Chronic Pain as the Embodiment of Hardship:
A Narrative Study

by

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Abstract

This narrative study explored the subjective experiences of 12 individuals (eight women, four men) who had suffered from chronic pain for at least one year. Among participants, the etiology of their pain was often unknown; however, when diagnostic testing had isolated an organic cause, physicians had informed them that the degree of pain they were experiencing exceeded the level of pain expected from their injuries. A phenomenological theory of embodiment was used as a framework for this study. Guided by the belief that the body is a carrier of meaning, the researcher aimed to discover patterns in chronic pain sufferers’ narratives, which may have contributed to the onset and/or prolongation of their pain. When invited to speak about momentous life events, all participants disclosed hardships they had endured. Furthermore, respondents had a strong propensity to downplay, or even deny, the severity of their often-traumatic life events. A tendency was also noted for respondents to act as caregivers and to place other people’s needs above their own. The implications of the study’s findings for theory and practice related to counselling psychology are discussed.
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Chapter One

Introduction

A growing body of literature demonstrates that chronic pain is not purely a corporal phenomenon, but can also stem from subjective factors (Lima, 2014). More specifically, a robust connection has been identified between traumatic life experiences and the onset of chronic pain (Anda et al., 2006; McGrady & Moss, 2013; Rubin, 2005). Nevertheless, a disconnect exists between this knowledge and prevailing psychological interventions for chronic pain sufferers. When chronic pain sufferers are referred for psychotherapy, the exploration of past trauma is rarely presented as formal objective of treatment (Rubin, 2005). Instead, most standardized interventions focus on the mere management of pain (Grant & Haverkamp, 1995; Songer, 2005). Tellingly, the American Psychological Association (APA), recognized as the largest scientific and professional organization representing psychology, has not formally addressed the trauma-pain relationship, possibly since additional research is still needed to inform its practices.

A foundational article on the APA website, entitled Managing chronic pain: How psychologists can help with pain management, reports that a treatment plan for chronic pain sufferers “often involves teaching relaxation techniques, changing old beliefs about pain, building new coping skills, and addressing any anxiety or depression that may accompany your pain” (APA, n.d., p. 1). Moreover, this APA article states that “chronic pain can cause feelings, such as anger, hopelessness, sadness and anxiety” (APA, n.d., p. 1). However, the article fails to report that these same subjective experiences can predate chronic pain and possibly contribute to its onset.

One can argue that at the core of the problem is the biomedical model upon which
the Western healthcare system is structured, and to which the majority of mental health clinicians subscribe (Eriksen, Kirkengen, & Vetlesen, 2013; Fava & Sonino, 2008). The biomedical model is a conceptual model of illness, which postulates that all disease is a product of biologic defect. The model is reductionist and understands ill health as the product of a “malfuntioning machine” (Bullington, 2009, p. 100), reducing health and disease to the basic components of organs and biochemicals (Kato & Mann, 1996). Although most clinicians implicitly recognize the biomedical model’s shortfalls, it continues to be the framework on which most chronic pain treatment, including psychotherapeutic interventions, is built (Fava & Sonino, 2008).

To be certain, the biomedical model is responsible for countless successes, particularly those related to infectious diseases and cancer (Steen & Haugli, 2000a). However, there is growing concern that too much of what affects society’s general sense of health falls outside the domain of biomedicine. It appears that the biomedical model, with its emphasis on the mechanical nature of the body, represents a barrier to understanding and treating chronic pain, since it places emphasis on objective, rather than subjective, evidence. Deep-seated reliance on the biomedical model has, to some degree, hindered the development of psychotherapy strategies that explore the subjective roots of chronic pain (Lima, 2014).

**Overview of Conceptual Framework – Phenomenology**

This project was guided by the general principles of phenomenology, specifically those related to embodiment, a construct that refers to the experiencing and experienced living body as a reflection of one’s state of being (Merleau-Ponty, 1989). Phenomenological philosopher Maurice Merleau-Ponty has been particularly critical of
how biomedical culture makes the body an object – something we have, rather than what we are (Merleau-Ponty, 1989). Merleau-Ponty emphasized that the body is more than a simple sum of parts and is not a mere product of the influences of the world. Rather, the body, mind, and world are equivalent, intertwined, and inseparable. He stated, “I am conscious of the world through my body” (Merleau-Ponty, 1989, p. 82). By extension, the body is a subjective site that senses and experiences the world meaningfully. A powerful poem by Flora Wuellner is written from the perspective of her body and reflects the concept of embodiment. Particularly poignant lines include the following:

I am the truth-teller. I witness to you your unknown self... I am the stored wisdom and hurts of the ages and generations before you... I am your partner in stress and pain. I carry much of your suffering, so your spirit does not need to carry it all alone. (Wilde, 2003, p. 15-17)

The above lines illustrate the phenomenological belief that the human body is our center and carrier of experiences, as well as a barometer of our perceptions and emotions. Stresses inherent in the mind and world are paralleled in the body. By extension, psychotherapy could potentially be used to explore the types of experiences that individuals have ‘embodied,’ as well as how these experiences may be contributing to sufferers’ somatic pain.

**Rationale**

Chronic pain has reached epidemic proportions in Western society and has become a widespread public health concern (Brennan, Carr, & Cousins, 2007; King et al., 2011). According to community-based surveys, one in five Canadians contends with chronic pain (Schopflocher, Jovey, et al., 2011), and rates are increasing (King et al., 2011).
Despite the sweeping nature of this problem, reliable interventions are unavailable. Frequently, even the most sophisticated forms of diagnostic testing are unable to detect anything that deviates from the norm of measurable biological parameters in the bodies of chronic pain patients (Lima, 2014; Steen & Haugli, 2000a, 2000b), and standard biomedical treatments tend to be unsuccessful at alleviating distress (Turk, Wilson, & Cahana, 2011). Moreover, cognitive behavioural therapy, the most commonly prescribed psychological intervention, is minimally effective at reducing somatic symptoms (Henschke et al., 2010; Williams, Eccleston, & Morley, 2012).

As stated, a growing body of research demonstrates an intimate relationship between traumatic life experiences and chronic pain. Various hypotheses have been proffered to account for this linkage. Two theories, in particular – ecological systems theory and allostatic load theory – have received a great deal of support.

The first theory posits that, due to the influence of their environments, victimized individuals have less effective psychological defense and coping styles than do others, and these tendencies may lead to unhealthy behaviours and lifestyle choices (such as excessive drinking, eating, or smoking) and exaggerated health care seeking (carrying the risk of medical overconsumption, iatrogenic complications, and increased disability). These factors may directly or indirectly contribute to the onset of chronic pain (Lampe et al., 2003; Nickel & Egle, 2006).

The relationship between trauma and chronic pain has also been explained by McEwen and Stellar’s (1993) theory of Allostatic Load. According to this theory, the human body achieves system-wide stability, in spite of fluctuations in its surroundings, by an ongoing brain-coordinated process of generalized physiological adjustment called
allostasis. Adaptation to a current stressor is referred to as allostatic accommodation, whereas the collective deterioration resulting from the repeated use of the body’s allostatic mechanisms over the lifespan is called allostatic load (Simandar, 2010). As allostatic load accumulates, the body’s capacity for effective allostatic accommodation decreases, leading to increased vulnerability to new stressors and, eventually, to compromised physical health (Simandar, 2010).

Certainly, these theories have merit and are worthy of further exploration. However, the rationale of the present research was to place the human subjective experience above other methods of exploration, which depend on objective evidence. Stated an alternate way, the present inquiry involved a theoretical shift from the body of biomedicine to the “lived body,” which is described by the phenomenological theory of embodiment.

With few exceptions, prevailing research related to the relationship between trauma and chronic pain has relied upon quantitative models of research. Quantitative research can be useful for establishing causal relationships, exploring correlations, and gauging the effectiveness of interventions. However, it is less suited to capturing the richness and nuances of pain sufferers’ experiences (Blood, 2005). The current study was qualitative in nature and employed a narrative approach.

Twelve chronic pain sufferers were interviewed between December 2014 and February 2015. Participants were recruited in the Greater Toronto Area from a psychological clinic that specializes in chronic pain management. The stories shared by these 12 individuals represent the basis of this research, which employed a narrative methodology within an overarching conceptual framework of a phenomenological theory.
of embodiment.

**Purpose**

This study endeavored to give voice to chronic pain sufferers in order to expand current conceptualizations of their lifeworlds. The study’s overarching purpose was to strengthen understanding of the relationship between chronic pain sufferers’ subjective experiences and the onset and/or perpetuation of their pain. Information derived from the present study was intended to assist with the creation of improved psychotherapy interventions to treat these individuals.

**Research Question**

The guiding research question was as follows: Do patterns exist in chronic pain sufferers’ subjective experiences, which may contribute to the onset and/or persistence of their somatic symptoms? In an effort to answer this question, the researcher inquired about momentous events in pain sufferers’ lives before they developed their somatic symptoms, as well as their responses to these experiences, and the ways they have derived meaning from them. The researcher was also interested in learning if the momentous events that participants described would be of a traumatic nature, as existing research suggested it would be.

**Definition of Terms**

A definition of terms used throughout this dissertation will clarify specific meaning used within the research. These terms include: “trauma,” “pain,” “lifeworld,” and “subjective experience.”
Trauma

The word “trauma” derives from the Greek word for wound. According to the American Psychiatric Association (1994), trauma occurs when a person experiences, witnesses, or is confronted with an event that involves actual or threatened death or serious injury, or a threat to the physical integrity of self or others. The person’s response must have involved intense fear, helplessness, or horror. This definition is referring to what some psychologists call “big T trauma” (Wheeler, 2014). However, among other experts in the field of psychology, the definition of trauma is broadened to include “small T trauma” – that is, distressing events that shatter a person’s sense of security and result in feelings of helplessness and a sense of being alone and vulnerable in the world. Divorce or job loss could very well be examples of “small T trauma” (Wheeler, 2014). Psychiatrist Mark Epstein has eloquently described how trauma affects all of us at various points in our lives:

An undercurrent of trauma runs through ordinary life, shot through as it is with the poignancy of impermanence... One way or another, death (and its cousins: old age, illness, accidents, separation and loss) hangs over all of us. Nobody is immune. Our world is unstable and unpredictable, and operates, to a great degree and despite incredible scientific advancement, outside our ability to control it.

(Epstein, 2013, p. 20)

Indeed, trauma knows no boundaries, and no person is immune to it. However, while some individuals recover quickly, others seem predisposed to subsequent adverse effects, such as somatic pain.
Pain

The International Association for the Study of Pain (IASP) defines “pain” as an unpleasant sensory and emotional experience related to tissue damage (IASP, 2013). The IASP (2013) dichotomizes pain into acute and chronic.

Acute pain begins suddenly and is usually sharp in quality. It serves as a warning of disease or other threat to the body (Loeser, 1991; Slover, Coy & Davids, 2009). Schug (2011) indicates that “acute pain is usually... caused by signaling as a consequence of mechanical, thermal and chemical (noxious) irritation of the peripheral nervous system” (p. 11). Treatment of acute pain has two components: the temporary relief of pain by analgesics or anesthetics, and the establishment of an appropriate environment in which healing can occur (Loeser, 1991). A patient’s discomfort normally diminishes as healing occurs, and more than 90% of persons with acute pain recover in eight weeks (Radomsky, 1995). Both clinicians and patients are generally comfortable with acute pain problems because they are easily diagnosed and are resolved in a straightforward manner (Radomsky, 1995).

Chronic pain is a significantly different phenomenon. It is defined by IASP (2013) as pain that exceeds three to six months in duration. It has also been defined as pain lasting longer than the temporal course of natural healing that is associated with a particular type of injury or disease process (Shipton & Tait, 1995), and as pain associated with progressive, non-malignant disease (Ashburn & Staats, 1999). Commonly, the etiology of chronic pain is unknown, and treatment options are generally ineffective (Turk, Wilson, & Cahana, 2011). According to Loeser (1991), acute pain and chronic pain have just two things in common: the four letter word, “pain,” and pain-related
behaviour. There is little evidence that they share any physiologic or anatomic mechanisms (Loeser, 1991).

**Lifeworld**

Edmund Husserl introduced the concept of the “lifeworld” in his book, *The Crisis of European Sciences and Transcendental Phenomenology* (1936). The lifeworld can be thought of as the horizon of all a person’s experiences, or as the background on which all things appear as themselves and meaningful. More simply, the lifeworld refers to a person’s subjective construction of reality, which one forms under the condition of one’s life circumstances.

**Subjective Experience**

A “subjective experience” refers to a person’s internal events, such as feelings and desires, which are entwined with occurrences in the physical world. Subjective experiences appear to be closely related to people’s interpretations or perceptions of events (Buck, 1993). Pain is an example of a subjective experience.

**Summary of Chapter One and Overview of Dissertation**

Research is needed to fill the gap related to the subjective experiences of chronic pain sufferers, in order to help move away from the dominant belief that chronic pain is a purely corporal, biologically based experience. Furthermore, psychotherapy strategies for chronic pain sufferers, which explore the possibility that physical pain can represent the embodiment of subjective experiences, are warranted. This study sought to achieve these goals by asking chronic pain sufferers to tell their stories about momentous experiences in their lives, prior to the onset of their pain. It is hoped that these stories will provide clinicians, researchers, and educators with a glimpse into the rich lifeworlds of chronic
pain sufferers, highlighting both the similarities and the uniqueness of their stories, and thus assisting with the development of psychotherapy interventions to address their needs.

The first chapter included a brief background, rationale, and purpose for the study. The research question, as well as the conceptual framework in which the research was conducted, were also provided. Furthermore, the context and direction of this project were delineated, and definitions of relevant terms were included.

In Chapter Two, a review of relevant literature is presented. The review includes a description of chronic pain and its effects, followed by an examination of the relationship between culture and pain, a historical overview of how the biomedical model became paramount, and an explanation of how the biomedical model is grossly ineffective at addressing chronic pain. Chapter Two also outlines the current psychological interventions utilized to treat chronic pain, (notably, cognitive behavioural therapy, which largely focuses on helping patients to cope with their discomfort, rather than untangling its possible emotional causes). An example of a phenomenological psychotherapy program for chronic pain sufferers is also included.

Chapter Three presents the methodology used in this research, beginning with the reasons for choosing a narrative approach, with reference to the research question. Also included is a detailed description of the procedures used in the study and the narrative analysis method employed.

Chapter Four contains a summary of the results from the narrative interviews. For each participant the within-participant analysis is described and includes an outline of each participant’s identified themes.
In Chapter Five, the research data results, as a whole, are outlined. This chapter includes across-participant analysis, which examines the metathemes that emerged as being important to the participants’ narratives.

Chapter Six contains a discussion of how these metathemes are useful at strengthening the phenomenological theory of chronic pain, and includes strategies for applying the findings within a psychotherapy context. More specifically, it invites clinicians to understand pain sufferers from a new perspective that values their entire being, and takes into consideration the relationship between body, mind, and world. Chapter Six also includes the strengths and limitations of the study, directions for future research, and concluding comments.
Chapter Two

Literature Review

This chapter contains a review of current literature relevant to the research topic. More specifically, it includes the following:

- An examination of chronic pain, including its effects on sufferers, their family units, and society as a whole;
- An analysis of the relationship between culture and the experience of pain;
- An overview of the biomedical model of illness. Despite its limitations regarding the treatment of chronic pain, the biomedical model has remained a dominant force in the field of healthcare;
- A critique of cognitive behavioural therapy, the most commonly prescribed psychological intervention for the treatment of chronic pain; and
- A description of how phenomenology can be employed for the treatment of chronic pain, and an examination of an existing phenomenological treatment program.

Chronic Pain and Its Effects

As stated in the previous chapter, chronic pain refers to pain that has lasted longer than three to six months (IASP, 2013). Reflecting on his personal struggles with chronic pain, Heshusius (2009) provided the following tongue-in-cheek definition: “The words ‘chronic pain’ essentially mean, ‘You have had pain for over half a year, and we have no real clue what to do about it’” (p. 2). Heshusius’s comment hearkens to the fact that, among chronic pain sufferers, the etiology of their illness is often unknown (Creed et al., 2011; Crowley-Matoka, Saha, Dobscha, & Burgess, 2009; Steen & Haugli, 2000a,
According to Morris (1991), chronic pain often robs sufferers of their ordinary belief in medical solutions. As treatment after treatment fails, it becomes an experience about which there is increasingly “nothing to say, nothing to hope, nothing to do” (p. 78).

Since chronic pain is generally accompanied by a constellation of maladaptive symptoms such as loss of strength, disturbed sleep, and immune impairment, it is regarded as a disease entity (Brennan, Carr, & Cousins, 2007).

Chronic pain sufferers are a diverse group comprised of people from all vocations, socioeconomic backgrounds, ages, sexes, genders, and cultures. Nevertheless, an analysis of the 2000-2001 Canadian Community Health Survey indicated that chronic pain is more common among persons reporting a lower income, three or more chronic health conditions, depression, and high levels of stress (Canadian Pain Strategy, 2010). In women, being overweight, according to the Body Mass Index (BMI), also shares a correlation with chronic pain (Canadian Pain Strategy, 2010). As one may expect, rates of chronic pain increase with age (Canadian Pain Strategy, 2010).

It is critical to emphasize that chronic pain does not occur in a vacuum. Individuals’ unique genotypes, previous learning histories, environmental and socioeconomic resources, cognitive, emotional, and behavioural factors, and physical pathology interact to mediate and moderate the experience of pain (Turk et al., 2011).

