

**A phenomenological study of the experience of pathological pain
in individuals undergoing Spontaneous Healing Intrasytemic**

Process (SHIP®) therapy

by

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Abstract

This study undertook to explore the experience of pathological pain of twelve individuals from a psychological perspective, within the context of Spontaneous Healing Intrasystemic Process (SHIP®), using an interpretative phenomenological analysis as method. All of the participants are Caucasian South Africans, of which eleven are women, and one a man.

Various aspects of the influence of physical symptoms and psychological influences are expanded upon in the available literature, indicating a greater association of relationship than is generally accepted in the treatment modalities from a medical perspective.

The experience of each of these individuals was explored to gain information on the impact of this bidirectional influence in the lives of these persons. Although each experience held a uniqueness to that particular individual, a shared process of meaning evolved in many of the themes derived from the study.

The themes derived from the research are discussed, embedded within the relevant literature supporting it. It is seen from the results of this study that the individuals gained a sense of ownership of their own experiences and an empowerment which they carried through into their lives, as a consequence of their experience of pain. The psychotherapy process that they entered into provided the platform from which this empowerment could be engendered. Although many of the findings were corroborated by the literature, each of these people had an experience that was unique to them, derived from every aspect of their lives and all that had influenced it. Several facets that emerged were not found in the literature.

From the experiences of the participants in this research project, it appears that the experience of pain may have far greater value in a broader epistemological context than just the physical function generally attributed to it. What becomes clear is that neither the pain nor these experiences should be ignored on this level or taken merely at face value. Controlling or trying to contain pain may sometimes have less value than validating it, exploring it and surrendering to other facets of its contents. Allowing the human system its spontaneous expression of physical manifestations as it would unfold if not inhibited, may produce a surprisingly abundant spectrum of otherwise hidden wealth.

CHAPTER 1

INTRODUCTION

Overview

This chapter introduces the researcher and provides background information on the stance of the researcher towards the material researched. Motivation for the study is explained. The research question is stated and the research problem portrayed. The overall research goal is presented, with a brief discussion of more specific goals entertained. The structure of the research report is given, concluded with a summary of this chapter.

Background

The human experience of life entails more than existence, procreation and survival on an evolutionary basis. What separates us from other organisms is essentially the ability and desire to create and find meaning in our lives. All of our sensory modalities enable us to add to our experience of life in all of its facets. Our very structure is geared not only towards physical survival, but to attain a sense of appreciation of what we experience. Thus we are endowed with the capability to feel a plethora of internal sensations we call emotions, ranging from ecstatically pleasant to the agonisingly unpleasant, with a whole range of nuances in between. We look for symbolic value in our existence, and we share our very being in the intimate interactions we entertain with others. Emotions shape all aspects of how we experience ourselves to be in this world.

Pain is a sensation developed by our organism to aid our survival. Physical pain is unpleasant to the extent that it motivates us to stop the activity that causes it. Emotional pain informs us of something that is causing distress to our wellbeing on some level. Traditionally these two modalities are perceived to be experienced on different levels and

treated as separate entities by different healing methods. Both are however accepted as an inevitable part of the human experience.

Considering the fact that pain is an unpleasant sensation, we normally aim to avoid it, and when it does occur we employ all types of methods to curtail its effects. We try to control it, suppress it, deny it, and put in every effort to make it go away. When our attempts to understand it are thwarted we feel confounded and exasperated and redouble our efforts to control it at all costs.

Having been in private practice as a medical doctor for several years, I am in a position to see the various facets of people's experience of physical pain. My own interest has been kindled in the different experiences that individuals have of their physical pain, and the emotional aspects of it as well. Having completed an honours degree in psychology enhanced my interest in the psychological concepts of physical symptoms, and the interaction and overlapping between these modalities.

Many possibilities for research present themselves in this regard. Pain is a symptom that is so frequently encountered in the medical world, with such a variety of concomitant emotional responses. The occurrence of pain without an obvious proven physiological cause is often found to be both perplexing and frustrating to individuals, who in their efforts to seek control of it at all costs need to find logic and reason in their suffering. Especially pain, without known cause, that repeats or persists despite efforts to contain and control it, seem to present opportunities for exploration. Research into this aspect of pain thus appeared to be an easy choice.

Motivation for this study

Having encountered many patients over years with unexplained pains in various muscles in their bodies, looking into this aspect of the experience of pain appeared to be a point of

departure. Individuals often spontaneously gave the information that they were having some stress or emotional problems in their lives at the time when their muscle pains started. Thus it seemed that some of them had made a connection to the emotional expression on a physical level already. Investigating the experience from this vantage point became the focus point of this study.

Literature provided some information on the tendency and mechanisms of pain in the musculature (Hendler, 1981; Juhan, 2003; Woolf, 2004). It soon became clear that these pains often were not experienced in isolation but combined with other physical pains and symptoms (Scaer, 2001; Levine, 2005), and on exploring the emotional components, various psychological aspects were described (Herman, 2001; JOS, 2005; Juhan, 2003; Yehuda, 2002).

As will be presented in the literature review, both pain and emotions constitute subjective experiences of individuals, and thus it was decided that it would be this experience of pain on a subjective level by an individual that would be the focus of this study. As it is stated in the context of postmodern viewpoints (Alvesson, 2002; Gergen & Gergen, 2003), it is the actual experience of the individual that constitutes the reality of it.

Brief Description of Research Question

The research question originated as a question about myofascial pain as an entity on its own. Participants who experienced this pain however often also had other unexplained pain symptoms in the same or different contexts. Thus much of the literature explored in depth revolved around unexplained myofascial pains in particular. The research question however was extended to include the chronic unexplained pain experienced on various levels by individuals.

This study endeavours to gain information and insight into the experience of people suffering pathological pain symptoms from a phenomenological stance. The study is undertaken with individuals undergoing Spontaneous Healing Intrasytemic Process (SHIP®), and this approach forms the therapeutic context of the study.

Research Question

How do people with pathological pain symptoms experience their pain from a psychological perspective, within the context of psychotherapy?

Research Problem

Pain is a very subjective experience, the existence, quality and intensity of which cannot be proved or measured empirically (Metzack, 1983; Kugelman, 2000). Woolf (2004) describes why nociceptive pain, defined as transient pain in response to a noxious substance, is a vital physiologic sensation, the loss of which leads to self-induced mutilation and destruction of tissue. He further describes the function of inflammatory pain, which occurs spontaneously as a result of inflammatory processes initiated by the body in an attempt to promote healing. It appears that the actual original pain sensation, which is stimulated by nerve cell receptors in the body due to tissue damage, is nearly identical in all human beings (Guyton & Hall, 2006). What makes it subjective is the influence of various emotional factors, the individual's state of attention, as well as past experiences the individual has been exposed to (Juhan, 2003).

As a mechanism of the body intended to protect against tissue damage, the experience of pain invariably includes the emotional components of anxiety and fear. These emotional features are created by complex mechanisms involving firstly the cognitive associations of impending harm or destruction of the organism associated with pain-producing incidents. Secondly, especially in situations perceived as threatening by the human

system, it involves the autonomous sympathetic reaction of “flight or fight” with its accompanying adrenalin and cortisol responses (Friedman, 2003; Yehuda, 2002). The combined effects of these create feelings of dread, sweating and trembling, and an acute sense of unpleasantness.

The stimulus of pain thus incites both a sensory feeling and emotional response to it, which results in a behavioural response of withdrawal or some other defensive behaviour of varying intensity. The emotional response is thus also an essential component of the mechanisms maintaining the safety of the organism. These combined effects are described by Juhan as creating the powerful psychological component of pain. He illustrates this by citing the example of the most effective pain-relieving drugs such as morphine, which does not act directly on the local pain sensing nerves, but only on the emotional centres of the brain. Juhan explains that an individual receiving morphine for pain does not cease to feel the pain at the nerve endings, but the psychological component of the pain is altered to the extent that the patient does not care about the pain as much (Juhan, 2003).

Situations in which a person experiences pain are often traumatic in nature due to the very fact that pain indicates damage or threat of damage to the body. Part of the aim of pain is to create some response of defensive behaviour, such as the “fight or flight” response (Levine & Frederick, 1997). This response assumes that the individual is in control and able to effect such a response. Herman (2001) describes the onset of psychological trauma within the context of powerlessness, explaining that traumatic events overwhelm the individual's capacity for the ordinary adaptations of the body system. Many of these events entail physical pain, such as physical violence, rape, motor vehicle accidents, war conditions and injury in natural disasters. Herman further states that when the person cannot escape or resist the traumatic experience, the normal defensive mechanisms becomes disorganised and tend to cause fragmentation. In response, the normal complex

bodily systems of self-defence employ other compensating reactions. One such reaction in response to pain associated with trauma is dissociation. In such situations, it is not uncommon for people to experience an absence of sensation in what should be an excruciatingly painful event. It appears, however, that these individuals often experience various emotional and physical pain symptoms for extended periods later on, if they develop the psychological condition of posttraumatic stress disorder or related conditions (Herman, 2001).

Obvious visible sources of pain such as open wounds, broken bones and infected tissues are easily understood and need no explanation. Some other sources of pain confound all medical tests by indicating nothing tangible, and nothing to validate the experience for the sufferer. There are many examples of such pain, such as chronic headaches, back pain, and irritable bowel syndrome.

One example of such pain is muscle pain which is experienced repeatedly in certain areas. This can sometimes be associated with 'healed' previous trauma to the area, although there is often no specific known trauma in the person's history. In my experience in the medical field, I often find that patients are merely aware of pain in a muscle, muscle group, or soft tissue area that starts spontaneously with no obvious instigating factor at the time. This can increase in intensity to various levels of discomfort for varying periods of time.

Some known 'syndromes' fall into this category of chronic intermittent muscle or soft tissue pain, such as whiplash syndrome, fibromyalgia, or chronic fibrositis. The term myofascial pain describes the underlying anatomical structures involved, denoting the muscle tissue and the fascia which are part of the connective tissue structures interwoven throughout the body. The characteristic feature of myofascial pain is that clinical physical examination

does not reveal any definite physiological abnormality, and neither do laboratory investigations. And yet the pain repeats, often driving the bearers of it to their wits' end.

In my professional experience in the medical field, I also often find these painful symptoms to be associated with the onset of stress situations in patients, and they often report that the pain dissipates when emotional or stress situations are expressed or dealt with conclusively. These clinical observations are confirmed by other researchers (Brannon & Feist, 2007; JOS, 2005; Scaer, 2001; Taylor, 2006).

Pain is highly subjective and cannot be proved empirically. Psychological experiences such as emotional trauma are also subjective and cannot be proved empirically. However, substantive claims are made that relief from psychological problems lessens the negative experience of pain, and vice versa (Juhan, 2003; Rothschild, 2000; Scaer, 2001). Going through the vast amount of literature, it is clear that this concept could be studied further from many angles.

Kugelman surmises that psychological and physical pain have similar phenomenological structures. It is experienced by individuals as felt bodily sensations, with the potential for disabling the individual at least temporarily. Both physical and emotional pain are described as wounding; both alter the person's existential world; and both are often experienced as isolating. He relates that the felt sense of emotions is commonly described in terms of bodily locations, such as sadness in the chest, or sense of loss in the heart, as heartache. A burden is carried as a weight on shoulders with the sense of pain associated with it, and feeling dumbstruck is described as a punch in the stomach. He concludes that psychological pain is pain, and equals suffering no less than physical pain (Kugelman, 2000). The implication of this for the person experiencing pain lies in the possibility that the individual may experience less discomfort, or may find meaning in the experience, which may assist in lessening or removing the pain.

Specifically, pain is a phenomenon experienced by an individual, and as such, the experience of it can be subject to many nuances and influences. The context and the individual's whole psychological and existential background would theoretically shape this experience and give it a particular meaning. The way in which an individual perceives mortality and in what way pain would influence this awareness of mortality would subconsciously affect the experience of pain (Yalom, 1980). From a psychological perspective, the experience of pain would influence the quality of life of an individual on all levels of functioning, including the way in which the person would relate to significant others and the world at large. In my experience with patients, individuals with recurring pain symptoms are often desperate to find some physical cause for their pain in order to feel validated when they perceive that others ridicule or minimise their symptoms due to the lack of physical findings.

A search for literature on the connection between psychological aspects of pain and chronic pain syndromes revealed a dearth on the subject – searches on Sabinet and other sources via library request produced literature on various aspects of the emotional and psychological aspects of pain, but scanty material on the specific combination of chronic pathological pain and psychological experiences or psychotherapy. This suggests that the field is not well-researched, and implies a potential need for further study.

Primary research goal

The primary goal for this research is stated in the research question, that is, to gain information on the experience of individuals of pathological pain from a psychological perspective, within the context of psychotherapy

Secondary research goals

The secondary research goals are aimed at gaining information on the spontaneous associations of individuals between emotions and physical pain and what their experience of this is. Furthermore, whether any changes are observed in the experience of physical pain or emotions within the context of therapy. It is also hoped to gain insight into possible changes experienced in their lives, and the meaning derived from this experience by individuals.

This study is not aimed at proving the efficacy of psychotherapy, and more specifically SHIP® therapy, in treating pain symptoms.

Structure of research report

The research will be reported on in the format of a dissertation outlining the process of research within the chosen methodology of an interpretative phenomenological analysis.

Selected paradigm

The research entails describing the concept of pain from the vantage points of integrating the psychological aspects and physical experience. This is the concept proposed and described by the broad field of psychoneuroimmunology.

Orientation to this study

A postmodern orientation is entertained in seeking the lived experience of individuals of the concept of pain, in the sense that the research does not seek an ultimate truth, but the truth of each individual person. This research is explorative and interpretive in nature.

Research design

The emphasis of this research is on exploring the experience of individuals on a subjective level of pain, from a psychological perspective, within the context of exploring their symptoms in psychotherapy. Hence, the research design will be qualitative in nature.

Research method

Literature was explored with particular relevance to the topic being investigated.

The chosen method is an interpretative phenomenological analysis (IPA). Data was accumulated by the method of interviews, which were followed by analysis and structuring into themes. A discussion of these with their relevance towards the literature studied are entertained and commented on, with recommendations for future research.

The research method is discussed in detail in chapter 3.

Measures to ensure quality of research

The concept of the trinity of generalisability, reliability and validity constitute the trustworthiness of the research, and is seen from the perspective of achieving accurate results even within the realm of subjective and intersubjective material (Kvale, 1996). Trust engendered, credibility, dependability, conformability and transferability are methods used to ensure trustworthiness, and are discussed in chapter 3.

Ethical considerations

It was considered important throughout the research process to ensure vigilance with regards to ethical matters. Anonymity and confidentiality of participants had to be ensured, they had to be assured of their right to self-determination throughout, and respect and trust maintained. The research had to be conducted in a way that would not expose the participants to harm at any time. This aspect of the study is discussed in chapter 3.

Structure of the dissertation – outline of the chapters

Chapter 1 – provides the background and rationale for the study, and introduces the stance of the researcher.

Chapter 2 – provides an exploration of the relevant literature and the points salient to this specific study.

Chapter 3 – discusses the research methodology and the salient points with regards to this study

Chapter 4 – delineates the results of the study, the analysis of the data collected and the themes derived from them.

Chapter 5 – provides a discussion of the results and integrates these with the relevant literature. Limitations, strengths and recommendations conclude the study report.

Definition of terminology

A brief definition of pertinent terms used in this study is given to provide clarity on the use thereof:

SHIP® - an acronym for Spontaneous Healing Intrasystemic Process, which is a psychotherapy method, experiential in nature, that allows the spontaneous responses of the human system to emerge as it presents at any given time in therapy (JOS, 2005).

System – in the context of this dissertation it is used, unless specifically noted otherwise, as denoting the complete system of the human entity in its totality, including both the psyche and body aspects.

Pathological pain – defined as pain that has no obvious cause in terms of tissue injury or physical findings, and has no obvious protective function in the normal sense of indicating imminent tissue danger (Schug, 2006).

Summary chapter 1

Considering the experience of unexplained pain by individuals on a physical level, the possible connection of emotions to it, and the dearth of literature specifically exploring this phenomenon as an experience, a research study is proposed and a research question stated upon which the goals for this research are based. The experience of individuals of pathological pain will be explored and reported on in the format outlined.

CHAPTER 2

LITERATURE REVIEW

Introduction

Pain being such a universal experience, literature expands on a vast variety of aspects of it, not all of which is relevant in this study. In this chapter literature pertaining specifically to the sections of the experience of pain under study will be explored. This includes literature on the mechanisms of pain in the situations of stress, emotional duress and trauma. Physiological aspects of pain relevant to this study will be discussed on its own merits, as well as in conjunction with the emotional aspects surrounding it.

Considering the overlapping nature of the physiology and emotional contents, much of the literature also displayed a tendency to include both physiological and psychological perspectives in the same studies. It therefore became difficult to separate the two components for the purpose of structure. Thus the literature review on the perspectives of pain includes the subject in the context of both physiological and emotional material in unison, although mentioned under separate headings where mainly focused on.

Literature on the psychotherapeutic perspectives, also interwoven with the physical and psychological aspects, concludes the literature review.

This chapter firstly presents a brief overview of the traditional ideas surrounding physical pain and emotional matters.

Traditional views on pain and emotions

Damasio (2006) eloquently summarises the pervading sentiments regarding the separate functioning of physical and emotional aspects of the human system. The dualist views regarding the emotional and physical structures of the human system have been pervasive

since being instigated by Descartes during the Renaissance period several centuries ago. His famous proclamation: 'I think, therefore I am', has led to science often overlooking emotions as an essential component to a person's whole being. Modern medical- and neuroscience has tended to concentrate mainly on the cognitive and neurological aspects of brain function, and on physical malfunction of the body as the sole cause of any perceived problems thereof. Damasio (2006), in this work, demonstrates that emotions are not a flimsy, erratic luxury, but essential to rational thinking.

Pain is traditionally regarded as an unpleasant nuisance that needs to be controlled. Various regimes proposing methods for adequate control abound in medical textbooks, illustrated by Sadock & Sadock, (2003). Aggressive behaviour is traditionally seen to be acceptably associated with pain, especially chronic pain. Sadock & Sadock (2003) acknowledges that physical pain may arouse an aggressive drive which includes the motive to harm or injure others. This hypothesis is used to partly explain why persons act aggressively towards others who are not even deemed to be a threat to their survival, and has been used as defence in legal proceedings. It follows that pain is regarded socially as unwanted suffering that evokes a response of sympathy from those surrounding the sufferer.

Physiological and Psychological Perspectives on Pain

Physiological perspective

The literature abounds with studies on different aspects of pain (e.g., Bellamy, 2006; Hendler, 1981; Metzack, 1983; Porreca, 2006; Schug, 2006; Skevington, 1995; Solomon, 2000; Tunks, Bellissimo & Roy, 1990; Woolf, 2004). The International Association for the Study of Pain (IASP) defines pain as follows: 'An unpleasant sensory and emotional experience associated with actual or potential tissue damage' (cited in Schug, 2006, ¶ 3). Porreca (2006) describes the mechanism of a pain sensation to be produced by the types

of stimuli in the physical body that would be capable of producing damage to tissue. This has the specific function in the body of alerting the nervous system to detect these tissue-damaging stimuli, in order for the organism to register the potential harm and take steps to avoid it – thus preventing tissue damage.

Guyton & Hall (2006) categorically states that many, if not most, ailments of the body cause pain. Even though it is a subjective experience, the ability to diagnose different diseases accurately depends on knowledge of pain and discerning between different qualities of pain.

On a physical level, subconscious shifts and adaptations of the body to pain sensations are acknowledged and described as spontaneous protective measures instigated by the body to preserve and protect the body tissues. This includes subtle or even overt repeated changing of the position of the body to allow constant maximal blood flow and tissue perfusion. The loss of these mechanisms in certain diseases, such as spinal cord injury or leprosy, leads to inability to sense imminent tissue damage through the feeling of pain, and thus these subconscious adaptations fail to occur and result in breakdown of cells (Guyton & Hall, 2006).

The sensation of pain is transmitted by specific nerve receptors adapted to perceive situations of possible tissue damage such as heat, lack of nutrients including oxygen, or disruption of the integrity of the tissue such as cuts. These pain receptors are free nerve endings within the skin and other internal tissue structures which are stimulated through various mechanical, chemical and thermal mechanisms instigated by possible harm inducing entities to relay a perception of pain to the central nervous system (Guyton & Hall, 2006; Widmaier, Raff & Strang, 2005).

Two main types of pain are described by Guyton & Hall (2006), namely fast pain, which includes pain referred to as sharp, acute, electric or pricking in quality, and slow pain, which is referred to as aching, burning, throbbing, nauseous and chronic pain. Fast pain is considered to not be felt in deeper tissues of the body, whilst slow pain occurs in both skin as well as almost any deep tissue or organs and is associated with tissue destruction. This is the type of pain that can involve what is described as prolonged, unmanageable suffering. Note that all of these descriptions for the quality of pain are subjective in nature, and yet contribute to a more accurate awareness of the type of tissue problem it may indicate.

Another characteristic of pain receptors aimed at protecting the organism, is that they adapt very little if at all to continuous stimulus (Guyton & Hall, 2006). What this means is that a person will not become numb to a continued sensation of pain due to an effect of desensitisation. This is in contrast to many other sensory receptors of the body, which do adapt in such situations. Pain would be continuously felt as long as the pain inducing stimulus persists, and in fact it often becomes progressively more intensely felt, which can easily be understood as an attempt to increase awareness of the imminent ensuing damage in progress.

From a psychological perspective, pain is accompanied by feelings in varying degrees of anxiety, dread, fear and general unpleasantness, which affects the sufferer's sense of well-being (Juhan, 2003). Pain is described by Widmaier, Raff & Strang (2005) as specifically differing from other somatosensory modalities by the fact that negative emotions such as fear and anxiety accompanies the perceived sensation. The physiological changes similar to those elicited during extreme fear, aggression or rage, such as seen in the fight or flight response, are often evoked as part of the protective mechanism to create a reflex withdrawal or escape response. This sympathetic nervous system mediated response includes the increased adrenalin secretion, increased blood

glucose, increase in heart rate and blood pressure, and sweating. Thus the pain stimulus results not only in an unpleasant sensory experience, but also in an unpleasant physical reaction to it.

It is stated that pain differs from other sensations also due to the fact that the level at which it is perceived is not solely a physical property of the specific stimulus such as the texture or shape, but that this would be altered by past experiences, emotions, suggestions as well as the simultaneous activation of other sensory modalities (Vander, Sherman & Luciano, 1994). Juhan argues that, because of the body's ability to magnify pain sensations as well as diminishing them, depending upon the emotional context of it, the mere anticipation of a specific pain may result in the physical reaction that would accompany the pain in reality. Thus anticipating the pain would activate the adrenaline and cortisol responses on physical level, with all the dread, anxiety, sweating, trembling, and the emotional suffering that the actual stimulus of the pain receptors themselves would produce. He further reasons that this anticipation and the anxiety associated with it may become so closely associated with the whole painful experience, that the individual cannot discern between the fear, the actual tissue damage, all the glandular responses and the behavioural reactions to this (Juhan, 2003).

If it occurs without a shown physical cause, the individual is also subject to feelings of shame, guilt, helplessness, anger, depression, inadequacy and self-doubt, and it is often described as an important factor in deteriorating functionality and dysfunctional interpersonal relations (Herman, 2001).

Traditionally, chronic pain was described as pain that persisted for at least three to six months' duration. However, in light of the various experiences of pain, this description has been revised, and is now defined as pain that extends beyond the period of tissue healing and/or with low levels of identified pathology that are insufficient to explain the presence

and/or extent of the pain (Schug, 2006). It has become clear that pain can in fact occur without obvious tissue damage. Schug prefers to use the term 'pathological pain', because pain experienced in this way is not visibly physiologic in its context – it is not linked to tissue injury or to physical findings. In terms of the functional survival value of pain, this chronic/pathological pain has no protective value in the normal sense – there is no imminent danger to the tissue in terms of damage. Rather, it is considered to be a change in the dynamics of nervous tissue towards perceiving stimuli from the tissue where the pain originates, which is derived from some other source (Porreca, 2006). This pain becomes a disease process in itself. Woolf (2004) describes this as maladaptive pain and considers it an area of enormous unmet clinical need because the understanding of it in the clinical world is incomplete and treatment options are thus limited. To explain the mechanisms by which the central nervous system may be sensitised into producing sensations of pain from stimuli other than actual damage to the tissues, a brief description of the way in which this process develops follows.

Chemical energy from the outside world is transduced into an energy currency, that is, an electrical signal that can be understood by a peripheral nociceptive terminal, or sensory receptor, in the body of the organism. This activates a change in the membranes of this peripheral cell of the nervous system, which in turn activates a cascade of events that is transmitted via the cell to the central nervous system where it is detected and registered as a sensation of pain (Widmaier, Raff & Strang, 2005).

Conditions named hyperalgesia and allodynia occur when stimuli of less intensity induce pain sensations of increased severity, both at the injury site as well as in surrounding areas. Areas of tissue that are not damaged also become increasingly sensitive to any sort of stimulus, including those that are not necessarily painful or dangerous. This reflects a state of central sensitisation - a state in which the central nervous system has been

secondarily sensitised through a process of activation of intracellular cascades. This has been demonstrated to include the activation of different substances in the body such as cyclooxygenase-2 (COX-2) enzymes, nerve growth factor, cytokines, tumour necrosis factor alpha (TNF alpha), and other mediators. The end result is a plasticity that occurs over longer periods of time so that the characteristics of the peripheral nociceptors can be dramatically changed. This results in increases in excitation of the connecting nervous tissue cells or dorsal horns of the spinal cord, which then secondarily leads to changes in the characteristics of these cells in the spinal dorsal horn. This results in a process described as central sensitisation (Porreca, 2006). At this point an alteration of the cells causes an increase in the activation of intracellular cascades with increased excitability and increased efficacy of the synaptic processes, which means that stimuli that would not normally produce activation of these structures can now do so (Porreca, 2006). The induction of any of the inflammatory substances throughout the body that may increase the production of prostaglandins and other excitatory substances now has the potential to provide stimuli that could lead to the experience of pain in these hypersensitised areas of the central nervous system.

Muscle spasm is acknowledged by Guyton & Hall (2006) as a common cause of pain, and considered to be the basis of many clinical pain syndromes. It is proposed that this could happen due to the direct stimulus of the contracting fibres on the pain receptors, the indirect effect of muscle spasm to compress the blood vessels supplying the muscles which would cause ischemia, as well as by increasing the metabolism rate in the muscle fibres which would intensify the relative ischemia and thus create conditions ideal for the release of pain-inducing chemicals within the muscle tissue. Juhan (2003) considers the pain sensed from muscle spasm to be derived from the nerve endings intertwined within the connective tissue surrounding the muscle.

