study. It was in cooperation and agreement with the co-searchers that the data became authentic.

Polanyi (1983) describes the researcher as, "A discoverer [who] is filled with a compelling sense of responsibility for the pursuit of a hidden truth, which demands the researcher's services for revealing it (p.25). A vision must turn into a personal obsession, for a problem that does not worry us is no problem: there is no drive in it; it does not exist. This obsession, which spurs and guides us, is about something that no one can tell: its content is indefinable, indeterminate, strictly personal (p.75).

The term 'heuristic method' defines a system of education under which the pupil is trained to find out things for him/herself -(Concise Oxford Dictionary, New Edition). Heuristic research falls under the

umbrella of phenomenology; however there are important differences to be noted. Phenomenologists are encouraged to detach from the phenomenon whereas heuristic researchers must have a connectedness and a relationship to the phenomenon that is under study. Heuristics reintegrates the knowledge gained, producing a synthesis of discovery that includes intuition and the tacit dimension within the researcher. The tacit dimension is an integral piece of heuristic research work. Polanyi (1983) makes reference to a dimension we possess that cannot be put into words. "We know more than we can express with our language skills. We recognize a face instantly, and yet were we to be asked how we recognize that face, we probably cannot express how this comes about. We recognize the moods of the human face, without being able to tell, except quite vaguely, by what signs we know it "(p.5) Rousseau, in his Confessions (Book 6) makes reference to the tacit dimension in that, "True happiness is quite indescribable: it can only be felt and the stronger the feeling, the less it can be described. (p.224).

According to Patton (1990) the rigor of heuristic inquiry comes from systematic observation of and dialogues with self and others as well as depth interviewing of co-searchers. The power of heuristic inquiry lies in its potential for disclosing truth. (p.72) Truth is subjective. What emerges in the end is a depiction of the experiences and ideas of the co-searchers blended into a creative synthesis that Patton (1990) observes

as a process that, "...points the way for new perspectives and meanings, a new vision of the experience" (Patton, 1990, p.410).

Douglass and Moustakas (1985) observed that:

"Learning that proceeds heuristically has a path of it's own. It is self-directed, self-motivated, and open to spontaneous shift. It defies the shackles of convention and tradition...It pushes beyond the known, the expected, or the merely possible. Without the restraining leash of formal hypotheses, and free from external methodological structures that limit awareness or channel it, the one who searches heuristically may draw upon the perceptual powers afforded by ... direct experience (p.44).

The Six Phases Of Heuristic Research

Moustakas (1990) suggests there are six phases that comprise the basic heuristic research design.

1. Initial Engagement

Initial engagement means searching inward for the topic, theme, problem and eventually the question one chooses to research. Many life experiences were stored in pockets within that were brought together through in-dwelling as I moved toward the formulation of a question that would open a connection creating an understanding that would sustain others and myself. In this research I wanted to understand rather than define or explain. The life experiences I have had led to a passionate

desire to uncover, discover and explore and search out others who experienced profound transformation in their way of being as a result of critical illness. I wrote of my experiences, and kept journals of exchanges that occurred in conversation with others that held meaning for me through the years. I created questions I had no answers for..... many of them,..... until I was able to formulate the question that finally expressed and summarized what would become the crux of my work. The question was there, in a tacit dimension. It was as though I had to move through the fog and clouds before the light appeared and I could be explicit in knowing the question. "What is the essence of transformation that occurs when critical illness is experienced" became my entire focus. It was with me every day, and even in my dreams and, as Moustakas says "everything in my life became crystallized around the question."

2. Immersion

Immersion is living the question, day in and day out, month in and month out, while reviewing the literature that surrounds the chosen topic and drawing from the mystery and knowledge stored in a tacit dimension. My research was motivated by questions I could not answer, events in my life I did not understand, and a deep sense of uncertainty around my own beliefs. This led to reviewing literature that often took me on side roads of thought not necessarily connected to my search but eventually clarifying unknown facets that lead me to a definite sense of

direction. I took courses and did directed study papers that had some connection to the phenomenon of transformation at a very personal level. I explored such things as “what is spirituality”, “the Christian roots, for example, the Desert Fathers, St. John of the Cross, Origen and others. These studies were my own journey to develop a certainty and conviction around my own beliefs. They were undertaken under the direction of Harold Coward, who pointed out to me, one cannot ask others to identify their way of being unless one can be certain one has discovered themselves. Virtually anything connected with the question impact of religions on health and healing”, “what constitutes health” “the connection of spirituality, and religion to healing”, and I explored “traditional healing practices, meaning First Nation’s beliefs regarding illness and healing. I developed a knowledge and understanding of other worldviews as seen from the perspective of eastern beliefs, First Nations spirituality and early became raw material for immersion. I was guided intuitively to make connections between the directed papers I have mentioned and their relationship to the experience of transformation. I moved forward to interview people who called me as a result of a poster in two physician’s offices, or word of mouth – friends discussing my work with others who wanted to have their stories heard and felt they had been transformed through critical illness. During the time of the interviews, I made personal notes after each interview – thoughts that came to me as I listened to the stories.

3. Incubation

Incubation allows the time needed for the tacit dimension and intuition to clarify awareness and thought that are simply non-existent in the moment. e.g. “Put it out of your mind – sleep on it – it will come to you eventually” are some of the clichés that fit the incubation period Moustakas speaks of. Through the process of incubation I became aware of clarity of thought that existed upon awakening. In the time before the intellect took over to consume the day, the conscious and unconscious met and assimilation occurred. At this point, sudden connections were made and the Eureka or AHA experiences began. This is the crux of the term heuristic. – to discover. Discovery comes from what Moustakas describes as “a kind of being wide open in surrender to the thing itself.”

4. Illumination

Illumination is a time when doors open to reveal new awareness, modification, and synthesizing of knowledge that were previously fragmented. This occurred following the incubation period. Clusters I had previously been unaware of became apparent when I revisited the transcripts. Common threads appeared in a different light. My focus opened to an inclusiveness I had not previously possessed. My thoughts coming out of the incubation period were shared with the co-searchers, and we reflected upon these awareness's together. Michael Quinn Patton notes that “a sense of connectedness develops between the

researcher and what he calls the co-researcher as they mutually endeavour to elucidate the nature, meaning, and essence of a significant human experience. I have used the term Co-searcher as appropriate to this method. I was RE searching my memories, experiences and feeling and the participants were searching along with me. My own personal experiences and those of the participants began to fall into meaningful units. One of the feelings I had noted in the notes I kept following each interview was that of comfort. Each person within moments seemed as though they had always been a part of my life. I identified this as a sense of familiarity, a similar way of being. We had similar experiences, similar interests, and a desire to record and share our new awareness of life for the benefit of others. We were all striving to make sense of our experience. Moustakas says the illumination period opens a door to a new awareness of an old understanding. I had begun intuitively to uncover pieces that were essential to the truth of my experience. It was time to begin to explicate repetitive phrases, words and similar concepts that were emerging. This was done by colour coding phrases with similar meanings, and repetitive words. In sharing my awareness with the co-searchers, we validated and celebrated the common truth that was evolving.

5. Explication

Explication is a time of focusing on that which was unknown prior to the illumination phase. New information moves from the tacit

dimension to the awareness of the researcher to become meaningful; an awakening to consciousness of a variety of layers that are unique and distinctive within the experience of researcher and contributors. Nuances, textures, and constituents of the phenomenon are more fully elucidated through this process of indwelling and explication. I was now focused on the data – my journals – my transcripts – and continued to record dialogue between the co-searchers and myself. The similar phrases, and the identical meaning words were creating a generic picture. Although each co-searchers experience is unique, the benefits they perceived from illness were beginning to emerge in a universal sense. These were pulled from my thoughts, my field notes, the transcripts, the feedback from the participants and I was surrounded with the efforts of all the participants to express what had existed only in the tacit dimension prior to their experience and my own. My intuitive sense of meaning was recognizing repetitive feelings, thoughts and changes we had in common.

6. Creative Synthesis

Creative Synthesis is the comprehensive depiction of the core or dominant themes revealing the essence of the experience under study. A draft was done that included quotes from the co-searchers, pictures and poetry they had shared to describe what they felt, and each co-

searcher was given a copy. Again, new memories surfaced adding specificity to the journey's we had all taken. Each communication elicited a response, taking us a step further toward identifying the essence of transformation. Together, we sorted through and identified the essential and non-essential aspects of transformation as we had experienced it. If I had, in isolation, made a distinction between essential and nonessential elements that would be a bias on my part. It became a mutual choice. I may have identified something as nonessential that was a focus for someone else had I attempted this independently. It is a strength of heuristic research that the participants are a part of the whole up to and including validation of the study.

Moustakas (1990) sums up these phases that identify a heuristic study in the following manner:

Behavior is governed and experience is determined by the unique perceptions, feelings, intuitions, beliefs and judgments housed in the internal frame of reference of a person. Meanings are inherent in a particular worldview, an individual life, and the connections between self, other, and world. (p. 32)

Academic requisites are met following these six stages of development as outlined by Moustakas. The data gathered was a beginning to carry me deeper into the experiences of those transcending a serious illness following this process. The interviews, the explication of

data to discover the essence of the experience, and continuing exchanges with the co-searchers brought us all to a place that recognized a synthesis we desired to share with others.

The Question

The journaling I had done, the soul searching and recall of my own experiences that led to the formulation of this study created questions that were considered and discarded as I researched relevant literature.

- *“What is the essence of facing our mortality?”*
- *“What is the impact of religion/spirituality on healing from illness?”*

The question I would eventually discover to move forward with my research became the focus of my search for many months. I began to realize that words carried their own bias and assumptions. The discarded questions were based on the assumption that the co-searcher accepted s/he was facing mortality and/or that s/he had a religious/spiritual frame of reference. The question that shaped both the chosen method of inquiry and the basis of the study became, *“What is the essence of transformation that occurs when critical illness is experienced.”*

Krishnamurti (1956) notes that, “The approach decides the face of the problem. How you regard the problem is of the greatest importance because your attitude and prejudices, your fears and your hopes, color it” (99).

General questions to be included in the interviews were formulated:

- What qualities or dimensions of this experience stand out for you?
- What examples are particularly vivid?
- What feelings and thoughts have been generated by your experience?
- What time and space factors (meaning in the moment changes and looking back at changes) have affected your awareness and meaning of your experience?

Each participant encompassed these questions within their stories in the sharing of their journey from illness to what they consider to be wellness. They seemed to feel an urgency to be specific, recording minute details during the interview. These possible questions were never asked as a result of the co-searchers attention to detail.

The question I intended to ask at the beginning of each interview was, *"What changes occurred for you as a result of the journey through illness you have taken?"* This question varied slightly in wording after the initial interview. The change occurred as I recognized that, *"What changes occurred"* was interpreted as, *"What physical changes occurred"* in some instances by the co-searchers.