Chronic pain takes an immense toll on its sufferers. The financial ramifications of this illness are particularly significant, since chronic pain is the single most common cause of disability among working-age adults in Canada (Canadian Pain Strategy, 2010). Sixty percent of people with chronic pain eventually lose their jobs, suffer loss of income, or have a reduction in responsibilities as a result of their pain. For those who remain
employed, it is anticipated that they will have a mean number of 28.5 lost workdays per year (Canadian Pain Strategy, 2010).

The psychological effects of chronic pain are equally profound. A World Health Organization study revealed that individuals who live with chronic pain are four times more likely than those without pain to suffer from depression or anxiety (Brennan et al., 2007). Furthermore, there is double the risk of suicide as compared with people without chronic pain (Ratcliffe, Enns, Belik, & Sareen, 2008; Tang & Crane, 2006). It should be noted that suicide rates remain higher, even when controlling for mental illness (Ratcliffe et al., 2008). Morris (2009) has eloquently described the emotional experience of this intractable condition. The following quote preserves the poignancy of his view:

We enter into a very different state of being when our pain passes, at whatever arbitrary point, from acute to chronic ... Chronic pain destroys our normal assumptions about the world. It never releases us from its grip, and continually frustrates our hopes for its gradual improvement. Ultimately, it introduces us to an unsettling counter-world where, as Emily Dickinson described it, time has stopped ... It is a place where, gradually, almost without noticing, you find yourself alone. (p. 71)

Above, Morris (2009) describes what seems to be a place of horror, which does not allow for escape. Similarly, Bury (2001) has defined chronic illness as “biographical disruption” (p. 263). To elaborate, the occurrence of chronic illness disrupts the structures of everyday life and future plans and, as such, represents the shattering of an individual’s sense of identity.

Furthermore, the impact of chronic pain extends to sufferers’ familial units in a
very significant manner. As a result of role-shifting, family members might need to invest considerably more time on housekeeping and home maintenance, a change that can produce tension (West, Usher, Foster, & Stewart, 2012). Furthermore, individuals with chronic pain tend to become passive and regretful about their illness and have a reduced inclination to participate in family life (West et al., 2012). This shift can create further distance from their loved ones (Soderberg & Lundman, 2001). Finally, sexual satisfaction commonly lessens with the onset of chronic pain (Flor, Turk, & Rudy, 1987; Maruta, Osborne, Swanson, & Halling, 1981).

It is also crucial to address the stigma attached to chronic pain – a reality with which most sufferers contend at some point. According to Goldberg (2010), society unconsciously draws a connection between sin and suffering and so, at least on an unconscious level, people tend to blame those afflicted with chronic pain for their maladies. It is interesting that the word pain is derived from the Latin word poena, which means a fine or a penalty (Free, 2002). Goldberg (2010) traces this tendency to blame the sufferer to biblical times and cites the Book of Job in the Bible, where Job’s friends express that he must have committed some evil act to bring about his deplorable illness. According to Jackson (2005), “chronic pain’s chronicity – that it never ends – means that it is accorded less legitimacy than acute conditions” (p. 333). Similarly, Parsons (1958) has pointed out that a person’s “sick role” is accepted only for a limited period of time. Eventually, chronic pain sufferers tend to be seen as resisting recovery, under the assumption that they are motivated by secondary gain, or the benefits acquired through being ill.

Chronic pain’s economic burden on society is also enormous. Related expenditures
include direct costs related to treatment and provisions of health care services and indirect costs, such as those associated with loss of productivity, lost tax revenues, and disability payments (Schopflocher et al., 2011). In fact, chronic pain costs more than cancer, heart disease, and HIV combined (Schopflocher et al., 2011).

Estimates place direct health care costs for Canada at more than $6 billion per year, and productivity costs related to job loss and sick days at $37 billion per year (Schopflocher et al., 2010). These dire facts alone should be enough to persuade researchers to investigate chronic pain in greater detail. However, according to Lynch, Schopflocher, Taenzer, and Sinclair (2009), research for pain is grossly underfunded in Canada, compared to the burden of illness. Of 79 active researchers undertaking pain-related studies, just 65 had received funding over the past five years, which amounted to $80.9 million. This represents less than 1% of total funding provided by the Canadian Institutes for Health Research (CIHR) and only 0.25% of the funding for all health research (Lynch, Schopflocher et al. 2009).

**Relationship Between Culture and Pain**

There is a definite relationship between culture and the experience of pain. Broadly, culture can be defined as an enduring pattern of perceptions, structures, and beliefs, which are stable across various contexts (Keefe, Lumley, Buffington, Carson, Studts et al., 2002). An alternative definition identifies culture as an assemblage of received knowledge passed down through generations, which enables groups to make sense of their experiences and to direct their behaviours (Turner, 2005).

Before objects and events can be made phenomenologically real, their existence must be acknowledged through a process of naming and classification. Such recognition,
including the diagnosis and management of disease, is the product of culture, and comes about as the result of particular practices embedded in specific historical, political, social, and technical relationships (Lock & Nguyen, 2010).

That being stated, culture should be understood as neither static nor all-encompassing. Culturally informed values are subject to debate, and are never distributed equally across named groups of people. Moreover, in light of the effects of globalization, borders are less rigid, and so cultures have become less homogenous than in the past (Lock & Nguyen, 2010).

Nonetheless, several studies have addressed the way that culture assists in giving meaning to pain. Some cultural systems promote a positive acceptance of pain. Relatedly, within the Hindu culture, pain and suffering are generally viewed as inevitable aspects of life, rather than as things against which one should struggle. According to the Hindu culture, pain is a consequence and unfolding of karma (Whitman, 2007).

In a qualitative study with older Korean women, researchers also found a positive acceptance of chronic pain, since they perceive it to be a meaningful component of aging, rather than a problem to be solved (Dickson & Kim, 2003). Furthermore, in a study among the South American Quechus, pain is conceptualized within a cosmology of interrelatedness (Incayawar & Saucier, 2010). Other studies, still, have suggested that cultural identifications can be bound up with collective histories of hardship and resilience, with persons from cultures that have historically been disenfranchised or exploited being more prone toward stoic presentations of pain (Baker et al., 2008; Bates et al., 1993).
Kirmayer and Young (1998) have described how individuals’ reports of bodily symptoms can be understood as “encoded cultural models of sickness” (p. 424). That is, within each culture, it is only acceptable to express certain types of pain, and only in certain ways. These cultural models supply individuals with a “vocabulary” (p. 424) of symptoms, and provide explanations for these symptoms and the associated suffering. Somatic symptoms express discomfort and distress in ways that are intelligible within the individuals’ social milieu, but may have different meanings to outsiders (Kirmayer & Young, 1998).

Complaints that seem, to a North American practitioner, to be evidence of a syndrome of somatic symptoms may, in reality, encode an ethnomedical theory. Consequently, a person’s narrative of his or her illness may include a significant subtext, linking his or her physical distress to social predicaments, moral sentiments, and otherwise unexpressed emotions (Kirmayer & Young, 1998). For instance, the idiom of “heart distress” among Iranians could be understood as a culturally prescribed way of talking about a host of personal and social concerns primarily related to loss and grief. Throughout the Middle East, references to the heart are commonly understood, not just as potential signs of illness, but as natural metaphors for a range of emotions. Similar metaphors are found in the complaints of chest tightness among Turkish women (Kirmayer & Young, 1998) and the corresponding Greek symptom of stenohoria. Additionally, nervios (Mexican-American) and nevra (Greek) are characterized by headaches and chest pain, among other symptoms, and have been interpreted as common as somatized forms of anxiety and depression (Kirmayer & Young, 1998).

In Korea, ‘Hwa-Byung’ is a condition that is roughly believed to be a somatic
expression of suppressed rage (Kim, 1993; Pang, 1990). It is viewed within the context of ‘haan,’ an accumulation of anger, despair, and resentment toward historical injustices. The physical symptoms of Hwa-Byung may include muscle pain, burning in the epigastric region, headaches, dry mouth, heart palpitations, indigestion, and a sense of heaviness. Hwa-Byung is not interpreted as a somatization disorder in Korean culture; it tends to be naturally identifiable among Koreans who are experiencing social and intrapersonal problems that contribute to the suppression of anger leading to illness (Kirmayer & Young, 1998).

Fabrega (1991) has pointed out that in most of the great traditions of medicine, there is no distinction between the “mental” and the “physical.” In the case of traditional Chinese medicine, there is no ontological notion of disease at all. Rather, Chinese medicine is based on symptom clusters or syndromes that reflect imbalances in bodily systems that are aligned with aspects of larger social and ecological systems. It is worth noting that Chinese medicine has not developed psychology as a separate realm of discourse (Fabrega, 1991).

Similarly, in traditional Aboriginal cultures, emotional states, mind, and form are interrelated (Shapiro, 2006). According to Sun Bear, an esteemed Native American author, and a proponent of traditional healing:

The most common blocks are the negative attitudes that a lot of people carry around all the time… In order to become healed, a person has to throw out hatred, envy, jealousy, and other destructive attitudes and feelings. Although such factors start within the mind, they quickly manifest in the body, becoming a stiff shoulder, a sluggish liver, cancer, or other illnesses. I believe that all genuine healing
addresses the problem of unblocking negativities in one way or another. (Shapiro, 2006, p. 29-30)

For the reasons illustrated by Sun Bear, Native American doctors are traditionally viewed as healers of the soul as well as of the physical body (Shapiro, 2006).

In India, medical beliefs have been comparable. In the words of Yogi Paramahansa Yogananda, an eminent yogi and guru, “There is an innate connection between the mind and the body… All diseases have their origins in the mind. The pains that affect the physical body are secondary diseases” (Shapiro, 2006, p. 17). Yogananda goes on to state that thoughts and emotions have energy. When people do not express what is happening on an emotional or psychological level, their feelings can become embodied, and then manifest through the physical body (Shapiro, 2006).

**Biomedical Treatment of Chronic Pain**

Within most contemporary medical settings, chronic pain is treated within the framework of the biomedical model, such that the body is interpreted as an entity that is primarily mechanical in nature. Certainly, this understanding is in sharp contrast to traditional systems of medicine. A belief in the dichotomy of mind and body can be traced to the 15th century, when the practice of anatomical dissection, often carried out as public spectacle, became commonplace (Lock & Nguyen, 2010). Anatomists’ findings suggested that illness was caused by concrete, visible distortions of anatomy, and not by other factors (Sternberg, 2000). In the 17th century, philosopher Rene Descartes fortified anatomists’ theory when he formulated the concepts of rationalism and the necessity of visible proof that were to become the founding principles of “modern science.” In Descartes’ division of the world into provable and improvable (the Cartesian Split),
emotions and their relationship to health and disease fell neatly into the latter domain (Sternberg, 2000).

Descartes’ era signaled the dawn of the biomedical age, with “rational” pitted against “irrational”: “[O]n the one side, the clear-headed, masculine spirit of science; on the other side, a dark morass of female superstition, old wives’ tales, rumours preserved as fact” (Ehrenreich & English, 1978, p. 33). Arguably, the transformation of regular medicine into “scientific medicine” has resulted in the emergence of a system in which scientists and the objective world have assumed a sacred quality. According to Rich (1976), any deviance from a quality valued by the biomedical culture is dismissed as negative: “‘rationality’ is posited as sanity, legitimate method, ‘real thinking,’ while alternative, intuitive supersensory, or poetic knowledge are labeled ‘irrational’” (p. 62).

As previously indicated, the Western healthcare system has become increasingly laboratory-oriented, such that external means (e.g., diagnostic tests) are often seen as the sole, and only respected, methods of investigating illness.

The biomedical model of illness excludes subjective factors, when trying to understand a person’s malady (Bullington, 2009; Steen & Haugli, 2000a, 2000b). Instead, it focuses on biological factors – the pathology, the biochemistry, and the physiology of a disease. One of the model’s underlying premises is a disconnect between the material and immaterial world; the body is seen as separate from the mind and the external environment, and understanding the body can only proceed from knowledge of its parts and how they interrelate (Steen & Haugli, 2000a). Viewing a person from this positivistic perspective assumes a fixed and predetermined reality; “relevant evidence” refers to evidence that can be objectively measured using diagnostic techniques (Steen & Haugli,
For these reasons, the biomedical model is unable to adequately explain the etiology of chronic pain, or prescribe adequate treatments. Frequently, even the most sophisticated forms of diagnostic testing are unable to detect anything that deviates from the norm of measurable biological parameters in chronic pain sufferers’ bodies (Lima, 2014; Steen & Haugli, 2000a, 2000b). Quoted in the New York Times, an Institute of Medicine committee member stated, “If the doctor can’t figure out what the underlying problem is ... then the pain is not treated. It’s dismissed and the patient falls down the rabbit hole” (Parker-Pope, 2011, online).

It is worth noting that emerging evidence about the relationship between a history of trauma and chronic pain has challenged certain principles of the biomedical model of illness, suggesting that other factors are at work than simply biology. Significant evidence came to light in 1967 when Holmes and Rahe reviewed the medical records of approximately 5,000 individuals and subsequently developed the “Social Readjustment Rating Scale,” generally referred to as the Holmes-Rahe Life Events Scale (Holmes & Rahe, 1967). The scale includes 43 stressful life events and assigns a numerical value to each event. A series of studies using this scale have revealed that a higher-than-average number of adverse life events, such as being fired from work or obtaining a divorce, is predictive of the onset of illness (Miller & Rahe, 1997; Rahe, 1990; Rahe & Arthur, 1978; Rahe et al., 1972; Rahe, Mahan, & Arthur, 1970). Though nearly all life events have the potential to be stressful – that is, to produce mental or emotional strain – traumatic events seem to have the greatest negative impact on people’s health, particularly if the activities occurred during childhood (McGrady & Moss, 2013). Anda et al. (2006) reported that four kinds of adverse childhood events (ACEs) seem to be most
predictive of adult illness: psychological abuse, physical abuse, sexual abuse, and exposure to parental substance abuse, mental illness, partner abuse or criminal behaviour. People who endure more of these ACEs than the average individual tend to have a higher incidence of chronic pain, along with other medical problems, such as ischemic heart disease, cancer, stroke, chronic bronchitis, emphysema, diabetes, skeletal fractures, and hepatitis.

Sareen et al. (2007) have produced comparable findings to the above mentioned. They analyzed the responses of 36,984 individuals who participated in the Canadian Community Health Survey and found that respondents with a trauma history displayed higher rates of chronic pain syndrome, as well as chronic fatigue syndrome, among other ailments.

Sachs-Erickson, Kendall-Tackett, and Hernandez (2007), reporting on data obtained in the National Co-morbidity Study, also found that people with a history of childhood physical abuse or sexual abuse disclosed a greater number of current health problems than those without trauma. Furthermore, these individuals described more pain complaints, when outlining their current symptoms, than did respondents without a trauma history. It is worth underlining that childhood abuse predicted the results in these pain reports independently of the presence of depression.

The research of Van Houdenhove, Luyten, and Egle (2009) is equally compelling. They studied the role of trauma in individuals with chronic pain and fatigue, and discovered that 64 percent of respondents with fibromyalgia and chronic fatigue syndrome disclosed either childhood or adult trauma, and 39 percent of these individuals reported both childhood and adult trauma. Van Houdenhove, Luyten, and Egle’s (2009)
research supports the conclusion that trauma in either childhood or the adult years is a predisposing factor for both fibromyalgia and chronic fatigue syndrome, two forms of chronic pain.

As a group, individuals with chronic pain report much higher rates of having experienced trauma in their pasts when compared to persons without chronic pain. Upwards of 90% of women with fibromyalgia syndrome report trauma in either their childhood or adulthood, and 60% of those with arthritis report a trauma history. Additionally, upwards of 76% of individuals with chronic low back pain report having had at least one trauma in their past. Sixty-six percent of women with chronic headaches report a past history of physical or sexual abuse. Among men, 58% of patients with migraines report histories of childhood physical or sexual abuse or neglect. Moreover, 56% of women with chronic pelvic pain report high rates of sexual abuse in their pasts. To compare, rates in the general population for physical abuse in childhood are 22% for males and 19% for females. Rates in the general population for self-reported childhood sexual abuse are 14% for males and 32% for females. Rates of adult sexual assault in the general population are 22% for women, and 4% for men. Domestic violence occurs in an estimated 21% of the general population (Institute for Chronic Pain, n.d.).

Findings related to the relationship between trauma and illness led some researchers to highlight the inadequacies and limitations of the biomedical model of illness. Notably, Engel (1977) developed and promoted a biopsychosocial approach to medicine, which interprets illness as the result of interacting mechanisms at the cellular, tissue, organismic, interpersonal, and environmental levels (Engel, 1977). Engel described his proposed model thusly:
Predicated on the systems approach, the biopsychosocial model dispenses with the scientifically archaic principles of dualism and reductionism, and replaces the simple cause-and-effect explanations of linear causality with reciprocal causal models. Health, disease and disability thus are conceptualized in terms of the relative intactness and functioning of each component system on each hierarchical level. (p. 175)

According to Engel, overall health is dependent upon a high level of intra and inter-systemic harmony. Such harmony may be disrupted at any level, including at the cellular level, at the organ system, at the whole person, or at the community level. He emphasized that, while a clinician practicing within the biomedical framework would view disease as a discrete entity, the biopsychosocial-oriented clinician would tackle each problem as part of a series of ongoing dynamic events (Engel, 1977).