A physiological analgesia system is described (Guyton & Hall, 2006; Juhan, 2003; Vander, Sherman & Luciano, 1994), which entails the capability of the nervous system and specifically the brain itself to suppress the input of pain signals through several mechanisms. This would partly explain the phenomenon of the tremendous variety of degree to which an individual reacts to pain sensations. Amongst the mechanisms are several chemical transmitter substances secreted by the body, such as serotonin and enkephalin. Serotonin is a transmitter known to be involved in the realm of emotions, with several qualities of the sense of well-being being presumed to be associated with its secretion, such as contentment, happiness, good sleep and appetite. The body's own opiate-like substances, including the endorphins, have been shown to suppress pain at central nervous system level, although the mechanism of this process is not quite clear (Guyton & Hall, 2006). As stated previously, the powerful opiate or morphine-like analgesic agents, act on the central nervous system level to create relief from pain, and not on the peripheral nerve endings where the pain sensation is initiated. The physiological processes of pain thus clearly indicate emotional involvement in its perception (Juhan, 2003).

The body system releases endorphins and enkephalins, grouped together under the name opioids, in response to pain, and also during stress without physical pain. It has been shown that endorphins and other opioids can be elicited by various types of brain stimulation, by acupuncture needles, and by thoughts. Endorphins are released regardless of the nature of the pain, whether it is physical or psychological. It appears that opiate-like substances can be found in nearly every body fluid, including tears. The receptors for these substances have been found in virtually all types of cellular structures, including the immune system and endocrine system. It would appear that the body has the capacity to utilise the effects of its own pain neutralising agents on every cellular level (Janov, 2001; Rabin, 1999).

The effect of emotions on the physical body is well established, as is the specific influence of many aspects of psychological material on the experience of symptoms of pain (Ader, Felten & Cohen, 2001). In the field of psychoneuroimmunology (PNI) vast amounts of research have proven beyond doubt the connection between psychological influences on the functioning of the endocrine, neurological and immunological systems of the human body (Ader et al., 2001; Kiecolt-Glazer, 2002). All of these systems interact and influence human physiology on every level, including the muscle and connective tissue, as well as all of the pain-inducing mechanisms (Guyton & Hall, 2006; Widmaier, Raff & Strang, 2005).

An integrated medical – psychological approach is suggested by Sharpe and Wessely (1997) for looking at the pathological pain symptoms from a psychoneuroimmunology perspective. They describe predisposing, precipitating and perpetuating factors in these symptoms, on the levels of biological, psychological and social categories of contributing causes. Each of these factors have numerous facets pertaining to the physiology as well as the psychology of it, all of which is described, in infinite possible permutations, to pave the way towards manifested pain.

The autonomic nervous system regulates many body functions without any conscious awareness of the individual. Briefly, it is comprised of two broad systems, the sympathetic system which prepares the body to cope with emergencies, and the parasympathetic system which helps the body conserve energy. The sympathetic system and emotions are interrelated, and when emotions are activated that indicate the need to flee or fight for survival, the sympathetic system is activated with the resultant stimulus of body systems as described previously. In addition the immune system is suppressed and thus the individual becomes more susceptible to infections. This reaction to emotional stress is intended to be a short-term response only. Over a short period this would not be very relevant in terms of observed effects, but with long term emotional stress and trauma the

suppression of the immune system has more noticeable effects. Several other chemical substances come in to play in this chronic stress situation which would seem to contribute to a heightening of the experience of pain (Rabin, 1999).

It has been shown that the body's own opioid-chemical substances, or endorphins, enkephalins and dynorphins, are also produced by the cells of the immune system which would be active at the sites of infection, inflammation and pain. Rabin (1999) postulates that these may help to relieve the pain at localised sites of tissue damage.

Other theories arose on the importance of connective tissue, parts of which are termed fascia, and the influence of psychological aspects on these structures (Juhan, 2003). In order to clarify the mechanism by which connective tissue is involved in the process of storing and transferring the impact of trauma memory, a brief summary is given of Juhan's (2003) exploration of this topic. Contrary to previous thought, connective tissue is not merely a body substance that holds all the rest together. It is a functional system or 'organ' in itself. It takes on many shapes and properties, and has different qualities depending on its locality in the body. In the form of fluid ground substances, it is the immediate environment of every cell in the body, and thus undoubtedly has a wide range of effects upon every cellular membrane. This includes a vast range of chemical activities, amongst which a direct influence on the passage of all sorts of gases, hormones, nutrients, antibodies, waste products and white blood cells between the blood vessel capillary cells and the other tissue cells they envelop. These ground substances can thus be regarded as chemical filters which regulate many interactions in the body (Juhan, 2003).

Other forms of connective tissue are found in abundance throughout the body. More than one third of body protein is made up of collagen fibres, which is present in a variety of formats. These fibres are the chief fibrous content of skin, ligament, tendon, cartilage, bone, blood vessels, and all organs. Among its chief characteristics is its flexible nature,

and the fact that these fibres can be arranged in any number of ways to produce a wide variety of properties. The fibres are made up of fibrils. Juhan (2003) describes the hollowness of these collagen fibrils as one of its fascinating aspects. Research has found cerebrospinal fluid in these hollows, which suggests that the connective tissue framework is one of the circulatory systems of the body that may play a role in the body's chemical messages and balances in a far more sophisticated way than has presently been revealed. New connective tissue is formed on a constant basis by cells called fibroblasts.

Two hormones of the endocrine system are known to have a powerful effect on connective tissue. The first is growth hormone, which is secreted by the pituitary gland, and which directly stimulates the fibroblasts to increase the production of collagen. The second is cortisone, which is secreted by the adrenal glands, specifically more so under situations of stress. Cortisone inhibits the activity of fibroblasts, thus interfering with the normal maintenance and healing of the support structure of all tissues (Juhan, 2003).

Muscle tissue itself has no or very little sensation. As noted previously, the feeling derived from a muscle group is supplied by the nerves serving the surrounding structures, specifically the connective tissue and muscle spindles. For motor function, nerves are blended into the structure of muscle spindles so perfectly that it is hard to decide whether these can be regarded as sensory endings that contract and lengthen, or as muscle cells that feel. These are described by Juhan (2003) as creating the whole sense of memory in the body, and specifically the sensory memory of muscle groups, in that the memory of how it feels to execute any delicate nuance of any activity is the actual learning process of the body.

The connective tissue, muscle spindles and nerves that relay all the delicate sensory messages cause the muscle fibres to contract to a greater or lesser extent on a constant basis, creating a feeling of pressure or tension or weight in a muscle. This feeling

becomes a 'sensory memory' for that muscle in that specific state of experiencing – the tissue has 'learned' and will remember what it has learned (Juhan, 2003). Thus as specific physical sensations are experienced by the body in combination with certain emotional sensations, the combination of the experience is felt as a unit, and the memory of the sensation is laid down in the body tissue as such a felt sensation. Juhan (2003) provides the example of the experience of shame as an emotion, with the musculature in a certain subtle way of contraction at that point. The specific felt sensation of that muscle/connective tissue format will reveal a concurrent feeling of shame in future for that particular person. This is of course a repetitive process.

Psychological perspective

From a psychological perspective, Juhan (2003) explains this as a specific method of 'capturing' an emotional trauma memory in the connective tissue through changes in the molecular functioning of such tissue. The effects of it are expanded upon by other authors. The psychological impact of perceived threats to survival, such as motor vehicle accidents (Scaer, 2001) or dog attacks (Rothschild, 2000), are described in numerous case studies (Herman, 2001; Levine, 2005; Levine & Kline, 2007).

A 'gate control theory' is explained by Crossley (2000) as the way in which pain perception involves a multidimensional process in which many factors play a role, not just a single physical cause. A three process model of pain is described, in which individual differences in the perception of pain is contributed to by three interacting dimensions, namely a physiological, a subjective-affective-cognitive, and behavioural. Thus many psychological variables are included in the eventual experience of pain, such as attention, coping style, self-efficacy, locus of control, memory, anxiety, learned behaviour, depression and personality.

Dissociation is described by Scaer (2001) as a term coined by Janet in the late nineteenth century for the mental state of disruption of conscious awareness. This would include distortion of perception, memory, affect and sense of identity, which could result in altered perceptions of time and physical sensations, amnesia, and feelings of unreality. The amnesia is especially common in adult survivors of child abuse, who often have little if any memory of their trauma, or distorted memories of it. It appears that they often have very little memory of any childhood events as a result of this phenomenon.

Several dissociative physical symptoms are noted by Scaer (2001). Changes in visual acuity and perception are common, and so is distortion of sensation such as loss or exacerbation of sense of pain, touch and vibrations. These dissociative physical responses are often exacerbated within current traumatic situations in persons who have had previous trauma such as childhood abuse. Persons with a history of childhood trauma, especially when inflicted by their caregiver, are described to be exquisitely sensitive to retraumatisation. Scaer (2001) states that these individuals often present with more complex physical symptoms.

Herman (2001) argues that the process of dissociation occurs at the moment of trauma within a context of powerlessness, enabling the individual to escape the sensation of pain as well as the accompanying feelings of terror. However, this process of dissociation results in the physical and emotional traumatic experiences being 'captured' in the system to repeat themselves in various formats later in the individual's life. To a greater or lesser extent these can result in the conditions described in psychological terms as posttraumatic stress disorder and borderline personality disorder.

Van der Kolk (2006) describes the neurobiological changes explained by observation in neuroimaging studies of PTSD, with the resultant effects on neuronal activation of emotional responses as well as body responses. His research has found that many

individuals, when exposed to chronically overwhelming emotions, lose the capacity to recognise what they are feeling, and thus lose the ability to use emotions as guides for an appropriate response to a situation. He uses the term 'alexithymia' for this inability to recognise the meaning of one's own physical and emotional sensations and muscle activation, and the consequent failure to appreciate one's own and others' needs.

The inability to align one's emotional responses to appropriate actions leads to repetitive instances of ineffective interaction with others, for instance a withdrawal or freeze response, or alternatively an overreaction or intimidating response to even minor incidents. Eventually such people perceive that just having feelings is dangerous, and experience emotions as merely reminders of their inability to influence the outcome of situation, which are therefore best avoided completely (Van der Kolk, McFarlane & Weisaeth, 2007).

Lack of assertiveness, or of ability to express anger appropriately, has been demonstrated by Solomon (2000) to be a more common trait amongst groups of people treated for chronic arthritis. Different tests such as MMPI scales, and psychodrama enactments exposed trends of self-sacrifice, unassertiveness, feelings of guilt, denial of hostile feelings and masochistic behaviour in individuals suffering from severe arthritis. These patients, from families with histories of genetically inherited rheumatoid arthritis, were compared in studies with siblings who did not suffer from the disease, even though their autoantibody rheumatoid factors were positive. The siblings were invariably more assertive and expressive, especially about their anger. Solomon found that many of his arthritic patients had anger turned inwards, towards themselves. More specifically there was anger about not being able to assert themselves or claim their own needs as valid.

Scaer (2001) describes symptoms arising from known traumatic experiences via pain in specific muscle, soft-tissue or fascia areas, including 'whiplash syndrome'. He states that the combination of myofascial pain and other symptoms which comprise this syndrome is

not related to soft tissue injury of the neck, shoulder and back areas, as is generally believed. His studies indicate that the symptoms of myofascial pain, dizziness, anxiety, and cognitive dysfunction that are termed 'whiplash syndrome' occur in individuals who have undergone an episode of trauma involving a feeling of helplessness as the common denominator. Some cases are connected to a motor vehicle accident. Many, however, are not, but entail various other episodes of trauma. This result in repeated intermittent pain in the neck, back and shoulder muscle areas, such as the pain originally experienced right after a motor vehicle accident with a whiplash type injury. Scaer characterises this myofascial pain as a chronic, self-perpetuating condition that is remarkably resistant to treatment, is often regionally specific, and in some cases may last indefinitely. He explores this more broadly as a model of traumatisation, with long-standing neurophysiological changes that are experience-based, rather than injury-based (Scaer, 2001). That is, the extent of the physical injury does not determine the level of the trauma, but the experience as it is perceived does.

Scaer postulates that the phenomenon of regional somatic dissociation is directly linked to the freeze or dissociative response, occurring at the moment of a traumatic event in a state of helplessness. This entails the experience of unexplained chronic regional pains by these individuals which may include other dystrophic sympathetic symptoms, such as lack of hair growth, redness of the skin, numbness, unusual burning and atrophy of the skin. These features will be imprinted in implicit memory unless the experience related to the traumatic event is dissipated through completion of the physiological cycle of trauma by intense motor activity. The pain perception will specifically be powerfully imprinted, and dissociation will cause fragmentation and distortion of the memories surrounding the event, including that of the pain. Thus pain exaggeration in relation to the specific trauma experienced may be observed in these chronic pain syndromes. Dissociation appears to be the most critical element contributing to the physical symptoms of traumatisation (Scaer, 2001).

Juhan (2003) explains that much of the escalating or chronic nature of muscle spasm and pain is due to the sense of loss of control or feelings of helplessness the individual experiences. He describes studies done on animals in which specifically those who had no control over their situations developed physical pathology and died, as opposed to those exposed to exactly the same conditions but with some aspect of control over their situations. Methods employed to create a sense of pleasure in the body in contrast to the discomfort experienced because of pain, have been shown to increase an awareness of the possibility of control over the pain, which changes the meaning of the pain and therefore the response to it. Thus bodywork, or different methods of massaging, with its resultant soothing tactile stimulation of the skin and musculature, as well as the lessening of anxiety it creates, has a greater function according to Juhan (2003), in breaking these pain-spasm cycles through the sense of control that it instils. Thus it appears that experiencing some level of control in body pain contributes to alleviate the pain because it diminishes the feeling of helplessness. This finding is corroborated by other authors (Holey & Cook, 2004).

Various aspects of the importance of a perceived sense of control are commented on by Walker (2001). He elaborates on the physiological context of a feeling of control and the loss of it, and states that control has a direct effect on emotional states. Perceived loss of control has been shown to be associated with anxiety and depression. Studies indicate that individuals could produce voluntary analgesia of their pain within the setting of belief that they have control in a given situation. Specifically endurance is ascribed to a feeling of hope that relief will ensue, and experiencing pain as debilitating ascribed to the fear arising of it as being unendurable (Walker, 2001).

Rothschild (2000) describes the physical symptoms, including pain, which occur when individuals relive specific emotionally traumatic events such as an incident of rape,

especially if the emotional aspects of the trauma have not been dealt with. She explains how autonomous body reactions triggered by the memory of trauma such as pain and shock resolves and disappears after working through the incident in a therapeutic process. The opposite, in which an emotional memory is brought to the surface by certain positions of the body structure, is also observed. The example is given of a woman who got her arm bent in a certain position and suddenly went into an acute state of panic. It transpired that when she had been raped years before, the arm had been forced into this position by her assailant. The memory had been dissociated from at that time, but the specific position of the bent arm brought it into her conscious memory again (Rothschild, 2000).

Levine & Frederick (1997) developed a theory from the way in which animals are observed to release immediate fright responses through body reactions directly after life threatening situations, implying that these animals do not suffer from chronic pain syndromes or psychological conditions because they can immediately release trauma responses. Prey animals in the wild are routinely threatened but rarely traumatised. They have a physiological process for returning to a normal state after a narrow escape from death, in which their bodies undergo shaking, trembling and jerking of limbs, after which they are able to carry on without any sign of being traumatised. He has found that humans who experience what their systems perceive as a life-threatening situation may develop various symptoms, including pathological pain syndromes. These often improve and disappear after the body had gone through a process similar to the spontaneous trembling and shaking observed in animals. He expands on this with techniques for encouraging similar responses in humans through therapeutic processes, with resultant relief from chronic symptoms (Levine, 2005). Levine emphasises that trauma does not actually have to be life-threatening, but merely has to be perceived as such by the body to create the physical responses described. He includes situations such as minor motor vehicle accidents, medical or dental procedures (especially where a child has to be anaesthetised or immobilised by force for the procedure), falls (such as falling off a bicycle), losing a loved

one, birth stress, and so on, as situations which could elicit a trauma response. He stresses that this response is an autonomic process of the body which is not under voluntary control.

Levine and Kline (2007) consider the core symptoms of trauma to be physiological, and therefore they need to be released through the body. These authors distinguish between the experience of sensations such as warmth, shakiness, 'butterflies', pressure and jitteriness for example, and emotions such as fear, anger and sadness. Both have a basis in physiological changes and as such hold an energetic charge in the body's physiology; they can be pinpointed as a physical feeling in a specific area of the body. Sensations derive from the reptilian forebrain, and Levine and Kline believe that the capacity to navigate these sensations is responsible for the internal shifts that can lead to transformation. According to them, emotional difficulties arise as a combination of thought and sensations. Focusing on the sensations (and thus on the physical feelings of these sensations) with a sense of patient watchfulness and curiosity leads to a reduction in the sensation to a more comfortable level of alertness. In this way sensation shifts, and the emotion, which was a result of the combination of sensation and thought, transforms (Levine & Kline, 2007).

Levine and Kline (2007) describe the fragile balance between developing children's need to safeguard their selves against intrusions that violate their boundaries, whilst simultaneously needing to nourish their selves through contact with others on an intimate level. Psychological trauma is described as often causing chaotic development or fracture of these boundaries, leading to anxiety and other psychological problems (Herman, 2001; Scaer, 2001; Yehuda, 2002). Laing expands on this by describing the gradual disintegration of boundaries intertwined with extreme emotional pain and overwhelming anxiety for the protection of the integrity of self, which leads to dissociation in the form known as schizophrenia (Laing, 1990).

Levine and Kline (2007) note the significance of the emotion of disgust working in unison with the body's digestive tract to form natural boundaries between the self and experiences perceived as disgusting. On a symbolic level it appears as if the body senses a primal need to rid itself of something experienced as intrusive psychologically, and individuals develop nausea and vomiting, as well as diarrhoea as a means of getting something perceived as disgusting out of the system. This pertains to emotionally disgusting experiences specifically. They note how spontaneous nausea in association with emotional distress should create an awareness of some memory of a feeling of disgust that needs to be explored.

The importance of experiencing the actual emotional and/or physical pain in context is emphasised by Janov (2001). He considers the repression of painful material in childhood as an important survival strategy and thus a specific function developed by the human nervous system in its evolutionary evolution and expansion. He states that it would not be possible for infants or small children to manage the emotional or physical pain of many traumatic experiences, including supposedly lesser trauma of more subtle nature on a long term. The body system therefore gates, or closes off to the actual experience, thus protecting the child from the overwhelming pain. These suppressed pain experiences are not merely lost, however, but continues to influence the individual's functioning on all levels subconsciously, until the individual develops the maturity and ability to deal with it. Working through the material does not entail cognitively thinking about it or discussing it, but very specifically needs to be felt at the original level of intensity. Janov stresses the fact that it is essential to feel the original painful emotional sensation as it had felt at the moment of its repression, in order for it to clear. This sensation cannot be forced either, but has to be accessed and relived spontaneously to provide effective relief. He describes the occurrence of physical pain memories surfacing and experienced in the present, concurrently with the emotional experiences in this context. He also relates the occurrence

of visible tissue changes during such experiences, such as the appearance of red marks during psychotherapy sessions working with the impact of birth, as it would have been left by forceps during a difficult delivery (Janov, 2001).

JOS (2005) describes how pain of an emotional nature becomes dissociated from the conscious mind because it is too much to tolerate consciously. This may commence in childhood or even earlier. Emotional pain can include any of innumerable feelings, such as helplessness, shame, isolation, loneliness, anger, anxiety, worthlessness, rejection, depression and so forth. Not being allowed to run its course, it persists in the disconnected-memory imprint centre, and is stored in parts of the body that later produce symptoms of chronic systemic stress reactions. These feelings could present as physical feelings in various areas of the body when some incident occurs to activate the subconscious memory of the emotional discomfort. Physical symptoms may include headaches, stomach pains, nausea, muscle spasms and pains, and various others, depending on the individual's genetic and physical predisposition.

These physical symptoms typically also appear when the individual becomes aware of the emotional problems that were previously repressed or dissociated from. The process is explained by JOS as that of the innate wisdom of the body that, if allowed to unfold and be expressed spontaneously, will allow healing of the original disconnected imprint to take place. As a result of this process, both physical and emotional dysfunction and symptoms will lessen or dissolve.

Clients involved with Spontaneous Healing Intrasytemic Process (SHIP®), as explained by JOS (2005), are specifically encouraged to stay with the physical experiences that they perceive during therapy, and to focus on these sensations as they arise. Many different sensations are described, including neurological symptoms such as pins and needles, tingling, numbness, and cardiovascular symptoms such as palpitations, chest pain, a

feeling of shortness of breath, and so on. Pain of various levels of intensity may occur in various locations in the body.

JOS (2005) also elaborates on the use of psychobiological stimulants during therapy. For instance, a client is asked to focus on the specifics of bodily sensations while working with psychological material, such as feeling the precise nature, location or physical sensation of an emotion. This often leads to the emergence of further disconnected psychological material. This material is encouraged expression, allowing any feelings or physical sensations to follow their course of expression spontaneously until they dissipate or end, and are experienced no further.

Amongst other physiological changes, JOS (2005) reports a decrease in the perception of previous chronic pain symptoms experienced by individuals undergoing SHIP®. Pain that surfaces during the therapeutic process may elicit certain emotional connections, and contrarily working through emotional experiences during therapy can bring pain symptoms to the surface that dissipate when the specific psychological content is dealt with.

Methods for working with chronic pain through imagery techniques are described by Korn (in Sheikh, 2002). Pain and anxiety are grouped together as entities that occur in connection with each other, and thus can be worked with together in imagery therapy. Body movement is considered to be a non-verbal form of imagining by Sawyer (in Sheikh, 2002). Sawyer reports that it is not unusual or difficult to elicit responses from the body in the form of movement in connection with an emotional feeling. She finds that any emotion or mood can be felt by body parts, either in the body as a whole, or in localised areas such as a left side, right side, arms, chest, knees or legs. She describes how this physical feeling of an emotion can be encouraged to unfold in whatever way the body chooses to portray it, either on a spontaneous physical level, or symbolically. This is used to facilitate the integration of emotional material for an individual through physical experiencing of it.

Goodman (1990) and Gore (1995) both describe various aspects of the way in which body postures can elicit specific emotional experiences.

Goodbread (1997) provides an explanation of how deeper unconscious material can be accessed through a process-orientated psychotherapy, and describes the experience of a process of pain as it may evolve within a therapeutic context. The process entails focusing on the specifics of the actual perceptions as it unfolds, with whatever other material that becomes associated with it. Integration of the experience is described as not a state, or complete event, but a process in itself that takes place on different levels at different times.

Taylor (2002) considers the experience and effects of mothering, nurturing, or tending, as crucial to the survival of the human being, and describes how mothering can forestall the potential effects of inherited genetic traits. She further explains how nurturing can prevent a risk for disease to materialise, and why a genetic propensity may lead to disease outcome for one person and the opposite for another, including the way in which an individual deals with pain symptoms, depending on the nurturing they received. She believes the instinct of tending is evolutionary developed, equally strong in men and women, and motherhood is thus not a personal desire, but encompasses a collective survival drive with deeply rooted feelings involved.

The experience of motherhood is described by Northrup (1998) as a powerful part of feminine psychology on physical, emotional and symbolic levels. Miscarriage happens in two out of six pregnancies for various reasons, and apart from the medical aspects of managing them, she argues for the validation of intense grief processes that is part of the process of integration of such an occurrence. She comments on the fact that mourning about a miscarriage is generally not accepted to the extent in which she finds women often need to mourn. Her findings suggest that women experience a loss of trust in their bodies,

and in their ability to create, after a miscarriage, more specifically because the intense experience of it is not worked through effectively.

Walsh (in Corsini & Wedding, 2000) explores the ways in which psychotherapies can transform pain into a feeling of compassion through increased awareness. He considers successful therapy to depend upon a sense of awareness developing on all levels of life, and expands on the concepts that therapy should extend to careful reflection on our life and inevitable death as a powerful means to develop wisdom. Thus embracing all of the feelings, without fear of them or trying to avoid them, encompasses the true human experience.

The concept of physical distress is considered by Yalom (1980) from the vantage point of being a reminder of the essential mortality of the human being. He argues that the concept of death, and the fear thereof, plays a major part in the existential crisis underlying the development of many emotional problems. He considers that the anxiety provoked by many other aspects of our existence is derived from the basic lack of safety from the continuous presence of death, and our attempts at control.

This study aims to look at pain not from the vantage point of being either a physiological process or an emotional process, but from the point of accepting that the experience of pain is simultaneously a physiological and an emotional process. It entails a description of the concept of pain from the vantage point of integrating psychological aspects and physical experience. This is the concept as proposed and described within the broad field of psychoneuroimmunology.

The psychotherapeutic model of SHIP® is an experiential therapeutic model, which accepts and incorporates the notion that pain is an experience involving both physiology and psyche. The SHIP® therapeutic process aims at facilitating healing on both physical

and emotional levels by accessing both emotional and physical symptoms, including pain. It utilises an individual's own spontaneous process of the manifestation of bodily sensations and emotional experiences as it unfolds during the therapeutic time frame. As such, it embraces a psychobiological paradigm.

Objectives

No literature could be found describing the experience of chronic or pathological pain by individuals affected by it in the context of psychotherapeutic intervention, thus the emotional experience of it, or describing their experience of pain during or after psychotherapeutic processes. It is nevertheless an affliction that I see frequently in my professional work. It is also often described by patients to be less intense or as having disappeared when stressful or negative emotional situations have been dealt with. The literature presented here provides theories and concepts which I find relevant and fascinating; and which I feel warrant further investigation and exploration. These theories are considered therefore to be subjects worthwhile of further research.

Both pain and emotions are substantial and given aspects of the human condition; unfortunately, so is trauma on various levels. The experience of both pain and emotions is subjective in nature – it cannot be measured. Even so, both entities can and do contribute extensively to the whole experience and development of any human being on all levels of life.

The theories described in this dissertation reflect an expansion on and diversification of the ways in which the experience of pain could be approached, specifically from a psychological perspective.

The scientific value of this study lies in the information gained of the psychological themes that emerged through the analysis of the experience of pain that people have on an intimate and personal level. This may create an understanding of the connection between the modalities of pathological pain and emotions, on a greater scale. It could lead to formulation of further theories, or it could allow for a more sophisticated development of the current theories and methods for applying them.

The primary objective of this study can thus be stated as follows: to gain information on and insight into the experience of chronic pathological pain symptoms within the context of a psychotherapeutic intervention, using an interpretative phenomenological analysis.

The secondary objectives found their way into the research through the questions I compiled for myself to guide me in the interviews, as more detailed descriptions of what is hoped to be achieved with the primary objective in mind:

- In the lived experience of each individual, were there any spontaneous associations between emotions and physical pain, both before or after initiating psychotherapy?
- What was the experience of each participant of this connection between physical pain and emotional matter, if any?
- Did the participants observe any changes in their experience of physical pain within the context of therapy?
- Did they perceive any changes in their experience of emotions within this context?
- Did the participants perceive any changes in their lives after experiencing the pain, emotions, and psychotherapy in the context of therapy?
- Did the participants derive any meaning from the experience of pain?

Structure of the dissertation

The research is reported on in the format of a dissertation. The results are presented as proposed within the context of the methodology chosen, as described in the following chapter.