In my first interview I started the tape and began the interview by saying, *"What changes occurred for you as a result of the journey through illness you have taken?"* Erica's response to this was, *"It's hard to start there. I have to talk about the experiences to bring out the*

feelings and the changes."

That was my first lesson in knowing I was not the director of this research – I was only the means the co-searchers had chosen to record, validate, and offer their incredible stories to others.

Betty told me, *"I thought your paper would be a perfect avenue to express how love, strength, support, belief and courage, can make the difference when one is very ill. I hope that those who listen to your defense of this paper know very little about illness and the affect it has on people so that they can glean some new info from this to help themselves and/or others in the future. If just one person gets insight from my story...all the time is worth it."*

Interview Approach

Patton (1980) presents three basic interviewing approaches to collecting data that are appropriate for heuristic research.

A. An informal conversational interview

B. A general interview guide outlining a set of issues or topics to be explored as the interview moves forward

C. The standard open-ended interview, consisting of carefully worded questions that would be asked of all research participants

I chose the first option, an informal conversational interview allowing for spontaneity, and a natural unfolding and exchange between the co-searcher and myself. I learned in my first interview not to present pre-conceived questions during the course of the interview, realizing that

any questions I might formulate would impose my own frame of reference on the interview. I did interrupt with a question that seemed relevant to the statement the co-searcher was making on one occasion. This interrupted the flow of the co-searcher's thoughts. Betty actually stopped – thought for a moment and said to me, "*Could you just hold that thought until I've finished my train of thought and then we can come back to it?*" I can only excuse myself by saying I'm definitely an experiential learner. This taught me a valuable lesson. When the experts such as Moustakas and Patton tell you, "Asking questions does not permit the respondents to elaborate their own sense of the phenomenon that is being explored," theirs is the voice of experience. No matter how intellectually conversant we are as researchers, each new research project has it's own warp and woof to the weaving. All the co-searchers and I listened, learned, shared, and gained a keener insight into transformations that occurred within each other, from each other.

Validity & Generalizability

In heuristic investigations Moustakas urges that verification be acquired from the participants themselves as a method of validation, comprehensiveness and accuracy. It is their stories that are reported, their words that produced the essence of transformation through illness. They reviewed the patterns, themes, and clusters, that appeared to me as I immersed myself in the transcriptions of the interviews having gone through a period of incubation, meaning allowing my intuition to bring to

the front particular repetitive words, sentences, thoughts, meanings and discussing these awareness's with the co-searchers to see if they found these thoughts to be reflective of their experience. You can walk in another person's shoes but your feet will never fit in the same mold. You can have the same experience of illness but your responses, emotions, thought processes, and feelings will not be the same as the next person. It is the essence of each unique individual's experience that is uncovered. It is therefore a criterion of heuristic research to validate each step the researcher takes by sharing the outcome with the co-searchers. The researcher does not validate the outcome in isolation. The co-searchers considerate participation leads to validation of the research.

Polanyi (1969) has emphasized that, "There are no rules to guide verification that can be relied on. In the last resort the scientist (researcher) must make the ultimate judgment (p.120). Denzin & Lincoln (1998) speak to the issue of validity and generalizability in the following way:

...for those of us interested in questions of meaning and interpretation in individual cases, traditional thinking about generalizability falls shortthe value of the case study is it's uniqueness, consequently, reliability in the traditional sense of replicability is pointless... we need to get on with the ...studies that uncover the meanings of events in

individuals' lives. (p. 51)

Polanyi (1969) emphasizes, "Certain visions of the truth, having made their appearance, continue to gain strength both by further reflection and additional evidence. These are the claims which may be accepted as final by the investigator and for which s/he may assume responsibility by communicating them in print." (p.30).

This study offers analytical generalizability as it explores the processes and experiences that occurred for the co-searchers revealing those things they were found to share in common. Erine saw the potential to take her personal lived experience into the workplace. She envisioned this unfolding by asking herself, *"How do I relate this to this organization I am in? It's really just like a big organism – it's got energy blocks and it's got sickness here, and it's got some health over there. It's a tangible thing.....so how can I, within this organization I'm working in, how can I bring healing here, thinking about it in exactly the same kind of way. How can it start to learn about it's own blocks. So, I got very interested in the working of healing within an organization, and seeing what that was about. The focus was on healing and values within the work place and it was all about healing in the work place, and everything I had learned on my own, everything I had come up against, everything I had faced, every moment of despair, everything. Along that journey I had taken myself, I could see played out over and over again the same scenario in the work place. It had just taken a different form...it was*

physical – you know? Work leave because of stress...it was emotional and sometimes it was spiritual. The malaise, when people have forgotten who they are. I moved at work to just working with employees around personal and professional healing, so it has become my full time job.”

Our conversation moved to Steven Hawking's “big bang theory” and Erica added, *“Inherent in his whole theory too, is the basics of quantum mechanics: that the observer of the wave or the particle influences what it becomes, so, in that sense, how do I observe my world and what do I bring to it that creates possibility?”*

This type of “possibility thinking” is the crux of think tanks created by conglomerates to improve customer relationships, and productivity within employee relations. Erica came to this whole thought process as a result of new thinking engendered by her engagement with critical illness.

This study offers a stepping stone to move from specificity (the individual in the situation) to a more general concept (the organization or society in the situation) by using a different investigative tool such as symbolic interactionism as described under my cursory look at other methods of research. Stainton-Rogers (1991) stated, “We need to use a variety of methodologies in conjunction with each other if we are to do justice to the richness and complexity of accounts themselves, and to their cultural and social as well as psychological articulation and development” (p. 13).

CHAPTER 5

Traveling From Diagnosis to Transformation

The chapter that follows offers an analysis and discussion of the data collected from the participants in this study, known as co-searchers. Together we search for the power that exists within illness. In a heuristic study, the researcher shares with the co-searchers intuitive perceptions as they present themselves. The co-searchers then share with the researcher their perspectives regarding the researcher's thoughts and perceptions. These are integrated into the whole. The experiences of the co-searchers after the diagnosis they received have been taken directly from the transcriptions of the interviews.

In my search for meaning within the transcriptions I began to recognize patterns that led to transformation. I began to cluster the information as I became aware that as individual and unique as each particular story was, within the framework of the journey there were commonalities of previously unknown strengths, skills, and personality traits that dwelled within each co-searcher. Had they not already existed within, they would not have been present to draw on. Movement from knowledge that previously existed only innately and as a consequence dwelt within the tacit dimension to a place of knowing came about through catastrophic events in their lives. The essence of transformation requires that older, unfulfilling and un-constructive forms, be they mental, or emotional, must cease to be if there is to be new life, new ideas, or

new advancements. The co-searchers in this study found a new way of feeling, seeing, and doing that altered their life path.

The significance of the information shared with me began to take shape intuitively. The value of the profile of their worldview and view of self prior to illness and following diagnosis became important. Each story described the person's life, feelings, and thoughts before and after the diagnosis they received. There was a distinct pattern that emerged. That of "before" and "after". Each life story shared was unique with different side roads taken. I moved through explication of first themes (particular thought patterns that formed an action the co-searcher chose) and then patterns (movement through old ways of thinking and opening to new ways of doing), and finally clusters (particular words and expressions used that resonated with me as similar in value). These side roads came back to form a super highway.

The Road Taken

...One can alter one's life until...but only until...the last moment (Yalom, 1980, p.162)

Prior to being diagnosed with a potentially life threatening disease, fulfilling the expectations of others in spite of their own needs was the measure of a healthy and productive life for the co-searchers prior to their illness. This view altered as they looked inward and discovered a deeper understanding of the way they had been functioning in the world. Johnson (1979) explains this process in the following way:

It is a paradox that my social being is not determined by my relationship to others, but by my relationship to myself. I can experience the world of the other only to the depth that I can experience my own subjective world. (p.118)

Abraham Maslow echoed Johnson's realization just prior to his death. In talks he gave to audiences in the last few months of his life, Maslow made reference to his lack of need to perform to the expectations of others. He no longer needed to live up to the image others had of him. He had reached a point that he did not need to please others to validate himself. He turned inward to enrich his own world rather than the world of others (Cleary & Shapiro, 1995).

The co-searchers had shifts in their focus from their way of thinking prior to illness and the realization that their own inner world had priority for them after they found they had a serious illness. Donna described her reaction and the beginnings of change for her by using a metaphor.

"The whole thing shook the world up like an earthquake – shook it up like an earthquake – I'm a totally different person now than I was five years ago. I used to pussy foot around with people – now I don't. I don't put up with anything any more. If I'm not happy about something, I speak up. I'm much more tolerant now. Before, I wasted time being mad at people or fighting with people – I don't have time to be unhappy now. I was living for everyone else. It was almost like an overnight revelation

for me – like “HEY...I’m not going to do that any more.” I see myself as selfish now and I see that as a good thing. Five years ago all I worried about was what people thought about me and now I don’t care. A lot of people go through life doing what they think they are supposed to do or living with someone because they think that’s what they are supposed to do. Now, I don’t do those things any more. I do what I want to do and what makes me happy because that’s the most important thing. I was in a terrible marriage for decades and I left it right after I became sick. I used to have long dyed hair everybody loved. I cut it really short and let it go gray because I wanted it that way. I just live day by day now, day by day.”

Donna gave me a poem that is very special for her, written by Veronica Shoffstall called After Awhile:

After awhile, you learn the subtle difference
Between holding a hand and chaining a soul
And you learn that love doesn’t mean leaning
And company doesn’t mean security
And you begin to learn that kisses aren’t contracts
And presents aren’t promises
And you begin to accept your defeats
With your head up and your eyes open
With the grace of a woman, not the grief of a child
And you learn to build all your roads on today

Because tomorrow's ground is too uncertain for plans
And futures have a way of falling down in mid flight
After awhile, you learn
That even sunshine burns if you get too much
So you plant your own garden
And decorate your own soul
Instead of waiting for someone to bring you flowers
And you learn that you really can endure...
That you really are strong
And you really do have worth
And you learn and learn
With every goodbye you learn.

Donna found that Wicca offered her support, growth, and spiritual connection, however she withheld this from her family and friends. *"It's been in my life for 30 years, but it was buried – it was in the same cage as my spirit was in. I wasn't allowed to speak it or tell people that's what I was, because it wasn't accepted. I don't care what people think any more."*

William commented that, *"Prior to being told I had prostate cancer, I got up each morning with thoughts of what I had to accomplish that day. Now my first thought when I wake up is, "What a beautiful day and the world is perfect just the way it is." I look around and I don't see any more what I need to have, but I see what I've got and I focus on*

enjoying it. I have forgotten about amassing a fortune and I am happy to have the few material things I have. I need far less now than before I was diagnosed. I no longer will endure a situation or relationship in which I am not comfortable. Before, I was somewhat reserved in expressing my affection for fear of rejection. Now, it doesn't seem that important that the someone I love loves me because I receive pleasure from the fact that I feel love for them. I never really thought about death. Now I live for to day, for to day may be all I have."