Nevertheless, the biopsychosocial model is unsatisfactory, in that it remains within the analytic philosophical tradition of the biomedical model (Butler, 2004). According to Traverso-Yépez (2001, as cited in Lima et al., 2014), the biopsychosocial model shares with the biomedical model the positivist premise of pursuing a single reality to be uncovered by the methods of natural science, which denotes a merely palliative stance in relation to the biomedical perspective. According to Lima (2014), “the biopsychosocial model adds psychological and social dimensions to the understanding of the process of falling ill more as rhetoric than as a legitimate practice” (p. 7). Perhaps more importantly, in the daily routine of health services, clinicians who subscribe to the biopsychosocial approach to medicine continue to think of a divided individual, composed of the sum of biological, psychological, and social parts, to the detriment of a unified view (Lima,
Regardless, the dominant model of illness, today, remains biomedical in nature, with molecular biology being the basic scientific discipline (Fava & Sonino, 2008). Moreover, many authorities vociferously argue that further technological mastery is vital for continued progress, in terms of health and wellbeing (Lock & Nguyen, 2010). As David and Holloway (2005) have succinctly stated, “the biopsychosocial model ... has had relatively limited acceptance” (p. 15).

Similarly, in most North American hospitals and clinics the traditional boundaries among medical specialties, based mostly on organ systems (e.g. cardiology, psychiatry), remain, despite the fact that they appear to be increasingly inadequate for addressing people’s complex symptoms, which cut across organ system subdivisions (Fava & Sonino, 2008). In the daily routine of health services, clinicians continue to view pain sufferers as divided individuals. Generally, they ignore individuals’ subjective experiences, preferring to focus on the narrow biomedical task of searching for objective findings (Dowrick, Ring, Humphris, & Salmon, 2004).

Today, the most common interventions for chronic pain include pharmacotherapy, nerve blocks, and physiotherapy (Turk, Wilson, & Cahana, 2011). However, overall treatment effectiveness remains inconsistent and fairly poor. According to Turk et al. (2011), “people with chronic pain will continue to live with some level of pain, irrespective of the treatment or treatments they receive” (p. 2226). Furthermore, even when an intervention manages to reduce pain, the change is usually temporary (Turk et al., 2011).
Psychological Treatment of Chronic Pain

When biomedical interventions prove ineffective, chronic pain patients are sometimes referred for psychological treatment (Turk et al., 2011). Numerous psychotherapeutic interventions related to chronic pain exist, including solution focused strategies, motivational interviewing, and psychodynamic therapy. However, by far the most widely prescribed form of treatment for chronic pain is cognitive behavioural in nature (Ehde, Dillworth, & Turner, 2014; Grant & Haverkamp, 1995). It is focused on the management of pain and is not interested in isolating underlying causes.

Cognitive behavioural therapy. Over the past three decades, cognitive behavioural therapy (CBT) has become the prevailing psychological treatment for individuals with chronic pain (Ehde et al., 2014), being named the “first line” (Ehde et al., 2014, p. 153) treatment. A survey of its members, conducted by the International Association for the Study of Pain, found that 73% of respondents named CBT as their primary clinical approach to treating chronic pain (Grant & Haverkamp, 1995).

The goals of CBT among chronic pain sufferers are to alleviate physical discomfort and psychological distress, and to improve physical and role function by helping individuals decrease maladaptive behaviours, increase adaptive behaviours, identify and correct maladaptive thoughts and beliefs, and increase self-efficacy for pain management (Turner & Romano, 2001). According to Ehde et al. (2014), there is no standard CBT protocol; CBT, when conducted in research and clinical practice, varies in number of sessions and specific techniques. However, CBT treatment typically includes the following components: cognitive restructuring; relaxation training; and time-based activity planning. Between-session activities (often called “homework assignments”) are
also employed so that chronic pain sufferers can practice and apply the new skills they learned from the clinician (Otis, 2007).

The efficacy of CBT for individuals with chronic pain has been evaluated in randomized controlled trials (RCTs) for more than three decades, primarily in samples of adults with chronic back pain, headaches, orofacial pain, and arthritis-related pain. A Cochrane review of behavioural treatments (including CBT) for chronic low back pain, which included 30 RCTs, concluded that behavioural treatments were more effective than usual care for pain post-treatment, but not different in intermediate to long-term effects on pain or functional status (Henschke et al., 2010). There was little or no difference between behavioural treatment and group exercise in improving pain and depressive symptoms over the intermediate to long term. However, for most of the comparisons there was only low- or very low-quality evidence, and no high-quality evidence existed for any comparison. Furthermore, variability in outcome measures greatly limited ability to compare across studies (Henschke et al., 2010).

A more recent Cochrane review (Williams, Eccleston, & Morley, 2012) concluded that CBT, compared with treatment-as-usual or wait-list control conditions, had statistically significant but small effects on pain and disability, and moderate effects on mood and catastrophizing, post-treatment. However, by 6- to 12- month follow-up, the only significant effect was for mood. Compared with active control conditions, CBT was not superior for pain or mood outcomes. However, CBT showed small, statistically significant benefits for disability and catastrophizing post-treatment. At 6- to 12- month follow-up, benefits were found for disability only.

Other reviews have focused on CBT for specific types of chronic pain. For
example, a meta-analysis of 22 RCTs of psychological treatments for chronic back pain indicated that psychological interventions, contrasted with various control conditions, had positive effects on pain, pain-related interference with activities, health-related quality of life, and depression (Hoffman, Papas, Chatkoff, & Kerns, 2007). CBT was found to be superior to wait-list controls for improving pain intensity post-treatment, but not for health-related quality of life or depression.

**Chronic pain intervention within a phenomenological framework.** Certainly, cognitive behavioural therapy has assisted in giving some chronic pain sufferers relief from their condition. It represents a positive and important step, since it recognizes the connection between psyche and soma, and acknowledges that chronic pain is not solely a corporal issue. Nevertheless, CBT is in line with that of Cartesian duality and the positivist premise of a single reality. Conversely, within phenomenology, the individual in his/her unity is more than a simple sum of parts. Phenomenology conceptualizes a human being as an intending entity, in which body, mind, and the world are intertwined and constitute each other mutually, thus establishing the human being’s integral functioning (Lima et al., 2014). According to Honkasalo (2000), “[i]t is through the body in pain that the lived world is grasped in its wholeness” (p. 205). To explicate, the suffering body reflects the totality of a person’s life experiences.

Phenomenology was, in origin, a reaction to the fact that science has traditionally only concerned itself with what is “objective” and measurable. Phenomenology draws attention to the facts that no perception is entirely objective, that every perception owes as much to the mentality of the perceiver as it does to the structure of the object, and that a great deal of human experience is non-repeatable and so virtually immeasurable
(Brazier, 1991). The phenomenological method, developed by Edmund Husserl, involves an effort to refrain from labeling things and making assumptions, in order to achieve increased innocence of perception. This means allowing things to speak for themselves, rather than proffering concrete interpretations. Similarly, it means listening to the experiences, as lived by the individual “who expresses and communicates pain” (Lima et al., 2014, p. 1).

According to Honkasalo (2000), pain is “an embodied relation to the world, a posture towards the world” (p. 205), so it is important to determine what that “posture” is, and then seek to modify it. As such, the definitive goal of phenomenologically-minded psychotherapy for chronic pain sufferers should be to offer clients the means to examine and reassess their understanding of life, the problems they have encountered throughout life, and the limits imposed upon the possibilities inherent in being-in-the-world.

But how exactly can psychotherapists assist clients in clarifying their worldviews? According to phenomenological thought, all people’s worldviews consist of four dimensions, which should be explored: the Umwelt, the Mitwelt, the Eigenwelt, and the Uberwelt (Binswanger, 1967; Sharf, 2016; van Deurzen-Smith, 2012). It should be noted that none of these dimensions has been tailored specifically for work with chronic pain sufferers.

The Umwelt refers to the biological world or the environment (Sharf, 2016). All individuals develop unique meanings about the physical world in which they reside. People might experience the physical dimension as largely secure and enjoyable, or they might struggle with anxiety, due to the dangers and injustices they perceive. People’s attitudes to variables within the physical dimension – be it their bodies, or even the
weather – should be thoroughly examined during psychotherapy, and viewed as important means for clarifying clients’ meanings and concerns (Binswanger, 1967; van Deurzen-Smith, 2012).

The Mitwelt dimension refers to everyday, human relationships (Sharf, 2016), which are coloured by people’s inferences about race, social class, gender, language, and culture. Depending on their attitudes and values, individuals might feel empowered or invalidated by their public-world interactions. Again, clients’ stated perceptions of their relationships demand attention and investigation (Binswanger, 1967; van Deurzen-Smith, 2012).

The Eigenwelt is a self-awareness from which individuals see the world (Sharf, 2016). It encompasses how people view themselves, and the ways they interpret their interactions with family, friends and sexual partners (Binswanger, 1967; van Deurzen-Smith, 2012). All of these perceptions are valuable fodder for psychotherapy.

The Uberwelt refers to people’s connection to the abstract and absolute aspect of living, and incorporates their ideological outlook on life, and the beliefs they hold about life, death and existence. In voicing their related attitudes and beliefs, individuals begin to assess them more carefully and truthfully. Through this process, clients clarify their beliefs, and may choose to adopt alternate perspectives (van Deurzen-Smith, 2012).

All these dimensions are open to exploration; in doing so, pain sufferers confront the attitudes, assumptions, and values they place upon each and, as a result, are more likely to make sense of the problematic “symptoms” in their lives as extensions of, or defensive reactions to, any of these dimensions. Young (2010) emphasized that, by
clarifying one’s worldview, more intrusive biomedical interventions could possibly be avoided:

We can heal our... wounds not by taking in some chemical substance, nor by having this or that ‘treatment’, but essentially by accepting how these wounds have shaped us; why they might have been necessary to our survival (once upon a time); how we survived with them, or despite them; and even how and what we can learn from them now. But we have to not only accept them, but also be able to step outside them and look at them clearly. (p. 51)

There is a deep existential level where somatic pain is related to the meanings that people ascribe to their world, their relationships, and life in general. A frank exploration is necessary in order to loosen the ties binding the body to their interpretations and perceptions.

It is also worth stating that, while cognitive behavioural therapy relies on a series of techniques, this practice has been challenged by adherents of the phenomenological approach to psychotherapy. Phenomenologists hold that an overemphasis on technique can be a substantial obstacle to understanding the client and, thus, to achieving long-lasting outcomes in therapy (Spinelli, 1989). According to Spinelli (1989), it is not the understanding that follows technique, but the technique that follows understanding.

Steen and Haugli (2000a & 2000b) have made important contributions to the phenomenological exploration of somatic pain. Residing in Norway, they developed an intervention program for chronic pain sufferers, which is built upon the premise that chronic pain does not exist in a vacuum. Moreover, people do not experience pain as a
pure sensation; for them, pain “arrives as a complete package… painful, miserable, disturbing…” (Steen & Haugli, 2000a, p. 149).

The primary goal of Steen and Haugli’s program was to help participants view their bodies as “talking subjects” rather than as “objects.” Through the use of various exercises, program participants became aware of their embodied knowledge about their chronic pain. Furthermore, they gained insight into why their ailments may have developed and, sometimes, how they could alleviate their symptoms by making changes in their personal lives (Steen and Haugli, 2000a & 2000b).

According to Steen and Haugli (2000a), the terms disease, patient, and therapy carry very different meanings when rooted in a phenomenological understanding of them. In contrast to the biomedical view, disease is more than a physical problem. A person’s subjective experiences, sensations, motives, and beliefs are vitally important. Furthermore, a diagnosis must be the sum of human interpretation, understanding, and interrelations. The patient is a person whose meaning, values, and gender are important in relation to his/her symptoms, as well as his/her cultural and historic situation. Finally, the person’s entire situation needs to be taken into account when determining therapy. As per Steen and Haugli (2000b), listening to pain sufferers’ experiences of their situation and helping them to search for meaning are essential tasks for the clinician (Steen and Haugli, 2000a). Certainly, one of the weaknesses of the biomedical approach is that physicians, psychotherapists, and other clinicians are often regarded as authority figures, while the pain sufferer is viewed as the mere recipient of treatment (Mate, 2003).

With these redefined terms in mind (disease, patient, and therapy), Steen and Haugli (2000a and 2000b) conducted a randomized controlled study on the effects of a
group intervention program for persons with generalized chronic musculoskeletal pain. The program was rooted in phenomenological concepts and was based on the understanding that the embodiment of lived experiences can express itself within the person as a painful body. Steen and Haugli (2000b) aimed to help participants make a shift in personal insights “from the body as object to the body as a ‘talking’ subject,” (p. 186) and, thus, help them create new meanings.

The group met 12 times, four hours each time, over a period of eight months. Participation was voluntary. Of the 78 participants who began the program, nine left the group during the first half of the program. In interviews, approximately half of them indicated they had quit the group because they found it “too psychological” (Steen & Haugli, 2000b, p. 185).

On average, participants had experienced pain in their musculoskeletal systems for nine years. All group members had an extensive history of consulting physicians and physiotherapists. According to Steen and Haugli (2000b), the many consultations had not yielded what group participants had hoped for; instead, these interactions had reinforced the dualism of mind and body.

Each group meeting had a defined theme, with some themes explored over the course of two sessions. These themes included, “if the body could talk”; “strengthening of the self”; “who am I?”; “strong and weak traits”; “humour, laughter, joy”; “guilt”; “anger”; and “resources, possibilities, choices” (Steen & Haugli, 2000a, p. 592). The program’s exercises were intended to make participants aware of themselves and, if possible, take a metaview of themselves, and “see themselves from the outside” (Steen & Haugli, 2000a, p. 592). Pain in itself was not a topic that was explicitly introduced;
however, the group leaders provided a simple description of pain physiology during the first session.

To enhance discovery of tacit knowledge embedded in the body, group leaders frequently used paradoxical and hypothetical questions. For example:

“Your body can’t talk, but if it could talk, what would it tell you…?” “What if your drawing of your guilt could talk...?” “I wonder what it would be like for you in your everyday life if your breathing was less shallow than it is now…” “I wonder how your body would react if you, instead of saying ‘yes’ when you want to say ‘no,’ start saying no” (Steen & Haugli, 2000b, p. 188).

Such questions were used both as exercises in themselves and as follow-up sentences after an exercise.

The use of metaphor was also explored in the group. Participants’ statements were taken literally to facilitate the discovery of tacit knowledge and personal meaning. Steen and Haugli (2000b) provide the following sample questions, which employ metaphors:

“You say that you have a lump in your stomach. How big is it? . . . Does it have any colour? . . . What if the lump had a message to give to you; what do you think it would say? . . .” “You say that it feels like you are in a tunnel . . . Tell me what the tunnel is like . . . What kind of tunnel is it? . . . What is it like for you to be in this tunnel? . . . Do you know how long you have been in the tunnel? . . . Are you in it all the time?” (p. 189)

Steen and Haugli (2000b) have explained that metaphors are capable of giving participants new understanding of their lives and of their pain. According to the researchers, metaphors are grounded within people’s experiences and embedded in
cultural assumptions, values, and attitudes. As such, they highlight certain features of people’s experiences of which they may be unaware. Steen and Haugli (2000b) stated, “Metaphors can be tools for trying to comprehend partially what we cannot comprehend totally – our feelings, aesthetic experiences, moral and spiritual awareness” (p. 189).

Ultimately, the intervention group was successful. For the group as a whole, Steen and Haugli (2000b) found no significant differences in the scores on pain and pain coping one month after the intervention had ended. However, one year later, participants reported less pain and improved coping than did the control group. The participants’ conceptions of their ability to take care of themselves were also significantly increased in the intervention group one month after the program had ended. This higher level was maintained during the follow-up year. Steen and Haugli (2000b) provided the following success story about a participant named Greta:

Through the program, she slowly became more aware of how her habitual acting and different patterns in her life slowly had ‘occupied her body,’ and thus had created muscular pain. At the end of the program she told us that she was now working daily on not taking responsibility for her whole family’s well being, and especially not all the stupid things she thought her husband was saying. She had also discovered that he also said many good things! She had stopped calling her children daily to find out how they were . . . She had not taken any sick leave in the eight months the program lasted, and she had not been to see her physician or her physiotherapist. (p. 593-4)

It appears from the above example that the interventions were effective at increasing Greta’s awareness of the self and of developing a stronger connection to her body.
Reportedly, many participants enjoyed such positive changes. According to Steen and Haugli (2000b), improved awareness was made possible by giving increased control to the participants; they were informed that only individual sufferers know the truth about their pain.

It was Steen and Haugli’s (2000a) hope that “searching for possible hidden meaning in painful muscles” (p. 596) would eventually become a task that healthcare workers and pain sufferers would undertake together. Despite this hope, an article search on this topic on the University of Toronto’s research database did not yield any other studies of this type. A notable exception related to this topic includes Bullington’s (2009) article, which emphasizes that “rehabilitation must not only address the material (medical) body, but also the diminished sense of self as well as the retreat from the world outside of the painful body” (p. 100). As well, an article by Lima et al. (2014) posits that real understanding of the chronic pain process is only possible from engaging in a dialogue with the “individual who expresses and communicates pain” (p. 1). However, neither of these articles goes into detail about specific psychotherapy interventions, from a phenomenological perspective. Though an article by Young (2010) is partially in line with the objectives of the present study, in that it describes a phenomenological approach to psychotherapy, it does not speak directly to chronic pain sufferers. Young notes that the phenomenological approach contradicts the supposedly “objective” scientific method, as the experiences of the researcher are essential to the research. He also states that phenomenological research has largely been marginalized by North American psychology, since it does not believe in the pursuit of a single discovered truth.