Summary of chapter 2

In summary, it is postulated that psychological trauma can be 'captured' in bodily tissue via physiological processes, more specifically via the neurological system and the connective tissue surrounding all bodily tissues, including muscle fibres. It has also been shown that tissues can be hypersensitised in the central nervous system, causing other stimulants such as hormones and stress responses to activate the sensation of pain. It seems that specific areas are targeted as consequently compromised areas that later present with repeated episodes of pain, such as myofascial pain, typically in the trapezius or other back, neck or shoulder muscles. It would seem that this pain could be a gauge of some aspects of emotional stress, and that working with the bi-directional communication between psyche and physiology in a psychotherapeutic context could lead to healing of both types of symptoms, or a sense of a shift in the intensity of the experience of the pain.

Various aspects of the bidirectional influence of physical symptoms and psychological influences are expanded upon in the available literature, indicating a greater association of relationship than is generally accepted in the treatment modalities from a medical perspective. It is clear from the literature that psychological injury plays an extremely important role in the development of several physical symptoms, and that alleviating the psychological distress could enhance a positive outcome for the physical distress.

CHAPTER 3

RESEARCH METHODOLOGY

Introduction

This chapter provides an overview of the paradigm for the chosen research method and how it was implemented. The choice of an interpretative phenomenological analysis as research method is theoretically contextualised and described. Salient points about the methods of sampling, data collection and analysis of the material are discussed. Aspects considered to ensure research quality and uncompromised ethical standards are expanded upon, and a description provided of the implementing of the research project.

Research design

Considering the subjective nature of the experience of both pain and emotions, a quantitative design for research may not provide the information required for this study. The fact that neither pain nor emotions can be proven or measured makes it no less valid experiences of the human condition. Specifically what is required is information on the lived experience of pain. This objective fits into a postmodern social construction of reality (Alvesson, 2002), which acknowledges the complexity of people and their experiences, and recognises that what is being observed in the research is not one objective truth, but one of many valid truths (Gergen & Gergen, 2003). Postmodern viewpoints embrace a qualitative approach to research which explores the complexity and subjectivity of a lived experience. Thus the most appropriate format of research for this study would appear to be a design falling within the broad framework of qualitative research.

Qualitative Research

The map designed for research in the Western scientific world during the last few centuries is described by Polkinghorne (1989) as being based on the notion that reality consists of natural objects; and that any knowledge gained would be a description of these objects as they exist in themselves. Specifically, research should eliminate any distorting influences from the personal perspectives and subjective properties of researchers or subjects/objects. Experiencing consists of subjective bias and feeling, and should be sifted out through methodological techniques that recognise only those experiences that comprise directly perceived objects on which there is intersubjective agreement.

This approach leaves no room for an exploration of subjects like pain and emotions that are clearly subjective in nature and exist purely through experience on a very personal and intimate level (Neuman, 2000). Neither construct can be proved or measured in objective ways within a laboratory-type environment. There can therefore be no intersubjective agreement on them (Kvale, 1996; Polkinghorne, 1989).

As Creswell (1998) states, qualitative research takes the researcher out of a laboratory environment and into a context where phenomena can actually be studied. Kvale (1996) describes qualitative research as being sensitive to the true context in which people live. This includes a postmodern social construction of reality, hermeneutical interpretations of the meanings of reality and phenomenological descriptions of consciousness. The qualitative interview fits in with the chosen research methodology partly due to its correspondence to the postmodern approach, which emphasises the constructive nature of knowledge created through the partners in the interview situation. Smith (2003) and Van Vuuren (1989) describes qualitative approaches as being generally engaged in exploring, describing and interpreting the personal and social experiences of participants. It endeavours to understand a small number of participants' own frames of reference

towards an experience, instead of trying to test a preconceived hypothesis on a bigger sample. It involves collecting data in the form of verbal reports such as interviews or written accounts. The analysis consists of interpreting these detailed narrative reports in different ways, as perceptions or understanding of the phenomenon, instead of finding numerical properties in it. The researcher invariably contributes to the process and is not a mere bystander who observes and analyses.

De Vos and Fouché (1998) describe different research designs in the field of qualitative research such as phenomenology, grounded theory, ethnography, ethnomethodology, and symbolic interactionism. Smith (2003) includes interpretative phenomenology, narrative psychology, conversation analysis, discourse analysis, focus groups and cooperative inquiry into the palette of qualitative research.

Phenomenological Research

After considering the numerous possibilities and various aspects of the interactive dynamics of physical pain and psychotherapy, it was decided to apply the method of ***interpretative phenomenological analysis (IPA)***. This method specifically aims to explore in detail how individuals make sense of their personal world (Conroy, 2003; Smith & Osborn, 2003). Within the context of this study this methodology would entail the researcher's interpretation of the phenomenon of pathological pain as experienced by chosen subjects.

Huysamen (1997) explains the phenomenological study as the logical consequence of the theme that what a researcher observes is not reality as such, but an interpreted reality. We cannot detach ourselves from the realisation that the human experience necessarily constitutes an essentially subjective experience.

Polkinghorne (1989) argues that phenomenology differs from the natural sciences where the person is a passive recipient of reflective sensations from natural objects. Rather, phenomenology holds that experience involves the operation of active processes that both encompass and constitute the various contents that become present to the awareness of an individual. He describes this content as including not only the specific objects being perceived, but also feeling, imagination and memory. He considers the locus of phenomenological research to be the human experience, approaching the topics of interest to psychology through their presence in conscious awareness. Thus instead of studying the human body as an organic object, phenomenology studies the experiences people have of their bodies. This, he believes, provides access to all that can be directly known, because all knowledge is ultimately grounded in human experience. There is no viewpoint outside of consciousness from which to view the experience as it exists independently of our own experience.

Two types of phenomenologically-based inquiries are identified by Polkinghorne (1989), namely those that inquire how an object or subject is perceived by the various modes of conscious experience, or the memory of it; and those that seek information on how the meaning presents itself in the experience. This research seeks to gain knowledge of the experience of pain through a phenomenological investigation of both the conscious and memory perceptions of individuals, and their perceived meanings of the experience.

Sample

Strydom and Venter (in De Vos., 2002) state that the method of sampling is one of the most important aspects of a research endeavour, and therefore needs careful attention. The type of study and the research method chosen determines the type and size of the sample required. Two broad kinds of sampling are available to researchers: probability sampling, which entails random sampling, and non-probability sampling, which is not based on randomisation.

Qualitative research often requires smaller sample sizes than quantitative research; and phenomenological research, being involved with the description of an experience, does not lend itself to large, randomised sampling methods (Cresswell, 1998; Huysamen, 1997). Thus non-probability sampling methods are utilised. Strydom and Venter (in De Vos, 2002) describe various types of sampling methods within this frame, such as accidental, purposive, quota, dimensional and target samples.

IPA studies are typically conducted on small samples (Huysamen, 1997; Smith & Osborne 2003). The aim of the study is to explore the detailed perceptions of a group of people. A total of six to ten participants is suggested by Smith and Osborne (in Smith, 2003). Creswell (1998) recommends that a maximum of 10 people be interviewed.

In choosing participants, it is important to consider the specifics of the variable, that is, the experience of pain on a pathological level, over a period of time, and within the context of a therapeutic intervention. Participants need to experience what is termed pathological pain; in other words (for our purposes), pain in muscle areas which has no basis in found tissue damage, or recurrent 'unexplained' pain. To ensure that the experience of this pain is a valid construct for the purposes of this study, a specific minimum period of time is required. An arbitrary minimum period of three months' duration of pain symptoms was chosen. This was deemed a reasonable period for the condition to conform to the definition of chronic pain as stipulated in traditional descriptions of chronic pain (Schug, 2006).

To enable the evaluation of the experience of pain within the context of a therapeutic intervention, one of the prerequisites was that the participants were involved in a psychotherapeutic process, which does not necessarily appeal to all persons who experience chronic pain. Such a process also has financial implications. It was therefore

convenient to select participants from a pool of clients already undergoing psychotherapy and who had reported pain symptoms of the specific nature in question over the required period of time. This constituted a sample of convenience, with elements common to accidental samples, purposive samples, and even quota samples (Strydom & Venter, in De Vos, 2002). Both men and women were included to exclude gender bias.

A therapeutic model that specifically addresses physical pain in the therapeutic process – SHIP® – was utilised for this study. The participants were recruited from clients in the process of undergoing SHIP® therapy. No patient records were accessed or utilised for the study. The SHIP® Foundation formally gave permission for me to contact selected clients. Consequently, SHIP® psychotherapy clients of both sexes who reported pathological pain symptoms in the back, trunk, or neck muscle areas for a minimum period of three months were selected for participation.

The period of therapy was not considered to be a fixed criterion for selecting participants, as this can vary tremendously depending on individual circumstances. In terms of attaining results that could be meaningful, it was deemed preferable to select participants who had been in a therapeutic process for more than merely a short period of time. Thus when choosing participants from the available pool, those who had been in therapy longer were considered to be better candidates for providing an in-depth description of their experience. For this reason, a retrospective study was considered more feasible.

It needs to be noted that this sample consists of persons who have already invested some form of belief in the importance of their psychological lives and thus embarked on a process of psychotherapy. It implies that these participants have some connection of understanding shared with the researcher on this level.

A retrospective study was considered for practical/time reasons; however, it may be argued that the memory of pain changes after a period of time and may not be very accurate (Skevington, 1995). This may constitute a confounding variable, and it could be suggested that a prospective study of the same nature be conducted in which a longer period of time were available for utilising the process. If viewed as the specific experience of a phenomenon, the changing perception of the nature of the pain over time could, also be seen as part of the nature of the experience. It may also be of value to interview these same participants again at a much later stage, after time has elapsed, to obtain a new view of their experiences.

In summary, the sample was chosen according to the following participant characteristics:

- adults
- males and females
- pathological pain
- pain duration of at least three months, constantly or intermittently
- involved in psychotherapy (SHIP®)

Data Collection

Von Echartsberg (1998) describes two approaches to phenomenological research that would influence the method of data collection, namely, empirical phenomenology and hermeneutical phenomenology. The hermeneutical approach entails a totally spontaneous expression in the form of art, writing or speech, with no starting point. The empirical phenomenological method allows the researcher to ask certain questions to guide the participants in eliciting their spontaneous responses on the phenomenon under study. For this study, the data collection was conducted with the aid of specific questions of how the client perceived pain prior to initiating therapy, and then also at the time of the current investigation. An empirical phenomenological approach was therefore used.

Essentially the data collection consists of having personal interviews with participants, which entails the initial interaction of the researcher and thus the researcher's personal contribution. The researcher as interviewer needs to maintain an objective stance while being aware that it is an acknowledged part of qualitative research to have a contributing role from the outset. Ivey & Ivey (2003) recommends an intentionality in the interview process. Intentionality entails that the interviewer is required to be him/herself in a congruent way, but to also realise that it is necessary to be flexible and adaptable, and constantly be alert to new ways of being in a specific interview.

To increase reliability, Kvale (1996) advises that the interviewer refrain from asking leading questions which, if they are not a deliberate part of the interviewing technique, may inadvertently influence the answers given by participants.

The interview schedule therefore included the following general instructions:

1. Describe your reflections on the experience of pain before initiating psychotherapy.
2. Describe your experience of pain during the process of psychotherapy.
3. Describe your experience of pain after the process of psychotherapy (if applicable), or currently.

The researcher tape-recorded the responses of the participants, in line with suggestions by several authors on phenomenological research. She then transcribed the data as accurately as possible, including the nuances of nonverbal gestures such as sighs, excitement, and so on. Kvale (1996) argues that the recorded material should be transcribed by the same person who conducted the interviews. He makes the point that the conversation is live material and should be transcribed as such, with all the meaning and innuendos intended through nonverbal communication, as it enhances the end meaning and reliability of the product.

Analysis

The meaning of the experience is central to the aim of this study. As such, the analysis of meaning is the focus, rather than measuring frequency or intensity. The analysis itself is the interpretative work that the investigator does – this constitutes the inevitable personal process of qualitative research (Smith & Osborne, 2003). As Huysamen (1997) states, the interviewer interacts with and tries to understand how the individuals experience their world (in this case, their world of pain), and how they try to make sense of it in their lives. Themes are collected from the interviewees' data and themes are identified in terms of their psychological meanings.

Giorgi (1985) proposes five steps to analyse data in a phenomenological research study, which seem to be congruent with the type of design of this project:

1. The researcher reads the entire description as given by the participant.
2. The researcher identifies the meaning units as subjectively presented by the participant in the description.
3. The researcher connects meaning units with one another and with the whole.
4. The researcher 'transcribes' the descriptive meanings into scientific psychological language.
5. The researcher integrates the results with the construction of themes that emerge, which can be presented in report form.

To improve the dependability of the data analysis, the technique of coding-recoding was used, as described by Krefting (1991), in which the data are analysed twice – they are left for a while after the initial analysis and then analysed again. The two sets of analysed data are then compared and integrated.

Several authors (Conroy, 2003; Kvale, 1996; Valle, 1989) agree that there are no standard methods to arrive at essential meanings in qualitative analysis. Kvale (1996) describes five general approaches to the generation of meaning or implications, namely categorisation, condensation, narrative structuring, deeper interpretations and ad hoc tactics or mixed tactics. He advises approaching the transcripts of the interviews as living conversations with which the researcher engages in a “dialogue” in order to extract information that would enrich and deepen the meaning of their words. The researcher has a perspective on what is investigated and interprets the interviews from this perspective. Adding a deeper dimension from the perspective of a hermeneutical philosophy, the interpreting goes beyond what is directly said to work out structures of meaning not directly apparent from the original transcribed text.

For this study the five step method of Giorgi (1985) was used to arrive at themes. In addition, the ad hoc tactics of interpreting through different tools was used, as described by Kvale (1996). In particular, some of the deeper dimensions were derived through utilising the latter. To enhance dependability, the technique of coding-recoding was utilised in accordance with Krefting’s (1991) recommendation: the transcribed material was left for a period of two months and then analysed again.

Research Quality

Certain steps can be included to lessen the possible bias that a single researcher may bring into such an analysis (Human, 2006). Krefting (1991) proposes the application of the criteria of credibility, transferability, dependability and conformability.

Credibility can be attained by member validation and peer evaluation. *Member validation* is achieved by presenting the participants individually with the themes that emerge from the analysed data in a follow-up interview. The aim is to allow participants the opportunity to

evaluate their own sense of the congruence of the results and comment on it. Follow-up interviews with feedback discussions were implemented in this study.

Transferability enables other practitioners to transfer the findings of the research to other applications in the field, and may be achieved by describing all aspects of the participants as well as the research context in precise detail (Krefting, 1991). Within the constraints provided by ethical considerations, the participants and the context are described as far as possible in this study.

Dependability could be enhanced by giving a very thorough description of the methodology of the research, including that of the data collection and analysis. This entails the use of the strategies of stepwise replication and coding-recoding as described under data analysis method. As stated, the data were analysed twice with a period of two months in between.

Conformability may be enhanced by applying the strategy of researcher reflexivity. Human (2006) describes this as the supervision process with another psychologist, entailing focusing in supervision of the project on all the aspects that the researcher could bring into the project from a personal perspective. As in most qualitative research, and accepted as an acknowledged component in phenomenological research, the researcher is not an objective bystander but a contributing partner in the whole process of research. This study was supervised by a clinical psychologist throughout.

Quality of the research pertains to the whole process as it is implemented from the initial steps of the design of the project, through the selection of participants, up to the interviewing and analysis. The concept of the trinity of generalisability, reliability and validity of a qualitative research study is seen from the perspective of achieving accurate

results even within a subjective/objective realm, and even in terms of intersubjective exploration of the subject matter (Kvale, 1996).

An aspect that is often assumed by implication but not actively pursued in such interviews is the concept of trust. Considering the fact that the quality of the research depends on accuracy, which would be difficult to achieve without there being a basic feeling of trust between the interviewee and the researcher, this aspect becomes very important. It is expected of the participants to share very personal information of their intimate lived experience with another person, the interviewer. Such a semi structured interview entertains the expectation of few boundaries or limitations on the content, and depends on a great amount of trust established within a fairly short period of time. To achieve this, the basic principles of a client- centred approach, as described by Rogers (1967), namely warmth, empathy and congruence, should be kept in mind during the interview.

Ethical Considerations

According to Clandinin and Connelly (2000), ethics should be thought of in terms of relational matters. The research material gathered for this study is considered private; therefore signed informed consent had to be obtained. Confidentiality was at all times ensured from the researcher's side.

A letter was given to each participant prior to the interviews, stating the nature of the interview process, the structure of the interviews, and follow-up discussions. Clarity and transparency were emphasised and participants were invited to ask questions they had regarding their contributions.

The research procedure itself was described in full to each participant before the interviews commenced. The nature of the study was made clear, and participants informed

that they would have access to the resultant information as feedback, for further input and validation. They were also given the assurance that they were taking part on a voluntary basis at all times, and were free to withdraw at any time should they become uncomfortable about their participation. Anonymity is a matter that must be guaranteed at all times in research (Clandinin & Connelly, 2000). Pseudonyms were used to provide participants with anonymity. All material resulting from the research process will be kept safe.

Dissemination of research results

Research findings are reported on in the form of a dissertation. This is also made available in electronic format.

Summary of chapter 3

The qualitative research design of an interpretative phenomenological analysis was implemented. Sample criteria was determined and presented to The SHIP® Foundation. A pool of possible candidates was provided by the foundation, from which participants were selected. Letters of consent, providing information and ensuring confidentiality, were signed by all participants. Individual interviews were conducted during which relating the experience of their pain was requested of each of the individuals, and the narratives tape recorded. The material was transcribed and analysed according to the principles proposed in this chapter. Quality of the research was ensured by all the means described in this chapter, and the ethical standards maintained as proposed. Follow-up feedback discussions were individually scheduled three months after the initial interviews, during which the results of the analyses were presented to the participants.

CHAPTER 4

RESULTS

Introduction

This study undertook to explore the experience of pathological pain in twelve individuals within the context of psychotherapy. This chapter provides an overview of the research process. The individual participants' are introduced, firstly summarised in table format, followed by short versions of the salient points of their stories. Focusing on the research question and secondary objectives, the story of each participant is concluded with a summary of their experience of pain specifically before psychotherapy, during psychotherapy as well as afterwards.

The themes derived from analysing the material are presented then. A structured summary of the themes is given in the form of a diagram, which presents the themes grouped into two broad and four more general categories. Each theme is discussed separately in a sequence of how it unfolded more or less in chronological order in the process of occurrence.

Overview

The study included interviews with 12 participants. The number is greater than is recommended in the literature purely because the information given during the screening conversations proved so interesting that I felt compelled to include these individuals. The interviews were conducted over a period of a month, and the feedback discussions were held about three months afterwards.

It was proposed to include participants with a longer experience of psychotherapy as this was deemed to produce more pertinent information. As it transpired, some of the participants had been in therapy for only a few months at the time of the interviews, and it did not detract from the value of their information. None of the participants withdrew. One individual relocated to Cape Town shortly after the first interview, and the feedback discussion was done telephonically, but otherwise in exactly the same format. It proved completely satisfactory for both participant and researcher.

The interviews were informal and relaxed, and were conducted in the atmosphere of a social conversation. Information was given to each participant at the start of the interview regarding the background of the study. Very brief summaries of the nature of the research literature were given in a format appropriate to the situation. Each person was told that neither pain nor emotions are measurable, nor can their existence be proved, but that the experience of each was considered to be unique and valid for every individual – hence my interest in the experience of this person participating in the current interview.

The concept of trust in such an interview situation was discussed as part of the strategies to ensure quality. Confidentiality was once again emphasised. The interviews were conducted in an atmosphere of congruence, warmth and empathy, which actually developed spontaneously without contrived effort.

Most of the participants related their stories freely and easily, with very little encouragement being necessary for them to share fairly intimate details of their lives. I generally merely asked questions to elicit information on specific connections between emotional and physical symptoms where the meaning of what was said was not quite clear, and to encourage further exploration of thoughts ventured by participants.

One participant found it hard to spontaneously share emotional contents. This seemed to be related to a difficulty in talking easily. A fair amount of encouragement and the application of interviewing skills were necessary to gain a greater depth of information. One person, who could talk easily and spontaneously, especially about physical symptoms, shared very little emotional content. One of the participants talked freely but it transpired during the feedback discussion that she had forgotten to share very important traumatic experiences during the initial interview, which she proceeded to do during the feedback. Several participants gave additional information during the feedback discussion about further experiences they had had since the previous contact.

At the end of each interview, I presented a short summary of what the participant had shared, as well as how the researcher interpreted the information. This was well received by all the participants. Kvale argues that the analysis in a phenomenological study is not an isolated stage, but that it actually permeates the entire interview inquiry. Thus the interviewer clarifies meaning and interpretation throughout the interview so that the ideal interview would actually be interpreted by the end of the interaction (Kvale, 1996). With this in mind, my first impression or initial interpretation was offered to each participant at the end of the interview, with excellent results. This provided an opportunity to verify the accuracy of analysis to some extent in advance.

The feedback discussions focused on the analysis of the original material given by the participants during the interviews; and were presented to each participant individually for their verification three months after the initial interviews. At this meeting some of the participants reported further development and progression of their therapy processes. All of them enjoyed hearing this summary of their stories. They all agreed with the contents of the analysis derived from their experiences – there were no areas in which any of them felt that they differed or had intended a different meaning, or felt that their experience had been different from what was related back to them. Most of them received the themes

presented to them with a sense of awe and amazement, and expressed that it actually enhanced their experience. They all confirmed the accuracy of these themes.

Many of the participants spontaneously began their experience or their story with their life experiences starting in childhood, prior to their pain experience. As adults, they had already made the connection between their experience of pain symptoms and what they had brought with them from childhood – their experiences, their fears, their relationships with their parents, incidents that had occurred, and the coping strategies that they had inadvertently devised for themselves in order to survive emotionally.

It became clear that reporting on this study would not be complete without relating the richness of these stories, in order to give a background of the actual life experiences of each individual which led to the eventual extraction of all the themes identified in the study. These stories are thus not presented as case studies, but as extracts of the life stories of participants, indicating how the symptoms of pain, intertwined with their emotional experiences, presented themselves in these people's lives.

Names used are pseudonyms, and where necessary slight changes were made to descriptions of situations in order to protect the identities of the participants.

Participants

Psychotherapists of the SHIP® Foundation asked clients whom they thought matched the required criteria whether they would be willing to participate in this research project. The therapists then passed on the contact details of those willing to me. The potential participants provided by the Foundation were screened through a brief telephonic conversation in which the purpose of the research was explained, and a brief summary of

their presenting pains requested. From the pool of possible candidates, the 12 participants were selected for the fact that they had experienced muscular pains, although many of them also had the experience of other physical pains in various areas.

All the participants were Caucasian living in Gauteng at the time of the study, of which one was English speaking and 11 were Afrikaans speaking. Eleven women and one man participated in the study. Their ages ranged between 28 years and 58 years old, with a mean age of 45.5 years.

Of these, seven participants were still currently in therapy at the time of the study whilst five had completed their therapeutic processes, in other words, they had achieved resolution and integration of the specific issues which had brought them to therapy. They were selected from the clientele of two psychotherapists. The duration of psychotherapy ranged from four months to 20 years, with an average of 5.1 years. Only two men were included in the original list of possible candidates to select from. A short description of each participant's demographics follows, together with a summary of the participant's experience of pain before initiating therapy, within the context of therapy, as well as after completing therapy (where relevant).

Table 4.1 summarises the basic characteristics of the participating individuals.

Table 4.1

Participant	Age (years)	Psycho therapy Duration	Pain before therapy	Pain in therapy	Pain after therapy	Type of pain
James	28	4 months Still current	Yes Incapacitating	Yes	Less & decreasing	Muscle & joints of arms & back
Cara	32	18 months concluded	Yes Incapacitating	Yes	No	Back & neck, headache
Peggy	35	2 ½ yrs concluded/ Occasional	Yes Incapacitating	Yes	Seldom	Whole body muscles

Erica	37	3 yrs Concluded	Yes Incapacitating at times	Some	No	Backache migraines
Helga	44	4 ½ years current	Yes inca- pacitating	Yes	Very little at present	Hips muscles back abdomen
Lynn	49	2 yrs concluded	Yes	Yes	No	Eye Back
Andrea	50	20 yrs temp completed	Yes	Yes	No	Whole body
Kylie	50	15 yrs current	Yes inca- pacitating	Yes	Only during therapy	Abdomen whole body muscles chest
Mona	52	1 yr concluded	Yes	Yes	Yes, less & in context	Back & neck muscles abdomen
Cynthia	54	1 yr current	Yes inca- pacitating	Yes	Seldom	Whole body muscles skin joints
Jane	57	6 months temp completed	Yes inca- pacitating	Yes	No	Arms back muscles neck
Sarah	58	10 yrs current	Yes inca- pacitating	Yes	Yes, less	Whole body

James

James is a 28 year-old man, who at the time of the interview had been in therapy for four months and still continuing. James qualified as an IT programmer and worked as such for six years, gradually becoming more dissatisfied and disillusioned with his work situation. Specifically the isolation and non-interactive characteristics of his daily working environment became very distressing – typically he would greet a few fellow workers on arrival, start working at the computer and continue thus for the whole day, exchange goodbye greetings at the end of the day and then leave – day after day after day. He was still dependant on his parents in terms of living arrangements, which was also a source of great frustration to him, as his relationship with his father was very strained. James related that at this point IT programming contained his whole identity, an identity given to him. He had nothing else to connect his identity with. At the same time it was slowly becoming clear to him that something was very wrong with his work – he was not enjoying

it at all. He was aware of his father's financial investment made in the training he had acquired, and felt obliged to pursue this career and use the training he had gained. He felt as if he had no choice in the matter. He therefore experienced severe dissonance in the sense that this work situation, which contained his whole concept of his own identity, and which he felt obliged to make a success of, made him very unhappy. He did not have conscious insight of these facts then, and merely experienced extreme dissatisfaction, guilt, powerlessness and anxiety. He became aware of mild feelings of discomfort and pain in his arms and hands during this time, but did not think much of it. Going to the UK for a change of scenery and possibly an improved job situation appeared to be a solution then. However, it transpired to entail the same working environment, with the same frustrations for him; but now he was in another country without his other supports and comfort structures. Very soon he started having pain in his hands, arms, neck and shoulders which rapidly escalated to the point that it completely incapacitated him – he could not sit and work at a computer at all any more. The moment he touched the mouse or keyboard the pains intensified and made it impossible to work. He could do other work fairly comfortably but no computer work.