Sandy told me, *"Before I was diagnosed with cancer, I thought of myself as a realist, or maybe even a pessimist. Since I had cancer, I see myself as being really optimistic."* After Sandy read the transcription of our time together she came back to me with a new insight into herself. She described herself as, *"having a very severe childhood,"* and she had to do a lot of repressing and denying of the bad things.

She was astounded, after reading the transcript to have the realization that she had transferred her need to repress to a positive thing. She used "denial" as a coping skill during her illness. She would read nothing that had to do with cancer and would not watch any program where someone was ill. These were things she had not known about herself at the time of our interview. She thanked me for giving her the opportunity to understand more of the transformation she sees herself as having experienced.

Janet, musing about how she was and how she is now said that,

"Before I went through this I was pretty self absorbed with my own life, and not even thinking about others....and now, what I do now too is I pray now, but I don't pray just for myself either...I pray for others (naming them). I talk to my friends who have already gone, saying, "Come on you guys...one of us has to make it – let it be me – help me out here...you've got to help me out because I'm still here...don't let it get me...help me out". These are all changes that have come about as a result of being so sick. I used to get pissed off by idiots that cut me off on the highway – now I wonder if they are going to the hospital or just found out they are really ill. My house used to be so crowded you could hardly move. Now, I have streamlined it and only have those things I need .I have cleaned all the clutter out of my life.

Erica summarized her sense of how things were before cancer and after when she said, *"So, this is where I was in my life – over giving, over loving and not giving anything to myself. I was not trusting anybody to take care of themselves. Since then, I see that as being very selfish and filling my own need to be needed. I recognized a different thread of purpose to my life. I started really working on the whole person without splitting off the body, mind, heart and spirit. I was really looking at my life in terms of "before cancer" and "after cancer" like BC and AD. I got clearly in touch with accepting I have a purpose. I did a complete turn around. I knew I had to start a transformational process from within. It is the healer that is within. I saw it almost immediately. I think illness is to*

discover information, to get our attention, to guide or direct. And I think it's very purposeful – I don't think it's accidental. It's an opportunity to do something with our selves, to transform ourselves, to use the time to go inward. I had a sense of "learning through pain" but I finally got it – that the stuff that happened to me, and the spiritual merged. After cancer they were no longer separate – they merged. It was a gift that was happening to me. I wasn't being truly loving by doing things for others. I thought I was being loving, running others lives, being strong, taking care of them, like they were not grown up enough that they could handle it if I said no? So I had to make it all okay. Now, I see that as arrogance. That was hard to look at because my whole sense of myself up to that point was that I was a very loving harmonious giving person and I began to separate sacrifice and service. I was the one that had to be giving or things would just not be okay."

What came out of all this for Erica was this understanding:

"I can serve you better now, because I don't need you – I am not serving you through need....I'm serving you through love because I am self sufficient. The previous and old way was parasitic – now there is a whole other quality and dimension."

The second gift I now have is that I don't know how long I have. I don't have any premonition. I see everything with different eyes. I don't have any guarantees. I walk this fine line between celebrating and honoring this scary place...this really really scary place...and I say I am

here – that’s all – really – that’s all any of us can do. I needed that kind of heavy-duty wake up so I could get on with growth.”

Betty had a special moment that is a lasting and wonderful memory regarding a profound change for her. *“The biggest change for me was the relationship I had with my husband before I knew I had cancer, and after. It was when the doctor told us and my husband burst into tears, and he said, “Why couldn’t it have been me?” And he looked at me and said, “Because you are such a good person.” We had a good marriage but this moment changed everything for me when I realized how much he really loved me and I felt so valued, and that was a turning point for me. When I look back, all the things I did were courageous, and I WAS brave, and I could give myself credit for that – that is the difference – that was a major transformation for me. That is the real transformation. I just went, “Oh my God, I am such a good person. That’s the transformation. I would never have had this experience without cancer.”*

Before Betty knew she was ill, she was involved with a work related group of people that experienced a drastic change after they knew of her illness. *“There was a group I worked with who were so disjointed and nitpicky, it was just terrible, and I hated going to meetings...and not only did my illness transform me, but it transformed this group as well. They had something to pull together for, and they did. It was like I stepped into that movie ‘It’s a Wonderful Life’. Before, I*

would think about how people would feel about something I might say or do. Now, I know I need not fear how these things are perceived. I more readily speak with words from my heart, not from my head, without fear of being judged or not liked. I have always felt, "To your own self be true, and it must follow as night the day, thou canst not be false to any man" but now I don't just feel it, I live it."

For Joan, the diagnosis of cancer was like a repeat performance. *"I had breast cancer four years ago, had surgery, and thought I was cancer free. Then, a year ago, the cancer came back, but more extensive this time. I could hardly imagine I would be called on to do a repeat performance. Since the first onset, my life has been so totally different. I used to have to give to everyone. It was my way of showing others that I cared for others. But now, I was forced to start taking care of myself, and I found myself alone a lot. Where were all those people I wondered? And I began to realize they could manage their lives quite well without me, and I saw that what I had been doing was making myself feel important, but when I needed something, nobody was there. I was one of those people that said, "Oh, no, thanks, I can do it", and now that I couldn't do it, they were gone. I had made myself so self-efficient, nobody asked any more. I would never have understood this, if I hadn't of been faced with such a serious illness. So, I went to my friends, and I told them I was sorry I had made them feel like they couldn't do anything right. That I now understood they could manage their own lives, and it*

was not my job to do that and that I needed them. Now, I am surrounded again, with all my good and dear friends. So, illness was a catalyst for me to learn to look inward, at myself, and not outward at other people. I learned that I had to take care of me, and ask for what I wanted. That was something I'd been taught not to do as a child. To ask for what I wanted. It took this illness for me to reach out to others, and now my life is much richer, and fuller of true friends. And now that cancer is again part of my body I don't have to do this alone and so I am grateful I had a rehearsal time. I've learned now, through my first round with cancer to wrap myself in love first, and then I can embrace others in that love."

Before Mavis was diagnosed with MS she had a deep belief in God. After experiencing a loss of health she feels that, "God has used the worst circumstances in my life to accomplish the best of results." Mavis's faith has been the pillar that allows her to declare, "I am a walking miracle. My miracle is a result of a series of events so incredible that can only be explained by divine intervention, as a result of the prayers of a multitude of people. After five major losses in my life, I decided that lying in bed watching the hour of Power was no longer adequate. That action marked a turnaround in my life. Because of my tribulation, perhaps, I have been given great gifts. I have received miraculous treatment (Mavis was wheel chair bound for 11 years with muscular dystrophy and is now walking and advocating to initiate a drug

treatment now only available in the United States). *I have learned, from my handicaps – important lessons perhaps that God intended. 2 Corinthians 1:4 tells us that God comforts us “IN” our tribulations not “FROM” our tribulations. This, I think is very significant and easy to miss. I am a much better person because I sat in a wheelchair for 11 years. I have become more compassionate. I accepted the diagnosis, but not the prognosis.”*

It took the necessity of focusing on them selves and what they had to do to meet their own needs physically, emotionally, and mentally to change the societal norms they felt they had to live by.

Separation

There were two types of separating from the reality of the situation brought to light during the interviews. One was separation and apparent disinterest in the diagnosis by children of the co-searchers. The other was separation of self-identity from the disease and medical procedures by the co-searchers.

Separation From Disease By Family Member

The adult female children of the co-searchers were primarily supportive, helpful, positive and hopeful. The adult male children were responsive when asked to contribute something but generally avoided any specific exposure or conversation regarding the illness of their parent.

Donna explained her feelings around the actions of her adult sons. *"I think, right at this point in my life, the only frustration I have is that people don't recognize my disease and they don't believe I'm sick, and it's very frustrating, because, like, my kids are the worst ones – they don't believe I'm sick. I just don't want them, after I'm gone, to be saying, "I wish I'd done this, or I wish I'd done more, or I wish I'd done that" you know. I'd like to spend more time with them and I'd like them to ...I can't explain it – I'd just like them to be different with me, because what if I'm gone tomorrow? There's no way of knowing....my father just dropped dead one day –he had what I've got – they didn't know it back then, but they know now, that that's what he had and if I go like that, I don't want to think that my son swore at me the day before and then I'm gone – how is he going to live with that? And I want them to try to – I don't know how to put it – to try to get along with me – try to make every moment we're together pleasant. Don't argue with me about things – don't say things to me that are going to upset me – don't call me names."*

The teenage girls appeared cold, withdrawn, and uninterested to the co-searcher parent. The teenage boys wanted specific information and once they understood, they were positive in their outlook, helpful when called upon, but otherwise removed from the situation. In the two interviews where there were teenage girls in the home, the same outlook was expressed.

Betty told me, *"My daughter was a huge problem to me, during*

my illness. I mean, she would be yelling at me from upstairs, "Mom, come here!" and I'd tell her. "I can't get up the stairs"...I mean I was just too weak to climb the stairs. Her behavior was terrible. Within one day, I got two pieces of advice from two different counselors – one said, "Kick her out. You can't heal yourself, with her in the home...you do need to kick her out." And my daughter's counselor was saying, "Don't kick her out, just let her be". So I had to learn how to focus on myself, not her...she was just there."

After I returned the typewritten transcript to Betty in order that she add or take away anything she either didn't want included, or new information she felt was important, she sent me an essay her daughter had written for a psychology class. The title of the paper was "Who has influenced you most in your life?" This is the paragraph she shared with me. *"My mother had cancer, and through her struggle to fight this disease, she taught me the inner power people have and to never give up. She showed me that if you work hard enough you can overcome almost anything. During this time I had to think about what my life would be like without her. I realized how important life is, that little "things" don't matter, the importance of family sticking together and how to be responsible during hard times".* When Betty read her daughter's words, she recognized her daughter coped with her illness in her own way.

Janet was telling me of all the positive support she had received..."except for my daughter...it broke my heart...it was like I

never ever was sick...she never bothered with me....she never tried to help me."

And yet, when Janet was first diagnosed and left the doctor's office, she called her daughter from her cell phone to tell her she had cancer. Her daughter's reaction was "*Oh my God, Mom Noooooo*" and she began to cry.