To summarize, despite the widespread effects of chronic pain, both on individual
sufferers and society as a whole, there is still scarce understanding of this condition, when interpreted within a biomedical framework. As such, it is imperative that research be further expanded to include how subjective factors may contribute to the onset and prolongation of this debilitating condition. Information derived from this study is intended to assist with the development of improved psychotherapy practices for chronic pain sufferers.

**Summary of Chapter Two**

In summary, this chapter demonstrated that, despite the biomedical models’ current dominance, it contains many gaps in understanding that are particularly evident in the context of chronic pain treatment. Furthermore, psychotherapy interventions, which purport to treat the emotional components of chronic pain, are rooted in the Cartesian framework and often ignore the how a person’s history and subjective experiences can have adverse effects on the body, potentially inciting somatic symptoms. Certainly, greater attention should be given to those interventions that encourage pain sufferers to become aware of the experience-based knowledge embedded in their bodies.

In the next chapter, this study’s research methods will be discussed and an overview of qualitative research will be provided. As well, the researcher’s narrative approach to analysis will be described, along with the procedures employed to gather, analyze, and present the data. Ethical considerations are also outlined in Chapter Three.
Chapter Three

Methodology

Thus far, this dissertation has presented an overview of why chronic pain should be re-examined in a manner that values subjective experiences. By asking chronic pain sufferers to tell their stories, the researcher was able to achieve a fuller picture of meaningful events that have shaped their lives, and thus gain insight into the possibility of chronic pain as the embodiment of hardship. The guiding research question was as follows: Do patterns exist in chronic pain sufferers’ subjective experiences, which may contribute to the onset and/or persistence of their somatic symptoms?

This chapter will discuss the specific ways that a qualitative approach, in the form of a narrative methodology and analysis, was employed.

Qualitative Approach to Research

Qualitative research methodology has a longstanding tradition in many of the social sciences, including psychology (Tesch, 1990). It follows a naturalistic paradigm based on the notion that reality is not predetermined and cannot be examined under artificial experimental conditions (Polit & Beck, 2001). An objective of qualitative researchers is to provide ways of understanding experiences from the perspective of those who live them (Schwandt, 1994). This approach is appropriate for the research question, since the researcher sought to learn about how chronic pain sufferers experience the world.

Six key research frameworks are frequently used in qualitative research studies. These frameworks include narrative, case study, grounded theory, phenomenology, participatory action research, and ethnography (Morse & Field, 1995). The choice of which research framework to employ is based on the type of research question being
investigated. For example, the narrative approach seeks to answer story-oriented questions that investigate the life experiences of individuals and how those experiences unfold over time. The narrative approach fit the present study, since the researcher was endeavoring to learn the stories of chronic pain sufferers, in order to gain insight into their lifeworlds.

Despite the differences between frameworks, most types of qualitative research share several commonalities. First, qualitative research generally recognizes that human experience is influenced by a person’s social, cultural, and historical contexts. The meanings of phenomena are developed and evolve within these larger contexts, and they are expressed and illuminated through socially discursive means, primarily verbal language. The information is typically communicated through in-depth interviews. Through these interviews, qualitative researchers aim to attain a rich description of the phenomenon of interest (Speziale, Streubert, & Carpenter, 2011).

Additionally, in the realm of qualitative research, the nature of reality is believed to be multiple, emergent, and evolving. Each individual’s experience and perspective is considered valuable and meaningful, and is honoured for what it is, with no single perspective enjoying superiority over another (Creswell, 1994; Denzin & Lincoln, 2000; Tesch, 1990). As such, data collection and methodology are typically elastic, allowing for modifications throughout the research process (Burns & Grove, 2003).

Given the depth and complexity of the experiences explored in this study, qualitative methodology was deemed appropriate. Qualitative research was particularly desirable for conducting the proposed research, because it permits the in-depth examination of the individual, familial, historical, and sociocultural influences impacting
chronic pain sufferers’ experiences. Furthermore, it allows for the exploration of participants’ meaning-making processes. Given that meaning-making is a subjective experience, and the researcher cannot make assumptions about it, the task of this study was to discover what this experience is like, and how it is perceived and interpreted from participants’ points of view. Chronic pain sufferers come from diverse backgrounds, with unique ways of perceiving and comprehending their life experiences. Thus, it was necessary that research focusing on their subjective experiences employ a paradigm that ensures the authenticity of their accounts in relation to the phenomenon in which their experiences are rooted. Similarly, it was essential that these individuals be given the opportunity to convey their experiences in their own words; it is only by learning the specifics of their lived experiences that this information can be effectively used to inform the discipline of counselling psychology, in order to formulate new interventions to address their distress.

**Narrative Inquiry**

To reiterate, narrative inquiry falls under the umbrella of qualitative research. One of the primary goals of narrative inquiry is to explore and understand the inner world of individuals. One of the clearest channels for learning about this world is through stories presented by individual narrators about their lives and their experienced reality. Seeing as the researcher sought to learn the stories of chronic pain sufferers and the meanings they attached to these experiences, narrative inquiry was deemed appropriate for this study.

Narratives – generally defined as connected accounts of events – focus on particular aspects of experience, which are most important to an individual. Narratives organize these aspects into a cohesive whole that adds to the speaker’s personal sense of
self by clarifying his or her place in the world (Elliott, 2005). Narratives not only represent a record of past experience, but also provide a key to the assumptions that guide identity development and interpersonal behaviours. The narratives that individuals create from life guide their present living, facilitate understanding, and direct behaviour, according to their own biases (Elliott, 2005).

There are several essential components to any narrative. First, these stories generally have a beginning, middle, and end (Chatman, 1980; Elliott, 2005). Temporality, also known as a chronological sequence, is another key feature. The plot within a narrative relates events to one another by linking a prior occurrence to a subsequent event (Elliott, 2005; Polkinghorne, 1995). Furthermore, these stories ordinarily involve a change in situation. Events in a story tend to upset an initial state of balance or represent a change in fortunes for the main characters (Elliott, 2005). An example provided by Elliott (2005) is: “The king died, and then the queen died of grief” (p. 11), a plot that possesses the aforementioned components, as well as an explicit causal link between the two events in the sequence.

However, a successful narrative – one that is effective at conveying the narrator’s inner reality to the outside world – is more than just a chronicle of events. Fully formed narratives typically have six separate elements: the abstract (a summary of the subject of the narrative); the orientation (time, place, situation, participants); the complicating action (what actually happened); the evaluation (the meaning and significance of the action); the resolution (what finally happened); and the coda, which returns the perspective to the present (Elliott, 2005; Labov & Waletzky, 1997). At minimum, a narrative must include the complicating action and the evaluation (Elliott, 2005). Lieblich
et al. (1998) note that one’s story comprises one’s identity; people know, discover, and reveal themselves to others through the stories they tell.

Furthermore, oral narratives presuppose an audience. The storyteller is influenced not only by the immediate listener, but also by those who might overhear the conversation. Within certain contexts, the narrator’s story may also be affected by imagined or possible future audiences (Elliott, 2005). This can apply to recorded research interviews, which can be listened to again, and which may be transcribed and included in a written text (Elliot, 2005).

According to Elliott (2005), various themes commonly run through narrative research. These may include the following:

• An interest in people’s lived experiences and an appreciation of the temporal nature of that experience;

• A desire to empower research participants and allow them to contribute to determining the most salient themes in an area of research;

• An interest in process and change over time;

• An interest in the self and representations of the self; and

• An awareness that the researcher is also a narrator (p. 10).

Evidently, as per these themes, narrative research is a mutual endeavor between the researcher and the participants. Both parties must have an interest in achieving a deeper understanding of the research topic and be curious about the way that experience evolves over time.

It is worth noting that in narrative research there is no ultimate truth; the story a person tells is not a black-and-white depiction of events, but is based on his/her
interpretation of the events. Narratives evolve in their telling and are representations of events rather than exact replicas. As people change and gain new insights, their recollection of events changes as well. Moreover, the listener has an influence on the storyteller’s narrative process (Riessman, 1993).

In its most prevalent form, narrative research does not require replicability of results as a criterion for its evaluation (Lieblich et al., 1998). Thus, readers need to rely more on the personal wisdom, skills, and integrity of the researcher. However, Lieblich et al. (1998) provide the following caveat:

[Int]erpretation does not mean absolute freedom for speculation and intuition. Rather, intuitive processes are recruited in the service of comprehension, which examines the basis for intuited and should test it repeatedly against the narrative material. Interpretive decisions are not “wild,” in other words, but require justification. (p. 14)

Stated an alternative way, although analysis of participants’ narratives is partially an intuitive process, interpretations made by the researcher must be grounded in some form of logic. Lieblich et al. (1998) assert that, while certain research methods – notably, quantitative methods – provide researchers with systematic inferential processes usually based on statistics, narrative work requires self-awareness and self-discipline in the ongoing examination of text against interpretation, and vice versa.

Researchers use numerous methods to interpret narratives. In keeping with the research question and the epistemological interest in narrative forms of psychology, the proposed study will employ an approach that attends both to what is being communicated (the content), and to how it is being relayed (the process of communication and the
meanings it conveys) (Elliott, 2005; Riessman, 2008).

**Research Process**

**Researcher Position**

Researchers’ personal life experiences deeply influence the focus and direction of their investigations, including the topics they study, the methods they use to collect data, and the interpretations they make. Thus, according to Seidman (1998), it is crucial for researchers to identify their autobiographical roots in the topics they choose to explore. Upon reflection, it is evident that my continued work at a psychological clinic specializing in chronic pain management greatly shaped this research.

I began working at a Toronto rehabilitation clinic in September 2009 while completing a master’s degree in Counselling Psychology. Soon after commencing my role as a psychotherapist at this site, I was struck by a startling realization: Although many clients were suffering from immense, unrelenting pain that had a highly detrimental effect on their functionality, the etiology of their conditions was often unknown. Furthermore, when diagnostic testing had isolated an organic cause, physicians often informed them that the degree of pain they were experiencing exceeded the level of pain expected from their injury, or that there was no discernible reason why their recovery was so protracted. Despite visiting numerous medical specialists, ingesting countless types of medications, and experimenting with various interventions, clients tended to achieve scarce relief from their pain.

On the surface, these individuals were very different. Their careers were diverse and included lawyers, bankers, bus drivers, mechanics, and sales clerks. Some had been born and raised in Canada, while others were immigrants from Europe or war-torn
countries such as Sri Lanka and Nigeria. Frequently, they were married and had children, but some led very isolated lives and resided alone. However, a common thread frequently ran through their narratives – a sense of powerlessness and loss of control. Though many had crafted jovial public images characterized by bright smiles and positive banter, they spoke far more candidly once my office door closed. The longer they spoke to me the more their mask of cheerfulness crumbled, revealing a well of fear and helplessness at their core. Often, clients recounted atrocities from their childhoods that continued to plague them – abuse, abandonment, or violation. Others described less sinister problems, though nevertheless distressing – collapsing marriages, stifling work schedules, or the burdens of being a caregiver to ailing parents. Most, however, perceived that prior to the onset of their pain, life had spiraled out of their control, becoming unmanageable and unbearable in at least one way. Often my clients had appraised their pre-pain situations as hopeless, and they felt incapable of adequately addressing at least one major problem in their lives. Among those who had experienced misfortune in their lives, minor accidents (such as a slip-and-fall) seemed to serve as catalysts for pain in the same way that tapping a cracked mirror, even ever so lightly, can cause the mirror to fragment into a pile of shards of glass.

It was these clinical encounters that inspired me to study the topic of chronic pain and the manner in which subjective experiences may contribute to the development and perpetuation of this debilitating condition. However, it is important to acknowledge that, on account of my growing familiarity with the chronic pain population, I had developed suppositions which could potentially bias the research process and, by extension, my findings. Moreover, since I was (and continue to be) passionate about helping chronic
pain sufferers, I worried that my eagerness to achieve greater understanding of this population might lead me to make premature conclusions. However, making diligent use of a self-reflective journal was intended to prevent these possibilities, through the facilitation of critical self-reflection. According to Russell and Kelly (2002), keeping a self-reflective journal can assist researchers in uncovering their “personal assumptions and goals” (p. 2) and can clarify “individual belief systems and subjectivities” (p. 2).

Van Manen (1990) has stated that, with research, the problem is usually not that researchers know too little about their topic of inquiry, but that they know too much. Indeed, using a reflective journal helped to make my experiences, opinions, and emotions more visible to me, thus minimizing partiality in my research interpretations. It was also important for me to be “forward looking rather than backward looking” (Dahlberg, Dahlberg, & Nystrom, 2008, p. 130) so that my previous clinical work with chronic pain sufferers would not cause me to believe that I was an expert on my participants.

**Participants**

The present research targeted adult males and females who had struggled with chronic pain for at least one year. All 12 participants were of diverse cultural backgrounds and different income levels. Four of the participants were male, while eight were female. All the participants were English-speaking and were able to effectively articulate their stories. Ten of the participants had been involved in one or more motor vehicle accident; however, rather than recovering from their injuries as their medical practitioners expected, their pain had become chronic and sometimes spread to other unrelated areas of their bodies.

The academic literature provided guidelines to assist the researcher in determining
how many participants were required to achieve saturation for this type of study. For example, Pollio, Henley, and Thompson (1997) state the following: “Although not a formal methodological rule, the situational diversity necessary for identifying thematic patterns is often provided by three to five interview transcripts” (p. 51). Morrow (2005) notes that “the magic number 12” is usually satisfactory to achieve this purpose. Warren (2002) has suggested that a pool of 20 to 30 interviews is sufficient to capture a full range of experiences for an interview-based qualitative study. As such, the researcher selected 12 participants as a suitable number based on the aforementioned guidelines.

Procedures

The researcher placed a recruitment poster at a private psychological practice that specializes in rehabilitation and pain management in the Greater Toronto Area. The poster described the study’s purpose and provided telephone contact information for the researcher. As potential participants contacted the researcher, she communicated with them orally to request their participation in the study. She also described the limits of confidentiality and assured their anonymity through the use of non-identifying quotations within the final project. Additionally, she requested their permission to record the interview. As well, the researcher explained the key benefit of participating in the study: It would provide an opportunity to learn about the possible relationship between their life experiences, their subjective responses to these experiences, and their chronic pain. Additionally, the researcher explained that their responses may contribute to the development of improved psychotherapy interventions for chronic pain sufferers. Finally, the interviewer advised potential participants that information from the study may be used in future publications and presentations; however, confidentiality would be
maintained. No names or identifying information would appear on any such materials.

Upon meeting with the selected participants, the researcher provided them with a consent form to read and sign prior to the initiation of the interview. The researcher also reiterated the limits of confidentiality and informed the participants of their right to withdraw from the study at any time and to refuse to answer any question to which they do not wish to respond. It should be noted that all participants were regular attendees of psychotherapy, which is the reason why they were visiting the aforementioned clinic; thus, they had ready access to psychological support in the event that the research interview would elicit any form of distress.

The researcher explained the purpose of the interview to the participants prior to its commencement, being very clear about her goal of developing a deeper understanding of their momentous life events, as well as the way they subjectively experienced these situations. Data collection occurred in person at a private psychological clinic. Interviews were recorded and then transcribed for analysis.

**Interview Protocol**

To begin the interview process, the researcher provided the following description to participants: “The purpose of today’s meeting is for me to learn more about the life experiences of chronic pain sufferers prior to the onset of their illness, and the way they make meaning of these experiences.” The following questions were used, as needed, to assist with the narrative exploration:

1. Tell me about events in your life that you deem to have been particularly momentous prior to the onset of your chronic pain.
2. How did these experiences affect you?
3. If you were to try to help someone understand the impact these events had on you personally, what would you tell them? What images or metaphors or phrases could you use to help them understand?

4. How were you coping with these events around the time of the onset of your chronic pain?

5. If you had to provide reasons for these events, what explanations would you offer?

6. Do you see any connection between your pre-pain experiences and the subsequent onset of your pain?

Through the researcher’s facilitative interaction, she created a conversational space for the interviews to unfold, that is, “an arena where respondents [felt] safe to share stories on their experiences and life worlds” (Pezalla, Pettigrew, & Miller-Day, 2012, p. 167). As per the recommendation of various qualitative research experts (e.g., Janesick, 2001; Mallozzi, 2009), the researcher opted to employ Rogerian interviewing strategies; her aim was for empathy, transparency, and unconditional positive regard to be experienced by the participants.

If requested, questions were re-stated or explained to the participants. The researcher probed respondents, as needed, in order to clarify or expand upon information. Creswell (2013) has emphasized the significance of being a good listener, rather than a frequent speaker during an interview, and the researcher endeavored to heed this recommendation. Moreover, Dahlberg, Dahlberg, and Nystrom (2008) have written that the “the things themselves…are always something more than what meets the eye” (p. 121), and so the researcher kept this axiom at the front of her mind throughout the process.
A de-briefing conversation concluded each interview, which involved the researcher and the participants exploring highlights and connections they made during their discourse. Finally, the researcher recorded her thoughts, insights, musings, and possible biases, shortly after each interview, in her reflective journal.

**Data Analysis**

Narrative research involves three steps: interviewing, transcription, and analysis. Upon completion of the interviews, the researcher transcribed them in their entirety as first drafts that captured all of the words and actions (e.g., crying, long pauses, laughing). Then the transcript was reviewed in order to gain familiarity and closeness with the interviews, and themes/patterns were identified. The goal was for the researcher to create a “meta-story” about the experiences under investigation. Through this process the participants’ individual narratives were then written.