After returning home he waited until his pain symptoms abated before starting a new IT job, but the moment he began working with a computer the pain returned with a vengeance. It now filtered into his other activities as well, causing problems with driving, sleeping, and any activities requiring arm muscle activity. Typically he experienced pain in the muscles and joints from the upper back, shoulders, upper and lower arms and fingers, bilaterally. He went through many medical tests and treatments – a diagnosis of repetitive strain injury was offered, as well as rheumatoid arthritis. None of the treatments provided relief. Working from home seemed to be a possible solution, so that he could work and rest as his body dictated. This however isolated him even further and increased his sense of dependence and guilt; and worsened his relations with his parents. At this point, he felt angry with himself, angry with the world, hopeless, lonely, alienated from and lost in a

world that could not understand his needs, as he also could not understand them himself. He had an intense need for interaction with others, intimacy, independence, and a need to do something that had some meaning, especially for others; yet it seemed as if these desires were unattainable. He relates that he did not really acknowledge these needs consciously but merely felt confused and angry. Feeling desperate, he opted for psychotherapy and started SHIP®. At the time of the feedback discussion he had been offered a diagnosis of fibromyalgia for his symptoms, and he had a sense of comfort with this, as he felt that it was not a physical disease with a bad prognosis, but something he could manage and clear up through psychotherapy. His pain symptoms had become far less by this time.

James's experience of pain :

Before psychotherapy:

James started experiencing pain in the muscles and joints of his neck, shoulders, arms and hands three years prior to this research project. Initially it was mild and he was barely aware of it, and was limited to work-related activity. The same pain increased in intensity when his work situation worsened. It became incapacitating and prevented him from work, and eventually also from other normal functioning. He did not make any connection between emotional matters and the physical pain.

During psychotherapy:

In therapy he focused on the physical pain symptoms, which led to an intensification of the pain. Emotions arose within this context, such as anger and guilt, which led to an exploration of matters that were experienced as problems. The emotional content also increased and was experienced in depth. This led to a gradual dissipation of the pain and the emotional content associated with it, until he experienced a sense of release and relief, as if a weight had been lifted from his shoulders.

After four months of psychotherapy he still experienced the pain symptoms, but they felt less intense and he did not feel threatened by the prospect of becoming an invalid. At the time of the feedback discussion his pain had become much less.

After initiating psychotherapy:

James reported that he still had pain at the time of the interview, but that it was less and manageable. At the time of the feedback interview he had far less pain and he was very comfortable with his experience of it and felt that he could manage it easily. He reported this as occurring without any medical treatment.

Cara

Cara is a 32 year-old woman who had been in therapy for 18 months, concluded in April 2006. Cara relates growing up with very fair but very strict parents. She developed a way of always pleasing other people, at the cost of her own interests, without consciously realising this. She was not connected to her own body messages, and was unaware of this. She would do what she considered would please others, at the cost of her own needs, and then experience a feeling of body fatigue. After her marriage she had another group of people to please— her in-laws. She experienced fertility problems, with a four-year history of infertility. Her work became unpleasant, and she experienced people as unpleasant. A miscarriage after eight weeks of pregnancy tipped the scales for her – she started experiencing extreme constant fatigue and pain in her neck, back and shoulder muscles as well as headaches on a daily basis, which she felt were definitely stress-related. She felt that she did not validate and respect her own needs, and her life felt joyless. Medical examinations left her with a diagnosis of chronic fatigue syndrome or yuppie flu. However, this diagnosis did not help improve her situation, and she opted for psychotherapy after experiencing about 18 months of these symptoms.

Her experience of pain:

Before psychotherapy:

For a period of one and a half years before initiating therapy, Cara had pain in the back of her head, down her neck into her back muscles extending to the middle back. She experienced this on a daily basis, nearly constantly, as if it were an accepted part of her life. She was constantly aware of it; and noticed that it increased markedly whenever she experienced a higher level of physical or emotional stress. With this she also experienced an intense sense of chronic fatigue. It felt as if the fatigue was a basic fact of life on an excessive level, which, when stress levels increased, intensified into the headaches and muscle pains that she developed. She also slept poorly during this time.

During psychotherapy:

Her therapy consisted of working through life incidents, and she had vivid images during the process which were connected to certain emotional events. The pain in the muscles of the neck and back appeared to be specifically connected to certain of these emotional issues, as were heart palpitations. She did not experience pain in any specific area associated with specific emotions. Usually the emotions that arose would intensify, whereupon the pain would emerge and increase. Working with these emotional issues led to the pain either dissipating after a while in the session, or later on after a few days. The occurrence of muscle pains in her daily life gradually lessened until it had abated completely. She very rarely experiences any of pain currently.

After psychotherapy:

Cara said that she experienced muscle pain on occasion now only when her stress levels increased and when she had not exercised for some time. Her usual exercise programme immediately cleared any pain she was experiencing.

Peggy

Peggy is a 35 year-old woman who completed her therapy process over a period of two and a half years, but still has occasional sessions as the need arises. She begins her story at the age of 10 years old, when she overheard her parents and grandparents discussing their moving from the farm where she had grown up into town, because the grandfather dictated it; and she specifically recalls her proud, in-control mother crying. She experienced intense fear with the realisation that her safety seemed compromised. She had been a happy, carefree child until then. It was at this time that an old family friend, who was staying the night with the family, molested her; and she recalls her disgust and her inability to tell anyone – everything seemed too uncertain and threatening then.

The move into town was the harbinger of the family's disintegration, as her father's broken dreams led him to engage in extramarital affairs, and he became aggressive and abusive, causing an atmosphere of fear and conflict at home. Peggy withdrew into her own world and developed a coping mechanism of suppressing emotions and being strong. She did all that was expected of her – she performed well in everything she took part in and generally was a model child, not displaying any rebelliousness, although she was aware of feeling intense emotions simmering inside. She felt apart from her peers because of a feeling of shame about her family situation. Her parents got divorced after her mother fled one day with the children and started out on her own. She lost contact with her father.

She went to Canada on an exchange scholarship, and interacting with her host family there gave her a feeling of what she had missed in a stable family life, and the loss of it. This encouraged her to make contact with her father again. In the middle of her year abroad, her beloved brother died in a car accident. This was a devastating experience, and marks the point where she recalls having the first pain symptoms of severe muscle spasms in her feet. Peggy had to make a choice to stay in Canada for financial reasons, and was not able to come home for the burial ceremony. She had to cope in a strange country amongst very pleasant but strange people, with whom she did not feel the liberty

of asking for the comfort and nurturance that she desperately craved during this time. She experienced this need intensely. On arriving back in South Africa she experienced the muscle spasms again, to the extent that her mother had to carry her to the car. After that she was aware of these muscle pains throughout her body, especially in her back and shoulders. These occurred regularly, and particularly during stressful situations, although she did not make the connection at the time.

Peggy reports that she studied and had her own business, as well as working as a part-time air hostess for the next few years – escaping from her emotional life in the process of these hectic activities. She broke off an engagement on the pretext that the man was not strong enough for her, and got involved with an older man and married him – she admits now that she was looking for a father figure. It transpired that he had a different agenda, and used her to safeguard his own fraudulent business deals. It was with the break-up of this marriage, whilst maintaining her ongoing business enterprises under difficult circumstances, that her body pain worsened to the extent that it became incapacitating. Medical tests revealed nothing specific, and eventually the diagnosis of fibromyalgia was made and treatment started. She was told that she would have to accept these pains as part of her life, and that some relief could be obtained from medical treatment, but that it would always be there to some extent. Her work activities were necessarily scaled down. Serious side effects of the fibromyalgia treatment led to her decision to stop medical treatment and continue only with SHIP® and craniosacral therapy. At the time of the interview she had experienced a complete remission of all pain symptoms for more than two years, remarried and had a baby, with no problems during her pregnancy.

Two weeks before the research interview a personal crisis involving a sense of betrayal had presented itself, and she had started experiencing the familiar pain once more, precisely at this time. She felt that this time, however, she knew exactly what they represented, and she had immediately resumed SHIP® therapy. With the feedback

discussion she reported that the emotional contents of the crisis had been dealt with during the intervening months, and the pain symptoms had once again abated and become negligible.

Her experience of pain:

Before psychotherapy:

Peggy started having body pain symptoms at the age of 19 years, and they continued and increased over the next ten years, reaching a crisis state at the age of 29 years. The pain started as muscle spasms in her feet and legs on hearing about her brother's death. Initially she was only vaguely aware of the constant pain and discomfort, and she reports that she was more focused on surviving and coping and so did not pay much attention to the spasms. Later on she experienced headaches, backache in the muscles of her shoulders and back, arms and legs, as well as stabbing chest pains. She felt extreme fatigue and a sense of not being able to breathe at times, and often rushed to hospital with a sense of impending death. It worsened and eventually became incapacitating, to the extent that she felt she could not get herself out of bed in the mornings for lack of energy and body pains.

She felt that the emotional upheaval of the final break-up of her first marriage induced the final deterioration of her physical state. The last straw was an incident of severe betrayal by an employee and friend. At this time she realised that she was trying to hold things together for the sake of others, and was trying to appear strong, when actually all she received was emotional denigration. After this realisation she experienced a feeling of complete disintegration of her body capabilities in the sense that the pain and fatigue became disabling. She could not function properly anymore. She scaled down her work activities.

After a year of increasing pain, Peggy realised that she had to admit to being in serious trouble; she felt overwhelmed and felt that she simply could not cope any longer; however, she still continued to try. The medical treatment she received for fibromyalgia (local infiltrations) induced depression and suicidal ideation. Peggy felt that the treatment was more destructive than helpful and so discontinued the treatment.

During psychotherapy:

Initially Peggy had no sense of a connection between the physical pain and emotional matters. She focused on the physical sensations in therapy, and on an awareness of the body localisation of certain feelings; in other words, she concentrated on what feelings arose and where they were situated in the body. The most pertinent of these was her muscle pain, as the most common symptom, and she found that, as she focused on these, emotional issues presented themselves. The body pains intensified with the emotions. In the beginning she seldom experienced dissipation of these symptoms during a therapy session. Rather the pain continued for a few days, during which her body felt bruised, burning, warm and aching, before tapering off.

The pains seemed clearly connected to emotions. Peggy could not discern any specific emotions being connected to specific areas or types of pain. However, she did find that experiencing an emotion led to the memory of certain incidents with which a specific sensation of the body was connected. This could be described as a feeling of cellular memory.

After two years of therapy Peggy also started craniosacral therapy. This treatment caused her body to move in certain ways while experiencing emotions; and the effect of this extended to her psychotherapy sessions. For example, a specific cue would evoke a certain emotion, and a painful sensation would occur in some area of her body. Her body would move in a way that would increase the physical sensation in the painful area, and

after a while she would experience an intense emotion such as vulnerability or fear. She would experience both the emotion and the associated pain intensely. Only a single emotion at a time would be dealt with. After a while the feeling would dissipate and the body would relax into a state of painless fatigue.

Peggy initially felt that it was difficult to surrender to the emotions, as if her system tried to contain them, keep them suppressed and hidden. The main problem was to allow herself to experience the suppressed emotions. Some of these feelings were difficult to describe, there being no adequate way of verbalising the experience.

After two and a half years of SHIP® her physical pain had abated to the extent that she seldom, if ever, experienced any pain. She had regained her energy levels and was functioning fully in her work and personal situations.

After psychotherapy:

Peggy's debilitating body pains had cleared up completely for two years, until two weeks prior to the initial interview. Then a personal crisis occurred and she felt the familiar pains returning, although to a lesser extent. She immediately entered therapy again, and at the time of the feedback discussion she reported a return to a painless status, with only occasional twitches of muscle aches.

Erica

Erica is a 37 year-old woman who underwent SHIP® psychotherapy for three years, terminating in June 2006. Erica did not share much of her previous emotional or childhood experiences, except to state that she had had a difficult childhood with a father who was an alcoholic.

Erica experienced a high baseline level of anxiety throughout her life, and was not aware of what it felt like to live without this until well into her therapy process. She reported that she had always experienced high levels of stress. Her narrative of her experience of pain suggested a pattern of feeling rejected, of friendships disintegrating and consequently feeling lonely. She is in a high profile profession with very exacting work demands, which she could cope with intellectually, although she often felt unable to handle trivial emotional upsets in her work situation, and often had emotional outbursts. Erica had no specific intentions of entering into psychotherapy, but after reading a publication about SHIP® she realised that her repeated migraines and backache were probably the way in which her system expressed stress.

Her experience of pain:

Before psychotherapy:

Erica was aware of two major types of pain that she had experienced since childhood whenever a stressful situation developed: migraines and muscular backaches. At the time, she was not aware of the connection between pain and emotional matters, but it became clear to her during therapy that her symptoms had always been stress-related.

Her migraines started at the age of 10, and were debilitating. Typically, she experienced extremely intense pain for about 24 hours, which occurred two to three times a week during periods of stress. She felt very familiar with the pattern of her migraines: she would encounter a situation that was either physically or emotionally stressful. She would cope and carry on, but at some point she would engage in an action that would not cause a migraine under normal circumstances, such as skipping a meal, or adding sugar to her tea. In her highly stressed state, however, such an action would tip the scales and result in a severe migraine. She could not function at all during a migraine and for a day or so afterwards. Her migraines followed the classical pattern: she experienced visual disturbances prior to the headache, including a type of neurological dyslectic dysfunction

in which the visual and motor functions of her system had fallout of coordination, with resulting abnormalities in activity.

The back pain Erica reported was never debilitating, but started during a stressful situation when some other physical trigger was added, such as sitting on an uncomfortable chair. It was always stress-related. The pain would start in the lower back and spread up through the back muscles; it would persist for a few days, sometimes longer and sometimes increasing in intensity. She had been for several medical examinations and tests, with no specific abnormalities diagnosed. Erica believes that she has weak muscles which predispose her to this problem – she has always perceived her muscular system as compromised and easily affected by problems such as stiffness after exercise, or becoming painful from insufficient use.

Erica felt that there was no specific emotion connected to these physical symptoms, although she felt that they were definitely associated with emotions in general. She identified the core emotional trigger as being anxiety. She felt that her high baseline level of anxiety was a constant in her life; and when this was unpacked, Erica experienced feelings of rejection and loneliness. Anxiety was thus her first emotional response or expression to which other emotions were added. Thus her experience of any other emotions, such as a feeling of loss in a failed relationship, grief or anger, heightened her anxiety. At this point then any small thing like sitting on a particular chair or eating incorrectly would inevitably lead either to migraine or to backache.

During psychotherapy:

Erica's therapy focused on her emotional discomfort and where this was located as a physical sensation in her body, such as the feeling of anxiety in her throat and chest. Working with this elicited some physical discomfort at times, and an intensification of the physical sensation associated with the emotions. She often had a tensed-up, tight feeling

in her shoulders and upper back, but no muscle pain. This would at times continue beyond the therapy session: she had very stiff muscles, as if she had worked out in a gym, and this would gradually lessen and disappear after a few days. She did not experience any extreme pain during her therapy sessions itself. In the initial stages of her therapy she had frequent episodes of migraine between sessions, at one time as often as every week. She reports that the muscle pain during the last year of therapy resulted from the intensity of the process; and this was not the same pain that she dealt with in the process, which consisted of stiff and painful back and shoulders mostly. She felt that her pain was always associated with emotions.

Erica also mentioned that her pain occurred in phases – that some issues that she thought had been dealt with recurred in the sense that when the issue came up in therapy, her body reacted again with a feeling of discomfort, and she had to work through the specific matter again on a different level until it was all worked through and she felt completely comfortable. Thus the body symptoms acted as sensors for feelings that still had to be dealt with.

After psychotherapy:

All the physical pains became less as the process progressed and eventually disappeared. Erica has not had any migraines whatsoever since completing her therapy, and only slight backache on a few occasions of high stress. She feels free from any sensation of anxiety, which was a completely new experience to her.

Helga

Helga is a 44 year-old woman who has been in therapy for 4 ½ years, still ongoing. Helga described having both back pain and abdominal pains combined with nausea intermittently since childhood, whenever she experienced a sense of anxiety. She also developed severe pain in both hips about six years ago, which was diagnosed as bursitis after

medical examinations and tests revealed no conclusive abnormalities. This pain was constant and at times debilitating.

The memory that stands out from her childhood is her training in pentathlon athletics, since the age of five years when she took part in her first competition. She was trained by her father, every day of her life, even on holidays at the sea, until she graduated from university. Her participation in sports entailed several athletic items, her outstanding points being hurdles and high jump. She then believed that she loved it. Now she realises that she actually hated it.

At the age of 19 years she lost a much loved brother in a motor vehicle accident, and stoically handled this without any emotion, somehow believing that she had to be strong for her parents, who were absolutely devastated. Helga did not cry at all, even though this brother had been her great friend since childhood.

She was aware of physical pains during her life, but was totally switched off emotionally, and felt that she was not really aware of the existence of emotions. She had three miscarriages, and was diagnosed with postpartum depression without really registering the emotional content of it. She considers herself to have been a generally angry, tough person, who did not stand nonsense.

She developed the pain in her hip joints, bilaterally, after starting athletic training again at the age of 34 years for no specific reason, although she feels she might have wanted to prove something to herself. However, stopping the training did not stop the hip pains. Numerous medical examinations, including MR scanning, revealed no obvious problems; and a diagnosis of bursitis was made and treatments initiated, without success.

She also reports having anger outbursts, which became more frequent until her husband delivered a diplomatic ultimatum – she had to get help. At this point she entered into SHIP® therapy.

Her experience of pain:

Before psychotherapy:

Helga describes the most prominent pain prior to psychotherapy as that in her hip joints. Although extensive medical tests found no specific pathology, the pain was so intense that it was often debilitating. It was more or less constant for three years prior to starting therapy. She also had backache intermittently since childhood, sometimes with muscle spasms on one or the other side. Abdominal pains associated with nausea was something that she experienced so commonly since childhood that it was considered a given in certain situations, mostly when she travelled. She does not associate it with motion sickness, and connects it more to a feeling of insecurity experienced at the prospect of strange surroundings. Any event that brought about such a feeling of insecurity led to these abdominal pains and nausea, and continued to do so as an adult. Her memory of these physical symptoms as a child was that they were so common that she was thought to be fabricating them after medical examinations found no cause. Her pain was never validated, and more often ridiculed. She learnt not to mention her pain symptoms and often did not even acknowledge them to herself. Any pain or discomfort associated with the athletics training was ignored by others, so she learnt to ignore it herself.

In the initial interview she said that she did not experience much emotional content connected to these symptoms, except a general feeling of depression and despair. During the feedback discussion she admitted to experiencing a great deal of anger, including several outbursts that increased over time. She feels that she was a difficult person to live with. She did not consciously acknowledge emotions. She felt that she lived to a large

extent in an emotional void, except for a constant level of anxiety which she thought to be normal.

During psychotherapy:

The initial focus was on emotional matters only, and Helga relates that she was so used to the physical pains that she did not even mention them. Focusing on the emotions then led to her feeling pain, which increased in intensity. Pain occurred most often in her hips, both in the joints and muscular areas of the hips, and then also in other muscle areas in the back, neck, limbs, as well as the abdomen. In the first year of therapy her whole body ached constantly. During the first three years she would wake up in the night from her body aching all over, when she felt as if every muscle in her body was throbbing. It felt too painful to turn around. This would last for a few days after a session and then clear up. She no longer experiences this.

At times focusing on the pain would elicit a spontaneous spasmodic type of reaction, which she demonstrated and which looked exactly like the Moro reflex found in small infants, and over which she had no control. She experienced it as her body trying to avoid an emotion. This reaction became less frequent with time.

She always experiences emotions associated with the pain in therapy, although not a specific emotion associated with pain in any specific area. She often felt angry about the pain, and then became angry with the therapist for eliciting it and not alleviating it. Having her anger validated in therapy was a new experience, and led to the anger and pain dissipating, usually within a few hours early on in therapy, and lately within a few minutes. At times the pain in her hips felt so intense that she would gouge at them as if to tear out her flesh. In the first year of therapy she spent her days sleeping; her husband had to take over the household tasks and care for the children.

Currently she still experiences some pain with the emotional content in therapy, but less intensely, and it decreases fairly quickly. She feels that she is capable of handling the pain symptoms easily, and feels more in touch with the messages from her body. She still finds it difficult to access her emotions, and explains that while she is aware that there is some emotion, it is too far to get a hold on, or she feels too frightened of the intensity of it. She had not known before that emotions could be felt so intensely.

After initiating psychotherapy:

Helga has no more hip pain at all. At the time of the interview she experienced muscle pains in her back and body only during therapy and for a short period after any very intense session, and no longer in between. The abdominal symptoms have also abated to the extent that she has some discomfort at times but overtly less than before.

Lynn

Lynn is a 49 year-old woman who entered into SHIP® therapy as part of a training programme for further growth and career enhancement. Her therapy lasted for two years and her process terminated about two years prior to this research. She related a story which started with a history of dysfunctional mother-daughter relationships in her family, going back several generations. Her own birth was unplanned, within a context of financial and marital difficulties. Her relationship with her mother was strained from the start, and an aunt took care of her in the first few years of her life. However, her rich and solid relationship with her father compensated for this in many ways.

Lynn developed a herpes infection of the cornea of her one eye at the age of nearly three years, which resulted in repeated electro cauterisation treatments in theatre, three times per week, for a few months. This process was accompanied by excruciating pain. Some eye damage and sensitivity remained, which required her wearing a patch and glasses, and entailed several adaptive strategies throughout her life. She recalls being aware that

her mother felt ashamed of her strange-looking child. She did not experience any further pain in the eye. Lynn recalled several incidents that illustrated the difficulty she experienced in feeling accepted and loved by her mother. She felt that even in her moments of joy and triumph her mother abandoned her emotionally.

Later in life, after having had three miscarriages, she experienced bad lower backache and pain in the lower back muscle areas regularly, nearly constantly, for a period of ten years prior to starting her SHIP® therapy. She did not specifically connect this to the miscarriages. Working in therapy with her difficult relationship with her mother, and specifically focusing repeatedly on the emotional content of the relationship, suddenly elicited excruciating pain in the eye which had been treated with electro cauterisation as a child.

Her experience of pain:

Before psychotherapy:

The only pain that Lynn had experienced was the lower backache and muscle pains, which had started after her third miscarriage, and continued over ten years on a regular, nearly constant basis. She never made any connection between this pain and the miscarriages or any other emotional contents.

Lynn was obviously aware of having had the herpes eye infection at the age of two, and remembered that it had been painful; but there was no recurrent experience of pain in the eye prior to commencing therapy. However, her right eye and surrounding facial area was more susceptible to displaying signs of fatigue, and a sensitivity during other infections, and she tended to get blisters more easily on this side.

During psychotherapy:

Therapy focused initially on interpersonal relationships in childhood, and the concept of visualising intimate contact with her mother as a child caused a physical reaction and sense of anxiety. Repeatedly visiting the emotional content of this reaction suddenly brought on the experience of intense pain in the eye which had suffered the herpes infection. It felt as if fire were burning into her eye and the surrounding skin. This experience repeated itself many times whilst encountering different aspects of emotional pain linked to her relationship with her mother. The eye pain was thus strongly connected to her feelings about her mother. Many aspects of this early relationship presented themselves when she experienced the eye pain, including memories of the hospital experience, the painful theatre episodes, the feeling of powerlessness in that situation, her mother leaving her to suffer this pain and not protecting her against it. It appeared that her perception of her mother was directly connected to the painful hospital experience; and an already fragile relationship with a mother who struggled to embrace her unconditionally from the start, was compromised irrevocably during the traumatic treatment for her eye condition.

Clear memories of Lynn's hospital and theatre experiences presented themselves repeatedly during therapy, associated with the intense pain in her eye, and always connected to the emotional pain surrounding her relationship with her mother. This continued until working with the material no longer elicited any physical or emotional discomfort, and she could integrate a feeling of compassion for the paradox of good and bad which was her mother. She never felt anger, only immense sadness and an intense feeling of loss. The therapy thus represented an integration of the two pains of eye/mother, which had not been bearable before, but could now be understood to the extent that pain about her mother could still be felt, but at a distance, without affecting her to the same extent as before. Lynn explained her comparison between the two pains, the emotional pain of the mother relationship, and that of the eye, and asked the question: which was

worse? She considered the matter of the eye pain to be a once-off thing, whilst the pain of her mother was a repeated ongoing pain, with greater implications.

Lynn also experienced the lower backache she had known before in therapy, and in a session made the emotional connection with her first miscarriage which had been very traumatic. During the therapy session, she experienced the physical pains of the whole process of the miscarriage as it had occurred at the time, with all of the emotional contents associated with it. This also repeated itself until she had worked through all of the emotional contents of validating the mourning for her unborn child, the loss of life and of motherhood, of carrying death as well as life. After this was dealt with, she never experienced the backache again.

After psychotherapy:

Lynn has not had any eye pain at all after the therapy, and no backache either.

Andrea

Andrea is a 50 year-old woman who has been in SHIP® therapy for 20 years. Therapy is on hold indefinitely because of her relocation. She became anorexic in her late adolescent years after experiencing serious gender identity conflict during the time of her developing sexuality. She had been told that she was supposed to have been the boy of the family, and had thus acted out the role of a boy in her childhood, especially with her father. She experienced the onset of puberty as a betrayal of her body, and she resisted and denied it with everything she could muster. Her mother had an irrational and apparently unrealistic aversion to fat people, and aggravated Andrea's sense of her own body image by making subtle and even blatant references to her developing curves as fat. The end result was that at the age of 20 years she was admitted to a psychiatric hospital for severe anorexia, with the threat (supported by her parents) of being certified if she did not cooperate and recover quickly.

She experienced her body as painful in totality, because it was female. Femininity equalled pain. Touching her body caused pain, and becoming aware of her body thus caused pain everywhere. Contact between parts of her body, such as her legs touching when walking, led to pain in the area. The only way to feel better was by not eating. A skinny body equalled a not-female body, which resulted in less pain.

At times Andrea went to the opposite extreme and became very fat, a “blob” as she describes herself, which she also considers a form of asexual protection. Her life became a see-saw of fluctuating between being extremely thin and obesity. Her body became the focus of her life. Her boundaries were determined by food. Her own limited food intake created a feeling of safety, whereas the anxiety of going beyond those boundaries escalated into a fear of annihilation. She literally felt that her very life, the preservation of self, depended on this. The abnormality of this perception was clear to her and she did indeed feel that it was crazy and detached from the reality of life, but she had no control over these fears. As she was aware that her whole existence revolved around her experience of her own body, she knew that any relationships that she had were based on a façade she presented to the world, with no sense of being spontaneous and real.

Andrea experienced discomfort and pain in her whole body, every part of it. She married suddenly at the age of 21 in the hope of escaping in some way from herself and becoming part of the real world. She was almost immediately aware of it being a disastrous move. Even within an intimate relationship her experience of herself persisted in the same way, and created havoc in the relationship. After many trials of life and therapy on different levels, she had a sense of extreme desperation and started SHIP®. She recalls being the thinnest she had ever been, and in the worst state of anorexia of her life, when she commenced therapy.

Her experience of pain:

Before psychotherapy:

Andrea described her entire body as being painful. Her first memory of this goes back to her late adolescent years, although the initial memory of it is vague. She experienced her whole body – the skin, joint and muscle areas of the trunk and limbs all over – as feeling painful to the touch, as if becoming aware of her body as a physical entity was immediately associated with pain. Touching her body meant becoming aware of it as something alien and unwanted and not fitting into it as a being. When parts of her body touched each other, for example when she was walking, it immediately caused discomfort and pain in the areas. Particularly the femaleness of her body was associated with the pain – being female equalled pain. Diminishing the femaleness, in other words, decreasing the body substance in the form of the female curves, lessened the pain for her. This continued until she started SHIP® at 30 years of age.