In both instances, I asked the co-searchers, "*Do you suppose your daughter needed you NOT to be sick? And so she was angry and taking care of herself by not participating in your sickness...withdrawing from it...not unlike you did yourself? Not that she didn't care, but that she cares SO deeply, and SO much that she couldn't even begin to look at it? To allow it?*"

In both instances, the parent had not considered that the children were actually handling it in the same way they did –placing the cancer "outside" of who they are – separating the disease from the person.

I suggested the children had chosen denial of their mom being seriously ill, as a coping mechanism. I include the exchange between myself and the co-searchers here to show that the responses from the teen age girls offers valuable insight into the emotional and mental state of children in a home that houses a member with a critical illness. Further study in this area is warranted.

Separation Of Self From Disease

Janet said that she walked the whole time she was having her

chemo treatment although hospital personnel disliked this practice of hers. Someone would say to her "Why don't you just save your strength and relax?" She told them, "No, no, no, you don't understand. *If I relax, it wins. When I'm walking, I'm in control...it's dying, but I'm not so just leave me alone.*"

Janet said, while she was walking she was, "Me, Janet.....the essence of me... my what makes me go, and then there was this stupid cancer. They could take care of what needed to be done, and I'd take care of me, Janet."

William totally denied he had cancer. The way he saw it was, "My body had cancer, but not me, the person, who I am." He saw the cancer as quite separate from his own identity.

William did in depth research on prostate cancer wanting to be totally informed while seeing cancer as a topic of interest but not part of his reality. "There was this denial thing that I didn't want to alarm anybody until I had all the facts and was sure I didn't have cancer. I decided the lab had made a big mistake and I would find out later I didn't have cancer. I only half listened to the doctors because I was sure they had made a big mistake." When surgery was booked, he still didn't tell his family. He felt he would not worry them needlessly, knowing that the surgeon would realize after the surgery it had all been a mistake.

Sandy would not familiarize herself with any knowledge of cancer. She refused booklets, pamphlets. She totally denied any need to be

informed. Her attitude was, *"This is something they can take care of. I don't need to know anything."* She said that, *"Sometimes I am watching TV and I see scenes where someone has cancer, and they die, and I'm very detached...I don't ummmm interpret this as being part of myself."* She surrounded herself with enjoyable books, shopping trips, and would not allow the topic to be discussed. It was of no interest to her.

Erica did not consider cancer as an illness, but rather a catalyst that came, *"To make me healthy. I saw it is a gift to guide me and direct me towards transformation – connecting inwards, moving from finite capacity to infinite capacity."*

Betty talked about how it was for her, when she was preparing for surgery. *"It was like I was in two pieces. There was me, the person, and there was my body. It wasn't like I was looking down at myself; I've had that experience before. It was like my mind was ok, but my body was still going to be going through this. It was like I spiritually distanced, I wasn't in my body. The spirit was removed from the physical body."*

Illness contributed to the co-searchers looking inward to capture what they needed regardless of how others viewed their actions. As I wove these experiences together I began to feel the power I was writing about that exists not just within me as a result of opening to the gifts that were there for me to take, but for the co-searchers who were so open to me with their honesty and strength. I was privileged to view how the mask of social pretense had been stripped away in favor of meeting the

challenges that were presented to them. They transformed emotions that previously had a negative connotation into positive healing form.

When they were totally engaged in the struggle to maintain control of their lives and were faced with situations controlled by others, the co-searchers empowered themselves in a very profound way. They looked upon the medical activity around them as something that had to be done; something their body needed. They maintained their sense of selfhood by separating what they required to sustain themselves in a meaningful way. They actively entered into self-care and self-healing.

In caring for self there was an awareness they had previously not known regarding what society had taught them as acceptable behavior and what they needed to use in order to survive this ordeal.

Emotions Can Empower

I was taught from an early age that selfishness is unacceptable behavior, that anger should be suppressed until I could look at the situation calmly and rationally, and that denying the reality of a situation was like hiding my head in the sand. These human reactions were to be discarded in favor of being generous to others without thought for myself, allowing my anger to dissipate without lashing out at anything or anyone, and looking reality in the face and seeing things as they really are without fanciful thought or considering any possibility other than the obvious facts. When I was faced with the reality of cancer these carefully planted seeds that had blossomed into huge trees withered and died. To

the last breath I didn't acknowledge for a moment my husband was actually that ill or that he would die. This attitude brought great joy as we expanded our thinking to levels we had never reached during our marriage. Our emotions of joy and happiness in each moment were multiplied a thousand fold. Denial contributed to many months of living in the heart of love.

Sandy's concerns were not with the diagnosis of cancer. *"I never thought in terms of death. I thought in terms of pain. I was afraid of pain... the new doctor told me I needed 25 treatments, so I was very disappointed again, but never did I think of death. In fact, it seems strange to me now, that it never occurred to me to think in those terms. I knew ultimately I would be cured. I surprised myself...that I was so optimistic."*

Visiting friends are not always a comfort as Betty discovered. *"A friend came to visit me, and he said, 'It must be something to face your own mortality' and I looked at him and I thought, 'Oh my GOD – you mean I might have DIED? What was he saying? This is not comforting – what a stupid thing to say'. I couldn't believe it. I would never have told him how this felt for me. Up to that point, I had never even thought about death. It was the first time, since the beginning, that I had a negative thought. I had children...I had colon cancer...I never thought about death. It wasn't ever an option. My attitude was 'what's to fuss about? So I have cancer.' The idea of death? Nothing...that never even*

occurred to me It just wasn't an option...it just wasn't an option."

Her doctor told Joan bluntly that he could buy her maybe two more years with treatment or six months without, but her chances of survival more than that were nonexistent. Her reaction was to think to herself, *"You don't even know me – the me that I am. You only know this disease that you see. That's not part of me, Joan, the person and I am not going to die."* She said, *"While he was talking to me, this feeling of strength came into me- I don't know how or from where; it just did and I knew he was wrong."*

Janet welcomed the pain that she experienced during her illness. *"I never took any of that codeine. When it started to hurt, I didn't let it hurt "ME". The cancer hurt and I wanted it to hurt, so if I took the pain stuff, it wouldn't hurt and it would sit back and relax and say, "Awww, I've got her now," so when it was hurting, that was good. When it was hurting it was dying and not me. I could feel it dying and I thought DIE...I knew it was dying, and that was good."*

Light In The Shadows

The shadow side of our psyche is the "other" or what is known as the alter ego or reverse side of normal behavior and patterns. References have been made to the "shadow" side of humankind for thousands of years. William Shakespeare said, "This thing of darkness I acknowledge mine." Friedrich Nietzsche thought, "Man's shadow is his vanity." (Zweig & Abrams, 1991). Moore (1992) speaks of our shadow

side as being necessary otherwise we would live in perpetual light with no choices at all to be made. We would have no self-learning from the pain and adversity we pass through if that were the case. We would live within the patterns set for us by our mentors, parents, and others we viewed as authority figures, never looking into the dark corners of our soul.

The patterns I acquired grew from the seeds planted by my parents when I was a child. Anger was to be avoided at all costs. Generosity was prized as a virtue. Selfishness was seen as an undesirable trait. Acquiescence to the wisdom and truth of those around me was considered a proper response when an authority figure offered an opinion that differed from my own. My shadow contained the undesirable traits of anger, selfishness and denial.

The co-searchers brought light into my shadow world. They cast aside the learned responses and patterns in their lives that were the composition of the mask they had previously worn. They used the emotions we were brought up to understand as negative to empower themselves. They had at their disposal a full range of emotions by shedding the mask created by society. They used denial, selfishness, and anger as tools that were instrumental in their feeling fulfilled and more complete and whole than ever before in their lives.

Coping Skills

Sandy began avoiding anything relating to cancer in magazines,

on TV or brochures that talked about possible action she might take. She occupied herself fully with things that made her happy. She gardened, read novels, and surrounded herself with people who had a positive outlook on life. She viewed her appointments for chemotherapy and radiation as trips that got her out of the house, and always did something for herself that pleased her before or after the treatments. She enjoyed a lunch at a favorite restaurant, visiting the library, or purchasing a small household item that she had put off having because it was not a necessity.

Janet viewed the diagnosis she received as separate from the person she was. The medical profession had their agenda, and she had her own. Her illness was something totally apart from the essence of her being. Janet insisted on seeing the fluid drawn from her lymph node. She told the surgeon, *"I can't fight what I can't see. I have to put a face on this so I can visualize it and force it from my body.. It is not my soul – it is not me, Janet, the person. It is something outside of who I am."*

Betty's doctor, about ten seconds into a sigmoidoscopy procedure said, "There it is – you have cancer." Betty said, *"Excuse me?"* He gave her the tube so she could see the cancer. She jokes about that, saying, *"I am one of the few people you will ever meet who has looked up their own butt." I was really glad I saw it, because then when I needed to visualize it gone, I had something to aim for. I don't think everybody could have looked, but I wanted to know everything about it".*

Mavis, having been told she must accept the fact she would be in a wheelchair for the rest of her life, hung onto her belief and faith that no matter how doubtful it looked her prayers would be answered. Realistically she heard the information she was given but, *"I learned as a child, to keep praying and to believe that the impossible is possible. My faith allowed me to believe that if I could just get through the tough times, if I could face each day smiling, no matter how much fatigue, weakness and pain I felt, that there would be an end to my suffering. I really believed this day could come. I had learned that God's delay, was not God's denial."*

Selfishness (Care Of Self)

Joan, Erica and Donna believed that caring for yourself was something done after everyone else's needs had been met. They had given little time to themselves prior to illness. They viewed their role in life as supporting others as a prime focus.

Joan left the doctor's office and headed for the library. By the time she reached home her arms were full of research material and books that could inform her of the pros and cons of the choices she would have to make. She told me, *" My husband came home from work, and the kids arrived and nothing was prepared for them. I think they thought this was only because of the news I'd received that day. I told them right then and there, "From now on, if you want to eat, cook. If you want your bed made, make it and the washer and dryer are right down the hall." I*

explained to them that for the first time in my life I am focusing on what I need, what I want. I totally became my own expert healer. I suddenly realized I hadn't done anything for my self in years, always thinking of others first. They could call me selfish, if they felt that way, but I hoped my friends would still be there when I surfaced again but I discouraged visits, phone calls and just was with myself – discovering who I really was, and what I really wanted out of life.”

The afternoon of the day Erica had surgery she went to her office to complete a project feeling she couldn't let her employer down. She was in a total state of shock, fevered, and bandaged. *“That's where I was at ...over giving, over loving, and I had to get that done. I knew I had to take control of my own destiny I was giving, giving, giving, giving. I was living the lives of so many people, you know, helping them get the right answer, and they were always coming. I spent endless amounts of my own time. I didn't have any sense of giving to myself to create a balance.”*

This description of the extent Erica felt others depended upon her reminded me of this scene from a Broadway musical Jesus Christ Super Star.