As previously noted, bias is inevitable, and so the researcher was continuously on guard so that her assumptions and personal beliefs would not mislead the understanding of meaning. Dahlberg, Dahlberg, and Nystrom (2008), have used the term “bridling” to describe this practice. They have written that bridling is “about the understanding as a whole, not just the pre-understanding” (p. 130). Moreover, they have emphasized that it is vital that researchers do not try to achieve “understanding too quickly, too carelessly” (p. 130). It is imperative for researchers to put aside their first guesses and continue questioning (Van Manen, 1990).

**Ethical Considerations**

Various ethical considerations were taken into account when conducting the current research, including obtaining approval from the University of Toronto’s Social
Sciences, Humanities, and Education Research Ethics Board (REB); properly obtaining consent; ensuring confidentiality; minimizing the creation of distress; and ensuring the validity of the results. REB approval was obtained on October 29, 2014. Afterward, the researcher hung recruitment posters at a local psychological clinic in order to secure participants for the study.

Informed consent is a prerequisite for all research involving identifiable subjects. For this study, the researcher obtained consent from all participants after they had been informed, verbally and in writing, about the following issues: the purpose and scope of the study; the types of questions which would be asked; how the results would be used; the method of anonymization; and the extent to which participants’ narratives would be used in reports. Participants were then given time to ask the researcher any questions they might have (Richards & Schwartz, 2001).

The researcher ensured the confidentiality of all participants throughout the process. To achieve this goal, all recordings of the interviews were erased once they were transcribed. As well, participants’ names and any other information that could identify them were not utilized on the transcripts or in final written materials. Instead, codes were used to mark information, and pseudonyms were utilized in the final write-up. All materials have been kept secure in a locked filing cabinet, to which only the principal investigator and the research supervisor have access. Materials will be kept for seven years and will then be destroyed. It is possible that information from this study will be used in future publications and presentations, but confidentiality will be maintained. No names or identifying information will ever appear on any such materials.

For the record, certain exceptional circumstances would have required the
researcher to break the aforementioned agreement. These circumstances include the following: 1) If a participant indicated that he/she was going to hurt someone else or him/herself; 2) If a participant advised the researcher that he/she was aware of a child’s being abused or neglected or in danger of being hurt; 3) If a participant reported that he/she was sexually abused by a registered health care professional (Richards & Schwartz, 2001). None of these circumstances was disclosed during the interview process.

Furthermore, as stated, it was crucial for the researcher to take steps to avoid undue distress of the participants. Qualitative research aims at an in-depth understanding of an issue, including an exploration of the reasons and context for participants’ beliefs and actions, so is often designed to be probing in nature. Some individuals find that participating in interviews allows them a space and opportunity to express themselves freely and openly in a non-judgmental atmosphere and, in doing so, to better understand their own experiences. However, these same methods sometimes engender anxiety in participants, depending on the personal biographies and experiences of the individuals. As such, the researcher ensured that resources were available to this study’s respondents, in case they required extra support during or after the interview. Since these individuals were recruited from a pain management clinic, each participant was already meeting with a mental health clinician, regularly (Richards & Schwartz, 2001).

Finally, it was important for the researcher to take steps to ensure the validity of the results. Although all research is, to some extent, socially constructed, one may argue that in qualitative studies, participants’ views could be taken out of context. This study’s researcher attained sufficient supervision and had regular contact during the process with
other researchers who were able to dialogue about and make connections between the contents of the interviews. As well, the researcher was aware of, and explicit about, possible biases (Richards & Schwartz, 2001).

**Summary of Chapter Three**

In Chapter Three, the methodological research approach was outlined. Narrative inquiry, within the conceptual framework of phenomenology, was discussed as appropriate for the research question and the context of the study. The researcher’s narrative approach to analysis was also described, along with the procedures employed to gather, analyze, and present the data. Furthermore, ethical considerations were outlined. In Chapter Four, the summarized findings from the 12 participants will be presented.
Chapter Four

Within-Participant Results

This chapter presents individual participant results and within-participant analysis for this study’s 12 participants: Cynthia, Tatiana, Costa, Flora, James, Renata, Mary, Nancy, Paula, Anthony, Carla, and Pardis. For each participant, three sections have been created:

In the first section, a summary chart is provided, which is intended to place that person’s experiences in context.

In the second section, the metathemes that apply to the participant are explored. For the purpose of clarification, definitions of the terms “theme” and “metatheme” will be provided here:

Tesch (1987) concluded that there are two main meanings to the word “theme” in human science research:

1. Theme can mean something akin to the content, topic, statement, or fact in a piece of data; expressed more simply, what the data segment is about;

2. Theme can also mean a major dimension, major aspect, or constituent of the phenomenon studied; expressed more simply, a partial descriptor of the phenomenon. (p. 230)

Conversely, a collection of themes helps to form “metathemes.” Tesch (1987) has provided the following analogy: “If metathemes were edifices and themes were building blocks, the metathemes could be constructed from the themes” (p. 232). In other words, a metatheme represents the “results,” or the totality of the phenomenon being researched (Tesch, 1987). While various smaller themes could be drawn from the individual
narratives, such as “experiences related to death” or “experiences related to neglect,” these smaller themes have been subsumed under the metatheme headings. According to Tesch (1987), it is not unusual for a researcher to “proceed directly from immersion in the totality of her unstructured data material to a contemplation of the metathemes and patterns” (p. 234-5), and this is precisely what occurred with the analysis of the current research.

Although each of the participant’s stories was varied and unique, three metathemes emerged:

1. A tendency to recount overwhelming and traumatic life events, with many experiences related to loss (“Recounting Traumatic Events”);
2. A propensity to downplay the severity of their experiences, and to avoid complaining (“Downplaying Experiences”);
3. An inclination to assume the role of caregiver, even though to do so might lead to self-neglect (“Acting as a Caregiver”).

In the third section, the participants’ reflections related to the relationship between mind and body are provided.

Please note that participants are presented in the same order in which they were interviewed.

Cynthia

Summary Chart

<table>
<thead>
<tr>
<th>Age</th>
<th>55</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>Birthplace</td>
<td>Toronto, Ontario</td>
</tr>
<tr>
<td>Description of pain</td>
<td>Cynthia began experiencing back pain of unknown etiology in 2006. Her pain intensified after a 2013 motor vehicle accident.</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Length of interview</td>
<td>2 hours</td>
</tr>
<tr>
<td>Applicable metathemes</td>
<td>Recounting Traumatic Events; Downplaying Experiences; Acting as a Caregiver</td>
</tr>
</tbody>
</table>

### Theme 1: Recounting traumatic events

Cynthia recounted her involvement in traumatic events including the demise of her marriage, challenges related to caring for her aging mother, losing a job and taking on a new position, and becoming the foster parent of a young boy.

**End of her marriage.** Cynthia relayed her involvement in an emotionally abusive marriage, which made her feel “used.” Near the end of her marriage she learned that her husband had never wanted to have children, and he subsequently rejected their two daughters. Though he has been gone for three years, Cynthia continues to mourn the loss of her husband, who is also the father of her children. Her spouse’s departure has left her questioning her judgment and her ability to make sound decisions.

**An aging mother.** Cynthia described immense worry related to her 81-year-old mother, whose memory is beginning to deteriorate. Perhaps even more disconcerting for Cynthia is that her mother is quite isolated. Although Cynthia has five siblings and many other people in her extended family, she is the only one who speaks to her mother. Cynthia noted the following: “She’s missed so much. She’s missed the birth of my youngest brother’s son, and the great-grandchildren as well. She doesn’t know anyone,
you know?” As such, the burden of her mother’s care falls almost solely on Cynthia’s shoulders.

**Problems at work.** Cynthia described her relatively new job as an executive legal assistant. She explained that she does not have the necessary training and experience for this job, which makes it highly stressful for her. Cynthia fears she will make errors that will have devastating consequences. Furthermore, Cynthia’s manager is pressuring her to start working on weekends, despite the fact that she already feels overwhelmed with her current obligations. As such, she has been neglecting her own needs. For example, she used to attend physiotherapy twice per week, which helped to alleviate her pain, but she can no longer fit these appointments into her solidly packed schedule.

Cynthia also revealed that she does not have a good relationship with her manager at work, and he places significant pressure on her. She also spoke about how her current employment is not a good fit with her personality:

It’s very, very driven, and it’s all about the buck, and I’m so not that way, you know? I’d be happier doing something that I could see benefiting other people. This [job] benefits other people, yes, but it benefits their bank accounts. I find I can’t utilize my compassion in a position like this. It makes you think about what you really want to do in life, you know? Is this what I’m really called to do?

As described, Cynthia would like to work in a helping role in which she benefits humanity in some way, rather than in a financially driven environment.

**Theme 2: Downplaying Experiences**

Despite Cynthia’s various concerns, she downplays her problems, noting that things are “even worse” for other people. As well, Cynthia has a tendency to apologize
during the interview, as though she worries that her insights, feelings, and comments will not be valued by the interviewer. For instance, she noted the following: “It’s hard, it’s not easy, and I can’t complain, ‘cause I know there’s a lot of people out there who have more difficulties than me.” It is evident that Cynthia worries about being perceived in a negative light. She stated the following: “I don’t have a choice, but hey, I’m not complaining. I’m not complaining, am I?” Similarly, Cynthia becomes nervous and apologetic when she feels that she is not contributing anything beneficial to the present interview: “I don’t really think about myself that much, but, uh, I don’t know, I just, I don’t know how else to tie it in.... I’m sorry. I feel like I’m not getting to the meat of it.... I just don’t like talking about myself much. I don’t like to complain.”

Rather than owning her feelings, Cynthia tries to excuse her manager’s poor behaviour. For example, she describes a difficult relationship with the manager, who does not adequately take her needs into account. Instead of deeming her anger to be justified, she stated, “Everybody’s got their own things to deal with. I understand that.”

**Theme 3: Acting as a Caregiver**

Cynthia reported that, in addition to her usual roles and responsibilities, she is helping to foster a young boy, Michael, at her daughter’s request. Particularly interesting is that Cynthia is not following her own dreams of finding a role where she can “utilize her compassion” (described above). Rather, she is caring for someone else’s son so the boy’s mother can go overseas to receive specialized training. Cynthia described a sense of being overwhelmed related to caring for Michael. She relayed a story about getting home from work at 7:30 p.m., and realizing that the child had urinated in bed, so she needed to wash the sheets before she could eat dinner. “It’s something I didn’t need to go
back to at this point in my life,” she disclosed. However, as seems to be a pattern in her narrative, she downplayed her concerns, stating that “it’s all good,” and she is “happy to help.”

**Relationship Between Mind and Body**

Cynthia offered significant insight into the mind-body connection. For example, she indicated that her tendency to give people the benefit of the doubt seems to have a direct impact on her health. Please note that, in the following quotation, when she refers to events that “came up at home,” she is speaking about circumstances with her ex-husband:

I find that I give people the benefit of the doubt, and I still do. Everyone feels the same, and I realize that. It’s gotta have some kind of impact on me. I have a lower back condition, and I know that when these things came up at home, that’s when the pain would start. My lower back would just go straight out.

The interviewer also asked Cynthia if her busy schedule might be contributing to her poor physical condition. She indicated her chronic pain is like an open wound that is constantly being aggravated: “It doesn’t have a chance to heal, and I’m going all the time, all the time, and I don’t have a chance to rest.” Similarly, Cynthia described her physical pain as a manifestation of the emotional pain: “It’s action-reaction, right? When you feel that stress, that’s exactly where it goes. My back is a home for the stress. It just manifests itself right there.”

**Tatiana**

**Summary Chart**

<p>| Age | 45 |</p>
<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthplace</td>
<td>Born in Ukraine; immigrated to Canada about 25 years ago</td>
</tr>
<tr>
<td>Description of pain</td>
<td>Tatiana has a longstanding history of migraines, as well as arthritis in her knees and elbows. Furthermore, she has suffered from pain of unknown etiology, in her back, shoulders, neck, arms, and ankles since 2013.</td>
</tr>
<tr>
<td>Length of interview</td>
<td>50 minutes</td>
</tr>
<tr>
<td>Applicable metathemes</td>
<td>Recounting Traumatic Events; Downplaying Experiences; Acting as a Caregiver</td>
</tr>
</tbody>
</table>

**Theme 1: Recounting Traumatic Events**

Tatiana described the following life events: the death of her mother and grandmother; being abandoned by her father; her immigration to Canada; the end of two marriages; and her children moving away.

**Death of mother and grandmother.** Tatiana began the interview by speaking about losses in her early life. She described the immense sense of grief that resulted:

My mother and then my grandmother died. My father left. And I was so alone as a child, and I was grieving for many, many, many years. My dad left when I was two and a half years old. My mom died when I was five. And then, within a year, my grandma died.

Though Tatiana was raised by her grandfather, whom she regarded as a “good man,” she desperately missed her mother and grandmother. Tatiana provided the interviewer with
an interesting perspective on how people sometimes deny that significant deaths have happened, since it is too painful to face such great losses:

*Tatiana:* Another thing, the death, some things happen to you and you deny them your whole life, you don’t want to remember. And then when you realize it happened, you still deny it, and I don’t want to remember and talk about this. I cannot erase this from my memory.

*Interviewer:* And whose death can you not erase?

*Tatiana:* The deaths of my mother and my grandmother.

**Immigration to Canada.** Next, Tatiana spoke of her immigration to Canada, noting that it has been challenging for her to adjust to the climate. She had previously lived in what she affectionately referred to as a “beach town” or a “little Florida” in Ukraine. In Toronto, however, her chronic pain is exacerbated by the cold.

**Death of first husband and divorce from second husband.** Tatiana noted that her first husband died. Though she briefly remarried in Canada, she and her spouse obtained a divorce soon afterward. Since that time, she has been single. Despite some gentle probing, Tatiana did not seem interested in exploring these issues, choosing instead to discuss her children.

**Children moving away.** Tatiana spoke of how painful it was for her when her children left home. She never overcame her childhood losses, and when her son and daughter moved away, their departures served to intensify her grief:

I’m grieving. I feel like somebody died. It’s grief. It’s a huge loss. This is very significant. I think it’s the most significant thing of sadness that I ever felt in my
life, when they left... My son just left last September for college, and my daughter left four years ago, and I’m still grieving for her.

**Theme 2: Downplaying Experiences**

Although Tatiana typically spoke in an overt manner about the distress engendered by her life’s various traumas, she also relayed her efforts to suppress certain events, in order to avoid feeling emotional pain. More specifically, Tatiana has tried to deny the deaths of her mother and grandmother, since it is too difficult to admit to herself that these events actually occurred:

> Another thing, the death, some things happen to you and you deny them your whole life, you don’t want to remember. And then, when you realize it happened, you still deny it, and I don’t want to remember and talk about this.

**Theme 3: Acting as a Caregiver**

Tatiana did not go into detail about her tendency to act as a caregiver. However, she noted that she greatly misses her children, who moved away, because she enjoyed going “above and beyond” to care for them.

**Relationship Between Mind and Body**

Tatiana perceives a connection between her physical pain and her emotional pain. She reported that her anguish over her mother’s death is particularly acute when she is struggling with physical pain. At these times, she longs to be nurtured:

> I want my mom to take care of me when I’m in pain. I want my mom to be there, and to make a soup for me, or something, to take care of me, and just be with me. I have those feelings.
As well, she has noticed a correlation between the severity of her physical pain and her emotional pain; when she is feeling particularly overwhelmed, that is when her somatic symptoms flare up.

Costa

Summary Chart

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
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<td><strong>Age</strong></td>
<td>27</td>
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<tr>
<td><strong>Gender</strong></td>
<td>Male</td>
</tr>
<tr>
<td><strong>Birthplace</strong></td>
<td>Brazil; immigrated to Canada 26 years ago</td>
</tr>
<tr>
<td><strong>Description of pain</strong></td>
<td>Costa developed back pain in 2012 following a motor vehicle accident. Over the subsequent two years, he developed mysterious pain in other locations in his body, which does not seem to stem from his accident.</td>
</tr>
<tr>
<td><strong>Length of interview</strong></td>
<td>75 minutes</td>
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<tr>
<td><strong>Applicable metathemes</strong></td>
<td>Recounting Traumatic Events; Downplaying Experiences; Acting as a Caregiver</td>
</tr>
</tbody>
</table>

Theme 1: Recounting Traumatic Events

Costa disclosed various distressing events in his life, such as being beaten by his mother, growing up without a father, gang involvement and arrest, and academic problems.

**Childhood abuse.** Costa began the interview by describing the abuse inflicted upon him as a child. Costa’s mother physically abused him, and he was also humiliated by his babysitter. He relayed a particularly heartbreaking event that occurred when his
mother thought he had recorded over a soap opera she had taped on their VCR. Enraged, she began striking him with a belt. However, after the beating, his mother realized that her television program actually was recorded on the tape, but it was toward the end of the tape: “I just remember her crying, and being so sorry that she hit me. But the damage was already done,” he stated.

Costa also narrated how, during these beatings, he would generally end up in the bathroom, in the bathtub: “I would feel trapped in the bathtub, and her hitting me.” Following the abuse, Costa would have numerous welts on his body. He recalled the day when his babysitter noticed the marks and then took him to show the neighbours. “She was showing me to the neighbours, like putting me on display and showing my marks,” he stated. Costa lowered both his head and his tone of voice while he described this experience; it is evident the incident engendered immense feelings of shame. No one – neither the babysitter nor the neighbours – took steps to report Costa’s abuse to the authorities.