During psychotherapy:

All the pain sensations continued during and between Andrea's therapy sessions for the first few years. She focused on her physical symptoms in therapy, which led to the emergence of associated emotions from her childhood. She often felt nausea, extreme pain in her throat and the desire to vomit, as if her body wanted to purge itself of matter. A feeling of discomfort in her throat occurred often. Chest pains and abdominal pains were common. She often felt swollen during the therapy and between sessions, and related feeling that reliving childhood emotions left her battered and bruised during the session and for the few days after each session. Mostly emotional memories from her childhood arose as being connected to the pain and other physical symptoms. She recalled trying to function as best as she could initially, but that it was extremely difficult for her, and eventually after a few days it felt as if the physical and emotional pain eased out and felt better.

Most of the material she had to work with revolved around coming to terms with being a woman, and accepting her female curves as part of her identity; and as she started feeling better this became increasingly feasible to her. Initially she gained excessive weight again and reverted to the 'blob' image, but when she left her body to its own devices, gradually over a period of five to ten years she decreased in weight naturally up to her current slim size, without resorting to any weight control methods whatsoever. During this time the physical pain and emotional discomfort decreased on par with the body changes, until she reached a point where she felt that she absolutely fitted into herself and felt at ease with her body. After two years of fairly intense therapy she felt that she could relate to her body and feel fairly comfortable with it, without experiencing pain.

Andrea started studying art whilst in therapy, and later made drawings of herself in the nude, which she describes as confrontational, and not meant to be flattering. At this point she could start appreciating her body as art, as being beautiful. Eventually she did not experience any physical pain in her throat, abdomen or the rest of body when moving at all, neither during therapy nor in between; and it was also not evoked by working with emotional matters. Andrea was convinced that she would not be able to go on a weight loss diet at this point even if she tried.

After psychotherapy:

Andrea stated that she feels totally comfortable in her feminine body now, and never has the perception of any part of her body as painful.

Kylie

Kylie is a 50 year-old woman who has been in SHIP® therapy for 15 years and still continuing. Kylie's experience of pain began in her twenties after the birth of her first child, when she started having repeated bouts of abdominal pains with diarrhoea and vomiting.

Intense sadness always accompanied the pain and evacuation, for no apparent reason. Despite numerous medical tests no specific cause could be found.

After the birth of three more children and an episode of intense conflict with her father, she was admitted to ICU with debilitating abdominal pains, vomiting, chest pains, headache, and deteriorating levels of energy. She had rectal and vaginal bleeding, despite an earlier hysterectomy. She recalls very specifically wanting to be dead. She went into cardiac arrest and was successfully resuscitated. No specific medical cause could be found for her condition.

While in hospital, a psychologist gave her reading material on various subjects, and an article on sexual abuse in children triggered an intense emotional response in her. As a result, she embarked on a psychotherapeutic process of SHIP® at the age of 35 years. Therapy focused on her pain symptoms, which included abdominal pains, pelvic pains, chest pains, headache, and muscle pains in various areas. Focusing on these symptoms in daily therapy for several months brought up images of being sexually molested as a baby, and eventually, after eight months of therapy, the face of the molester became clear – it was her father. This led to gradual development of memories of various aspects of the experience of having been repeatedly sexually abused as a small child by her father, and all of the emotional material connected to this.

Her experience of pain:

Before psychotherapy:

Kylie recalled her gastrointestinal symptoms starting soon after her first child was born, with recurrent episodes of abdominal pains, diarrhoea and vomiting occurring appearing without apparent cause. All the relevant medical investigations revealed no tangible explanation for these symptoms. Many treatments were given, and usually provided temporary relief, although at times there was no improvement for lengthy periods. She

remembers that these bouts of gastrointestinal problems were always associated with intense feelings of sadness, without a specific cause. She regularly used painkillers to ease the excessive muscular aches throughout her body. The episode which ended with her admission to ICU was associated with more general body pains and fatigue. She could not sleep or eat properly at that stage.

During psychotherapy:

Kylie's body pains expanded and intensified during her therapy process. She experienced intense pains in the muscles of her limbs and trunk, her chest, joints, abdominal cavity, pelvis and head during therapy, evoked by the visual images she had. At first therapy consisted of working with the physical symptoms of pains, vaginal bleeds, and diarrhoea, which gave way to the images of a baby being molested, which she eventually identified as herself. Initially she denied that the images were of herself, and she was convinced that she was fabricating the images. At this stage she felt that her lower body was totally numb, as if it were not there, while the pains continued unabated in the rest of her body. When she eventually accepted the fact that she had been sexually traumatised, the pains shifted to her lower body and the genital area in particular.

Initially she felt dissociated from the images, as if she was seeing them from a distance. At this stage she did not experience any emotions associated with the images. With repeated therapy work the images came closer until she felt as if she identified with the figure of the child as herself. With this she started encountering what was happening to the baby in her own body, and only then the emotional feelings were added to her experience. This came about gradually, piece by piece, as if it would have been too intense to be allowed all at once.

From then a typical pattern emerged in her therapeutic process: some emotional trigger in her life would cause her to feel upset, and would be accompanied by some physical

symptom such as abdominal pain. She would go for therapy, where she would focus on the pain in her belly area. Sometimes this would take some time, while she lay quite still, just focusing on this physical discomfort. It would increase and the pain would usually become quite intense. At some point an image would become clear in her mind, and an associated emotion would unfold. While working with the emotion, the intensity of both the physical pain and the emotions would increase, and eventually the abdominal pain would escalate into an extreme contraction, upon which it would relax and disappear, together with the emotional content.

With the intensity of the pains and the excruciating emotional contents she had to deal with, Kylie stated that she had been very suicidal in the first stages of her therapy process. She associated many of the physical feelings directly with specific trauma memories, and also had very specific emotional associations with certain physical pains. She described the memory of asphyxia deriving from being forced to swallow semen, which she could taste during the therapy experience. She felt the heavy pain and a sense of not being able to breathe with the feeling of her father's heavy body on top of her chest – after which experience she developed asthma attacks for a while.

Kylie presented a very specific perception of various facets in which the pain occurred in therapy: she felt that the physical sensations were experienced first without any emotions attached to them. That led to experiencing the emotions, gradually, piece by piece, as if her system were only allowed to integrate it all slowly, at a manageable pace. Only then, when enough of this had been integrated, could the pain of the actual experience of the physical penetration be accessed and felt during therapy. It came spontaneously and unexpectedly during one session. This, to her, symbolised a completion of the process of integration of her trauma.

Kylie explained that, to her, it seemed as if her body allowed pain in increments, increasing the amount that she was able to work with emotionally. This enabled her to become stronger and survive finally feeling the sensation of the actual deed, as she would not have been able to survive that pain from the start. She was also convinced that no toddler would have been able to survive feeling that sensation – a child would have to dissociate from it.

After initiating psychotherapy:

Kylie has very little pain now, except within the psychotherapeutic context. She stated that she still has intense pain and other physical sensations while working with specific emotional material in therapy, but experiences none of the previously debilitating symptoms in her normal working life. On occasion a specific emotional trigger or stressor activates some physical discomfort on a fairly low level, which she then explores in therapy with the usual pattern of intensification of the feeling before working through the process. Some of the pain elicited during therapy may also be carried over into her daily life for a period of time.

Mona

Mona is a 52 year-old woman who completed her therapeutic process in a year. Mona felt that a great part of her feeling of loss in life resulted from growing up without her father, her parents having been divorced when she was a year old and having no contact with her father after that. She also remembers an intense feeling of loneliness and longing as a child, as she went to boarding school at the age of six. She always felt different from other children because of not having a father, and her relationship with her stepfather was strained. She soon developed very powerful coping strategies, which included believing that expressing feelings indicated weakness.

Mona's first experience of pain was during her twenties, when she developed a peptic ulcer and abdominal cramps or spastic colon symptoms, which were always associated with a feeling of sadness. She married for convenience, a loveless match quite openly stated to be so, but with an absolute determination to make it successful and never divorce. She had three children, the youngest of whom was diagnosed as completely deaf at the age of 18 months. She remembers being absolutely calm and showing no emotion at receiving the news.

Shortly after this she made contact with her own father for the first time, and remembers the few occasions on which she saw him as extremely precious; just being near him gave her a great sense of satisfaction. When he died shortly after they made contact, she did experience and express her grief. Her son died two years ago following a motor vehicle accident, and it was her response in this situation that led to her eventually entering therapy. She once again showed no emotions during the time he spent in hospital after the accident and after his death, but kept on coping and being strong, focusing on her sense of survival and on protecting her deaf child from the impact of the tragedy. It was, however, at this time that she started experiencing pains in her back and shoulder muscles – pains that felt stabbing and extreme. She experienced the first of these the night before he died, and after that repeatedly during the year that followed whenever she felt her stress levels rising.

Mona knew that her inability to cry about her son's death was abnormal, and actively tried to allow herself to mourn and long for him, without success. On the one occasion that she did spontaneously burst into tears, she had to suppress it wilfully in order to handle the legal proceedings against her deaf child, who had been illegally driving the vehicle at the time of the accident.

The year following this she describes as a downhill road. In this year her health deteriorated, her body pain increased, she developed Bell's palsy, and generally felt agitated and aggressive. It was upon her reaction to an evaluation for her son as a prospective recipient of a cochlear implant that she was advised to seek psychotherapy, which she reluctantly did with the aim of being more available to help her son to adapt to his implant.

Her experience of pain:

Before psychotherapy:

Mona recalled having gastrointestinal pains since young adulthood, in the format of a peptic ulcer diagnosed through a gastroscopy in her early twenties, and intermittent abdominal cramps. She clearly remembers these as always being related to stress, and reports that the cramps were always associated with a feeling of sadness. It was as if she felt the cramps in lieu of the sadness.

Her first muscle spasms occurred the night before her son's death. She experienced headache, backache and severe painful spasms in the muscles of her back down into her legs. This experience repeated itself regularly afterwards whenever any increase in level of stress occurred, or more pertinently, whenever emotions appeared to surface. She could not mourn for her son on an emotional level, and even when she actively tried to trigger feelings of longing for him, her body responded by developing muscle spasms. She had extreme pain symptoms on the day that he was cremated even though she did not know about the cremation, and only discovered this fact much later. When she made that connection she had her first and only spontaneous grief reaction – only to suppress it wilfully in the presence of officials investigating the accident – once again coping for the sake of her deaf son. Thereafter no attempt from her could reactivate the emotions of grief.

In retrospect, she felt that her pain was a spontaneous response to emotions attempting to surface, since emotions were very hard for her to access. It was as if she had no frame of reference for feelings, and her system could not allow it. She reported that it specifically felt as if her system pushed any surfacing emotions away and replaced them with the familiar feeling of pain instead. The abdominal cramps also continued in the same way as they had before, with an associated sadness. She never surrendered to this sadness, but controlled and contained it.

During psychotherapy:

An emotional deluge was activated by talking about her unresolved longing for her father, and that served as the long-awaited trigger to actively mourn the loss of her son. Mona described that she had definite associations between emotions and her pain symptoms, and that pain always occurred with emotional contents as she dealt with them. The process usually started with the pain – the usual muscle spasms in her back, with a neck-ache, headache, and abdominal cramps. As she focused on the pain it escalated in intensity, and emotions would appear. These would also increase as she focused on them, along with the pain, and she had an immense amount of sadness and cried copiously. Both the pain and the emotions would gradually lessen until they eventually disappeared altogether.

Mona associates the pain she experiences currently with the emotions relevant to it, and believes that any occurring pain may be actively examined for a specific underlying emotion. She found that she could start searching for these emotions when the pains occurred between sessions. She reports that she sometimes became aware of the muscle pain starting without being aware of any emotional context, and then started searching for emotions, knowing that they had to be there. When she exposed herself to the process, she found that emotions eventually surfaced. She now always resorts to this technique when she feels pain developing.

After psychotherapy:

Mona has fewer muscle pains currently, but reported that they still occur. Although this disappoints her, she understands it. She utilises the pain specifically in the sense that it indicates suppressed emotional material, which she deliberately extracts by lying down and focusing on the pain in her own time, after which it always subsides.

Cynthia

Cynthia is a 54 year-old woman who had been in therapy for one year at the time of the interview. Her process was not considered completed but for practical reasons she was opting for a break at the time with the intention of resuming treatment at a later date. During the interview she related some aspects of her story which she then decided needed to be dealt with, and later resumed her therapy.

Cynthia's first memory relating to her current physical symptoms is receiving a gas anaesthetic as a small child for a tonsillectomy, during which she felt that she was suffocating and unable to breathe. Later in life, stressful situations were invariably associated with a feeling of not being able to breathe.

As a young woman she sustained severe burn wounds after an accidental explosion, and was hospitalised for a year, mostly in isolation. She had also suffered inhalation burns, and again experienced the sensation of not being able to breathe. Doctors were not optimistic about her chances of survival at the time, but she recalls her husband begging her to fight, as he could not live without her. Cynthia has no real memory of emotional trauma during her treatment in hospital. She has always had a strong sense of being able to cope and survive, and it was with determination and perseverance that she endured the repeated pain of numerous skin transplants, a very slow recovery, and a gradual regaining of body functioning. When she was eventually discharged from hospital, she discovered

that her husband had found succour in the arms of another woman. She was made to feel like a disfigured freak. Cynthia continued to cope and persevere, however. She managed her husband's business, although she experienced rejection, humiliation and abandonment, anger and powerlessness. She fell pregnant again and the marriage teetered back onto track for a while, with Cynthia coping for her husband on many levels.

To address some of the relationship issues, she resorted to family and individual therapy for her children, which her husband would have joined in an attempt to re-establish a functional relationship. However, an event occurred that she felt had a greater impact on her emotional life than her later divorce: the psychologist suggested to her husband that he should attempt to gain custody of their children, which swayed him towards divorce. Cynthia felt extremely powerless in this situation, and even though she could maintain a façade of coping to the world and herself, she felt that she had lost control of things. Law battles ensued, and ended with resentment and embitterment and a lot of anger within herself and her children. The psychologist offered a letter of apology after a reprimand from the HPCSA, which Cynthia felt was merely a courtesy token without any sincerity. Both she and her ex-husband later remarried.

About four years ago Cynthia and her new husband were involved in an armed robbery and hijacking attempt, in which a shootout ensued between the robbers and her husband. Her husband was seriously wounded and a robber was shot dead on top of Cynthia. Once again she coped until her husband was safely delivered to hospital personnel, when the feeling of not being able to breathe overwhelmed her.

Thereafter Cynthia developed several symptoms of traumatic stress, severe pains in her body, debilitating fatigue, numbness, and pins and needles in certain body areas for a period of two years. She woke regularly with a feeling of not being able to breathe. These pains became constant, incapacitating, and left her feeling unable to cope. After numerous

medical and alternative evaluations and treatments, she opted for psychotherapy and started with SHIP treatment.

Her experience of pain:

Before psychotherapy:

Cynthia experienced pins and needles accompanied by a burning sensation of her skin of all her extremities, and pain in her joints, hands, feet, trunk, arms and legs. Repeated episodes of severe pain and tingling occurred in the right side of her face, which she described as the feeling of shingles in the skin area, without the rash of blisters. She often had a feeling of numbness, especially in her extremities. There was less pain in the skin of her trunk, which she assumed was because of the previous burn injuries and scar tissue. She woke frequently because of a feeling of not being able to breathe, and felt fatigued to the point that she could not get herself out of bed in the mornings. These symptoms continued and worsened over a period of two years to the extent that it became debilitating, and was a constant feature of her life.

During psychotherapy:

It was in therapy that the childhood memory of struggling to breathe during the anaesthetic procedure was retrieved, and linked with the stress-induced sensations of not being able to breathe. Feeling the pain led to the sensation of not being able to breathe, but never the other way around. The painful breathing caused by the inhalation burn wounds, which also appeared in therapy, was also linked to her current episodes of waking out of breath.

In therapy Cynthia focused on the pain as she experienced it at that time. As a result, the pain increased in intensity, and emotions associated with the pain surfaced and were amplified. As Cynthia surrendered to these pains, her body often spontaneously started shivering and twitching with increasing intensity, as if there was an electric current running through it. She described feeling as if her body was ridding itself of toxins in the process.

This gradually subsided until the pain, emotions and body movement dissipated altogether. Focusing on the pain evoked emotional material about the explosion and her consequent burn wounds, aggression towards her ex-husband, and the humiliation, rejection and helplessness, amongst others, that she felt in the aftermath of this episode. The armed robbery seemed to have been a trigger for her pain, but was by far not the major factor associated with it.

After initiating psychotherapy:

Cynthia reported that her pains have cleared up almost completely. She still has occasional twinges of body pain, specifically when an emotional issue is triggered, and it still occurs within the context of therapy as she works with emotional material. She experienced some feelings of not being able to breathe while relating her story, which indicated to her that there are still aspects of her emotions that require further exploration and processing.

Jane

Jane is a 57 year-old woman who started therapy six months prior to the research interview. Her therapy was still ongoing, although she had put it on hold at the time of the feedback interview as she felt she had reached a space where she had resolved the specific emotional concerns she had been struggling with at the time, with the physical symptoms having abated almost completely.. Her intention was to continue as other problems arose.

Jane's description of her childhood was that a part of it had been stolen from her, as she was the eldest daughter who had to take over the total responsibility of caring for a baby sibling and housekeeping tasks in her early adolescent years. She also has memories of her father trying to molest her and insisting on her keeping the incident a secret, which she

felt obliged to do. Her memories of her father were that he was an aggressive man, who frequently shouted in order to get his way, especially when drunk.

She had a wonderful marriage which came to a tragic halt with the death of her husband in a motor vehicle accident. She felt that she had to be strong and cope with it for the sake of her children. This was an extremely traumatic event for her, and trying to adapt to a new life with two small children led to her being admitted in a psychiatric hospital. She entered into psychotherapy then which she felt gave relief, but no sustainable resolution to her problems. She entered into a second marriage four years ago. About two and a half years ago she started having severe pain in her neck, back and arms, and muscle spasms in her whole body. It started gradually and increased to the extent that the neck and arm pains became so severe that she battled to sleep. She could no longer do her typing work or hobby crafts, which she had always enjoyed so much – the pain incapacitated her regularly. She had many medical examinations and tests, and was diagnosed with spondilosis of the neck and lower back vertebrae. She was told that it would deteriorate and eventually lead to her not being able to use her arms at all, and that she would need surgery. Many different treatments were instigated – physiotherapy, NSAIDS, and so on, all with limited effect.

She also had many gastrointestinal symptoms such as abdominal pains and diarrhoea, which she realised to be associated with stress. These presented repeatedly but not on a chronic constant basis. At the same time she realised that her emotional world and marital relationship was deteriorating, and she became depressed. She did not consciously connect the physical symptoms with the emotional problems. Her marriage was running into trouble, but she felt compelled to stay in it, and felt trapped without consciously acknowledging this feeling. Specifically, many characteristics about her new husband reminded her more and more of her father. Finally, she became desperate and opted for psychotherapy, even though she felt sceptical.

Her experience of pain:

Before psychotherapy:

Jane started experiencing pain throughout her body about two and a half years prior to the interview, more or less at the same time that she became aware that her second marriage was deteriorating. She experienced pain everywhere in her body, specifically muscular pains. They were especially severe in the arms from the neck and shoulder blades, as well as the whole back. She had regular muscle spasms, which increased in intensity and became more or less constant. These started gradually and increased as she also became aware of experiencing emotional problems, but she did not connect the pain with the emotions at this stage. The pain became incapacitating at times, and she battled to dress herself and could not engage in her hobbies.

During psychotherapy:

The first awareness of a definite connection between the physical pain and her emotions occurred in therapy, and Jane experienced pain in certain areas together with specific emotions. For example, the pain in her arms was associated with a feeling of being held captive and helpless. She connected it to a memory of being held captive by her arms as a child.

Therapy elicited several memories of childhood incidents with strong emotional content, which were processed with resultant decrease in pain symptoms. In therapy, Jane would focus on whatever symptom her body presented with on that day, and as she did so it would intensify, and elicit a specific memory of an incident or an emotion. As she focused her attention on this, the pain and emotions would increase further, the pain becoming quite bad, until they started decreasing and dissipated completely.

Jane gradually experienced less pain between therapy sessions, until eventually she had no more pain at all, and could function normally again. She could partake in her hobbies as before, and surgery is no longer an option. She quickly made the connection between the feeling of being captive in her marriage with the pain in her arms, but did not make immediate decisions on the matter. As she dealt with other associations and memories of her childhood, such as an attempt by her father to molest her, the connections between more of her pain symptoms and the emotional content became clear to her. The triggers in her marriage, and why she had felt that she simply had to cope whatsoever the cost, also became clear and led to decisions regarding her marriage and work. By the time of the feedback discussion, Jane had divorced her husband, started a new job and physically felt healthy and pain free.

After psychotherapy:

Jane stated that she had no more pain symptoms at all after her therapy, and therefore felt that she did not specifically need any more sessions – she had achieved what she had set out to do.

Sarah

Sarah is a 58 year-old woman who has been in SHIP® therapy for ten years, and is still continuing. Sarah could recall very little of her childhood during her adult years. During her marriage of 15 years she started feeling body pains, which were exacerbated after her divorce 20 years ago. She had pain throughout her whole body, including muscles, skin, back, and joints. These became incapacitating at times and persisted for years. She consulted many specialists, including physicians, rheumatologists, and orthopaedic surgeons, and was diagnosed with a variety of problems, including fibromyalgia, yuppie flu, chronic fatigue syndrome, systemic lupus erythematosus, and systemic sclerosis. She underwent various treatment regimens, with many side-effects, but none was successful.

She also felt ridiculed and patronised by various doctors and felt exasperated, frustrated and hopeless about the very real pain for which she could find neither answers nor relief.

In this desperate state she entered into SHIP® therapy, and focusing on the pain symptoms brought up images which eventually led to memory retrieval of her being repeatedly sexually molested by her father, his friends and a few other family members as a small child. It was in therapy that parts of her childhood memories returned – specific incidents of trauma, being raped by drunken men, being shown pornography as “instruction”, being sent for an abortion. Her father was an alcoholic who ignored her during the day. Her mother beat her violently, repeatedly, so that she could never seek safety there. She recalls that her mother condoned the sexual abuse in that she allowed it, whilst punishing her for it at the same time. The only year of her childhood that Sarah could recall fairly easily was a year in which she was sent to live with her grandmother, who also treated her harshly, but at least there was no sexual abuse.

Her experience of pain:

Before psychotherapy:

Sarah recalls becoming aware of body pain more than 20 years ago, during her troubled marriage. This worsened after her divorce to include severe pain in all areas of her body – her joints, muscles of the trunk and limbs, her head, and her entire skin. She consulted with various medical specialists and had numerous investigations done, which resulted in differing diagnoses and many different treatments, none of which were successful. Her reality was constant pain, whilst the medical findings led her to doubt her own reality and consider that she was imagining herself to feel all this pain. Nonetheless, over the years she felt that something was very wrong with her, but no answer presented itself.

During psychotherapy:

Sarah recalls that she became more aware of her pain in therapy. She initially stated that the pain had only begun during therapy, and as she continued relating her story remembered that she had already consulted doctors about her pain during her marriage, and often afterwards – as if the immensity of her problem then had been suppressed to a degree. As she spoke it became clear that she had undoubtedly had serious pain symptoms for many years, and she had somehow tried to make less of them.

During therapy she experiences what she describes as a litany of pain – whatever subject is worked with, she immediately experiences intense pain in different areas of her body – headache, abdominal pains, pubic pain, pain in her spinal column, muscles, bones, joints, chest, spasms, and so on. She often cries because of the intensity of the physical pain itself. In the beginning of a session, Sarah usually feels pain in several areas focused on, intensifies in one area which then becomes the focus point of that particular session. Typically she experiences general pains, which lead to some area of more intense pain. When she focuses on this pain, an image starts to form in her mind of some memory of a situation to which this pain was relevant. For example, a specific pain in an certain area may be experienced as the painful position she was forced into during a traumatic situation in her childhood, such as the position of her arms and neck while being sexually abused. She experiences the pain in her body as she might have felt it during the traumatic event, and also recalls specific smells and tastes, as well as detailed visual memories of her surroundings.

Sarah describes her process as following a typical pattern in which she focuses on some cue linked to an incident or emotion, and becomes aware of the pain intensifying throughout her whole body. The pain in a single area intensifies, and as she focuses on that pain, it evokes an image of an abusive incident. She initially experiences the image as being at a distance, while the pain is experienced as being within her. The image is of her, but at a distance, while she is here, with the pain. As the process unfolds, the image

comes closer. As she allows herself to surrender to the actual pain she feels, in other words, as she goes into the pain itself, she experiences going into the image and reliving the abuse in totality. This process is repeated for the same incident following the same sequence, although she experiences different facets of the abuse on each occasion, until it appears to have been worked through and does not come up any more.

Sarah always experiences the pain first, and battles to access the emotions, though she is aware of there being emotions connected to the pain. The only emotional experience that seems to remain constant is extreme anxiety and fear. She explains that initially she feels no emotions, and as she relives different facets of a rape experience, different physical sensations become more apparent. After a while she has glimpses of emotions such as despair, powerlessness, and extreme loneliness. This process repeats itself. She experiences short, superficial feelings which immediately dissipate, as if she cannot hold on to them. More of the physical feelings, including the pain, recur on top of the brief emotional experience.

Sarah is aware that when she suppresses an emotion it immediately results in an increase in the intensity of the pain. At times she suppresses the image that she perceives because she fears the emotion that arises with it, which results in an increase of pain, as if the pain replaces the emotion, or covers it up.

Some other emotions that Sarah mentioned included shame, which she often experienced, and guilt that she could not prevent her body from going with what she was forced to do. She expressed surprise at the lack of anger which she feels should be there but which has not surfaced yet, and is concerned about the intensity of the eruption when it comes. Sarah experiences layers of pain, and explains this as working with a specific image and aspect of pain until it seems to be worked through and dissipates. It is not

being triggered again in that format with the same emotional cue, although a similar pain repeats at a later stage on a different level with different aspects of the traumatic memory.