I felt as though I was seeing myself portrayed. Being a 'giver' with little concern for my own needs, there were times when I was overwhelmed with what others needed from me. It seemed there were just too many hands reaching out, clutching, and needing. There seemed little left for "me". I suddenly understood I could be depleted. It was my responsibility to keep my vessel full. It was a moment of clarity, and a very humbling reality check. I could not know what others needed. Only they could give to themselves that which would enrich them. That was their job, not mine. It was at that very moment I began to understand it was not being selfish to give something to myself in order to replenish my soul. I had a sudden awareness that it was easier to be the giver. It is almost a place of power.

I shared these thoughts with Erica who agreed, continuing to explore and expose this transformation through her own journey and understanding.

“Yes, it is a place of power and control. I always said, “Oh yes, I’m being loving” but I wasn’t being truly loving because I was, like, who was I coddling? That I should know what they should do? That I should be running their life? I didn’t think they were grown up enough to handle it if I said “no” to them? I now see this as arrogance. So I began to separate service and sacrifice, because with sacrifice, which is what I did a lot, there was a feeling of control. Very soon 98% of my friends were gone. It was very painful, when I started saying “no” they just started moving away. This was a huge time of transition.”

Erica used a wonderful anecdote she experienced while in a clinic environment in Mexico of *“Over giving, over loving, over nurturing.”*

“I saw us with I.V.’s, skin and bones, and all of us women with breast cancer and, you know, we’d be hopping across the room to help some person – to give them something they needed, and the doctors there would be going, “WHAT are you doing?” and the response would be, “Oh, I’m helping Mary – she needs...” and they would say “LOOK at you – we have all kinds of staff to do that.” And someone in the group would say, “Oh, but we don’t want to bother them....they look too busy!!!!!!!!!!”

Erica thought that a crucial piece tied to all of this is, *“Really beginning to love yourself in a very profound way – not just a superficial way. It’s like the honoring and respecting of your whole being, and I knew in order to love myself I had to get out of this huge intertwined*

service thing I've been doing. So, I had this huge subtle shift in understanding and what comes out of it is, "I can serve you better now because I don't need you – I am not serving you through need...I'm serving you through love, because I am self-sufficient." The previous and old way is parasitic. Erica calls it, "Connecting to the whole in a place of oneness with humanity."

Donna has the feeling now that some people consider her as selfish and at times, she thinks of herself as selfish. I asked her if she saw this as a good thing or a bad thing.

"For me, personally, it's a good thing. In other people's eyes, I might look like a bad person because of it, but they don't know me – they are not in my body or in my mind – they are not living with what I am living with and what they think doesn't really bother me, whereas, five years ago, what people thought about me was all I worried about and now I don't care. A lot of people go through life doing what they think they are supposed to do, and living with someone because they think that's what they are supposed to do, and now I don't do that any more. I do what I want to do, and what makes me happy, and I think that is the most important thing. Before I had this illness I was living for everyone else. I was living for my mother, my kids, and my husband. Now I follow my soul and don't take on responsibility that belongs to others. It's not my job to make sure everybody is happy."

William told me he now recognizes, *"I no longer have to endure a*

situation or relationship in which I am not comfortable. I have the right to walk away. As the sign in the restaurant says, " We Reserve the Right to Refuse Service to Any One."

Things only have the value that we give them

Molière

Anger Used To Acquire Strength

Through a process of talking to her self, Janet refocused her energy placing value on what "is" and not on what " might be". After being told by her doctor the cancer was inoperable, Janet could only think, *"I've got to get home...the dog needs to go out....I've got to get home. I went upstairs to my bathroom, and started getting all the stuff out of my bathroom cupboards, and empty the drawers...I started throwing things in the garbage...so that my daughter and husband didn't have to do it, after I died....because they'd pretty much given me a death sentence and I was sitting on the bathroom floor and I was really crying, and the dog came over and I hugged her...she pulled away from me, and she ran down the stairs, she ran away from me...and I took a complete melt down. I was hysterical and hyperventilating and so angry, I couldn't breathe...I was now laying on the bathroom floor with all this stuff around me that I'd been pulling out of the cupboard and thinking, "Oh, God, I don't want to die...I don't want to die...I DON'T want to die..." Then all of a sudden, I quit crying and I was trying to breathe (gasp, gasp...) couldn't even breathe...and I just quit crying.... I stood up.....and*

I looked at myself in the mirror...and I thought "Holy shit...you've got cancer....but you know...just LOOK at this performance....like you just put on this wonderful performance – it was worthy of an Oscar!! And there is nobody here....like...what a waste of a performance...I mean, you know...WHAT are you doing? You scared the shit out of the dog that's downstairs...she wouldn't even come to meNobody is here...Ned is at work, Karen is downtown....and I thought ALL this wasted energy...this is stupid....I'm not going to die this minute....pull yourself together...I was talking to myself in the mirror...I said, "You're so weird...I mean, you don't get an Oscar for this." I cleaned out my clothes closet and then I thought, "Good. Now you've accomplished a job you were going to do, and I never did this any more. That was it."

Bringing The Shadow Into The Light

Erica addressed the idea of our need to look inward, past the obvious, past our intellect, when we are feeling disconnected with ourselves. When she feels this way she asks herself, *"What pain, what wounding, what is it I need to bring into the light? What is the shadow I need to bring into the light?"*

My response to this concept was, *"You find that the shadow self is there for a reason...that dark night of the soul they talk about...and people want to hide it, and bury it, and have it by themselves, but, what I hear you saying is that that shadow side of you, unconscious, or subconscious, whatever word you want to use, has value if we, as you*

put it, bring it out into the light?"

Erica's response to this question was, *"Yes, without judgment, because it's part of the whole, too. It's not "somewhere else"; it's part of everything. I just don't see it now, so I can't love it – so I bring it into the light, and then, in that place, I connect with the ultimate light – all that it is – whatever – all of that – and in those two connections, the first one between me and what I have hidden, or put away, and then, my higher being, and my higher self, then I can see it."*

Self Love

Each one of the co-searchers expressed an awareness of the importance of love, love of self having priority.

William found that having love in your heart was much more meaningful to him than looking to others for love. *"It felt like I'd been searching for love my entire life and failing miserably because I couldn't find it. I was walking down the street one day and found myself smiling at those I passed. It was like a light bulb turning on! Suddenly I realized it wasn't something I needed to FIND... it was something I needed to GIVE!"*

Joan having set her family aside in order to care for her self experienced a revelation around loving herself. She developed the ability to wrap herself in love first and then she could embrace others in that love. *"It was as though I'd been looking for love in all the wrong places, looking for love in so many faces like the song says, when all I had to do*

was wrap my arms around myself. Realizing I had to have it for myself before I could truly give it to others was a big lesson. I hadn't really been loving others when I was giving everything away. I had been hoping that love would come back to me if I gave enough of it away. I never thought before to keep some for myself."

Donna learned to love herself and allow herself to express her way of being in the world without fear of being criticized by others. *"Now, it's just who I am – my spirit is set free. It's what I am. It's ME. My spirit is me and what I believe in, and how I see the world, and how the world sees me. I'm just glad I could let it out of its cage. It was in a cage for so long and I'm so much happier. It's just, to me, everything I am. If you had known me before, while it was still in its cage, you wouldn't recognize me. People who knew me five years ago, like my kids...my kids are constantly commenting on how I've drastically changed – drastically is the word that they use - that I'm a totally different person now and it's better."*

Sandy found that loving her self enough to nurture herself was the newfound skill that saw her through the treatments she underwent. *"I always believed I was doing everything for my kids and not thinking anything about myself. Even when I pray I never prayed for myself but only for my kids. Then I started doing things for myself and realized I am an important person, to ME. Maybe I didn't even like myself before I got sick but I sure do now. When I started doing things for myself, it was like*

I became valuable inside, you know what I mean?"

Janet embraced life, finding her self having compassionate thoughts for strangers; the angry people, the sarcastic people, she ran into on a daily basis. *"Now I think maybe that woman is such a bitch because she's in pain, or maybe she's in chemo and didn't feel like coming out to-day because you don't know. I didn't look like I was in chemo. I went out with all my make up on – no one would know I was really sick. Now I say maybe they are on cancer treatment ... maybe they are in a bad mood. Less confrontation, less crap, less arguing. Someone would push ahead of me in the grocery store and piss me off, and I'd dwell on that idiot that cut me off on the highway, and I'd give him the finger sign. If someone butts in front of me now, I think maybe that person is in a hurry to get to the hospital – maybe that's why they cut me off."*

Erica expanded her sense of loving to include what came into her body seeing it as something that came to make her healthy in her mind, her heart and her spirit. *"I think it's very purposeful. I don't think it's accidental. It's an opportunity to do something with ourselves, to transform us, to use the time to go inward and I immediately think "thank you" and I'm really curious about what this illness is about. I am loving whatever is coming into my body as a chance to pay attention or whatever."*

Betty described herself as, *"Just like a sponge...soaking up all the*

knowledge I could, and soaking up all the love that I could....and unashamedly using it – just coveting it. It was an experience I would never have had without the cancer. Knowing in myself that people gave me energy, strength and love but only I could seek and find the strength I needed to get me through.”

Mavis had the realization that she was surrounded with love, God's love, which helped to dispel the darkness when it appeared her disease was progressive with no hopeful prognosis.

Polanyi (1958) remarked that, “There is a distinction between what we can know and prove and what we know and cannot prove” (p.266). My own experience and transformation through illness left me with a sense of knowing what I could not prove. I am now in a place of knowing as a result of the co-searcher's shared experiences, creating the proof of what had only existed in an innate dimension prior to the completion of this study. The co-searchers stripped away the masks they were taught to wear, embraced illness as a catalyst to healing wholly, and allowed themselves to love unconditionally. The ingredients to love my mind, my body, my emotions, my spirit and myself existed within me and now I can express them outwardly. The blinders placed upon me in my desire to respect the societal norms of my surroundings are removed. We have found a way to love ourselves and to love others while considering them capable and able to be the director of their own lives. “Love takes off masks that we fear we cannot live without and know we cannot live

within" (James A. Baldwin, 1924-1987). Woodman (1990) observed that, "If we have lived behind a mask all our lives, sooner or later, if we are lucky, that mask will be smashed. (p.100). Singer (1998) has spent his entire career as a Professor within the field of Philosophy. His work has explored the essence of love for over 50 years. In his expert opinion love is not merely a contributor to a meaningful life but it may underlie all other forms of meaning.