Growing up without a father. Costa also revealed that growing up without a father was momentous for him. He craved the presence and guidance of a man in his youth. He noted that at certain times in his life, he “needed more of a tough kind of perspective,” and he believed that his mother was unable to provide that for him. As well, when Costa was first learning how to drive, he longed for fatherly guidance: “I remember thinking that I wish I had a father to teach me these things.”

Costa disclosed that he does not share any type of relationship with his father. In fact, Costa views him as a “stranger.” He remembers meeting him while in Brazil, and the meeting was “really awkward,” since neither of them knew what to say.
Gang involvement and arrest. Costa also spoke about being arrested when he was “13 or 14” years old. He had joined a gang to achieve a sense of acceptance: “I, personally, believe that because my father wasn’t around and my mother was working constantly, constantly, and I wanted to feel like I belonged, and so I started hanging around with a gang.” As part of Costa’s role in the gang he was required to participate in the violent initiation of new members. However, one of these members went to the police after being beaten and the police charged Costa. He was sent to “juvenile jail” for what Costa estimates to have been between one and two weeks. Apparently, the police officers were “really rough” with him. They would say threatening things, such as, “Oh, you’re lucky I don’t take you to a laneway right now and beat the shit out of you.”

Academic problems. Costa went on to explain that, subsequent to his problems with police officers, he experienced problems at school. He described how he lost respect for his teachers, since he began to view people in authority roles in a negative light. Costa was eventually expelled and was placed in an adult school program: “I just remembered that was the lowest of the low point in my life, and on top of that, at that school I was robbed for over $150, and that was when I realized I was at the bottom, bottom, bottom, bottom,” he recalled.

It was at that time that positive changes began taking place in Costa’s life. He started to focus his energy on schoolwork and was transferred back into a regular school. He recalls a history teacher looking at his academic progress and calling him an anomaly: “I beat the odds, and I beat the statistics.”
Theme 2: Downplaying Experiences

Costa downplayed the brutality of his childhood abuse, emphasizing that it was not his mother’s fault, since it was a “difficult” time for her. Similarly, Costa indicated that he does not hold a “grudge” against his mother, since she has changed since that time:

I realize that she has gone through so much psychological stress as well, and she’s not the same person that she used to be when I was young. She has changed dramatically, and she’s a very nice mom, and she sacrificed a lot for me, because I grew up without my father, as well. So I know it was difficult for her to be both the father and the mother.

Costa also minimized his initiation into the gang, which involved other members viciously beating him. When asked if it was a frightening experience, he stated: “I didn’t see it as being very dramatic. I saw it as a badge of honour.”

Similarly, Costa noted that he no longer feels anger toward law enforcement workers, despite the way he was treated by police officers during his arrest.

Costa’s dialogue is peppered with positive comments. For example, when he noted that his father abandoned the family, he stated, “But it’s OK, that’s a long time ago.”

Costa tries very hard to “focus on the positive,” a coping strategy that may have helped him to move forward with his life, rather than remaining mired in the past. However, it is unclear how much he has actually processed his distressing life experiences.

Theme 3: Acting as a Caregiver

It should be noted that Costa is not being included in the classification of “Acting as a Caregiver” for the same reasons as the other participants, and the researcher sought guidance from her supervisor regarding whether he was a proper fit for this grouping.
However, the researcher’s justification is that, much like a caregiver, Costa has traditionally placed others’ needs above his own. Despite a history of victimization, notably at the hands of his mother and police officers, and neglect by his father, he has pardoned them. This action tends to reflect the way that he honours others’ feelings, possibly above his own, and in doing so conveys an uncommon sense of selflessness.

**Relationship Between Mind and Body**

When Costa was probed regarding his views on a possible connection between his life experiences and his physical pain, he reported that his pain becomes worse when he worries about the possibility of unconsciously mirroring the actions of his own parents. Costa added that the physical implications of these thoughts include “muscles tightening up, or shortness of breath, or tight chest.” Similarly, Costa noted that when he feels emotional pain, such as when he contemplates traumas he has experienced, his physical pain intensifies.

**Flora**

**Summary Chart**

<table>
<thead>
<tr>
<th>Age</th>
<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>Birthplace</td>
<td>Philippines; immigrated to Canada 25 years ago</td>
</tr>
<tr>
<td>Description of pain</td>
<td>Flora was involved in a minor motor vehicle accident in 2012, and has experienced persistent headaches, as well as intermittent back and neck pain, since that time.</td>
</tr>
<tr>
<td>Length of interview</td>
<td>1 hour</td>
</tr>
<tr>
<td>Applicable metathemes</td>
<td>Recounting Traumatic Events; Downplaying Experiences;</td>
</tr>
</tbody>
</table>
Theme 1: Recounting Traumatic Events

Flora recounted various distressing events in her life, including her immigration to Canada and her inability to bear children.

Immigration to Canada. When asked to describe momentous events, Flora spoke about how she came to Canada to have a different life and a brighter future. She disclosed the following: “When I was younger, I was so aggressive and was dreaming so high.” However, her voice became low and solemn when she described the challenges inherent in her integration process. Despite her advanced education, she began working as a live-in caregiver, as a means to eventually acquire Canadian citizenship. Securing citizenship appears to have been a protracted process, taking several years. It required a great deal of patience and waiting. When asked to describe if all her efforts were “worth it,” she answered with hesitation. She had imagined working in a role that inspired passion in her and had planned to upgrade her education in Canada. However, she was forced to keep working so she could send money back to the Philippines to support her family. In addition to working as a caregiver, she also worked at two retail stores and as a tutor. Learning how to drive is a goal that Flora has been unable to achieve, since she has struggled to fit lessons into her schedule. Instead, she usually relies on her brother to drive her places, or she takes public transit.

Inability to bear children. It is evident that Flora is disheartened by the direction her life has taken since immigrating to Canada. However, it was only after speaking together for about half-an-hour that the greatest source of her suffering emerged – the fact
that, at the age of 49, she has no children of her own: “When I think of that, I start to feel pain, and I feel, ‘I have to erase this,’” she stated, as she tried to articulate the devastating effect of not having children. This comment is reminiscent of Tatiana’s story, which refers to her inability to “erase” her various traumas from her memory.

Flora also described her efforts to accept that she will likely never bear children:

[I]t pains me, but I’m not as bad as before. I was depressed because of that. But now, I’m learning to accept it. I still haven’t fully accepted it, but maybe 70 or 80 percent, I’ve accepted it... It’s hard to talk about it. I don’t want to talk about it that much. (She becomes tearful)... If I keep on thinking about it, my mind will explode.”

Flora and her husband had been trying to conceive a child for many years, and she wonders if she should have tried other fertility methods before reaching this age: “If only things had been different, if only I had made good decisions. Like that. That hurts me. That gives me pain,” she stated. However, due to her poor income and the fact that she was sending part of her wages home to the Philippines, costly fertility treatments were not an option.

**Theme 2: Downplaying Experiences**

Flora makes a valiant effort to focus on the positive and to downplay her difficulties – even though it sometimes seems difficult for her to think of positive aspects. For example, she noted that she is appreciative of her chronic pain because, due to the pain, she received free physiotherapy and free orthopedic shoes from her insurer. However, these statements are not entirely logical, since Flora would not have needed such perks if she had not developed the pain.
Theme 3: Acting as a Caregiver

Perhaps the greatest example of Flora’s selflessness is that she ignored her own goal of returning to college in order to send her tuition money to the Philippines to support her family. She stated, “I wanted to do something different, but unfortunately, I wasn’t able to do that because I was helping my family back home [financially].” Flora also noted that these funds could have been used to fund fertility treatments to help her conceive a child. Her narrative is tinged by both loss and regret.

Relationship Between Mind and Body

When queried about the potential connection between her emotions and her pain, she responded that it “pains” her to think about the past. Moreover, when she thinks about her regrets, her pain becomes worse.

James

Summary Chart

<table>
<thead>
<tr>
<th>Age</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
</tr>
<tr>
<td>Description of pain</td>
<td>James developed pain of unknown etiology approximately two years ago following the death of his father. This pain grew worse following a minor motor vehicle accident. James’s pain is concentrated in his neck, right shoulder, lower back, left knee, and head. However, unlike the other participants in this study, he believes that his pain is</td>
</tr>
</tbody>
</table>
Theme 1: Recounting Traumatic Events

Despite conveying his curiosity about this project’s purpose, James was the least candid of the participants. When asked to speak about momentous events in his life, he spoke of just one in detail, the death of his father.

Debt of his father. James left Somalia in 1991 when the civil war began. He moved to Kenya before immigrating to Canada in 1995. James’s immediate family, with whom he had always shared close relationships, became scattered at that time. Although two of his siblings also settled in Toronto, one sister moved to Switzerland, and two brothers moved to England. His parents immigrated to England. However, all of these events seemed merely an afterthought for James. He reported that the most momentous event in his life – if not the only truly momentous event – was the death of his father.

James told the interviewer that his father died in 2009. At that time, James had not seen him for 18 years. For a great deal of that time his father was residing in a “war zone” in Somalia, so James was not able to visit. Once his father moved to England, James was busy raising his children and was waiting for “the right timing” to visit. After postponing this visit many times, James finally booked a flight to see his father. Unfortunately, James’s father died a few short days before the scheduled visit. As his eyes teared up, James spoke about his regret:
What if I had gone sooner, and booked my flight, and taken that time off work, and decided to take vacation earlier to see my Dad? But I cannot bring back the time. That’s a regret I have... For 18 years, I hadn’t had a chance to shake his hand, or sit beside him, or have a cup of tea with him. It’s those moments I miss. James described how, after his father’s passing, he struggled with grief, which stole his appetite. He also missed opportunities for promotion at work, since he “wasn’t there at that moment,” mentally, and had difficulty focusing on his job.

Theme 2: Downplaying Experiences

When encouraged to elaborate on his emotional experience, James began to deny his feelings of regret. He stated, “The luck wasn’t there to see him again. It had been 18 years that I hadn’t seen him. But God called him, and then he left us.” When asked if he questions either the unfairness of his father’s death or the unfortunate timing, James replied: “We all die one day. It’s not like, why did he die? I’m not going to ask God, why did he die. His time was up.”

Relationship Between Mind and Body

James sees a modest relationship between his emotional pain and his somatic symptoms. He noted that when he is missing his father and feeling lonely, the intensity of his pain increases: “Sometimes, my lonely feeling connected with him not being there anymore makes the pain worse.” However, with the passage of time, James’s grief is subsiding and his somatic pain is also lessening. He noted the following: “My wife was there and my kids were there, and my mom, my brothers and sisters were with me. They’ve helped me to recover.”
Renata

Summary Chart

<table>
<thead>
<tr>
<th>Age</th>
<th>55 years old</th>
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<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>Birthplace</td>
<td>Toronto, Ontario</td>
</tr>
<tr>
<td>Description of pain</td>
<td>Renata experiences pain throughout her body. She first developed pain after a motor vehicle accident in 2013 and was later diagnosed with fibromyalgia.</td>
</tr>
<tr>
<td>Length of interview</td>
<td>1 hour</td>
</tr>
<tr>
<td>Applicable metathemes</td>
<td>Recounting Traumatic Events; Downplaying Experiences; Acting as a Caregiver</td>
</tr>
</tbody>
</table>

**Theme 1: Recounting Traumatic Events**

Renata disclosed various momentous events in her life, including being raised without her biological parents, her husband’s death, and her motor vehicle accident.

**Missing her parents.** Renata described how her childhood was characterized by feelings of both loss and confusion. Her father abandoned her family when she was a baby, so she never met him. Renata does not know who he is or if he is even alive. Furthermore, Renata’s mother died when she was just nine months old, so she was raised by her mother’s friend, who was single. Though Renata indicated that she was close to the person who raised her, she remained unsettled by the fact that she did not know her biological parents, and this was “a hole in her heart that would never be filled.”

**Widowhood.** Renata disclosed that the most challenging experience in her life was
the death of her husband approximately five years ago. She stated, “I’ve never had anything that’s been as traumatic as the death of my husband. That’s the most traumatic incident in my life.” As per Renata’s account, he was a cross border truck driver who became caught in a blizzard in Buffalo. An estimated nine feet of snow had fallen when his truck broke down, and he had no heat in his vehicle. He tried to wrap himself in all his clothing, but he was still extremely cold.

He eventually managed to return home and visited his family doctor, since he felt very sick. However, the physician informed him that he was fine. “[My husband] was strong, so we took it like that. We thought, there’s no problem with him,” said Renata. Unfortunately, he had a lung infection that had gone undiagnosed, and the infection “crossed from his lung to his heart.” At that point, he developed pain in his chest and in his arm. Not long after, Renata arrived home from work one day to find her son squeezing her husband’s chest. She described the following:

[My husband] said, ‘Oh my God, I’m going to die,’ and I said, ‘No, you’re not going to die, I’m going to call the ambulance, and they’ll take you right now to the hospital.’ But it was too late. They said it was a simple surgery that was needed, but because of the infection, they had to wait until the infection had gone for them to do the surgery, and he passed away. He went to the hospital on Wednesday night, and Friday morning he passed away.

Renata insisted that she has “accepted” the death of her husband, but her account is coloured by regret and sorrow. She ruminates about how, if she had taken him to the hospital sooner, perhaps he would have survived.
**Renata’s accident.** Renata reported that a motor vehicle accident was also a notable event in her life, since her pain developed soon after the collision. She noted that since the accident her pain has continued to worsen:

> I feel I’m getting worse with the pain. Even right now, I have this pain in my chest. I went to the hospital for it, I thought maybe it was a heart attack because maybe my pressure was too high, but they said it’s fine. And sometimes I feel that I don’t want to eat because I feel full all the time. But there are explanations for all these things.

**Theme 2: Downplaying Experiences**

A pattern emerged when speaking with Renata: she would indicate something that seemed to bother her, but then downplay the situation so it appeared as though she had come to terms with the issue. With respect to not having known her biological parents, she stated, “I would have liked to know who they were. I would have liked to live with them, but if it doesn’t happen, it doesn’t happen.” Regarding her husband’s passing she noted, “I would like to be with him, but things have happened and I cannot be.”

Similarly, Renata downplayed the significance of the car accident:

> Maybe I was careless? I don’t know. So how do I make sense of it? It had to happen, and so it happened. Right? If it happened, it had to happen. That’s my opinion. And I’m not really mad at this guy, [the other driver]. I hope he was not injured as badly as I was.

Renata also reported that her accident “doesn’t bother [her] too much,” when she thinks of it.
The interviewer also asked Renata whether any of the events she described upset her. Here is her reply:

Sometimes I get upset, mostly because of the pain. But I don’t have anyone to lash out at, because I can’t lash out at my grandchildren, and my children are so good to me. But sometimes I’m mad at myself. I ask, ‘why did I take that route? Why didn’t I take a different route?’ Sometimes I get upset at myself for that... I have to bear the pain. I have to do whatever I’m told to do...

**Theme 3: Acting as a Caregiver**

Though Renata mentioned that she assists with the care of her grandchildren, she does not seem to be a “caregiver” to the extent of other participants. However, a dominant characteristic of the caregivers interviewed was a tendency to put others’ needs above their own, and this was also the case with Renata. This propensity was illustrated when the interviewer asked her if she has spoken to anyone about her difficulty coping with events in her life. She responded, “I don’t want to burden anyone.” Although she does not hesitate to assist her family members as necessary, she tries not to make many demands of them.

**Relationship Between Mind and Body**

Renata denied a connection between her thoughts, emotions, life experiences, and the continuation of her somatic symptoms. She believes that her chronic pain, including her fibromyalgia, is attributable to her motor vehicle accident. However, Renata added that as time goes on, her pain continues to worsen, and she is unsure why.
Mary

Summary Chart

<table>
<thead>
<tr>
<th>Age</th>
<th>40 years old</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>Birthplace</td>
<td>Ireland; she immigrated to Canada about 10 years ago.</td>
</tr>
<tr>
<td>Description of pain</td>
<td>Mary has experienced pain of unknown etiology in her neck, shoulders, and head since 2014.</td>
</tr>
<tr>
<td>Length of interview</td>
<td>35 minutes</td>
</tr>
<tr>
<td>Applicable metathemes</td>
<td>Recounting Traumatic Events; Downplaying Experiences; Acting as a Caregiver</td>
</tr>
</tbody>
</table>

Mary’s brother died in 2014, and she now experiences persistent pain in her neck, shoulders, and head. Two key themes were identified in Mary’s narrative: “Recounting Traumatic Events” and “Acting as a Caregiver.”

Mary perceives a connection between body and mind, and she believes that her problematic relationships with her husband and children are perpetuating the pain.

**Theme 1: Recounting Traumatic Events**

When the interviewer asked Mary to describe a momentous experience from her life, she immediately began to cry, before responding, “My parents splitting up.” Mary’s parents separated when she was 12 years old. According to her account, she was “dumped” with an aunt and uncle for a year without knowing where her parents were. She then began living with her mother, but “things were tough there, too.” Mary noted that they resided in an impoverished area where drug use was rampant: “We grew up in a
drug culture, and both my brothers got caught with drugs.” She noted that one of her brothers died last year of an overdose: “My brother died, so that triggered things. Everything came crashing down. I wish I’d done something to help him. I wish I’d tried harder to help him, but he just wouldn’t take it.”