After initiating psychotherapy:

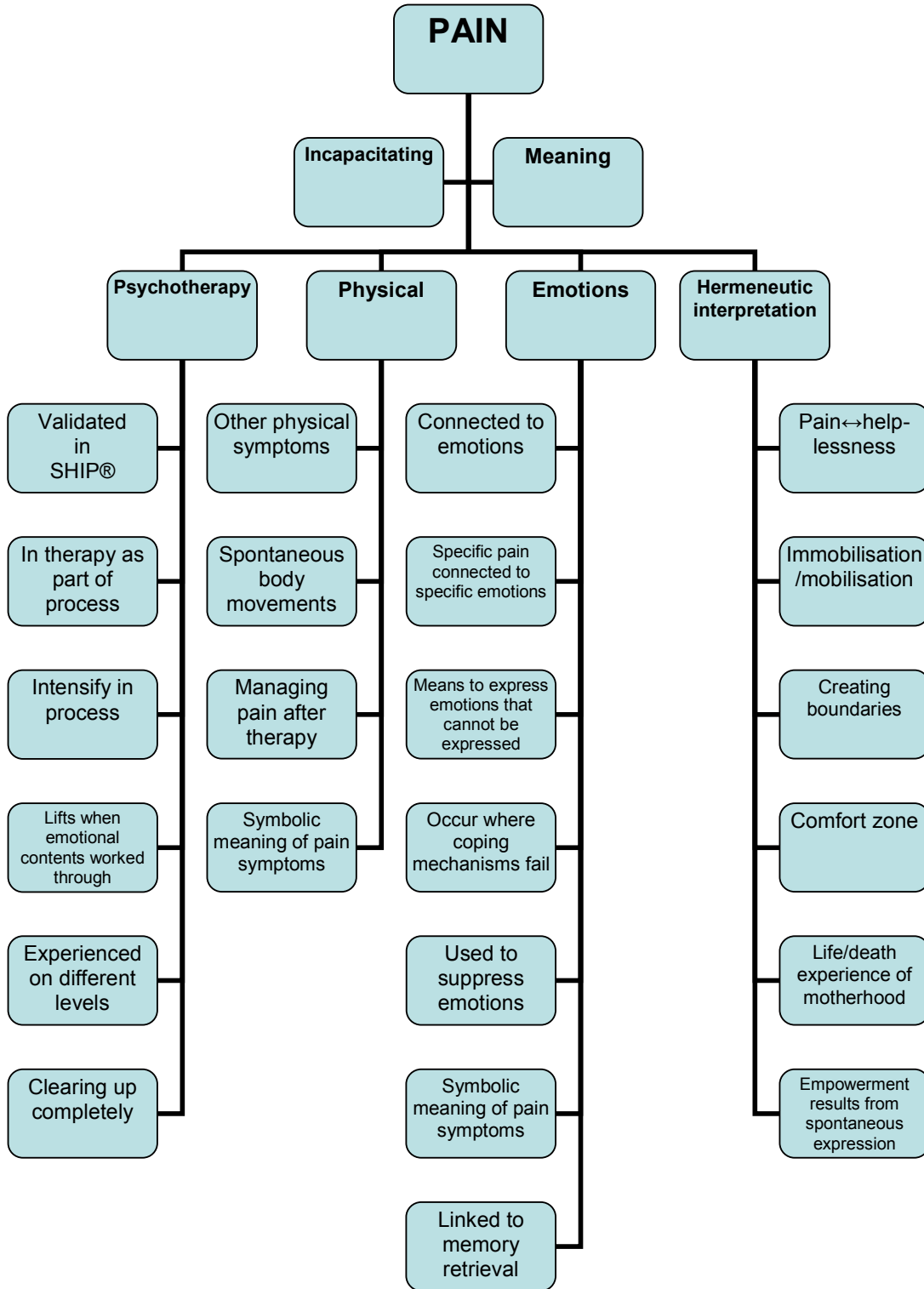
Sarah still experiences pain both during therapy as well as in her daily life, but she stated emphatically that her life was manageable and the intensity of the pain was less. She felt that she knew that her pain had meaning and therefore she embraced it, even though it caused discomfort. She could therefore cope with it easily.

Themes Derived from the Analysis

Several general themes emerged, stemming from the related experiences of all or nearly all of the participants. A number of other themes emerged that were not reported by all participants but occurred frequently during the narratives. Some themes arose less often in the interviews, but nevertheless appear to be significant in their own right and are therefore mentioned. Kvale (1996) states that a reporting style on phenomenological analyses that uses interminable quotes as becoming very boring, and suggests a deviation from that method as being more conducive to interesting reading. Thus this report on the themes derived follows Kvale's suggestions and includes only a few select quotes from the vast range of narratives produced.

Diagram 4.1 provides a summary of the themes divided into the broad groups of those derived from the physical symptoms, those pertaining to the psychotherapeutic aspects, those pertaining to the emotional material, and those based on a more hermeneutical philosophy of interpretation by the researcher. The themes of the meaning derived from the pain symptoms and the pain being incapacitating are presented as a more central or overriding aspect of the interpretation.

Diagram 4.1



Pain Symptoms Become Incapacitating

Nine of the twelve participants reported their pain symptoms as having been incapacitating, in the sense that they experienced them so severely that they could no longer function normally in their ordinary daily living. For eight of these people, the deterioration in functioning was gradual, until they were obliged to acknowledge that they were no longer functioning to capacity. By the time that these participants entered into psychotherapy, the pain affected their lives on a continuous basis. As Peggy relates: “At that stage my whole body felt like a bruised blue area, if I lay down it felt as if I’m lying on stones...everything you touch pains...in your hands, in your heel, it burns, and you feel like you want to lift your arm and you can’t...your whole body burns, it’s just heat...pain....pain...pain...”. Erica had migraines that were incapacitating when they occurred, although this was not a constant pain. Kylie was admitted to ICU with physical abnormalities in addition to pain, and had a life-threatening cardiac arrest. She concluded afterwards that although the pain as such was not life-threatening, her whole physical condition had deteriorated to the extent that she wished to die. No specific medical abnormalities could be found to explain her physical condition at that point, despite extensive pathology tests. Kylie describes the experience as absolutely chaotic: “There are no words to describe the pain in my heart, you know, it felt as if it was exploding; I was dying, I saw weird things on the walls attacking me; I ...am...dying .”

The three people whose pain was not incapacitating were Andrea, Lynn and Mona. Andrea described having a female body to be a painful state of being that led to the deterioration of her whole physical condition to a life-threatening point. Although the physical pain itself was not incapacitating, it was debilitating on that level, and she could not function normally. Andrea stated: “I was going to die. If I did not do something, if I did not start with SHIP® I would have died, you know.” Lynn dealt with her lower backache as it occurred and did not experience it as incapacitating, but related that she was always

aware of it as something that she had to care for and attend to. The eye pain had never occurred beyond the original experience as a child until she entered therapy. Mona felt that her muscle spasms and pain were severe but she always dealt with it on a practical level. Although on occasion she was temporarily incapacitated because of it, this was never for prolonged periods of time. She always had a basic sense that she would just get over it somehow.

Pain Appears in Psychotherapy as Part of the Process

For nearly every one of the participants, the pain they experienced became part of the psychotherapeutic process they entered into, to the surprise of some of them. Erica was the only participant who did not experience the particular pains she had problems with in her life, during the therapy process. She described feeling physical discomfort during therapy in an area associated with certain emotions, and muscle pain and tightness accompanied by emotional tension during therapy, which continued for a few days afterwards.

For Lynn the appearance of pain in her eye was an absolute surprise as she had not felt that pain for more than 40 years: “Here we were working around this relationship with my mother, over and over, around and around, for several sessions, and suddenly during one session, this excruciating pain in my eye appears! Out of the blue. And with it came all the memories of the hospital. And all the sadness about my mother. And this repeated again, and then again, in the next sessions. Until eventually there was no pain any more.” The back pain she had regularly experienced for ten years surfaced in therapy within the context of her miscarriages, which also came as a surprise.

Pain Intensifies During the Therapy Process

Every one of the participants described an intensification of their pain as it arose and was focused on in therapy. All the participants related a process in which the pain initially

worsened and then gradually subsided as they surrendered to the experience and the emotional material that accompanied it. It was as if feeling the pain in its totality gave it permission, so to speak, and allowing it full expression led to its dissipation after a time. Lynn related: “It was very tough, and you feel immensely exposed, but if that thing takes hold of you, it’s like a pain cycle that wants to complete, that only wants some acknowledging. And with that, also the acknowledgement that it’s not only painful in your body, but you also have emotional pain, and it is valid, you are allowed to experience so much pain around this.”

In some instances the intensification and dissipation occurred within the same session. This varied, depending on the person and the occasion. In some instances the pain intensified and continued beyond the session, and was repeated in a number of sessions before it disappeared. For some, the pain intensified during a therapy session, but did not persist beyond the therapy context, recurring again only in future sessions. Lynn described the pain in her eye as following this pattern.

Pain is Relieved when the Emotional Contents are Worked Through in Therapy

All of the participants disclosed that the pain and discomfort that they experienced as intensifying during the process with its accompanying emotional material, decreased and dissipated completely when they felt that the emotional contents had been worked through. For many, the experience of working through emotional contents meant that the intensity of the emotions increased to an extent that they had difficulty staying with the feelings, and experienced a great deal of discomfort. This discomfort equalled a level at which they would normally escape through repression or dissociation. The therapist helped them to stay with the experience of the emotion to its full extent, and at some point the feeling would begin to ease and finally dissipate. Their whole body would then often experience a state of extreme fatigue and relaxation afterwards, and the emotional discomfort of that specific issue would be gone.

James reported that after a session, he felt that a massive weight had been lifted from his shoulders. He also suddenly felt a sense of hope after such an experience, and a feeling of regaining his creative energy. For him, the pain remained after the first sessions of working through some of the emotional material in this way, although it did not have the devastating impact it had before – it was as if it did not matter at that point. He had an immense sense of relief.

Peggy recalled feeling the same sudden sense of extreme relief as the emotion she was wrestling with gradually eased and dissipated, shortly after the specific pain in that session also ceased. Cynthia said that when she focused on the pain, it would bring to the surface some emotional content such as anger, and both the pain and anger would intensify until she had spontaneous, severe tremors in some area. After a while the anger would lift and her body would relax, and she would experience deep relief.

Jane described her experience thus: “It was really as if someone was grabbing my arms, as if they were clamped tight; it started here and felt as if someone is pressing the blood through, and it felt as if I could not advance, felt stuck. It was literally what was happening in my marriage, that I felt I had to carry on, I’m into this, but all this emotional stress with my husband was holding me back, fast, stuck. And the moment I admitted this, the pains in my arms became excruciating. Luckily she guarantees that you won’t die here on this bed! One can’t measure this type of pain, but it just becomes worse and worse, and as you zoom in on it even worse. And the next moment, without you knowing why, it’s an absolutely amazing feeling, it becomes totally slack. And then you sigh....and you take a deep breath....and you relax completely. And you know then that it’s gone.”

Pain is Experienced on Different Levels in Therapy

Several of the participants described their experience of pain as occurring on different levels, each level indicating a different aspect of experience or emotion. General body pains spread over different areas were interpreted as the expression of a system in crisis, while more specific pain in a local area was interpreted as tissue memory of past trauma. Many reported that they first experienced the general body pain, interpreted as the system in crisis, without emotional associations. When they focused on this pain, emotional pain was evoked, and eventually led to feeling the localised pain while remembering the actual original traumatic event. As Kylie put it, the broader pain brings the system to the point where it can experience and acknowledge emotions previously hidden from consciousness. The pain currently experienced in the system leads to an exposure of suppressed emotions. The pain allows the system to access these feelings repeatedly, until eventually revealing the full physical pain in the body area in which the original pain of the trauma was experienced.

Kylie felt that the pain forced the system to surrender its defences and to reveal the full extent of the emotional trauma from which the person previously dissociated. Only then could the system access and manifest the actual pain of the specific incident as it had been experienced originally. She illustrated this by relating how general pains in her pelvic area led her to images of herself as a toddler being molested by her father, seeing the image from a distance at first, and eventually moving in and identifying with the image as herself. This occurred for a period of several years with all the terrifying emotions associated with it: fear, anxiety, feeling as if she was going to die, abandonment, extreme aloneness, shame, and so on. After many years of working through different aspects of this material, Kylie only recently experienced the actual pain of being physically penetrated.

Several of the participants revealed that they perceived the pain to occur in increments associated with emotions which they then worked through and integrated, with increasing

associated memory recall, as if the system gradually paved the way towards deeper, more painful levels of emotional material. It seemed to them as if the system deliberately did not expose all the worst emotional material from the onset, but had an innate wisdom of knowing how much they could handle at a time, how much to expose, how to increase the memory recall gradually as they were able to handle more intense material. They felt that their systems gave them pain and emotional material connected to it in increments in order to integrate these in manageable chunks of information and emotion. As they completed a specific aspect of this process, and came to a point of feeling more comfortable with it, something on a deeper level was revealed and experienced.

Thus the system ensured that they were not flooded and overwhelmed by the intensity of the experience as it unfolded in the here-and-now. Erica explained it thus: "...it goes through alterations, you go through phases and you feel that you've dealt with everything of that particular feeling, and then you realise you have to walk another journey, and then another one, and another one until eventually you've worked through everything and feel that you've brought it all back to a place where, well, I think it's just...I feel comfortable...and less stressed...and relaxed".

Pain is Connected to Emotions

All the participants experienced pain symptoms in their bodies prior to initiating psychotherapy. Every participant, without exception, concluded that their pain experience and their emotional experience were connected. Most of them did not make this connection from the start, and the realisation came within the very direct therapeutic context of experiencing the two modalities as interactive in a very significant way. Erica had surmised that her pains were stress-related, but it was on reading the literature on SHIP® that she realised that it may have been her body expressing itself on an emotional level through the pain symptoms. Erica was the only participant whose original pain

symptoms were not elicited in the therapeutic context, although different painful sensations occurred for her in therapy.

Lynn was the only participant who did not seek therapy to resolve personal problems – she entered into therapy for career growth and expansion. For Lynn the severe eye pain had only been a memory and had never been experienced since the original incident until she worked with her relationship with her mother in therapy. The link between the relationship difficulties and the extreme pain she had suffered as a small child had not even occurred to her before. Neither had her lower backache been linked to suppressed emotions about her miscarriages. Only after the backaches ceased after working through the traumatic emotional memories, as well as the physical memory experience of the lower back pain while having the miscarriage, did she make the connection.

Several of the participants expressed their initial perception that they had developed emotional problems as a result of their physical pain, and did not realise that it could be the other way around until well into their therapy. Then it became very clear to them that they had unaddressed, unacknowledged emotional content that they could now directly see was linked to the pains. Before psychotherapy the pain was experienced as the only reality whereas the emotions were often invisible, although seen to be there in retrospect. In therapy the focus was either on the pain symptoms, which then elicited emotions linked to these, or the initial focus was on emotional content or specific episodes in the participant's life, which produced the same physical sensations that they had experienced before.

All the participants expressed their surprise and awe at the realisation of how intricately their physical body sensations and emotional sensations were connected, and how they had developed a high regard and respect for any physical pain symptom their bodies might present to them now.

Spontaneous Body Movements are Elicited with Pain in Therapy

Five of the participants reported experiencing spontaneous body movements or reactions in some form during therapy, associated with the pain and the emotional material elicited by it. Peggy related that her body spontaneously went into spasms or movements after she had added craniosacral therapy to her program. Focusing on emotional material thence evolved into experiencing pain in a certain body area, whereupon her body moved in a way to emphasise the pain in that area, such as arching. This would exacerbate the experience of pain and the intensity of emotion, until it subsided spontaneously again.

Lynn recalled the memory of fighting to free her arm as a child when it was immobilised to insert intravenous infusion lines, and experienced the actual vigorous flapping and flailing movements of the arm in therapy sessions. She relates that she thought that she was having a hysterical reaction in therapy, which is absolutely contrary to her personality, and realised that it was completely spontaneous and would not abate until that specific aspect of her trauma was worked through.

Cynthia found her body going into spontaneous tremors and twitches as her pain and emotional experienced escalated in intensity during therapy. This feature repeated itself, and she explains that she initially felt frightened by it, not knowing what was going on and not being able to stop it. Her therapist encouraged her to stay with the experience and to allow it. As it decreased she felt fatigue and relief from the pain and emotions accompanying it.

Helga described how she would feel the emotion and pain increasing and then at a certain point her body would jerk into a type of spasm which she demonstrated to the researcher. It looked exactly like the Moro reflex, a primitive reflex seen in very small infants, and is considered a neurological developmental abnormality if it persists or appears after a

certain age (Coovadia & Wittenberg, 1999; Guyton & Hall, 2006). Helga felt that it represented a way for her system to avoid going into the full extent of the emotional experience; she had no way of controlling it at all. This process occurred very commonly during the earlier part of her therapy, and had gradually become less frequent.

Sarah found that her head, neck and upper trunk arches into hyperextension or hyperflexion at times during her therapeutic process, her upper body completely lifting off the surface of the bed.

Pain is validated in SHIP®

This theme was not directly given by the participants in their stories or directly and consciously experienced by them, but was indirectly arrived at by interpreting how they understood their experience. Whereas all the participants had pain symptoms in their bodies prior to psychotherapy, before therapy the pain was considered merely something that had to be managed. It had been investigated medically in various ways; it had been subjected to a variety of tests and treatments; it had been given various diagnoses and ascribed to several causes. Different treatments had been used as well as lifestyle changes made in the hope of alleviating the pain. In many cases the pain had become debilitating and curtailed the individual's normal functioning. For some it predicted deterioration and eventual debilitation. For some the whole process of seeking answers and relief became humiliating and repressive. Many experienced relationship problems because of the pain symptoms. One participant spent time in an intensive care unit as a result of her physical symptoms, including the unexplained pain.

In all cases the participants' aim was to manage and control the pain, and thus to suppress it as far as possible. SHIP® therapy provided a totally different vantage point by validating the pain instead of trying to control it. Rather than making the pain go away, it presented the participants with the challenge of just feeling their pain, and experiencing it

in its full depth and all its facets. When validated in this way it gained a different character, in which it was accepted and accorded a voice. This then allowed the unfolding of emotional contents connected to the pain, which in turn led to the decrease and cessation of pain in most of the participants.

For those who continued to have pain, it was perceived differently: it had a meaning and function, and was no longer the unmanageable problem it had been before. Where the starting point in therapy was emotional issues, the therapeutic approach validated the emotional pain instead of suppressing it, which in turn allowed the physical pain to be experienced in connection with the emotional pain. It seems that validating the pain allowed a process in which the body system was spontaneously allowed to express whatever material it presented in the moment, in order to facilitate the participant's own innate tempo of dealing with both the emotional material and the physical pain. Where there was distrust and perturbation before, this was replaced by developing a trust in their own system's experience and responses, and that seemed to make the difference.

Specific Pain is Associated with Specific Emotions

Several participants reported that they felt pain in specific parts of their bodies linked to specific emotional experiences, but this only transpired after becoming aware of these links in therapy. They did not make this connection until well into their therapeutic process. Jane reported the pain in her arms to be directly connected to a feeling of being held captive, ensnared, and powerless to escape her situation. Kylie made several associations: pain in her chest and heart were linked to extreme fear, fear of death; pain in her arms represented feeling helpless and unable to defend herself; pain in her legs also meant being helpless and unable to run away; and abdominal pains were linked to feelings of shame. Sarah reported abdominal pains as being linked to shame. For Lynn the pain in her eye was synonymous with her intense feeling of emotional abandonment. The low backache linked directly to her intense feelings of loss after miscarrying, which then also

connected with her lack of being mothered herself, which was something she so had wanted to give to her unborn children. Thus the backache also became connected to her emotional experience of loss of the bond with her mother. Andrea felt that her body hurt all over with the shame of being female.

Pain is a Means of Expressing Emotions that Cannot be Expressed

For every participant, pain had emerged as a way in which their bodies expressed emotional distress of some sort. Several facets emerged around this broad theme:

- It appeared that physical pain had occurred in lieu of emotions that had not been acknowledged. In many cases these emotions were not granted a voice because they had either not been known, or because the frame of reference was such that the experience of emotions was not a known, accepted aspect of life.

Helga described being totally blunt to the experience of emotions, as if she lived in an emotional void. James had grown up not knowing how to voice emotions – it was as if this possibility did not exist for him. He stated: “One experiences these feelings and then you reason all around them to convince yourself of it being invalid”. For Cara everything was aimed at pleasing others at the cost of own emotions, as if the only permitted emotions were assessing the possible satisfaction of pleasing another.

- For many, the pain represented emotions which could not be verbalised, either because they were not conscious, or because they had to be suppressed for some reason perceived by the individual. For those participants whose pain symptoms led to the retrieval of traumatic memories of childhood abuse, their pain was the only real tangible way in which their systems could express distress, and draw some attention to this distress. The original physical and emotional pain had been dissociated, but the bodies still held tangible signs of trauma that had not been addressed.

Sarah disclosed: “I just always knew something was very wrong, something was so wrong. And nobody could tell me what was going on.”

- For many individuals, the pain represented a way for the body to express emotional energy where it was denied expression on its own merits.

Helga said: “I did not really know about emotions. I didn’t know they could be this painful. I was just so switched off about it.”

- For some participants, it was a way of expressing emotions which they knew were there, but could not be validated.

Mona experienced severe muscle spasms in lieu of mourning for her son, a process she knew should have occurred but could not allow. “I always had this idea that to show emotions made one a loser. It was just in my system.”

- When emotions were not consciously experienced, or were avoided due to fear of discomfort, or were experienced consciously but not acknowledged and attended to, physical pain symptoms resulted. Thus it seems clear that these individuals developed pain as a result of ignoring their emotions, for whatever reasons.
- For several participants, it appeared that their pain developed as the only way that their being could escape from an untenable situation; or where they perceived themselves as stuck with no way out. In such cases, pain also functioned to indicate an untenable situation that they had no other known way from which to honourably extricate themselves.

James felt powerless to change his career situation for various reasons which made up part of his value systems at the time. He felt ensnared in a job that he hated, and firmly believed that he had no alternative whatsoever but to continue and try and make the best of his situation. Since his whole identity was encapsulated in this work capacity, it represented a crisis which he had no way of even knowing how to handle. His body had to make it impossible for him to do this work in order to validate his needs.

Jane found herself in a new marriage that was floundering; yet within her frame of reference and values at the time, it would be unthinkable to end such a relationship. Many

aspects of the relationship acted as memory triggers for her own childhood and revealed similarities with her relationship with her father. It did not occur to her consciously that many of her pains were associated with feelings of being ensnared in an untenable situation. However, this quickly became apparent to her in therapy.

- It seemed that for many individuals who did not know how to verbalise emotions, pain became the way in which their systems learnt to express emotional need. Their pain thus became representative of emotions, increasing with stress and decreasing when stress abated. The only way that they had contact with their stress levels was through experiencing the pain their body offered.

Mona had regular muscle spasms after initially experiencing them following her son's death, and she made the association with stress or possible emotional matters early on. At times she was aware of an emotion, but deliberately suppressed it and surrendered to the muscle pain instead. Andrea's body ached all over when she focused on being an asexual body and especially not a female body, thus denying any aspect of female emotionality.

Pain Occurs when Coping Mechanisms Fail

Most of the participants reported having very strong abilities to cope in dire circumstances, and it appeared that most of them had a cognitive value system linked to high expectations of themselves to cope in all situations. Several participants related incidents which clearly had to have had an immense emotional impact on them, which they handled without emotional distress. Many participants reported numerous such incidents, and many even related how they had coped for other significant people in their lives without wavering. At some point, however, a specific incident or accumulated stress occurred which stripped them of their abilities gradually or suddenly. They started experiencing pain in situations that were emotionally overwhelming and in which they felt incapable of coping to the extent they had before. In other words, people who had the tendency to continue coping through severe emotional strain without expressing the emotional contents, got to a

stage where they found the emotional contents of a situation overwhelming and could not cope further.

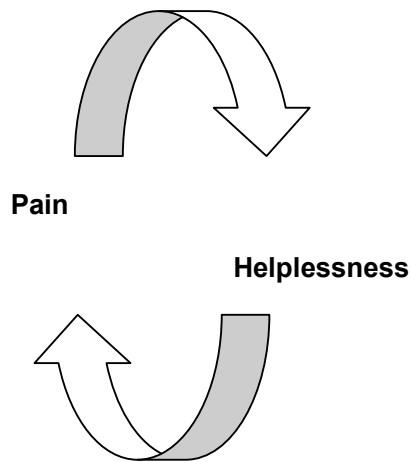
Cynthia told a story illustrating her tremendous coping abilities in the face of life-threatening burn wounds, and returning to a world filled with rejection, humiliation and abandonment, whilst supporting others emotionally. Eventually the trauma of an armed robbery brought on her severe physical pain. Peggy learnt to contain her emotions at a young age as a coping strategy, and continued to do so relentlessly through extreme emotional turmoil as a teenager, her brother's death, and a façade of a marriage with hidden agendas. Her system displayed pain that could no longer be ignored after a final act of betrayal by an employee and friend. Helga spent her entire childhood pushing her body into physical sports activities that she actually hated, and coped, both for herself as well as her parents, through the death of her brother. She also endured several miscarriages without qualms, but her body developed intractable pain when she recommenced extreme exercise.

Several of the participants admitted that, prior to their therapy, they believed it was expected of them to be strong in time of crisis; and that being strong included not displaying emotion. They felt that they would feel helpless if they surrendered to their emotions; but they were projecting this feeling by believing that they would appear helpless to others, which was not allowable. It would be a clear display of weakness to do so. Through therapy, the participants realised that this belief and their strong desire (and ability) to cope in extreme adversity caused their bodies to eventually develop pain symptoms. Mona still feels that her surrendering to crying during therapy means that she is weak and a loser, but admits that it was essential for her to do so.

Reciprocal Interaction between Pain and Helplessness

A very strong theme emerged in terms of a link between feeling helpless and physical pain. All of the participants agreed that this connection was indeed present, could identify with this concept and concede that it was a powerful part of their experience. The link works both ways: in experiencing helplessness, the individuals eventually succumbed to physical pain symptoms; and the pain that they felt eventually left them feeling helpless.

Diagram 4.2



Few of the participants consciously experienced and expressed feeling helpless. The individuals who had experienced sexual abuse as children could relate to this feeling consciously at the time of the interview, as it was a part of the emotions they had been dealing with during therapy and had become very aware of it. They had felt helpless as small children during the abuse, and then felt the same way again as adults in trying to come to terms with the physical pains they were experiencing.

Many of the participants felt that they could not allow themselves to acknowledge the feeling of being incapable and powerless; they felt that they had to persist with the belief that they could manage their situations. In so doing, for the sake of emotional survival,

they created a false belief that they were coping. In retrospect it was clear to them that they were experiencing increasing feelings of helplessness in their situations.

Specifically, those participants who had strong values about not displaying an inability to cope, and who were unable or unwilling to express the other emotions they were increasingly subject to, found that they did not recognise a feeling of helplessness by the time that their symptoms started. The link became very obvious to them, however, once they began exploring the process in therapy. Many of them displayed a mild sense of shame that they had not recognised the desperation that their systems had tried to convey.

Many of the participants also felt that they were rendered helpless to some extent by their physical pain symptoms. With the exception of Lynn and Mona, all of the participants had experienced their pain as incapacitating and physically disabling; and barred them from normal functioning. While Erica experienced her migraines only on certain occasions, they were debilitating and unpredictable, and thus caused havoc in her life when they occurred. For every one of the other participants, their pain was more or less constant and curbed their normal functioning severely, leaving them at their wits' end and feeling helpless.