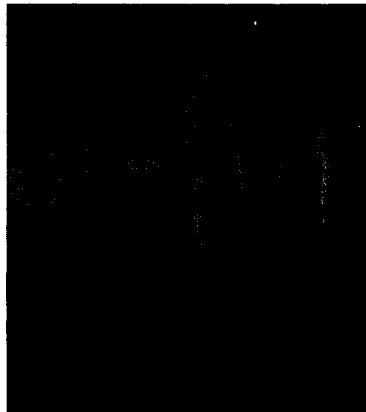
The Voice Within

In his book *The Idea Of The Holy* (1920) Rudolph Otto presents his conceptual framework to describe the feeling of the word 'numinous' which he coined from the word 'numen' (the sense of the felt presence of a divine spirit). Otto defines numinous as containing a sense of the mysterious (that which is beyond the familiar and fills us with wonder) and awe (which intimates fear of the unknown). Therefore, the experiences that follow might be described as containing a feeling sense of the numinous.

Working in Wahta Mohawk territory it was my job to support those who had experienced grief and loss issues. I was called to visit a resident who had lost her mother. She told me this story. *"It was the dead of winter. Snow lay on the ground. There was a sudden knock at my door and a woman's voice called to me to open the door. I glanced at the clock to see it was 3.30 a.m. I arose from my bed, turned on the light, and called out, "Who's there?" No one answered. I cautiously opened*

the door. No one was there. There were no tracks in the snow. "A dream, perhaps", I thought. Morning came and the phone rang. It was my sister to tell me my mother had died, at 3.30 a.m. the previous night." Janet shared her story with me. *"I was made to go to church as a child, and haven't thought about praying or going to church until this happened. So, we're going to Vegas, and it was 40,000 feet up ...I was looking out the window at all these white clouds. All of a sudden, in my head, this voice said, "Well, you're not going to die, I'm not going to let you die....trust me.....you have to trust in me....." and I think it was God. I mean, I don't know if it was my soul telling myself that it was God, but I think it was God."*

Betty's memories brought to mind an old memory that resurfaced for me. I remembered lying on a gurney in the hospital, in an emergency room. I can still see and feel the warmth and light that surrounded me. I could see a hand stretching toward me, reaching out to me, calling my name in a gentle and compassionate voice.

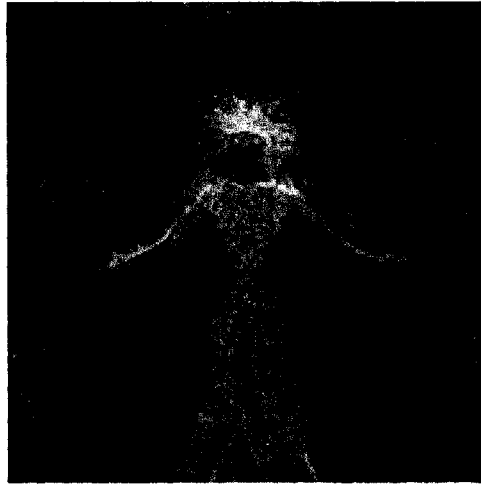


I tried to speak, but there was no sound. I watched, as the hand

began to disappear from view. Suddenly, the physical action around me became real and my body felt the coldness of the steel I was lying on."

Joan talked to me about her reaction to hearing from her doctor that the biopsy confirmed there was a recurrence of breast cancer. *"I was called by the nurse in my doctor's office to arrange an appointment. I was really scared, 'cause I knew there must have been something or they would have just said everything was fine. I was sitting there, across from him, and he told me I would have to have what he called a modified radical mastectomy. But there was another voice that was louder than his. I don't know whose voice it was. It was a woman's voice...maybe it was my guardian angel but I'd never heard it before and I haven't heard it since. So loud, she said, "Don't be afraid...I'll take care of you. Just trust me, trust me", and I kept hearing, "Trust me", and the voice just faded away. The doctor was saying, "Are you okay?" And I just smiled and said "Yup."*

Joan sent me a picture that she found because she wanted to have a face that belonged to the voice. When she saw this picture, she knew this was what her guardian angel looked like.



William told me, *"I always knew I had someone watching over me. I still had lots of things to do in this lifetime, and it never crossed my mind to even consider dying. I knew I had to take care of the small things, and my Higher Power would take care of the rest."*

All of the co-searchers had a strong sense of spiritual guidance in their lives and some were attached to a particular faith community. Their cultural upbringing is part of the Judeo-Christian western world inheritance from their families and as a consequence, the language and the metaphors have a Christian reference point.

Death reminds us that existence cannot be postponed and that there is still time for life. An awareness of death shifts one away from trivial preoccupations and provides life with depth and poignancy and an entirely different perspective (Yalom, 1980, p.162).

Reaching A Destination

The descriptions provided to me by the co-searchers provided a text that became open to a form of interpretive inquiry. I was searching to make explicit the tacit concerns that motivated and guided me in doing this research. I sought to identify particular patterns of change within myself through others. I wanted to gain insight into how some individuals changed their way of being in the world both with themselves and in relation to others after having a serious illness. I have discovered that the people in this study experienced amazing transitions and transformation that resulted in an ability to pass into a mode of existence much richer than that prior to their illness. They have drastically altered their way of thinking in many instances. They have a deeper sense of embracing life and an understanding of the gifts they have received as a result of having a life threatening illness.

Erica spoke of, "*...the huge gift I have been given - to know that every day I have to look at the flowers, to look at my house with different eyes and I look at your face that is so beautiful...and just where ever I am... I don't have any more guarantees ... so I walk this fine line between celebrating and honoring this scary place, this really really scary place....and I say that I am here – that's all – really – that's all any of us can do.*"

William told me, "*I no longer take things for granted. I try to make each day the best day of my life now. When I awake each morning, I*

thank God for giving me one more day to enjoy life."

Donna feels she has an advantage. She said, *"This may sound strange, but I honestly believe that if a person comes down with an illness – if they are diagnosed with any illness they think is going to shorten their life span I think in a way they have a benefit over other people, because it makes them get things done – where as other people, who think they are going to live forever, put things off and if you are diagnosed with a chronic illness, or a terminal illness, you don't put things off, you get things done and in a way, it's a bit of an advantage, which probably sounds weird."*

Sandy discovered feelings her children had she had not been aware of. *"As soon as I found out I had cancer and told my children, they told me how much they loved and needed me. Each one of them has sent me a ticket to visit them and I hadn't seen any of them for years before this. I wouldn't have known how they really felt if I hadn't become ill like this."*

Janet learned to live in the present moment and that the things she acquired were meaningless. She told me how her priorities had changed. *"Everything seems different...like if I don't vacuum for once...if the toilet's got a ring around it, oh well...I'll get it next week. You don't worry about yesterday, or even tomorrow. I was pretty self absorbed...I mean, I just had my little world. I think of things differently now. I've cleaned all the clutter out of my life. If I look at the moon even – I said to*

my husband last night – “look at it” I mean it’s just hanging there big and bright and beautiful.” Joan always thought without her in the house, the house would fall apart. She had not known the strengths that existed within her family unit until she allowed them to work with her – to work for her. Her family unit is now very strong. *“I thought I had to do everything for everybody. Being told I had this disease gave me the opportunity to see my family in a new light...something that might never have happened otherwise. My relationship with my husband and my children is different now. I’m almost sorry for people who don’t have a reason to stop and look around them. It probably sounds weird, but I’m almost glad this happened to me.”*

Betty discovered much about herself she had not been aware of before she was diagnosed with colon cancer. She made a list of things that she might not have known otherwise. *“I am REALLY loved - I am worthy of all good things that come my way - I can do almost anything I set my mind to, no matter how awful or how overpowering that might be or feel - I now know the importance of “being” and not “doing” - I need not fear how what I say or do is perceived - I don’t hesitate with my instincts or intuition. I more readily speak with words from my heart, not from my head, without fear of being judged or not liked - I can do almost anything I set my mind to no matter how awful or how overpowering that might be.”*

Mavis felt her faith severely tested. She learned in a very tangible

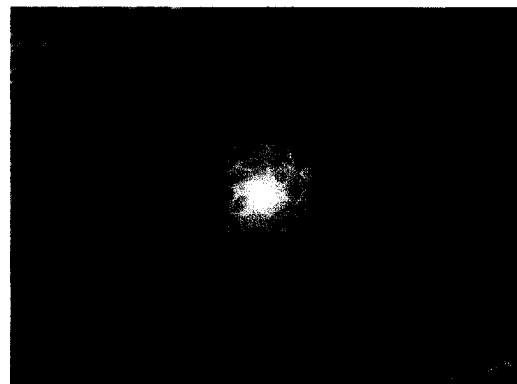
way through illness that God would never fail her and that miracles do happen. She shared with me that, *“Certainly this miracle is as a result of the prayers of many people. I am truly grateful for the caring people who have told me that they have prayed for me. My miracle is a result of a series of events so incredible that they can only be explained by divine intervention, as a result of the prayers of a multitude of people.”*

The interviews I have reported here created a sense of oneness during the time the co-searchers and I spent together that was healing for us both. It was important for most of the co-searchers to describe their experience in graphic detail, often painful to tell, and very often most painful to hear. Together we had moments of silence created by the enormity of it all. We were absorbing some new thought or feeling that had not existed within us before that moment. It was a moment of transformation in unison.

CHAPTER SIX

Reading The Map

I have found meaning in the text of the interviews by charting the journey of others. It is a very personal meaning composed of the experiences shared with me by the co-searchers that echoed many of my own thoughts, feelings, and emotions. Each of us arrived at our present destination via different roads yet the transformations that have occurred in our personal make-up and our worldview resonate in our souls in a very similar way. For many of the co-searchers it was the first time they had relived the entire process from diagnosis to the present moment and so we shared moments of discovery together as they gave voice to the transition in their thinking, doing, and being that had not been clear for them until this moment of sharing. Each of us discovered or uncovered realizations that had previously lain dormant in a tacit and innate dimension within us prior to this experience. We have spiraled downward and upward as a whirlpool takes a leaf spiraling downward and returns it to the surface.



The roads presented to me from childhood took me away from a personal road of discovery. I was blindly following the direction of others until I was confronted with a moment of choice. In that moment something beyond anything I had been taught moved into my conscious mind and brought me to my present world view which is one of a philosophical nature. The wisdom has been hard earned through grief and loss, joys and sorrows. For me, all there is is love. Each event in my life, each interaction with another, comes from a place of love. The essence of the transformation that has occurred for the co-searchers became apparent as I clustered together the most salient points from the interviews. The co-searchers' most common refrain was their uncovering or rediscovering the impact and power of love; love of self; love of the other and the role love plays in both their present state of well being and the healing journey they were gifted with. This concept was expressed in a variety of ways within the contents of the interviews I transcribed. Each one of the co-searchers used their own unique ability to express how they saw themselves loving in a truly holistic way since their body carried dis-ease. The following phrases were extracted from the data that led to my understanding of the awakening experience that led to the essence of transformation, as they perceived it.