Mary emphasized how she had always been very strong during her life but has recently felt unable to cope with the myriad of challenges she is facing. “Sometimes I question why I’ve been pushed as hard as I have and why I’ve been tested like this. I feel like every test I’ve been given in my life I’ve been able to stand up to, but this one I can’t.” She went on to describe a “snowball effect” in her life, and the greater the snowball of problems becomes, the more crushing its weight.

Mary noted that her marital difficulties have been taking a particularly severe toll on her. “My husband is like he’s on a seesaw. Sometimes he’s with me, sometimes he’s not. I don’t know where I am with him. I never know where I am with him,” she stated, tearfully.

On a separate topic, Mary reported that she was caught drinking and driving last January, and her husband has refused to forgive her – a situation that contributes to her shame. Mary also feels like a failure in the context of raising her children:

With my children it’s so hard. They’re both autistic. They’re very smart but they have behavioural problems. I get up with them in the morning, but once they leave, I go back to bed. It’s all too hard. I don’t know what to do. (Continues to cry). I’m sorry. I’m going to use this whole box of tissues.

Based on her comments, it is evident that Mary feels besieged. She tearfully stated, “I’m not coping with it well.”
Theme 3: Acting as a Caregiver

Mary also spoke of how overwhelmed she feels related to caring for two young sons who are both autistic and who have behavioural problems. However, despite her valiant efforts to be a good parent, she believes she is failing as a mother: “I feel useless in life. All I do is cause problems. I’m just a burden on everyone. I don’t help my family. I just cause them nothing but problems.”

Relationship Between Mind and Body

During the interview, Mary was able to offer insight into the reason her pain is not resolving. She told the researcher that her sense of instability, related to her problematic marital relationship, is perpetuating her pain. She also contends with immense guilt, which she considers to be prolonging her condition. Mary does not believe she is as kind and active of a mother as she had hoped. “I’m not the Mum I should be, and I hate myself for that. But I can’t. I’ve tried, and I can’t be any different now. I just can’t. I want to be a better Mum. I’m such a mess,” she stated.

Nancy

Summary Chart

<table>
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<tr>
<th>Age</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>Birthplace</td>
<td>Italy; immigrated to Canada 46 years ago</td>
</tr>
<tr>
<td>Description of pain</td>
<td>Nancy was involved in two minor motor vehicle accidents in 2011 and one in 2013. Since Nancy’s first accident she has struggled with physical pain, which is concentrated in her right knee and leg, shoulders, lower back, and head, including</td>
</tr>
<tr>
<td>Length of interview</td>
<td>2 hour and 10 minutes</td>
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<tr>
<td>---------------------</td>
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</tr>
<tr>
<td>Applicable metathemes</td>
<td>Recounting Traumatic Events; Downplaying Experiences; Acting as a Caregiver</td>
</tr>
</tbody>
</table>

**Theme 1: Recounting Traumatic Events**

Nancy relayed to the interviewer how afflicting it has been to deal with her family’s health problems, particularly her husband’s disability. Most of her other challenges (e.g., needing to be the sole breadwinner for her family) have resulted from her husband’s disability.

**Familial health problems.** When queried regarding momentous life experiences, Nancy began by telling the interviewer about her husband’s disability. He was a construction worker who fell off a roof, broke his foot, required the insertion of five pins, and “never went back to normal.” Nancy and her spouse have tried numerous strategies to alleviate his pain, but nothing has been effective:

Well, I’ve seen what he’s had to go through, and what we’ve had to fight, because information’s not easily volunteered to get assistance. And we’ve had to dig and dig and fight through many years and many people, and it’s tough. It puts a huge strain.

Furthermore, as Nancy’s husband’s pain has increased, he has developed depression, which has also been worsening. She disclosed that her oldest daughter has also been diagnosed with depression, and her youngest daughter has been diagnosed with a learning disability and Attention Deficit and Hyperactivity Disorder (ADHD).
Theme 2: Downplaying Experiences

It is apparent that Nancy has contended with many challenges in her life. What is interesting, however, is how she oscillates between describing a sense of being overwhelmed and then downplaying the severity of her struggles:

And I’ve said it sometimes, even dealing with other things – why can’t things just come easier? Why does it always have to be such a struggle? Maybe that’s life, but maybe, just once in awhile, it would be nice if it weren’t so hard... I’m just tired. It’s too much. I know it’s too much for me. It’s gotten to the point where it’s just too much.

However, upon catching herself in this moment of weakness, Nancy regained her composure, firmly stating, “I’ve dealt with it. It’s all something you just have to deal with. No one’s life is perfect.” Similarly, Nancy makes a point of stating that perhaps she is overreacting and her problems are no worse than anyone else’s: “And I know other people, you think they have it easy, but until you’re in their shoes you don’t really understand what they’re dealing with.”

Theme 3: Acting as a Caregiver

Another important feature of Nancy’s interview was her sense of selflessness. She described how, after her first accident, her pain was immense. Since she had cared for her ill husband for several years, she expected he would care for her while she recovered. Nancy was soon disappointed. She described the following:

I was the support in the family, so for the first few weeks [after my accident] it was okay. My husband tried to help me as much as he could for the first few weeks, but
then he was like, “now what?” So it’s been tough. And the kids always depended on me, so that’s hard.

As mentioned, her spouse stopped working after he developed chronic pain in his foot. However, Nancy did not feel she was afforded the same consideration after the onset of her pain:

And because I’m the sole breadwinner, I forced myself to go back to work. It’s been tough... I gotta keep working. I want to take the easy way out and go on disability, but I can’t do it.

At one point, the interviewer asked Nancy why she does not allow herself some periods of rest, and does not assign more responsibilities to others to lighten her load. She explained that, for reasons unbeknownst to her, she has substantial resistance around the idea of depending on others. Nancy also described how she longs to be taken care of, but her guilt interferes with her ability to realize that wish:

But sometimes I wish I wasn’t [so independent.] you know? Sometimes I wish someone would just take care of me. But then it’s a huge burden... That’s where I had to deal with a lot of guilt issues.

**Relationship Between Mind and Body**

Nancy believes that an intimate relationship exists between her emotional state and the intensity of her pain. She stated: “Your body is not just physical, it’s a bit of everything, and it gets out of balance.” More specifically, Nancy finds that when she is anxious, her pain flares up: “[There is] constant worry, worry, worry, worry. And as I’m getting older, it’s getting worse. I’d like to turn it off. And the worry and the pain is intertwined.”
Nancy also described a “wave of overwhelmingness,” which worsens her somatic symptoms by causing her muscles to tighten. Similarly, Nancy described a connection between her tendency to keep her pain “bottled up” and its chronicity:

There’s some pain, and I know it’s more physical, and others are more from keeping this all bottled up. The tension, the shoulder rolling, the jaw clenching.

As explained above, her emotional pain is matched by corresponding physical pain.

**Paula**

**Summary Chart**

<table>
<thead>
<tr>
<th>Age</th>
<th>57</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>Birthplace</td>
<td>Jamaica; immigrated to Canada in 1977</td>
</tr>
<tr>
<td>Description of pain</td>
<td>Paula has been involved in three motor vehicle accidents, in 2002, 2011, and 2013. She experiences pain throughout her body, including chronic headaches.</td>
</tr>
<tr>
<td>Length of interview</td>
<td>1 hour</td>
</tr>
<tr>
<td>Applicable metathemes</td>
<td>Recounting Traumatic Events; Acting as a Caregiver</td>
</tr>
</tbody>
</table>

**Theme 1: Recounting Traumatic Events**

Paula recounted her involvement in the following distressing events: being a single mother; problems with the police; and racism.

**Being a single mother.** As with all participants, this interview began with an invitation for Paula to recall particularly momentous life experiences. She immediately identified her separation from her husband 20 years ago as the most momentous event.
She confided that she has not been romantically involved with anyone since her husband, but if she had “settled down with someone,” then her “life would be better.” In particular, Paula emphasized that her children would have had a positive male role model in their lives. She went on to describe the many challenges she faced as the single mother of two sons:

It was hard though. I didn’t have money to do certain stuff, like take vacations, or giving them stuff that they needed at that time. We just barely managed to have a roof over our head, and food on the table...

**Problems with the police.** Paula also relayed her problems related to residing in co-operative housing. More specifically, she described how the police targeted her sons: “The police thought that, since we were in a low-income area, we must have been doing something bad.” She explained how police officers would “drive in, and question people. They would park outside our house to see.” Their situation with the police then escalated. Paula’s son lost his license plate, so he went to the police station to report it as “missing.” When he went to the station, the police “just assumed that he was on some kind of warrant, or some kind of order where he has to come sign in.” As such, when one police officer saw him, a few days later, he believed Paula’s son was outside illegally: “I think they thought he was on house arrest, and so they stopped him, and an altercation occurred, and they beat him up,” she stated. With Paula’s urging, her son filed a complaint with the human rights tribunal, and “everything worked out in his favour.” However, this was understandably a traumatic experience for Paula.

**Wrestling with racism.** Paula went on to describe another struggle she faced while working at a local hospital. She began having a difficult time with a manager who was
“really hard” on her. Paula had just returned to the hospital after taking a “stress leave,” and felt as though she was “getting [her] life back in order.” However, the manager’s poor attitude left her feeling overwhelmed and as though she was unable to please him.

Soon after, Paula was fired. “I don’t want to say it’s racism, but I think it is. I was the only black person there. Most of the time I felt alone,” she confided. When the interviewer asked Paula to describe the impact of these events, she responded thusly:

It does something to you. Sometimes you wonder, especially at the hospital, did I do something wrong? What could I have done to make the outcome different? So, some days, you feel your self-esteem is kind of low because you have so many battles to be fighting. But at the end of the day, you look back and you say, ‘but I know I didn’t do anything wrong,’ so you try not to let it impact your life too negatively.

Paula provided a metaphor she believes is reflective of her life experiences: “I know about the fight or flight situation, and I think that, before, I was willing to fight. Now, I just want to fly. I can’t be bothered to fight – it’s too much.”

**Theme 3: Acting as a Caregiver**

As a single woman, Paula made significant sacrifices to raise her children properly. She lacked the resources to provide various conveniences to them and certainly could not take holidays or nurture herself. She explained how much pressure she was under as a single mother to give up “a lot of [her] life” so that she could meet her children’s needs. She noted that, for her, the impact of being a single mother with little support was “devastation and hardship.”
Relationship Between Mind and Body

When asked if she perceived a relationship between the experiences in her life and her persistent pain, she reported that she had never given much thought to such a connection. Nevertheless, it made intuitive sense to her: “That makes sense, ‘cause if you clear your mind, you feel better mentally, and that lessens your pain.” Similarly, she noted that when she is not dwelling on the past, her pain lessens.

Anthony

Summary Chart

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<table>
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<th></th>
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<tbody>
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<td>Age</td>
<td>71</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Birthplace</td>
<td>Jamaica; immigrated to Canada in 1977</td>
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<tr>
<td>Description of pain</td>
<td>Following a minor motor vehicle accident in 2013, Anthony developed persistent pain in the entire left side of his body.</td>
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<tr>
<td>Length of interview</td>
<td>1 hour and 50 minutes</td>
</tr>
<tr>
<td>Applicable metathemes</td>
<td>Recounting Traumatic Events; Downplaying Experiences; Acting as a Caregiver</td>
</tr>
</tbody>
</table>

Theme 1: Recounting Traumatic Events

Anthony described numerous key events in his life, including the death of his mother; his imprisonment while he was in the army; his escape to Austria; and his immigration to Canada.

Death of his mother. When Anthony was eight years old, his mother died of kidney poisoning. However, as per his account, her passing did not particularly trouble
him, since he believed she would go to heaven. “I took it like an adult. Because of kidney poisoning, my mother’s illness had lasted for awhile, so it wasn’t all at once that I lost my mother. It was little bit, by little bit, so it wasn’t much of a shock for me. It’s the life, and so I take it.” Anthony explained that after his mother’s death, he became very independent: “I was very responsible for myself, rather than waiting for someone to help me. I was a fighter... not like a kid.”

**Military service.** Anthony also described his involvement in the army in Bulgaria, noting that he was a “very good soldier.” Anthony disclosed that he was imprisoned while in the army for refusing to work on the Sabbath. He indicated that working on the Sabbath is against his religion. However, although many people were forced to remain in jail for many years for disobeying military orders, Anthony’s positive relationships with his superiors allowed him to be released after just 15 days.

**Escaping from Bulgaria.** Seeking improved living conditions, Anthony organized an escape mission from Bulgaria. He travelled to Serbia by car through the Austrian border:

This was a very risky job. My wife was pregnant six months, and there was a little bit of stress, but mostly I believe that my religion and my belief in God took away the pressure. Some people don’t have any hope, you know. They try to kill themselves, or suicide, but for me, I don’t have those problems.

Anthony also organized the escape of four other people from Bulgaria.

**A new life in Canada.** Immigrating to Canada was another challenge for Anthony, but he denied that it was a stressful experience. Anthony surmised that the way people respond in challenging situations is a reflection of their upbringing: “I think it depends on
your childhood. If all the time you’re with your mommy, or the nanny, and they say, ‘don’t worry,’ and they make you a sandwich, it’s different. I made my own sandwiches. I took on a lot of responsibility.”

**Theme 2: Downplaying Experiences**

Anthony denied having encountered any difficult circumstances in his life. “I’ve always had a good life. I’ve never complained about my life... It’s a very quiet life.” However, he proceeded to disclose events that would test the resolve of the most resilient person. For example, he insisted that he “never felt any big stress” after the death of his mother, and experienced “no big stress” while he was involved in the Bulgarian military. Reportedly, immigrating to Canada and adjusting to a new culture was also an easy process for him. “I wasn’t even stressed about being in a new world in Canada, and Toronto was a big city. I didn’t have any stress.”

Certainly, at least to an outsider, these occurrences seem at least marginally upsetting, but Anthony continuously downplayed them. For example, he stated, “I’m in my 70s now, and I’ve never had a tough time.”

**Theme 3: Acting as a Caregiver**

It is evident that Anthony views himself as a person upon whom others depend for assistance. For example, Anthony helped four friends to escape from Bulgaria, although to do so placed his own life at risk. He also described how his friend, Daniel, who came to Canada before him, was dismayed by the immigration process. As such, Daniel sought Anthony’s help. Anthony recalls that his response to his friend was as follows: “Don’t worry, I’m coming.” Anthony seems to feel responsible for helping others when they are in difficult situations.
Relationship Between Mind and Body

Unlike other participants, Anthony does not see a connection between the momentous events in his life and the perpetuation of his somatic pain. He believes that all illness has a biological cause that simply needs to be identified by a properly trained specialist in order to be addressed. That being stated, he is uncertain why diagnostic testing has been unable to identify any “abnormalities” within his body.

Carla

Summary Chart

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<tr>
<td>Gender</td>
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<tr>
<td>Birthplace</td>
<td>Jamaica; immigrated to Canada 27 years ago</td>
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<tr>
<td>Description of pain</td>
<td>Her pain is concentrated in her arms and shoulders. It developed in 2008, following a motor vehicle accident.</td>
</tr>
<tr>
<td>Length of interview</td>
<td>1 hour and 15 minutes</td>
</tr>
<tr>
<td>Applicable metathemes</td>
<td>Recounting Traumatic Events; Downplaying Experiences; Acting as a Caregiver</td>
</tr>
</tbody>
</table>

Theme 1: Recounting Traumatic Events

Carla described many central events in her life. However, she noted that the most momentous were poverty during her childhood, her immigration to Canada from Jamaica, her academic studies, and her motor vehicle accident.

Childhood poverty. Carla described financial strain during her childhood, noting that her family “didn’t really have any money.” On a more positive note, Carla recalled
receiving her first pay cheque at the age of 16 after taking a job as a factory worker. She was elated to be able to buy things for her mother and for herself. “We could finally buy stuff,” she recalled. After dealing with so many years of “lack,” she felt abundant for perhaps the first time.

**Immigration to Canada.** Immigrating to Canada was another momentous event for Carla. After growing up in poverty, she came to Canada in search of new opportunities. In doing so, she left behind her siblings and parents and needed to start over. Carla described her immigration as “a culture shock... it was totally different [here].” She arrived in February, and was not expecting the cold and ice. She wore “fancy slippers,” instead of boots, and she fell “right in the snow” when exiting the airport. Carla noted that the adjustment was very difficult, and she was “locked up in the house” since she was afraid to contend with the frigid temperatures. She added, however, that since she was with her husband and children, things were manageable: “It was OK. It wasn’t what I expected, but it was OK.”

Carla also described a positive memory related to her immigration:

> When I came to Canada, it was a culture shock. I was coming from a place you couldn’t go to the supermarket, but then I came to the supermarket here, and there was all this stuff, so that was good. I wasn’t even thinking about that. I remember the first time I went to Knob Hill Farm. This was like the supermarket of supermarkets. I forgot about that. That was significant and life changing for me.

Carla and her husband had six children together, but their marriage ended in 1995, leaving her a single mother. While working as a personal support worker and a
“Tupperware salesperson,” she returned to a local college to study nursing. Carla worked long hours and was generally overwhelmed and overworked.

Nursing studies. Carla’s return to school was also momentous. Before the onset of her pain, she was in the last semester of studying nursing. She had plans to work in Jamaica during the winter, and then work in Canada during the summer so she could enjoy the “best of both worlds.” She wonders if God stopped her because she was going to make a fatal error as a nurse: “Sometimes I look back and I ask God, you know, was my plan too much? Was I planning too much? Why did you stop me? Or was I going to do something extremely outrageous, and you stopped me? You know?” She also wonders if the pain developed to prevent her from giving someone the “wrong medication” or the “wrong injection.”