Kylie had memories of extreme feelings of helplessness as a small baby who was sexually abused by her father. She was unable to ward off her attacker with her arms or run away, and was not even able to verbalise her horror and express her feeling of total annihilation. For many years as an adult she had no memory of this abuse, and felt helpless as her body was wracked by pain and dysfunction without an obvious cause.

Sarah cannot easily access emotions, but the feeling of helplessness is one of the few emotions she can recall from her memories of repeated childhood abuse. During her adult years she was confronted with ridicule and patronising attitudes from the medical fraternity

in her persistent search for answers to her pain, and described feeling repeatedly and profoundly helpless and filled with self-doubt. She was convinced that something was very wrong with her, and all her attempts to find answers, and her very real physical pain, left her feeling helpless.

Jane felt trapped and helpless in her marriage. Her husband's actions triggered memories of her childhood in which she had felt trapped and helpless. She developed pain which incapacitated her and which doctors predicted would deteriorate and become even more debilitating. She clearly linked her pain to her feeling of helplessness in therapy.

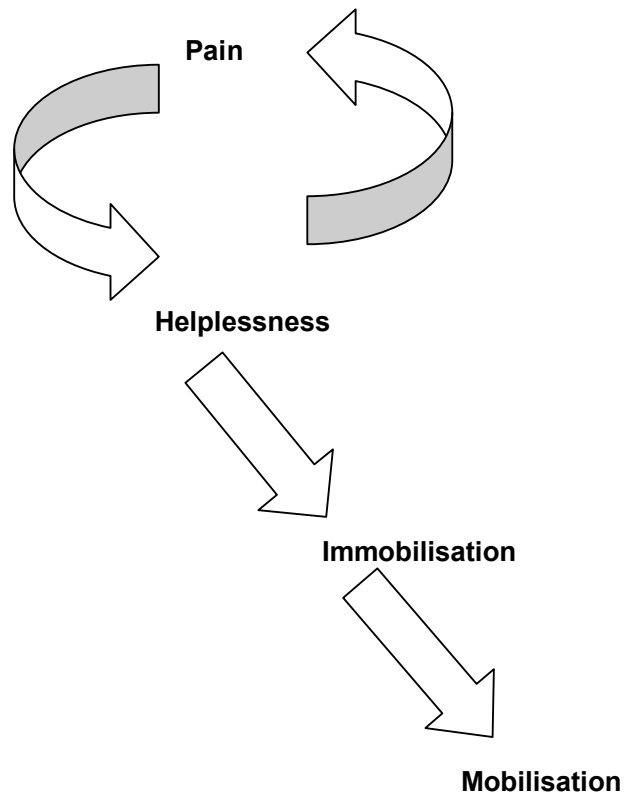
Cynthia's pains left her feeling helpless and debilitated. In therapy the pains led to her childhood memory of helplessness during surgery, and her feeling of helplessness during the treatment for her severe burn wounds, as well as the humiliating aftermath of this event. Andrea experienced her femininity as painful, and felt totally helpless about changing it, except by eating less. Peggy coped in situations in which she experienced an increasing sense of helplessness, and developed body pain within this attitude of coping, which left her completely helpless. James felt totally helpless to change a career that he disliked, but with which his whole identity was linked. He developed body pains that left him helpless, and unable to continue this work. Helga developed pains in her hips and muscles that left her helpless and unable to function normally. She linked these pains to the helplessness she had suppressed throughout her developing years in doing sports activities that she actually detested but had no voice to express it with.

Pain Results in Both Immobilisation and Mobilisation

From the narrative thread of all these stories, a clear theme emerged that each of these participants reached a state of immobilisation to some extent about aspects of their lives. Many reached a physical level of immobilisation. For some, the immobilisation presented on a relationship level. None of the participants were aware at the time that this was a

dimension of what they were experiencing in their lives, although when this possibility was presented to them in the feedback discussion each one concurred that it was an accurate observation derived from their story. Immobilisation was perceived as a dimension of the feeling of helplessness they had experienced. The irony was that after the initial immobilisation, the pain led to a mobilisation of their efforts to explore their situation and endeavour to resolve it.

Diagram 4.3



For James, the immobilisation was an unconscious mechanism to extricate himself from an untenable situation. His actual immobilisation led to the exploration of other options available to him, and thus became a mobilisation of his unrealised abilities. Lynn only experienced this aspect once she entered therapy and not before. Her immobilisation came in the form of her relationships, first with her mother and then with other women in the sense that her pain was associated with women, while relief from the pain was

associated with men. Mobilisation for her came on a psychological level in the form of her liberation from the constraints that these unconscious perceptions had previously placed on her relationships, especially her relationship with her mother, which occurred through an integration of the paradox that is her mother.

Pain is Linked to Memory Retrieval

Many of the participants reported that they recalled memories of significant emotional events while focusing on their physical pain. This occurred specifically during therapy sessions at first, although later the experience occurred at other times too. For many of them the link was threefold, and included pain, emotions and memory. This occurred when they were asked to accept their pain and challenged to focus on the pain, instead of trying to control it. Memories of emotionally laden incidents which linked to the pain often arose first. Several participants expressed their surprise at the detail with which they could remember long-forgotten incidents. Specifically, the individuals with histories of childhood trauma found that when they paid attention to their pain symptoms, these opened up a vast reservoir of trauma memories with all the associated emotional material. This reflects the reported tissue memory of traumatic pain.

Both Kylie and Sarah, who had been sexually and physically abused as children, related clear memories of the specific painful physical positions and the injuries sustained in childhood that they relived in actual pain during their therapy. Kylie could recall her hips being forced open when working with the pain she experienced in her hip areas. She made the memory association between several physical sensations experienced during her abuse as a toddler and the physical pain she felt during therapy. Pelvic pain sensations were a common occurrence that she associated with her memory of the sexual abuse. She frequently had vaginal bleeding during such pain experiences in therapy and in between sessions, even though she had had a hysterectomy previously. She had vivid physical sensations of being abused rectally, with concomitant rectal bleeding during

therapy. Sarah recalled the image of being sexually abused simultaneously by her father and another man in a certain posture when working with pain in her neck and shoulder, which was a new pain at the time – the posture had forced her neck and shoulder into the position she was now experiencing as painful in therapy.

When Lynn worked with the difficulties in her relationship with her mother, she felt severe pain in her eye exactly as it had felt for her as a two year-old undergoing the repeated painful electro cauterisation. This pain evoked feelings about her mother –sadness and loss, the feeling of abandonment, fear and a lack of nurturing and safety. All the memories of her experiences during her hospitalisation were vividly evoked in great detail, along with the intense pain in her eye. She even experienced a spontaneous flailing of her one arm in jerking motions with the helpless feeling of trying to avoid the insertion of a needle for intravenous infusion into her arm. In a few very painful sessions of psychotherapy, Lynn also had experienced the full physical process of losing a foetus, including the feeling of contractions in her lower back and the sensation of expelling the premature child. It was as if her body tissue remembered every detail of the process as she originally experienced it.

Pain is Used to Suppress Emotions

When it was pointed out to them, many of the participants recognised that they accepted pain symptoms more readily than feeling emotional pain, and unconsciously used pain to avoid feeling emotion. Several individuals mentioned that, prior to therapy, when they became aware of an emotion emerging, they consciously supplanted it and allowed the pain to come through instead. The pain seemed to be a more familiar feeling and thus less threatening. They agreed that they used the pain as a distracter in order not to experience the unknown territory of emotions. In this way the pain fulfilled a protective function. Sarah was aware of doing this in therapy when working intensely with the pain and the emotional contents associated with it, but not between therapy sessions in her day-to-day life. For these participants, pain comes freely and is well known, but emotions are difficult to allow.

Mona mentioned doing this after her son's death on a regular basis, and was even at times aware that it was probably not good for her; nevertheless, she continued to do so. The idea of surrendering to her emotions was just too threatening for her. The pain was bad but well-known, and was part of her comfort frame of reference. After completing her therapy she was duly aware of this phenomenon and described that she intentionally works on countering it when she becomes aware of it.

Pain is a Comfort Zone

A few of the participants could relate to the concept that their pain was a world with which they had been familiar as children, and as such, had become a part of their frame of reference. It was as if their system knew pain, and was comfortable with it; they could even feel safe with it in that context because they had survived it before and therefore did not feel that threatened by it. They had very few other frames of reference for being in their bodies.

The original source of pain had often been those people who were also the participants' primary caretaking figures, who were responsible for their feeling of safety and on whom they were dependent for survival, and the most powerful figures in their tiny lives. As such, this also constituted their experience of love at that time. The participants could see how their current pain therefore equalled love – they had not known it in a form in which their systems had felt cherished, precious and validated for themselves.

Kylie described how she even felt comfortable with the extremely uncomfortable sensations evoked during medical examinations for her chronic symptoms, ascribing it to her sense that "this is what comfort feels like", as a known frame of reference. She felt that her system connected this severe discomfort with love, as if this was what she knew as love, even if it could be destructive. "I didn't like it when they touched me, that was bad.

But the pain of the procedures, that was fine. It was as if I had to have pain, the operations and other tests. I think it was my comfort zone, I needed pain to feel okay in a way.”

Meaning is Derived from Pain

Without exception, the participants experienced their pain as meaningful when viewed from a broader perspective. All agreed that it was clear that their pain had forced them to look further, to explore their lives in more depth, and to examine other aspects of themselves. The pain was a tangible, intrusive, modality of their systems that could not be ignored. When it surfaced, it forced them to sit up and pay attention.

All felt that they had developed a greater awareness of themselves and their emotional worlds through engaging with the pain in therapy. Some even discovered emotions that had been alien to them before. Every one of the participants had the realisation that it made them more aware of their own needs, both emotionally and physically. All became aware of their physical bodies on a greater scale, and of their bodily sensations as a physical experience of their emotional worlds on a level which they were familiar with and could listen to. They all explained that they had started to claim their lives as their own after acknowledging the connection between pain and emotions. They described various levels of achieving a sense of liberation, freedom, validation of themselves, spontaneity of being, a release of energy previously applied in a dysfunctional way, and a feeling of empowerment in the process hitherto unknown.

Erica commented: “It’s great! Liberation! Empowerment! It’s so energising as well, I mean, I have enormous amounts of energy compared to my colleagues. The people at the office say working with me is hectic, I drive people crazy!” Kylie exclaimed: “I feel extremely privileged, that this thing has come over my path. I feel so privileged, I am standing in awe, that I could work with this thing that had slowly been murdering me, that I could address it

and work through it. Really, it's such an amazing privilege. And that I could get to know myself in the process, understand myself, achieve such a sense of awareness through it.”

The participants had attained a greater level of assertiveness, and a sense of realistic, healthy boundaries with a resultant change in the dynamics of their relationships and interaction with others. For some participants, the changes in these dynamics resulted in turmoil when the other parties in their relationships did not adapt to these changes, or had to re-examine their own position in relation to these dynamics. Participants described the growth they had attained through this process, and specifically mentioned achieving an acceptance of themselves which they did not have before, extending then also to a greater acceptance of others. A sense of self emerged which they claimed with enthusiasm and pride. Many spoke of feelings of despair being replaced with a profound sense of direction and hope.

All of them concluded that they were better off because of their pain symptoms than they had been before, although they conceded that it had been a rough ride and certainly not easy to stay with the process. Helga explained: “It is extremely painful, the emotional pain specifically, it is very bad, so bad that I sometimes just feel I can't go there, can't reach it, it feels as if I would die should I touch it. And then sometimes the physical pain is soooo bad that I become very angry about it, because I just can't believe that it's so painful! And then I become even angrier because I blame the therapist for not doing something about it, for not taking the pain away! How can he leave me like this! And this pain....!”

Pain Creates Boundaries

In the participants' description of the outcome of their experiences, a theme emerged of individuals being forced to relinquish coping mechanisms that were not serving them well. It appeared that they created coping mechanisms on various levels to conserve and protect their precarious boundary integrity and limits. Kylie described her body: “I had no

sense of a boundary of my body, my body was this boundary-less liquid that just flowed. So I did not have a shape, I did not have a stomach and legs and.....other pieces. I was just this formless blob, that was how I experienced my body. Now I have a body and it seems amazing to me that it could change like this! I have a body which can feel pain and softness, like the cream I rub on..."

It seemed from their descriptions that the participants were not aware of a fracture of boundaries before. Their systems reacted to this by presenting pain to indicate a problem. In retrospect, the feelings of helplessness were intertwined with this, and they did not know how to extricate themselves because of the vagueness of their boundary demarcation. Their experience of pain became a very solid physical experience coupled with the emotional content, which led them to eventually develop a far stronger sense of boundaries, with the resultant feelings of empowerment and liberty.

Through her pain, Andrea had to engage with the concept of her female body, with its boundaries as a body that she could relate to and identify with: "I had to be asexual, at all costs, to try and not be feminine. I was a blob, or I had to waste away my body – I had no sense of my body as real. I had to learn with this process of pain, what my body boundaries were. Had to come to terms with being in a feminine body."

In the feedback discussion, Sarah described an incident in which she was confronted with a potentially unpleasant interpersonal interaction. Afterwards she realised that this was the type of situation that would previously have caused extreme agitation and anxiety; however, this time she felt that she could maintain her own boundaries comfortably, and was able to handle the situation smoothly and with ease. She felt really good about this afterwards.

Cara said: “I always felt that I had to please others. Serve your neighbour sort of. Give without expecting anything back. Just give and give and give. And then do things that would be taxing to my system, and eventually sacrifice my own things. Since my childhood I’ve done this, tried to be a pleaser. And my parents were very strict and formidable, had a wonderful relationship with them, but scared of them. And I think that sort of had an influence. Now I realise how bad it was for me, and I am very aware of what I want to do, of what I can give and what I am not prepared to give. And then I say NO!”

It seemed, for some participants, as if pain as a commodity in itself, took over the function of creating boundaries in lieu of other boundaries. Working with the pain and the emotional material connected to it, transformed it into more realistic boundaries. Boundaries on different levels became apparent in the experiences related – those on an embodied level, those on an emotional level, and those on a behavioural level. Often the experience of these were intertwined and initially indistinguishable.

Motherhood is a Life/death Experience

Helga, Lynn, Cara, Mona and Kylie described aspects of their experiences of fertility, motherhood, and carrying both life and death as a woman. Helga, Lynn and Cara had miscarriages that made up part of the emotional material they had to work with in therapy, and underlay some of the pain symptoms they experienced within the therapeutic process. For Cara, infertility and her miscarriage contributed greatly to her feeling of distress prior to initiating therapy, and in retrospect, she felt that these experiences partly led to the body pains that she started experiencing. To her surprise, she dealt with this fairly briefly, and found that it did not constitute as much of her emotional material as she had thought. However, it did lead to an exploration of other emotional matters, which required more substantial consideration.

Helga experienced her repeated miscarriages with equanimity at the time, as if they were just another problem to deal with, and the full impact of what she was trying to integrate emotionally only became clear later on, after starting therapy. Lynn described the intensely painful experience of miscarrying a child, both physically and emotionally. For her the loss had been excruciating, and the process as it occurred held far more meaning than she was allowed to consciously acknowledge then. She felt that the social system she found herself in held no sympathy or empathy for the process of mourning that a woman goes through after losing a foetus, or for the fact that a woman still feel the effects of the hormones of pregnancy in her body for a period of time whilst knowing the child has gone. She felt that people expected her to brush over such an experience, and felt unable to process the contents appropriately. For her the importance of this event was even greater because she wanted to give life as a mother, in contrast to the life given to her by her mother who begrudged her the essence of life. It was a feeling that incorporated her own emotional battle with abandonment, loss and rejection by her mother, and felt that having a child was an act opposing this concept – to give life and to grant it, in all of its richness. Given her perception of motherhood, she found it profound that she could carry both life and death in her body. This had great significance for her in the meaning of her relationship with her mother, as she integrated it during therapy. Her relationship with her mother, the pain she experienced in her eye, and the pain she experienced in losing the life she was carrying were all connected emotionally and symbolically. As she said: “It was this paradox that is my mother, that is both good and bad, both life and death. And so I could also carry both life and death – even though I dearly wanted this child, wanted to nurture it and love it.” Associated with this, she also described her experience that the female entities in her life were connected to her experience of pain, and the male entities in her life were connected to light and relief.

Kylie had problems with infertility and conceived only after infertility treatment, giving birth to twins. She felt that her infertility was because her body rejected the process of creation

because of intense issues with trust with the male figure in her life, and with the lack of feeling safe enough within herself. She also concluded that, ironically, it was her children who contributed to the activation of the physical and emotional symptoms to the extent that they eventually opened up her “Pandora’s box”.

Mona lost an adult child to death, and had no doubt that this was the instigating event in her life that led, firstly to her body reacting with physical pain, and eventually led her to open herself in therapy to the emotional expression of all the other issues that had accumulated during her life. The significance of this was that in dying, the child she had given life to, in turn gave life to her emotionally again.

Pain Symptoms have Symbolic Meaning

Apart from the direct physical meaning of pain, many of the participants described the symbolism they saw in their pain symptoms. Some participants made direct associations between the specific painful area and the meaning of the pain, while some did so in a more indirect way. For all the participants, the symbolic meaning of the pain was very pertinent and profound. Kylie described the intense pain she felt in her heart, as if her heart was about to explode, as she visualised her father entering her room as a child. This pain represented a terror of death, the fear that she was about to be annihilated, as if the life force would be extinguished from her heart. She also explained the pain in her hands as symbolic of not being able to defend herself by using her hands as a barrier, as she was barely able to move her little arms at will. Jane described the feeling of pain in her arms as symbolic of a feeling of being held powerless in captivity.

The emotion of disgust was expressed by several participants through the body’s attempt to rid itself of the offensive intrusion through nausea, vomiting and diarrhoea. Kylie experienced this frequently and made the symbolic association quickly. Sarah had the same perception of these body symptoms. Both of them recalled their disgust at the

memory retrieval of the taste of semen in their mouths. Andrea described her perception of her body's need to rid itself of the 'stuff' that would make her body disgusting. All of them experienced the need to vomit in their therapy process.

Pain Dissipates Completely

Of the 12 participants, all of whom had had chronic body pain for extended periods of time, nine reported a complete remission of their pain symptoms after some time in therapy. The period of therapy before they experienced this level of relief varied for each person. The three individuals who did not report a remission in their pain in the initial interviews were James, Sarah, and Mona. However, all three emphasised that their pain had become more manageable, and had a better understanding of it that made it easier for them to deal with it. James reported a definite decrease in pain symptoms in the feedback discussion after about three months. Sarah had far less pain than originally although it still surfaced in stressful situations. The pain she experienced in therapy also generally persisted between sessions although it usually lessened and cleared up completely before her next session. Mona had less muscle pain but it still occurred whenever an overwhelming stressful situation occurred. She explained that she now knew how to deal with the pain: she would focus on it while lying down, and it invariably lifted and cleared up within a short space of time. Mona felt that she gained value from the pain as it immediately gives her an indication that there is an emotion unfolding to which she needs to pay attention. Peggy had a complete remission of her incapacitating pains for two years, and was disappointed when it recurred just before our initial interview. It was very clear, however, that a recent, significant emotional event had instigated these pains once more, which validated her feeling that her body gave expression to serious emotional matters through pain until she attended to them on a conscious level. At the time of the feedback discussion the pain had again disappeared. For Kylie, the body pain that had originally incapacitated her had abated completely. However, she still experienced intense pains during therapy, specifically within the context of the emotional material she was working

with. Kylie described this pain as occurring less often and being of shorter duration than her original experience.

Managing Pain after Therapy

For several individuals, the original pain symptoms still occurred on occasion after completing their therapy, or until they were well into their therapeutic processes. Without exception, each one of these participants remarked that although they still experienced some pain at times, they did not regard it at all in the same way as they had done before. Rather, they had patience and compassion for the pain, because they understood its meaning.

The participants experienced pain as a mechanism by which their systems gave them feedback or information about something that was activated in themselves, of some situation in their lives. They felt comfortable with managing their pain as it occurred; and it was as if the unknown element, the uncertainty of what it implicated, had disappeared. They felt that they owned their pain. Mona remarked: "Now I may even sometimes feel the muscle pains surface in my back without being aware of any emotions, and because I know that the spasms are indicating emotions that I am suppressing, I will go lie down and search for the emotions; try to feel what it is that my body is saying."

Pain is Associated with Other Physical Symptoms

This group of participants had been selected specifically because they experienced muscle pain, but the criteria did not exclude other symptoms. Most of the participants also experienced concurrent pain in some other area of their bodies, such as pain in the eye, abdomen, headache, hips, joints, pelvic area and genitals, chest, and skin. For some, this pain was associated fairly directly with their original areas of trauma.

Several participants also had other physical symptoms along with the experience of pain. Many spoke of a feeling of pins and needles in their limbs. Some described a feeling of numbness in a limb, or area of skin. Digestive system symptoms were frequently mentioned. Nausea was often associated with the emotion of disgust, the physical symptom arising long before the emotional connection was made. Diarrhoea and abdominal pains were mentioned by Helga, Kylie, Sarah, Cynthia, Andrea, Jane, and Mona. Erica stated: "I had a lot of other very weird-like physiological sensations, which I can't describe really." Cara described: "To me, fatigue was my pain. It was my biggest pain. You can say pain equalled fatigue for me. In every therapy session it was the overriding sensation, above the other pain. I had lots of images in therapy, often plants and flowers and such stuff. Sometimes I got the feeling of one limb being bigger and totally out of proportion. What freaked me out were palpitations, and then the pain in my neck would come." Kylie experienced vaginal as well as rectal bleeding on several occasions, even after having had a hysterectomy; in other words, there was no logical source of the vaginal bleeding. For Lynn, the integration of the relationship with her mother revolved around the experience of pain in her eye during therapy. Sarah related: "Often, especially towards the end of a therapy session, the pain evolves into a feeling I get on the top of my head, in my scalp, as if my hair, my whole scalp is electrified, as if my hair is standing on end. I can't stand it! It's the worst feeling! I try to suppress it, because I just can't stand this feeling, and I don't know what it is about. "

Empowerment Results from the Spontaneous Nature of Expression

This was also not a concept offered by the participants directly, but derived from how they described their experience. The initial experience was one of confusion and chaos about the unknown quality of the sensations that unfolded. When the realisation occurred that the spontaneity of their expression indicated ownership of these feelings, it felt empowering.

Jane commented on how sceptical she was prior to initiating therapy, but being desperate opted for it anyway. A paradoxical sense of control emerged for her when she experienced the spontaneous nature of how her physical and emotional material unfolded during the psychotherapy process. Although the process was spontaneous, it gave a sense of control specifically because of the fact that it was not initiated intentionally, but perceived to be natural and congruent with her being. The spontaneous way in which her memories flooded back, her body responded and her emotions were accessed just felt whole and in place. "This is real you know, it is not something which someone tries to force into you, it is absolutely natural!.....and now I feel as if I have a hold on things again."

Kylie spoke about the different levels that she experienced her pain at, describing the spontaneous way in which her system allowed it to unfold, as if protecting her in a natural way from an initial overwhelming of her capabilities to integrate the experience. She expressed a complete trust in what her body presented to her at the present time. Sarah told a similar story, acknowledging the different levels of experience her system presented to her in various stages. Her trust stemmed from the acceptance of the spontaneity of the reactions.

Indirectly this feature of their experiences presented itself in the stories of all the participants. The naturalness or realness of the experience of allowing their own physical and emotional material to surface, just by staying with the feeling of it, held a sense of surprise initially, and then paradoxically led to a feeling of control. This seemed to be something they owned, it was their property, they were entitled to it, and they had no intention of relinquishing it again. They learned to trust the physical and emotional feelings their bodies relayed to them, even though very unpleasant at times. This feature was reflected in the descriptions they gave about the meaning they derived from their experience of pain.

Answering the research question

How do people with pathological pain experience their pain from a psychological perspective, within the context of psychotherapy? This study provided rich data narrated by twelve individuals of their experience of pain and how it affected many facets of their being, in every sphere of their lives. Twenty four themes encapsulating these experiences were identified. Psychotherapy gave the participants a platform or basis of evolving awareness from which to formulate their experience.

Summary to chapter 4

Participants' narratives about their experience of pain unfolded in the research context, providing an abundance of material on the subject. Particularly, the experiences have been related from a vantage point of relative triumph, described by the individuals in the awareness derived from their psychotherapeutic involvement. Although each experience held a uniqueness to that particular individual, a shared process of meaning evolved in many of the themes, as well as the experience observed after initiating psychotherapy.

Participants gave voice to both the raw, primal facets of the agony of their experiences, prior to and within the psychotherapeutic context, and the profound, ecstatic growth they consequently embraced into their lives.

CHAPTER 5

DISCUSSION AND RECOMMENDATIONS

Introduction

This chapter aims to encapsulate and clarify aspects of the results produced by this research study, and compare it with that described in the literature. Considering the fact that qualitative research expects the researcher to make a contribution through interaction, it seems reasonable to include reflections on my own experience during the process. This is followed by reflections on the process in general. The themes derived from the research are discussed, embedded within the relevant literature supporting it. Recommendations are suggested for future research. The limitations and strengths that were observed in this study conclude the chapter.

Reflections on the effects of the research process on the researcher

Kvale (1996) argues that it is imperative for the researcher in a phenomenological study to have a good idea of the exact information that the research aims to elicit, and to structure the process accordingly. Thus the way in which the interviews are conducted can be planned beforehand. The interview questions should be well formulated, and a skilled interviewer will guide the interviewees in such a way so as not to ask leading questions that would compromise the validity of the research, but nevertheless to skilfully keep the participants focused on the scope of the research. He describes this as an art that is acquired through experience.

According to Kvale (1996), how this art is applied is part of the interactive process to which the researcher contributes. The researcher actively applies objective thoughts and ideas within the interview, keeping the focus of the research in mind, but maintaining the flow of narrative towards extracting the spontaneous lived experience of each individual. No doubt a daunting task! With these recommendations in mind, I compiled a set of guiding concepts concerning the information I hoped to gain from the lived experience of pain within a therapeutic context:

- In the lived experience of each individual, were there any spontaneous associations between emotions and physical pain, both before or after initiating psychotherapy?
- What was the experience of each participant of this connection, if any?
- Did the participants observe any changes in their experience of physical pain within the context of therapy?
- Did they perceive any changes in their experience of emotions within this context?
- Did the participants perceive any changes in their lives after experiencing the pain, emotions, and psychotherapy in this context?
- Did the participants derive any meaning from the experience of pain?

Since this was not a quantitative study, I did not seek proof that these events occurred, but rather investigated the participants' perceptions. The literature proposes that the researcher makes an active contribution through interaction during the interviews and his or her own interpretation of the material (Kvale, 1996; Van Vuuren, 1989). As such, it seemed appropriate to include comments on my experience of conducting the interviews and compiling the themes.