- I had a new realization that I was surrounded with God's love
- I had an expansion of the sense of loving in a new way that included what

came into my body seeing it as something purposeful to contribute to a healthy mind, heart and spirit

- I now have an ability to love myself, my body, my mind and my spirit just as they are
- I now love myself without needing validation from others
- For the first time in my life, I love myself enough to nurture myself
- I learned that love never ends
- Loving myself first, allows me then to embrace others, in that love
- I learned to love unconditionally
- Having someone else love me no longer seemed important. What was important was that I loved them. My loving others became most important
- I now have more compassionate thoughts toward strangers

Love of self has been maligned as a human defect throughout the centuries. Western thought has usually equated self-love with selfishness. I consider that an erroneous way of thinking. Self-love increases our capacity to extend love beyond ourselves. It seems an odd symptom of Judeo-Christian thought that love of self is generally considered as a bad thing and selfish since, if one follows the principle of the Christian Bible, the second commandment is, "Love your neighbour as yourself." Would this not suggest one must practice self-love? Certainly the participants in this study have clearly shown that in their opinion self-love has been the major contributor to what they

identify as a vastly improved state of well-being.

The participants experienced transformation in many ways. Their awareness of others, of their surroundings, their daily lives, their way of thinking, and their understanding that disease, for them, had a purpose. They have expressed in words much that was previously hidden from them in a place beyond their perception before they joined me in the interviews. Critical illness brought profound self-awareness. Participating in this study and telling their stories became an integral part of the healing process. Disease previously understood as something to avoid was embraced as producing riches that intensified and expanded their consciousness. The following phrases were explicated from the data:

- *Having cancer produced a wonderful experience*
- *I recognized a different thread of purpose to my life, an experience I would never have had without cancer*
- *Since I knew I was critically ill, my life has taken on a richness*
- *God has used the worst circumstances in my life to produce the best results*
- *I have a sense of gratitude*
- *I realize how important life is, and that the little things don't matter*
- *Cancer was a catalyst, that came to make me healthy*

- *Before I had this illness, I was living for everybody else*
- *. Because of my tribulation I have been given a great gift*
- *This is not a disease. This has come to make me healthy*
- *I have come to feel honoured that I have been entrusted with illness*

Within the transcriptions there were comments made that would suggest there are still many in the helping professions who are unwilling or unable to see the contribution the person with the illness can make. Some still consider the biomedical procedures to be of the greatest importance.

Betty saw the surgical waiting room as a place where, *"You're taken up into this little area, where people are all lined up, like a cattle call."*

Sandy told me, *"He wasn't very reassuring and I think if I were a doctor, I would have said we are going to try to eliminate all the cancer...something reassuring...but he didn't and I couldn't even ask him any questions and when he told me, I just got up and left."*

William said, *"The lowest point was after consulting with the second surgeon. He scared the hell out of me by telling me how terrible death can be in advanced prostate cancer."*

Diane found that, *"Doctors don't like to talk to you about how short your life is going to be – they just don't want to talk about it and I think it's something I want to knowdeserve to know."*

Nothing positive was offered to Erica by her doctor or by the doctor's receptionist. Erica's doctor told her, *"We'll do aggressive everything but you need to know you should be getting your affairs in order because we haven't had anybody who actually survived this. The receptionist in the office told me, "Everybody who has had this –I've had to take their files away."*

Janet's strength was in her sense of being in control of her body. A health care provider appeared to need to undermine Janet's conviction in the following way. *"...And she kept checking me for these mouth sores and I said, " I told you, I'm not going to get mouth sores" and she said, "Sometimes there's things you can't control Mrs. Grey," and I said, "Well, you don't know me, but I can do a lot of stuff. That's someone else, and I'm me. I'm still brushing my teeth, and doing my thing until I can't. And I never got a mouth sore....and I think that disappointed her....she kept looking for them, you know Yeah...she was bringing me down...or trying."*

Joan, knowing she again had cancer, was working with a therapist who told her, *"I will work with you toward acceptance." I was totally shocked by her attitude. I wasn't there to accept anything. I was there to look for ways to help myself heal myself. I left her office and never went back."*

Marie's faith in God and her continuing search to reach out to advanced medical procedures brought her from a life confined to a

wheel-chair to a position of advocating for more acceptance of the strengths the ill bring to their own healing, and advancements in medical science that the Canadian health authorities refuse to acknowledge at this time.

The co-searchers have clearly indicated by their responses that any one providing a service to someone who is ill needs to have the skill and knowledge to respect the contribution the person in the situation is capable of making to their own healing, in their own way. Encouraging the patient to draw on inner strengths they possess can offer a positive sense of contributing to one's own healing. A medical diagnosis and prognosis is only one aspect of the whole, for wellness does not only mean a healthy body. Wellness can be that of spirit, of mind, of emotions and is extremely subjective. Albert Schweitzer reportedly once observed, "The witch doctor succeeds for the same reason all the rest of us [doctors] succeed. Each patient carries his/her own doctor inside. They come to us not knowing this truth. We are at our best when we give the doctor who resides within each patient a chance to go to work."(Harner,1980, p.174)

Donna expressed much the same thinking when she spoke about the physician's relationship to the person with the illness. *"One thing I've noticed, and this is getting back to the medical profession, is that THEY DON'T LISTEN. They need to listen, because I said to my specialist one day, when I was in his office, 'This is MY body....you don't know how I'm*

feeling. I'm telling you I'm sick....and we need to change what's going on here – you know,' and I don't think people should have to get to that point. I think doctors and nurses and everybody should listen to the person right away. People should not be afraid. People should not be intimidated by professional people. You should be able to go into that office and tell them exactly what you are feeling, and that came to me only in the last year, and that's when I got the courage to mouth off to my doctor and you know, since then, things have been so much better."

Benefits Of This Study

The co-searchers have had an opportunity to reflect on their own personal growth and absorb the changes in their values, awareness, beliefs and understanding of themselves as they read the transcription of our interview. The co-searchers shared new insights they had after reading the transcript of our interview. The written words produced clarity for them regarding some aspects of their journey they had not had words for prior to this experience (thoughts moving from the tacit dimension). They have a sense of offering the gift of themselves to others who will read of their journey through the continuing exposure of the outcome of this dissertation as it is used in journal articles and other printed material. The co-searchers have now read the entire dissertation and viewed the journey others in a similar situation have taken. The outcome of critical illness for all the co-searchers validates their own journey and outcome. They now feel a sense of community.

The identified themes contribute a valuable resource for further study into the innate capacity we have that can move from a tacit dimension to one of power within the person with the illness. General members of society now have an opportunity to benefit from the themes that have appeared through the stories told by the co-searchers who have experienced positive and revealing transformation in their lives and are grateful for what they have named the 'gift of illness'. Healing does not necessarily mean only healing from illness, but can be understood as healing of relationships and self.

This research is also a contribution to bridging the gap between biomedical interventions and the patient's spiritual, philosophical and emotional strengths and needs. Other researchers interested in areas such as quality of life, religiosity, spirituality and philosophy can find beginnings for new research based on the findings expressed here. Philosophy provides a conceptual perspective that holds a commitment to the critical assessment and analysis of claims, and the rational description of the conceptual presuppositions and values that frame our lives. (Marty & Vaux, 1982: p.180)

I have reflected upon the stories shared with me and come to a renewed understanding of the true meaning of healing. I have a renewed self-awareness of what is needed when working with individuals who have suffered grief and loss as well as those searching within

themselves for the inner knowledge and strength they require in order to develop new perspectives. I now have this study to offer to clients who have a serious illness so that they may better understand the transformative process that may take place for them. I have allowed myself to become more vulnerable to others with less fear of exposing my inner thoughts and feelings and more faith that if I reveal what I feel, it will be embraced without judgment.

Potential For Future Research

The Egyptians offered a holistic approach to healing. The Western world has moved from this knowledge to separating mind, body, and spirit wellness and back to integration. Frances Galton in the early 1800's explored the impact of prayer at a distance and Wirth's studies more than 100 years later addressed the possibility that the person doing the praying might have some impact on the healing of another. We can hope we don't have to wait another hundred years to expand studies that confirm the inner power of the person who is ill.

This study affirms that more qualitative research that considers gender, age, and disease specificity is warranted. Research that explores the impact of critical illness on family members i.e. teens, pre-teens, and other support people, can contribute useful information for those in the health professions to better understand the inner world of the peripheral people involved with the person that is ill. It also offers positive outcomes for the consideration of psychologists, psychiatrists,

and counselors who work with clients who have a critical illness, and their families.

Psychoneuroimmunologists are doing the quantitative research and qualitative research such as my study reveals the lived experience of the individual. This contributes to evidence that a positive perspective can make a difference to the outcome. It has been proven that the chemicals secreted by the nerves when stress and anxiety are present can shut down or disturb the normal functioning of the immune system cells. Relieving the nervous system and immune system cells of this responsibility with a change of thinking regarding our emotions, our thoughts and our feelings contributes to the body's ability to focus on healing and health.

Perhaps researchers using qualitative methods and psychoneuroimmunologists working together will produce scientific tables that can measure and further illuminate the PS factor (emotions, feelings and psyche) in PSI (psychoneuroimmunology). There are important connections yet to be made regarding the beliefs and expectations of the person with a life threatening illness and healing that occurs.

Significance Of This Study

This study contributes a rationale for the modification and/or expansion of existing health care existing health care programs to include alternative healing methods in addition to biomedical techniques.

- Credible evidence is presented to support the importance of acknowledging the positive aspects within illness that can be included in courses offered within a variety of health related disciplines (psychology, counselling, nursing, and religious studies).
- The participants validate the importance of professionals hearing the stories the person who has experienced critical illness has to tell. Within the telling of a story, lies healing. The response from the co-searchers strongly validates the importance of this means of therapeutic intervention in cases of Post Traumatic Stress Disorder.
- There has been a significant contribution made to the co-searchers who participated in this study. The participants reported they had an even clearer understanding of the journey they had taken after reading the transcript of our time together. They now see themselves in the company of others who have been transformed through a critical illness. They have also had an opportunity to revisit a difficult period of their lives and rejoice in their privileged place of survivorship and transformation.
- Within my work lay opportunity for further qualitative research. The experience of critical illness from the perspective of supporting family members and friends and the transformation and/or changes for them is a study unto itself. The connection between a critical illness within a family and the experience for the children in that family is a relatively unexplored dimension.

- Many studies have focused on the persons in the situation (the way in which they redefine beliefs, values and their world view) however few have considered the relevance of changes that occur for the person in the situation that can contribute to Humanistic fields (i.e. counselling, social work, health providers, psychology and religious studies). Researchers in the field of psychoneuroimmunology have yet to establish tools that will reveal the connection of the PS factor (psyche, emotions, feelings) to the IS (immune system) and the CNS (central nervous system) even though research in the field of mind/body/spirit connection health and wellness is extensive.
- The co-searchers in this study have transcended serious illness. They contribute a positive outcome as a result of their ability to reverse their acceptance of the societal norm that views critical illness in a negative context. They have experienced transformation in many aspects of their lives. They discovered power within the context of their illness – the power to reassess all that was familiar to them, and find new meaning.

Limitations Of This Study

The views expressed by the co-searchers and the authors are based in a Judeo-Christian Eurocentric belief system. Nearly all the participants live in Canada, one residing in the United States. Beliefs may vary from culture to culture. A researcher working within a different culture may arrive at a different conclusion.

Although a qualitative study using a heuristic approach requires exploration only to the point of saturation (meaning there is no new information being generated), the number of people interviewed could limit the generalizability of this study.

The ability to generalize is not a strength of this type of study in an empirical manner, as it does not pertain to a particular population. A heuristic method is meant to report the lived felt experience of each individual person who participates in the study. This does not mean necessarily this would apply to all persons. Patton (1990) is a recognized authority as to the value of qualitative methodology. He has observed that data collection using a qualitative methodology considers each person as unique. This being the case, research that celebrates the uniqueness of individuals as opposed to generalizing a population offers a necessary balance to the field of research. There is also an imbalance of male/female perspectives. Although the request for participants was posted in a general practitioner's office, those that chose to participate were primarily female.

Age may be a limitation. Considering the response to the trauma of serious illness by the teenage children of the co-searchers, the inclusion of minors in this type of study would be a distinct asset to further explore the sense of there being a place of power within illness.

Transformation

McGuire (1988) found that, "Adherents of widely differing healing approaches considered the ultimate purpose of healing to be the transformation and in some cases, transcendence (lying beyond the ordinary range of perception) of the self " (p. 241). There has been a transformation for the participants in this study. Their journey from a diagnosis of critical illness to transformation of their thoughts, emotions, feelings and world view is offered here to encourage those in the helping professions i.e. medicine, counselling, social work, psychologists as well as courses offered in the humanities, education and religion, to consider the impact the person in the situation has on the outcome.

The co-searchers here have spoken to us of their ability to redefine their beliefs, values and worldview. Western medicine in the last century has moved from considering not only the external cause of illness but also the internal pathways taken. Biomedicine with all its advancements contributes the external requirements to heal and there is this power within that is being recognized and honored by some.

Not only medical procedures impact disease. The person in the situation contributes. It may be a matter of surrendering to change and in so doing we experience relaxation, which in itself contributes to healing. The participants in this study turned inward and discovered a path that led to healing in many ways other than physical well-being. Enriched perspectives and biomedicine contributed to their present sense of

wellness. They feel energized and healthier than ever before in their lives. Their medical records may show “remission” or “continuing treatment necessary” or “advanced stages of the diagnosed disease” but, for the co-searchers, the healing has been much more than just that of their bodies and that is what this study was meant to accomplish – to uncover the essence of transformation that occurs for some when critical illness is experienced. Credible evidence exists in this study to support there is power within illness – personal power claimed by the participants moving them from a place of fear of disease to a place of celebrating disease as the catalyst that lead them to enter into a transformative process.

This research began as a result of my desire to know I was not alone in my understanding of transformation that occurred for me as I experienced my own critical illness, participated in a support role with others facing illness, and witnessed what I saw as miraculous healings. What I have come to understand has been presented in the preceding chapters. I have created personal meaning from the meaning others have created in their own lives.

Humankind searches for a scheme of things larger than his/her own life, with greater authority to which s/he may belong. If s/he can find such a scheme and make his/her life mean something in it - that is - contribute to it, make a difference, s/he will have ferried something of his/her mortal self across the gulf of death

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APPENDIX A

CONSENT FORM FOR PARTICIPATION IN THE STUDY ENTITLED
THE POWER WITHIN ILLNESS

Uncovering The Essence Of Transformation Through The Experience Of
Illness

You are being invited to participate in a study that is being conducted by F. Marylou Spencer-Benson, who is a Graduate student enrolled in the University of Victoria Interdisciplinary PhD program. If you have further questions you may contact her by calling 477-2737 or emailing mspencerbenenson@shaw.ca.

As a GRADUATE student, this research is part of the requirements for a DOCTORATE OF PHILOSOPHY and it is being conducted under the supervision of Dr. Honore France. You may contact the supervisor at 721-7858 or via email at hfrance@uvic.ca

You are being invited to participate in this study because you have shared with me that you have experienced transformation in your life and are willing to share changes that have occurred in your beliefs and values as a result of transcending illness.

If you agree to voluntarily participate in this research, your participation will include an ongoing dialogue between us, free flowing in the beginning, followed by some specific questions, as it unfolds.

You will also be given the opportunity to read the transcriptions I will complete and provide me with changes or points of clarification should you feel this necessary. The research will be conducted from July 2002 to September 2002

There are no known or anticipated risks to you by participating in this research, however, I would be glad to discuss any risks you might perceive. The potential benefits of your participation in this research include the opportunity to reflect on your personal insights and to share your values, beliefs, and altered world view for the benefit of others who are just beginning this same journey.

The object of the research is to uncover the essence of the transformation that occurs for some through the experience of serious illness. This will contribute to a clearer understanding of the person in the situation for the benefit of health care providers, students in fields involving health care, social work, psychology, counselling and education, and biomedical practitioners in meeting the psychological, philosophical and spiritual needs of their clients.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or explanation. If you do withdraw from the study your data will not be used in the analysis. You may choose not to answer any questions you don't wish to answer during the interview process. If you

choose to complete only part of the questionnaire and choose to withdraw, data collected will be destroyed.

In terms of protecting your anonymity, I will be assigning code names to which all data will be matched. Transcripts of the written exchanges and/or any audio taped interviews will not include any personal information and your name will not appear in the PhD Dissertation, published articles or material prepared for conference or workshop presentations.

Your confidentiality and the confidentiality of the data will be protected by securing it in separate files locked in my house. No identifying data will be made available to anyone other than myself, the researcher, and by signing this informed consent form we have entered into an agreement with each other whereby I will guarantee that your confidentiality will be protected. All written data will be shredded through confidential shredding at the University of Victoria. The tapes used in the interviews will be erased at Computer User Services using the bulk magnetizer.

This data will be used to complete my research toward a PhD degree at the University of Victoria, B.C. The data may be used for articles for publication, class presentations, and for conferences and workshop presentations.

In addition to being able to contact myself and my 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 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's Signature

Date

APPENDIX B**RECRUITMENT LETTER FOR PARTICIPATION IN THE STUDY
ENTITLED:
THE POWER OF ILLNESS
Uncovering The Essence Of Transformation Through The Experience Of
Illness**

You are being invited to participate in a study entitled The Power Of Illness that is being conducted by Marylou Spencer-Benson. I am a graduate student at the University of Victoria and you may contact me by calling 477-2737 or emailing me at mspencerbenenson@shaw.ca regarding any further questions you may have after you have read my proposal to you. This research is part of the requirements for a degree in Interdisciplinary Studies and it is being conducted under the supervision of Dr. Honore France.

You are being invited to participate in this study because you have responded to a request to share your awarenesses and transformative process as a result of having transcended an illness experience. If you agree to participate in interviews with me, your participation will include meeting with me at an arranged time and day to share your experience. Initially, the interviews will be unstructured, with later interviews becoming more structured in order to obtain specific kinds of information that may appear to be significant aspects of the changes that took place for you. The information you provide me will be strictly confidential. Participation in this study may cause some inconvenience to you, including the fact that you might feel uncomfortable with some of the questions asked in terms of elaborating on your responses. You must know that at any given time, you can withdraw from the research and that the collected data to that date will be destroyed.

The purpose of this research project is to yield some insight concerning the changes that may have occurred in your thoughts, beliefs and/or world view as a result of your experience for the benefit of others (such as health care providers, students in fields involving health care, social work, psychology, counselling and education) as well as those who will take this same journey in their future health challenges.

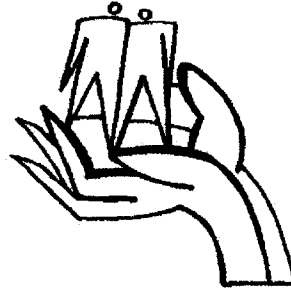
The contribution this study will have to further research may be to:

A) Assist in the modification and/or expansion of existing health care programs concerning terminal illness to include the person in the situation as an active participant.

B) Assist in supporting the need for inclusion and acknowledgement of the power within illness as an integral part of courses offered specifically within health related disciplines.

To assist in the accuracy of the data collection, the interviews will be tape-recorded. Transcription of tapes will be done after each interview. All participants will be provided copies of the transcriptions of their own tapes and an unidentifiable analysis of the transcribed tapes. Anonymity and confidentiality will be guaranteed. All participants will be given a code name that will be used throughout the study and transcripts of individual interviews will not include personal identifying information, nor will names of participants appear in the dissertation, published articles, or material presented at conferences or workshops. All tapes and written data collected during the research process will be destroyed following my aural examination at the University of Victoria, required to complete my degree in Interdisciplinary Studies.

Thank you for your consideration of this research. If you would like to participate in this study, or have specific questions about the study, please contact me at 250-477-2737 or email mspencerbenson@shaw.ca.



I NEED YOU

**IF YOU HAVE TRANSCENDED A LIFE THREATENING ILLNESS
AND ARE WILLING TO SHARE CHANGES THAT HAVE
OCCURRED FOR YOU AS A RESULT OF THIS EXPERIENCE
PLEASE CONTACT ME.**

**I AM A PHD CANDIDATE AT THE UNIVERSITY OF VICTORIA
LOOKING FOR CO-RESEARCHERS TO SHARE IN THE
CREATION OF A RESEARCH PROJECT ENTITLED "THE
POWER WITHIN ILLNESS".**

**THIS RESEARCH IS PART OF THE REQUIREMENTS TO
COMPLETE MY DOCTORATE OF PHILOSOPHY DEGREE.**

**IF YOU WOULD LIKE FURTHER CLARIFICATION, PLEASE
SPEAK TO DR. BROCK FRASER, WHO IS FAMILIAR WITH THE
GOALS AND OBJECTIVES OF MY RESEARCH. OR I CAN
DIRECT YOU TO THE DEPARTMENTS AT THE UNIVERSITY
WHO HAVE AUTHORIZED AND APPROVED MY WORK.**

**I CAN BE CONTACTED BY PHONING 250-477-2737 OR BY EMAIL
MSPENCERBENSON@SHAW.CA.**