It was thus with a sense of apprehension that I approached the first interview. My apprehension swiftly faded as the richness of the participant's spontaneous narrative unfolded. The entrancing nature of the story, combined with the respect and compassion elicited in its telling, rendered superfluous any conscious attempts to direct the narrative in

a specific direction. The interaction between the two participating entities simply flowed effortlessly. Each consecutive interview increased a sense of awe and gratitude for having been entrusted with the intimate details of the lived experience of these people's lives, and for having gained knowledge of the richness of their stories.

Reflections on the research process

The lived experience of pain within the context of psychotherapy, as related by these participants, gives an overall picture of the profound and rich connection between physical pain and emotion. Each of the 12 participants had a unique experience and personal narrative, with an abundance of intertwining descriptions of meaning attached to this experience. The participants were chosen specifically for their experience of myofascial pains; yet it became clear that these are not experienced in isolation, but that the body systems, when presenting pain, manifested it in various areas.

The research process presented the participants with the opportunity to capture their life experiences within their narratives. They had a validating audience in the form of the researcher, eager to listen and accept whatever it was that they had felt, perceived and derived from their pain. Many of the participants remarked on this, and noted that it was the first time that they had encountered this. They reported deriving great value from the process. Telling their stories became therapeutic for them, and added a different dimension to their therapy processes.

The participants who had completed their psychotherapy processes felt that the process of narrating their experiences gave them a sense of completion and closure on a different level. It gave them great satisfaction, and several remarked that telling their stories opened up a greater sense of appreciation and respect for what they had achieved. Several of the participants, who were still active in their therapy processes, remarked that telling their

stories emphasised certain aspects of their emotional material for them, gave them an enhanced level of understanding, and in some instances activated the unfolding of deeper material to work with. All of this came spontaneously from the participants themselves, without any directives from the researcher.

The feedback discussions, which were instituted to add to the validity of the research, proved to be very popular with the participants. They enjoyed hearing a summary of their stories, and delighted in the themes presented to them. Many of the participants requested a copy of their transcribed interviews and theme summaries – they felt that this document represented an encapsulated history of themselves, and as such was precious to them. Some felt that it would continue to activate their therapeutic processes if they were to read it from time to time. (No printed material was given to them.) This feedback suggested that the research process had enhanced the experiences of each of the participants.

Reflections on the themes

Overview

Bearing in mind the perspective on what was being investigated, the material was interpreted mostly for the meaning derived from the lived experience of the individuals. However, some aspects lent themselves to a deeper interpretation as constructed according to a hermeneutical philosophy (Valle, 1989; Polkinghorne, 1989). These themes were included in the results.

A general pattern emerged of people who had developed extremely well-functioning coping mechanisms, yet had to experience pain in a way that severely affected them in order to allow themselves to explore the parts of their self that had not been validated. For each of these participants, their experience of pain paved the way to a greater and richer meaning of their lives. All of them agreed that the pain that they had experienced had

been very bad indeed, and yet not one of them regretted having had the pain experience. However, it did appear that participating in this research and engaging in the interviews helped the participants to become aware of this having been a meaningful event in their lives.

Pain symptoms became incapacitating

It appeared that pain was the sentinel marker claiming attention and validation for other aspects of these participants' lives (Van der Kolk, McFarlane & Weisaeth, 2007). It seemed that pain demanded to be acknowledged, and demanded that attention be paid to the fact that emotional pain be acknowledged and completed. Physical pain could not be ignored, even though emotional pain could. The physical pain had a way of claiming completion. Only when it was acknowledged and validated did it dissipate. It appeared during psychotherapy as part of the material that surfaced to conscious awareness in order to be dealt with actively (JOS, 2005).

This theme links to the concepts described in the literature on the development of pain symptoms in individuals with a history of psychological trauma (Scaer, 2001; Rothschild, 2000; Levine, 2005). The concept that it becomes debilitating to the point of demanding attention is portrayed in the literature (Woolf, 2005, Porreca, 2006), but a different dimension is added in the experience of these participants: the physical pain claimed attention to emotional matters, and both claimed completion before the pain dissipated. It appeared within therapy in a bidirectional context as part of the total material to be dealt with. The experience of it was intertwined with the emotional experience all along the process, at points indistinguishable from each other.

Pain is validated in SHIP®

Pain which had previously been understood from the vantage point of medical diagnoses and control, was reported to be accepted and acknowledged as a valid experience. This

specific type of psychotherapy created a context for pain to be experienced differently, which led to a change in the negative experience attributed to it. Thus the previous learned model, as influenced by the cultural world (Crossley, 2000), within a medical model (Sadock & Sadock, 2003), was transformed onto a feeling of trust in their own perceptions. The fear associated with pain (Yalom, 1980) was given meaning and function. The therapy gave them a sense of greater awareness and acceptance of their own experience (Rogers, 1967; Walsh, 2000), and with this a paradoxical feeling of control of their own systems, within the context of unpredictable sensations (Walker, 2001).

Pain connected to emotional feelings, and the changes observed.

A very strong association was found between physical pain and emotional material. Some of the participants sensed a connection between stress (which was perceived on a different level from emotions) and their pain symptoms before initiating psychotherapy, but few made a direct connection between the pain and emotions beforehand. In retrospect, some could see that an obvious association had been there, but they had not been aware of it at the time. All the individuals taking part in the study emphatically claimed experiencing a definite association between their physical pains and their emotions once they had started with their SHIP® psychotherapeutic process. Some of them expressed surprise at this discovery. The connection continued for those who had completed their therapy; in other words, they now had a continuous sense of a connection between their physical experiences and their emotional world.

There were definite changes reported in the way that the participants experienced both pain and emotional material. Different changes were described, but mostly the experiences centred on the association between pain and emotions, with an increase in the intensity of both the emotions and the pain, until a sense of completion arose and both the factors lessened and eventually disappeared. The general pattern was that once the

emotional material had been processed, the pain disappeared and no longer disturbed the lives of the participants.

Various aspects of pain being linked to emotions are described in the literature (Ader et al, 2001; Brannon & Feist, 2007; Friedman, 2003; Herman, 2001; JOS, 2005; Juhan, 2003; Kiecolt-Glazer, 2002; Kugelman, 2000; Levine, 2005; Rothschild, 2000; Scaer, 2001; Skevington, 1995; Solomon, 2000; Taylor, 2006; Van der Kolk, 2006; Woolf, 2004; Yalom, 1980; Yehuda, 2002). The unfolding and development of both pain and emotional material as intensifying and decreasing in sequence, as well as the experience of it in different levels of intensity as the process advances are concepts added in these research findings. JOS (2005) enlarges on descriptions of some of these findings within the context of SHIP®. Levine & Kline (2007) explain how emotions are transformed by focusing on the sensations. Janov (2001) and Rothschild (2000) describe how specific pains are connected to specific feelings.

It should be noted that most of the participants did not make the connection between pain and emotional material from the start, but that the realisation only came within the very direct therapeutic context of experiencing the two modalities as interactive in a significant way. Thus it appears that psychotherapy provided the platform for validating this experience of connection.

Pain is a means of expressing emotions that cannot be expressed

This is a theme that emerged throughout, with different facets. It seemed that these participants had different reasons for not being able to express emotions, without being aware of the fact at the time. This is in accordance with the findings of Van der Kolk (2006), that many individuals who are exposed to chronically overwhelming emotions, lose the capacity to recognise what they are feeling. Van der Kolk, McFarlane & Weisaeth (2007) also noted the fact that individuals may eventually perceive emotions as reminders

of their inability to influence the outcome of a situation, and lose all trust in their own feelings, regarding them as dangerous. Solomon (2000) describes anger turned towards self expressed by means of extreme joint pains.

Pain linked to memory retrieval

Several authors (Janov, 2001; JOS, 2005; Juhan, 2003; Rothschild, 2000; Scaer, 2001) describe the occurrence of memories surfacing within the context of experiencing pain symptoms. Specifically the retrieval of trauma memory that had been dissociated from at the time of the original trauma is discussed. The experience described by the participants illustrates the same findings.

Pain symptoms have symbolic meaning

This theme links to several descriptions found in the literature. Sawyer (in Sheikh, 2002) finds that the symbolic links made between certain body parts and emotions can be utilised in therapeutic context to facilitate the integration of emotional material. Kugelman (2000) describes an overlapping of the felt sense of emotions in the body with a symbolic meaning attached to it. Levine & Kline (2007) note the significance of the association of the emotion of disgust with digestive symptom pains, along with attempts of the body to rid itself of the disgusting material on a symbolic level.

Pain dissipates when the emotional material is dealt with conclusively

Several descriptions are found in the literature to corroborate this finding. JOS (2005) mentions this as a finding that he often observes. Janov (2001) concludes that emotional material felt in the context of the original trauma, with the associated pain where relevant, allows physical symptoms to abate and dissipate. Levine & Kline (2007) describes the occurrence of complete dissipation of physical symptoms, as does Scaer (2001).

Pain is associated with other physical symptoms

This is a finding described in many of the literature sources and seems to be prevalent throughout the descriptions given (Brannon & Feist, 2007; Friedman, 2003; Guyton & Hall, 2006; Hendler, 1981; Herman, 2001; Holey & Cook, 2004; Janov, 2001; JOS, 2005; Juhan, 2003; Kugelman, 2000; Levine, 2005; Metzack, 1983; Rothschild, 2000; Skevington, 1995, Solomon, 2000; Taylor, 2006; Woolf, 2004).

Pain used to suppress emotions

This is a theme for which no link could be found in the literature as it appears within the context described.

Pain occurs when coping mechanisms fail

This is described by JOS (2005) as the personal limit of endurance, which varies between persons depending on many factors in their situation. Resilience factors are described by various authors which would contribute to the extent of stress and trauma any individual could cope with before reaching a personal limit (Friedman, 2003; Herman, 2001; Yehuda, 2002).

The meaning derived from the experience of pain

All the participants reported changes in their lives after having been exposed to this experience. They were all very enthusiastic about the positive nature of the changes in their lives, and about having discovered a different vantage point from which to view their lives. These changes were interconnected with what they perceived as the meaning of the whole experience for them (Rogers, 1967). Change consisted of the results of a whole new awareness, specifically about themselves (Walsh, 2000). It seemed as if parts of themselves that had hitherto been unrecognised and invisible were now claiming their territory, and would never be ignored again. This in turn created major shifts in the participants' perceptions about the world they lived in, as well as in their interactions with others. They had tasted aspects of life now which had been unknown to them before, and

they liked the flavour. Even the unpleasantness associated with their physical pains, and the extreme discomfort of newly discovered emotional material, could not detract from the overall enthusiasm for the liberation, self-empowerment and acceptance of their selves which they claimed as the most significant aspect of meaning they derived from their experiences.

Walsh (in Corsini & Wedding, 2000) as mentioned in the literature review, states that becoming more conscious and developing an awareness constitutes effective therapy. Rogers (1967) considers the goal of psychotherapy that of the clients becoming fully functional people, enabled to experience all of their feelings and afraid of none of them, with an awareness of all of it allowed to flow freely in their experience of themselves.

Spontaneous body movements

A number of clients reported spontaneous body movements during their therapeutic processes. This is in accordance with the methods of employing body movement in imagery techniques in psychotherapeutic treatment (Sawyer, 2002). However, it is interesting to note that the experience for these participants were not induced or suggested as a conscious strategy, but occurred completely spontaneously. Once the initial surprise about this was overcome, it appeared as if the spontaneous nature of the process gave them a sense of ownership and thus trust in it, leading to a feeling of control, even within the context of uncontrolled movements.

Guyton & Hall (2006) mentions the physiological process of the body shifting without conscious control into different positions in order to facilitate optimal blood flow to an area. It seems that the body has an innate sense of moving and positioning to maximise tissue health. Juhan (2003) explains the mechanisms through which emotions may be 'captured' in muscle tissue, and enable that specific muscle position to allow the emotion to emerge in future. Goodman (1990) and Gore (1995) describe the emotional effects triggered by

specific body positions. Levine & Frederick (1997) and Levine & Kline (2007) consider the core symptoms of trauma to be physiological, and describe the need for it to be released through the body, such as a trembling and shaking process. Rothschild (2000) explains how long forgotten traumatic memories and emotions are evoked with specific body postures. Janov (2001) provides several descriptions to illustrate his theory that the original painful sensations have to be felt in the context of its origin, emotionally and physically, in the now, spontaneously. This includes body movements associated with the painful sensations.

Managing pain after therapy

Those participants who still experienced pain after initiating therapy all reported that it did not cause as much distress either emotionally or physically. They disclosed a feeling of ownership felt about this pain, having an understanding of what the pain means, and a very definite sense of validating it instead of trying to make it go away. This seems to link very directly to the feeling of control engendered by trusting the spontaneous nature of their experience (JOS, 2005; Walker, 2001), developing an awareness of their own feelings (Walsh, 2000), losing their fear for pain and associated mortality on this level (Yalom, 1980), and embracing every aspect of this experience (Rogers, 1967).

Hermeneutical interpreted themes:

As mentioned, several themes emerged out of a recontextualisation of the information given from the perspective of a more hermeneutical philosophy, which was achieved by attaining distance from the actual conversation material.

Spontaneous expression of physical and emotional symptoms, and control

The starting point from which all of the participants' experiences flowed, was the concept that their pain, both physical and emotional, was validated and could be heard. This made an important difference in how the process continued from this point onwards.

From the above, one may deduce that the spontaneous nature of the body's process allowed the participants to feel safe enough to go along with it. They could allow the process as it was validated, and thus they could experience safety within the symptoms that had previously resulted in anxiety and fear because of a preconceived need to control and contain it.

From this validated stance of perception of safety, a paradoxical sense of control flowed. Because they could own these physical and emotional feelings as their own, without threat, it became empowering. Thus the feelings they had desperately tried to control before by not owning it or denying it, now engendered a sense of control specifically because they claimed it and allowed it its full expression. This was contrary to their learned experiences. For those who still had pain at the time of the research process, it appeared that specifically this sense of control made the pain manageable.

The importance of a sense of control in the lives of people, especially with regards to their health processes by Walker, (2001) was noted in the literature review. The finding portrayed by these participants would concur with those discussed by Walker. An interesting addition to this is the notion that it is specifically the spontaneous aspect of accessing the material by the individual, that contributes to the feeling of ownership and control.

As Yalom (1980) surmises, any experience that provides a constant memory of the mortal nature of our existence has the potential to create anxiety. Integrating the realistic nature of physical and emotional material to the extent that it would validate the feeling of

vulnerability and befriend it, creates growth on an existential level, even if not consciously acknowledged as such.

Pain / helplessness / immobilisation / mobilisation interaction

The reciprocal interaction between pain and helplessness, and as an extension of this, the concept of both immobilisation and mobilisation resulting from the experience of pain, were not presented directly by participants, but derived from a deeper interpretation of their lived material. It nevertheless emerged as a clear theme and was verified by all participants when presented with this interpretation in the feedback interview, with a response of amazed recognition by some.

As stated in the literature review, helplessness is considered by several authors to play an important part in the developing and presenting of psychological distress (Herman, 2001; Levine & Kline, 2007; Scaer, 2001). The literature on trauma emphasises that it is usually with the feeling of helplessness within a trauma situation that an individual's system dissociates as a mechanism of protection against overwhelming emotional and/or physical pain. Scaer (2001) finds it the definitive feature in the history of those individuals presenting with many unexplained physical and emotional problems later on. Herman (2001) considers it the main feature derived from the histories of persons with complex PTSD.

The finding of helplessness as a feature derived from this study thus correlates with the literature in this regard. That it would be found within the context of the experience of physical pain symptoms in the way in which it emerged in this research, is a different facet from that described in the literature.

Pain as a comfort zone

The participants' attitude towards pain as a comfortable known frame of reference was another interpretation that presented itself when some of the conversations were examined from a distance.

Herman (2001) describes the effect of a frame of reference from childhood experience which is devoid of the accepted context of loving behaviour. A child with no other frame of reference, however, embraces it as the only known and safe environment. Levine & Kline (2007) refers to the absence of a feeling of safety leading to this lack being established as the frame of reference. Scaer (2001) demonstrates the compounding effect of childhood trauma in creating a dysfunctional sense of self and surroundings.

Pain creates boundaries

Another theme was that pain results in the formation of more constructive and better functioning boundaries. This too was not a theme directly derived from the conversations, but became quite apparent in many of the interviews when the material was interpreted on a deeper level.

As seen from the literature, Herman, (2001) and Levine & Kline (2007) comments on the long term effects of disrupted boundary development in infancy and childhood. It was noted in this study that both physical and emotional boundaries presented as disrupted for some of the participants. This would correlate with the finding of Levine & Kline that the physical and emotional boundaries were intertwined and that a disruption in the developing aspects of it creates overlapping disturbances later on.

Life/death of motherhood

The life/death experience emerging from several of the female participants' stories held a poignant value within the overall experience of pain and other emotional matters on a literal as well as symbolic level.

This finding of the symbolic experience of carrying both life and death, expands on the meaning attributed to the concept of motherhood by Northrup (1998), and corroborates her finding that the experience of loss of motherhood, whether as a miscarriage or born child, needs to be given acknowledgement and full validation of all the emotional material derived from it.

When evaluated and validated by them, themes derived from interpretation on a level not directly worded by the participants constituted the essence of their experiences on a transpersonal level. This is described by Valle (1989) as that which does not seem to be fully captured by phenomenological reflections; it is 'unwordable', and is experienced as a prereflective sense prior to any thematised experience.

Recommendations

This study originally focused on the participants' experience of myofascial pain, that is, the combination of muscle and fascia. The participants displayed a variety of other physical pains and other symptoms, and illustrated that physical symptoms seldom occur in isolation. Most of the participants had various pains and symptoms of which the muscle pains were but one feature. A research project of similar format might take this opportunity to ask participants to reflect on their other physical experiences.

It is also clear from the literature (JOS, 2005; Levine, 2005; Rothschild, 2000; Scaer, 2001; Van der Kolk, 2006) that individuals encounter various physical symptoms during healing processes. It may therefore be valuable to gain more information on how people may experience such physical processes during psychotherapy.

As mentioned earlier, it would be interesting to gain information on participants' reflections on their experience of pain over a longer period of time, with interviews taking place over a period of several years.

This was a retrospective study, for the reasons discussed in chapter 3. It is possible, however, to plan a prospective study of the same kind, on different levels. Different methodological designs could be utilised to obtain different aspects on information, such as a cohort study over a longer time frame.

Ethnographic research constitutes the individual or shared views and values of a particular culture, and aims to describe the cultural knowledge of the participants (Maggs-Rapport, 2000). Using the method of triangulation, Maggs-Rapport suggests that a combination of ethnography and interpretative phenomenology may produce information on the experience of pain in a cultural context.

Results of a research study so often remain just that – results of a research study. With this study, results were found that would indicate a far richer meaning and function attributed to the experience of chronic pain, once an awareness of other aspects of it is engendered. The pain could even be experienced as disappearing out of the individuals' life as an end result. Those health professionals working with persons suffering from such pathological pains would find great value for themselves and their patients if they could be made aware of a spontaneous method of accessing and dealing with all the material encapsulated in the experience of pain. It is recommended that this information be made available to the health professions as an option for managing pain.

Limitations/weaknesses of this research

Methodology:

The descriptive methodology of an interpretative phenomenological analysis does not provide proof of any of the aspects under discussion. A quantitative study on experimental level may provide more information, but it would not be able to present information on experiences of individuals.

Participants

The number of participants, although more than recommended in the literature, is small. A larger number of participants may yield further information.

Only one man took part in the study. The original pool of possible candidates presented by the SHIP® Foundation for participation contained only two men. On inquiry with the relevant psychotherapists it appears as if the ratio of women entering psychotherapy exceeds that of men, and that men may less commonly present with physical pain responses in therapy than women. This is obviously not conclusive and a study may be undertaken to compare the occurrence of this type of physical manifestations between the two genders

Culture

This research included the experiences of Caucasian South African participants only. It is possible that individuals of other cultural groups, with different learned expectations and ideologies, may have completely different experiences of pathological pain in this context. It may be valuable to compare the experiences of various culture groups in a research study.

Strengths of this research

Methodology

The qualitative methodology provided the extracting of very rich material of individual experiences of pain and emotions in a psychotherapeutic context. Although it does not

prove any pertinent point, its value lies in the abundance of descriptive information delivered. This deepens an understanding of the unique aspects of experience that any individual may have.

Participants

Twelve participants took part – which is double the number recommended by several authors (Huysamen, 1997; Smith & Osborne, 2003), and more than recommended by others (Creswell, 1998). It thus presented a greater challenge, but resulted in more and richer material in the process. A time constraint was the only complicating factor of this situation. A bigger study could be considered allowing for more time.

Culture

This study researched the experience of only Caucasian South African individuals, of which eleven were women, and eleven were Afrikaans speaking persons. This constitutes a very homogenous sample, and the results can thus be considered within the context of a homogenous group.

Conclusion

Many of the themes derived from this study yielded concepts that have been described in the literature that was studied. Some of these expanded on the available descriptions, giving a richer meaning to the information gained. Facets of some of these emerged which gives a new perspective on the experience of pain on a psychological basis within a psychotherapeutic context. Aspects which could be improved and added on were noted.

In answer to the primary research question – all of these themes provide ample description of the experience of individuals of pathological pain, from a psychological perspective, within the context of psychotherapy.

In answer to the secondary questions:

- In the lived experience of each individual, were there any spontaneous associations between emotions and physical pain, both before or after initiating psychotherapy?

For many of the participants the association only came after initiating therapy, although some of them had a clear sense of the connection beforehand. All the participants related a spontaneous perception of this connection, without being asked about it, at the time of the interview.

- What was the experience of each participant of this connection, if any?

The results formulated in the preceding chapter amply describe the experience of each participant.

- Did the participants observe any changes in their experience of physical pain within the context of therapy?

All the participants described changes in the way they experienced their pain within the context of therapy. Intensifying of the pain, changes in the levels and other aspects of pain, as well as the dissipating of the pain are all aspects of these changes described in the results.

- Did they perceive any changes in their experience of emotions within this context?

All the participants described changes on several levels of their emotional experiences, as discussed in the results.

- Did the participants perceive any changes in their lives after experiencing the pain, emotions, and psychotherapy in this context?

Without exception, the participants related numerous changes in their lives, on various levels, after the experience of pain. Firstly the pain itself affected their lives pertinently, and secondly the therapeutic involvement and the results thereof affected their lives profoundly. This is described in depth in the results and discussion.

- Did the participants derive any meaning from the experience of pain?

A detailed discussion is provided on all the aspects of rich meaning derived by every participant in this study.

Summary of chapter 5

It is seen from the results of this study that the individuals gained a sense of ownership of their own experiences and an empowerment which they carried through into their lives, as a consequence of their experience of pain. The psychotherapy process that they entered into provided the platform from which this empowerment could be engendered. Although many of the findings were corroborated by the literature, each of these people had an experience that was unique to them, derived from every facet of their lives and all that had influenced it.

Conroy (2003) states:

A recognition that paradox exists and is integral in everyday existence acknowledges that change is possible in and endemic to life, and that our existence has elements of historicity (past, present and future) which shape and inform our lives as we shape others'. The recognition moves us past the idea of life being concrete and static into a position where everyday interpretation merges with re-interpretation, where our life in the world is co-constituted with the lives of others and our knowledge of the world is not constructed in an individualistic fashion (p. 3).

From the experiences of the participants in this research project, it appears that the experience of pain may have far greater value in a broader epistemological context than

just the physical function generally attributed to it. However, this may vary from person to person, given the wide scope of experiences displayed. What becomes clear is that neither the pain nor these experiences should be ignored on this level or taken merely at face value. Controlling or trying to contain pain may sometimes have less value than validating it, exploring it and surrendering to other facets of its contents. Allowing the human system its spontaneous expression of physical manifestations as it would unfold if not inhibited, may produce a surprisingly abundant spectrum of otherwise hidden wealth.

***“There are more things in heaven and earth, Horatio, than are dreamt of in
your philosophy”***

W. Shakespeare: Hamlet.

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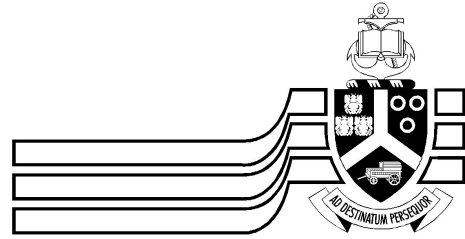
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Universiteit van Pretoria

Faculty of Humanities
Department of Psychology

Informed Consent

Dear Participant,

The following information has been compiled to enable you to be fully informed about the research study in which you have been asked to take part. It is important that you feel comfortable about your contribution and that the process takes place in an atmosphere of trust and transparency. If any aspect of it seems unclear, or should any matter of concern arise, please feel free to discuss it at all times.

The information pertains to the following study:

Title: A phenomenological study of the experience of pathological pain in individuals undergoing Spontaneous Healing Intrasytemic Process (SHIP®) therapy

Purpose of the study: The study aims to gain information of the individual experiences of people perceiving pain symptoms not explained by usual medical methods, within the context of psychotherapy, whether before, during or after psychotherapy. It is hoped to gain information on specific themes emerging through analysis of the different experiences of several individuals' unique perceptions. Specifically, it may create a greater understanding of the connection between the two modalities of pain and emotions.

Procedures:

- The process will consist of an interview the researcher will have with each participant, individually and privately. You will be asked to reflect on your experience of pain symptoms as they occurred, and to talk about anything that comes to mind on the experience as you recall it. You will be free to talk about it in the way that feels comfortable to you, and to not talk about any aspect which does not feel comfortable to you.
- The interview will be audio-recorded. Confidentiality will be assured at all times.

- The time required for the interview may depend on the amount of information, but as an estimate, one to two hours are considered to be the average time needed.
- Individual interviews will be scheduled according to each participant's preference.
- After assimilating and analysing the information, and extracting themes from each set of information, the themes derived from each participants interview will be presented to each participant individually again. The purpose of this is to give each person the opportunity to verify that the interpretation derived by the researcher from the information that was given by you, is in fact correct, and that you agree with the contents of it.
- The aim is to complete the study within the year of 2007.
- The results of the study will be reported on in the form of a dissertation.
- The data gathered will be safely stored for the duration of a maximum of 15 years should the need for further research arise

Risks: No risks or discomforts are foreseen.

Benefits: No specific benefits for participants are foreseen. No remuneration can be given for participating.

Participants' rights: Participation is voluntary. You may withdraw from the study at any time and without fearing negative consequences. You may feel free to ask about any aspect of which you are uncertain and need further clarification.

Confidentiality: Be assured that all information that you provide will be treated with the utmost of respect and confidentiality at all times. Pseudonyms will be used in the reported results – fictitious names will be used and your identity will not be revealed. This will be done from the outset so that the pseudonym is used from the very first word that is written about your experience.

The supervising promoter of this research will not have access to your identity, and neither will any other person involved in the research process.

If you should wish to withdraw at any stage, your data will be destroyed so that it can't compromise your feeling of privacy.

Thank you for being available for this research process.

Consent:

Ifully understand the nature of the research project and I am willing to take part in the process.

Signed aton thisday of.....2007.

.....
Participant

.....
Researcher