Carla noted that since arriving in Canada she feels that she has failed her family. She had desperately longed to make her parents proud, but she has lost hope that will happen:

I was a star. I used to be a star. I was the bright star in my family that was supposed to make everything happen. But my light went out. That’s it. I was talking with my dad, and he said how long I’ve been in Canada, and then I felt guilty. After so many years, I don’t have much to show for it.

The car accident. In 2008, Carla was involved in a motor vehicle accident: “That was a life changer. Everything else I could overcome, but, the accident, I don’t think I’ll ever overcome that.” She described how, on account of its effects, her plans have been sidelined:
[The accident] didn’t just happen and that’s it. It happened, and this is years later, and I’m still in pain from it. I was told, because of your age, don’t expect to be a hundred percent. And because of your age, it will get worse, because as you’re getting older, things are different. I don’t think I’ll ever get over it. There’s not one day I get up in the morning, and I don’t remember that I had an accident.

Carla went into great detail about the physical repercussions of the collision and how it influences almost every action she now takes:

I had so much freedom, so many plans, and now I can’t even get up and jump in the shower. I would like to run out there, but I can’t. I can’t jump too far, I can’t skip too high, I can’t lift too heavy, I can’t grab too quick. Everything I do, pain reminds me to slow down. Don’t hold your hand up too high, don’t grab the steering wheel too tight, don’t lift that bucket, that’s too heavy. It’s always continually there.

Carla also lamented how, despite the high degree of optimism she used to have for the future, she is now “running out of hope.”

**Theme 2: Downplaying Experiences**

Though Carla did not demonstrate as great a tendency to downplay her situation as did other participants, she exhibited a slight propensity to do so. For example, while describing the effects of her accident, she stated, “But I don’t want to get upset. I want to stay strong right now. I want to stay strong right now. I don’t want to get upset. But it’s not good. But that’s OK.” Similarly, after describing how she perceives that she has disappointed her family, she shrugged her shoulders, slowly shook her head, and then stated, “I guess it’s just one of those things.”
Theme 3: Acting as a Caregiver

Carla did not go into detail about being a caregiver. However, she noted that she chose nursing as a career because she wanted to help others and to make a positive difference.

Relationship Between Mind and Body

Carla does not perceive a connection between her momentous life experiences (other than the accident) and the onset of her pain. She stated:

There’s no connection, unless I’m missing something, but I can’t see any connection. No. Everything changed that night I had the accident. Mentally, physically, financially, psychologically, every kind of thing you could think of changed for me.

Pardis

Summary Chart

<table>
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<th>Age</th>
<th>47</th>
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</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
</tr>
<tr>
<td>Birthplace</td>
<td>Iran; escaped to Turkey 28 years ago, and then fled to Canada 25 years ago.</td>
</tr>
<tr>
<td>Description of pain</td>
<td>He developed chronic pain in his neck and back following a 2013 motor vehicle accident.</td>
</tr>
<tr>
<td>Length of interview</td>
<td>1 hour and 15 minutes</td>
</tr>
<tr>
<td>Applicable metathemes</td>
<td>Recounting Traumatic Events; Acting as a Caregiver</td>
</tr>
</tbody>
</table>
Theme 1: Recounting Traumatic Events

Pardis recounted his experience of the following stressful events: his escapes from Iran and Turkey; his immigration to Canada; and coping with his wife’s depression.

Fleeing from Iran. Pardis described how he and his wife were forced to leave Iran, their country of origin, and build a new life in Turkey. They were Muslim and wanted to convert to Christianity; however, it was dangerous to do so in Iran, since they were “killing Christians” there. Pardis and his spouse went to Turkey with just $500 and converted. They left their family, friends, and house behind.

Life in Turkey. Pardis proceeded to describe what was initially a peaceful life in Turkey. He found a job sewing suit pants while his wife was working as a clerk for the Catholic Church in Istanbul. After she had cooked dinner for the priests, Pardis would help her wash the dishes, and then they would walk home together. However, after about five years, terrorists affiliated with the Iranian government learned of their whereabouts. Faced with the threat of death, Pardis and his wife contacted the United Nations. Soon after, the Canadian Embassy learned of Pardis’s plight and offered to assist them. Pardis and his spouse then fled to Canada.

Adjustment in Canada. Pardis described various challenges associated with coming to Canada. He noted that “it’s so cold and not very beautiful” in this country, so it was difficult for him and his family to adjust. Furthermore, he was forced to become a pizza delivery person in order to financially support his family and pay for his wife’s university tuition. Pardis also described how “there’s no support here” for him and his wife. Though his brother has also immigrated to Canada, his sibling has done little to help him with the adjustment process.
**His wife’s depression.** Several years after immigrating to Canada, Pardis’s wife developed severe depression, which impaired her ability to continue her normal tasks of daily living. This change has been devastating for Pardis; the life he had envisioned for them in Canada has yet to materialize. Instead, they have faced great hardship and their lives have been marked by struggle and insecurity. Pardis also confided that since his spouse developed depression, their relationship has deteriorated and she has little inclination to spend time with him. It appears that perhaps the greatest loss in Pardis’s life has been his wife’s affection; although they were “childhood sweethearts,” he has become little more than her caregiver.

**Theme 3: Acting as a Caregiver**

Pardis’s marriage has been particularly strained since he developed chronic pain, since he is unable to be the caregiver to his wife that he used to be:

It’s hard for my wife because she was always in a lot of pain, and now I have it too. She’s not expecting me to be sick. So that makes things more difficult. We’ve been married just because she has a disability, and if she could afford someone else to care for her, maybe she would have already divorced me right now.

This comment seems to underline Pardis’s belief that he is not lovable of his own accord, but that his wife only stays with him because of what he can offer her – in this case, his caregiving services.

Pardis also disclosed that, due to the severity of his pain, he is no longer able to “perform” sexually. This change has been an added strain to his marriage and has left him feeling emasculated and inadequate.
Pardis described that, on account of the various challenges he has faced, he is losing his faith in God. “Now, I don’t see God at work,” he stated.

**Relationship Between Mind and Body**

When asked whether he sees a connection between the “momentous” events in his life, and his chronic pain, he expressed uncertainty:

The only way I can connect it is by saying it’s not fair. Why should I be able to overcome so many obstacles before the pain, only to have a small accident set me back so much? It’s just unfair.

He believes that the cause of his suffering is likely wholly disconnected from his experiences.

**Summary of Chapter Four**

In Chapter Four, individual participant results and within-participant analysis for the study’s participants were provided. Three key patterns were applied to the participants: A tendency to recount overwhelming, often traumatic, life events; a propensity to downplay the severity of their experiences and to avoid complaining; and an inclination to assume the role of caregiver, even though to do so might lead to self-neglect. Participants’ reflections on the relationship between mind and body were also provided. Chapter Five includes this study’s Across-Participant analysis.
Chapter Five

Across-Participant Results

This chapter contains the researcher’s understanding, as a whole, of participants’ narratives. In an effort to learn more about the subjective experiences of chronic pain sufferers, particularly in response to their momentous life events, the researcher asked them six key questions: (1) What are events in your life that you deem to have been particularly momentous prior to the onset of your chronic pain? (2) How did these experiences affect you? (3) If you were to try to help someone understand the impact these events had on you, what would you tell them; what images or metaphors or phrases could you use to help them understand? (4) How were you coping with these events around the time of the onset of your chronic pain? (5) If you had to provide reasons for these events, what explanations would you offer? (6) Do you see any connection between your pre-pain experiences and the subsequent onset of your pain?

The results and themes identified by participants in response to these questions are presented in Table 1 (below) and then discussed in detail.

Figure 1: Metathemes identified in the narratives of chronic pain sufferers

| A tendency to recall and recount stressful, often traumatic, events (“Recounting Traumatic Events”) | A propensity to downplay stressful and/or traumatic life experiences (“Downplaying Experiences”) | A pattern of acting as a caregiver (“Acting as a Caregiver”) |
The metathemes outlined in Figure 1 were identified through reading and re-reading both the transcripts and the researcher’s field notes, and through listening to the participants’ interviews again. The first metatheme applies to all 12 of the participants; the second metatheme applies to 10 of the 12 participants; and the third metatheme applies to 11 of the 12 participants.

**Metatheme 1: Recounting Traumatic Events**

After analyzing the narratives, the strongest metatheme that emerged was “Recounting Traumatic Events.” This metatheme can be defined as a tendency to spontaneously speak about overwhelming and traumatic life events, many of which occurred in the distant past. It is worth underscoring that at no point did the interviewer specify to respondents that they were to recount negative life experiences. As stated in previous chapters, each narrative was guided by the inquiry, “Tell me about events in your life that you deem to have been particularly momentous, prior to the onset of your chronic pain.” It appears that negative occurrences were at the top of these individuals’ minds, which is why memories of adverse incidents were so readily accessible to them.

Among the participants these traumatic events were varied, but included such occurrences as corporal punishment; disturbing interactions with the police; employment-related issues; immigration; death of a parent; abandonment; divorce; marital strife; and infertility.

In the case of Costa, he disclosed that the most momentous event he has experienced was the physical abuse that was inflicted by his mother when he was a child. Additionally, Costa disclosed that when he was in his early teens he became involved in a
gang. He was only granted membership to the group after enduring a violent initiation, which was used to test his toughness. Costa went on to participate in the brutal initiation of another member, after which he was arrested, and treated in a very threatening manner by the police officers. Costa was only “13 or 14” at the time of his arrest, and was placed in juvenile detention.

Like Costa, Paula’s story contained a disturbing interaction with the police. More specifically, she described her son being beaten by the police, although he had done no wrong. She believes that he was “targeted” by the officers because he was living in a housing co-operative. Though her son eventually appeared before a Human Rights Tribunal and won his case, the event has understandably left a mark on Paula: “It does something to you. Sometimes you wonder, did I do something wrong?”

Both Cynthia and Paula disclosed troubling experiences related to employment. Cynthia spoke at length about how, when she was in her fifties, she was forced to find a new job. She had worked for the same legal firm for much of her career, but the company closed down. Although Cynthia eventually found a new employment position, it has presented an enormous learning curve, and she is being asked to complete tasks for which she does not have the requisite training:

It’s been stressful. I had to learn a lot of stuff. My fear is that, because it’s law, I don’t have the credentials to do what I’m doing, and I’m worried. I don’t want it to fall back on me or the company, or shareholders, I don’t want to make errors, and there have been a couple of errors – nothing major, major – but, there’s a huge learning curve. So anyway, that’s my stress at work, and I haven’t enjoyed it, though I had always enjoyed my work, so it’s difficult.
Cynthia also noted that she has a grueling schedule at her new job: “I work 10 to 12 hour days, Monday to Friday, and [my manager] wants me to start working weekends, too...” Though Cynthia used to run errands after work, such as doing her grocery shopping, and would then have her weekends free, this arrangement is no longer feasible since she gets home so late each night. Furthermore, Cynthia does not get along well with her manager and feels uncomfortable about the highly driven climate of her workplace.

On the subject of employment, Paula spoke about being terminated from her job at a hospital. She believes the decision was motivated by race. This termination was understandably devastating for her and took a toll on her self-esteem. Paula disclosed to the interviewer that she became tired of fighting after this incident and has sought to withdraw her energy from the battles she has been facing.

Immigration was another common struggle that was discussed during the interviews. Flora, who came to Canada from the Philippines, described a difficult immigration process. Flora recalled that, before coming to Canada, she had hopes of achieving great things. More specifically, she had planned to attend college in Canada and eventually secure satisfying employment. Instead, she toiled long hours as a nanny, cashier, sales associate, and tutor, while awaiting Canadian citizenship. Although she is now 49, she has yet to accomplish anything she deems to be significant. Most of her energy has been spent on working to merely survive in Canada’s fast-paced and expensive society.

Anthony also narrated the story of his immigration. This participant fled across the border from Bulgaria to Serbia before coming to Canada. Similarly, Pardis spoke about how he was forced to flee Iran because of his desire to convert to Christianity. After
seeking refuge in Turkey, Pardis was once again uprooted when terrorists threatened his life and the lives of his wife and daughter. Canada is the country in which Pardis eventually settled.

Tatiana described how, although she moved to Canada more than 20 years ago, she has yet to adjust to this country’s weather. She used to live in a “beach town” in Ukraine, and she finds that Canada’s harsh climate “doesn’t connect with [her] nature.” Similarly, Paula spoke about her immigration from Jamaica to Canada. Not only was there a “culture shock,” but she was “locked up in the house” for many months in Canada when she first arrived, since she loathed the cold and snow.

**Experiences of loss.** As previously noted, the participants also outlined momentous events that were related to loss. It is worth reiterating that they narrated their stories of death, grief, and abandonment without any prompting by the interviewer to do so. (They were merely asked to recall “momentous” events.)

In the case of Tatiana, her mother and grandmother died when she was very young; her father abandoned her family; and her first husband died in a car accident. Tatiana also described a deep sense of grief related to her children moving away to attend university. “This is a significant thing for me. I’m grieving. I feel like somebody died. It’s grief. It’s a huge loss.”

Renata’s narrative is similar to Tatiana’s. Her mother died when she was just nine months old. Furthermore, Renata’s father abandoned her family, and she does not know if he is alive or dead, or where he lives. Renata also recounted the passing of her husband, which she called the most “traumatic” event of her life. Her husband almost froze to death when his truck broke down during a snowstorm. Although he managed to return
home, he developed a lung infection. According to Renata’s account, she came home from work one day and found her son squeezing her spouse’s chest. Her husband was saying, ‘Oh my God, I’m going to die.’ He was rushed to the hospital, but passed away two days later.

James also spoke about loss in the context of his father’s death. James’s story is particularly painful because, after many years of delaying a trip to England to visit his father, he finally purchased an airplane ticket. Lamentably, his father died a few short days before James’s scheduled departure.

In keeping with the theme of loss, Anthony spoke about how his mother died when he was just eight years of age. He was consequently forced to take on many responsibilities often reserved for children much older than eight. However, unlike the other participants, he did not describe any grief. Anthony indicated that his mother’s death helped to make him an independent person able to unflinchingly face challenges on his own:

My other friend, Daniel, came [to Toronto] before me, and he wrote me before I came to say, ‘This city is so big, it’s hard here.’ And I said, ‘don’t worry, I’m coming.’ He was stressed about the big city, but I said, ‘no.’

Anthony believes that because of the type of childhood he had, he was unaffected by the adjustment of immigrating to Canada.

Costa’s narrative was also characterized by a sense of loss, more specifically, his father abandoning him. In fact, Costa credited his gang involvement with his father’s desertion. “I wanted to feel like I belonged, and so I started hanging around a gang,” he stated. Costa noted that on various occasions he felt his father’s absence particularly
acutely. For example, when he was learning how to drive he longed for paternal guidance. Costa also contended with the loss of his mother. Although he had not literally “lost” her, in that she did not die, one could make a case that she did not embody the typical maternal role. His mother physically abused him, and Costa did not enjoy the love, safety, nurturance, and acceptance that one generally hopes to receive from a mother; this was clearly a great loss for Costa.

Divorce was another type of loss recounted by various participants. For instance, Cynthia had married a man with the expectation that they both wanted children. To her horror, after bearing two of his children, Cynthia discovered that he never wanted to be a father, and he left them. Cynthia now questions her judgment. Furthermore, she is devastated that, on account of her decisions, her children have been left fatherless.

Paula also spoke about divorce. She continues to experience a sense of emptiness in her life and has been unable to “settle down” with someone else. The end of her marital relationship was particularly momentous since it left her a single mother. As such, Paula was the sole income-earner in her family: “We just barely managed to have a roof over our head, and food on the table.” Similarly, Carla contended with the loss of her marriage. She and her spouse separated within a few years of moving to Canada, and she was left to raise her children on her own.

Pardis’s story was also stained by grief. His sense of loss was most apparent when he was discussing his wife’s depression. They were “childhood sweethearts,” but their relationship deteriorated upon coming to Canada. They became distant and often resembled strangers who lived in the same house. Pardis cried bitterly when he stated, “If she could afford someone else to care for her, maybe she would have already divorced
me right now.” It seems that depression had changed Pardis’s wife in a very real way, effectively stealing away the woman who had nurtured and loved him for so many years.

Mary also described the loss of her fulfilling marriage. Mary told the interviewer that she and her husband used to be close, but problems emerged after she was arrested for drinking and driving. Her spouse now refuses to forgive her, despite her remorse and heartfelt apologies. Mary noted that her marital issues have engendered various complex emotions, including confusion and shame.

Another momentous experience in Mary’s life coincided with her parents’ divorce: “I was left with an aunt and uncle for a year, without even knowing where my Mum was...” she stated. This event left her feeling abandoned and utterly alone. Additionally, Mary reported that her brother had recently died of a drug overdose and she was consequently wracked by grief on account of this loss.

Flora spoke candidly about a different type of loss – her inability to bear children. She had had a vision of what her life would look like once she immigrated to Canada, and that picture involved being a mother. Flora’s dream has died, and she is trying to come to terms with the fact that, at the age of 49, she has lost the chance of conceiving a child. She alluded that her inability to be a mother is synonymous with an inability to participate fully in womanhood.

**Metatheme 2: Downplaying Experiences**

Another metatheme identified in the narratives was “Downplaying Experiences.” This metatheme can be defined as a tendency to downplay, or even deny, the harshness of experiences. This propensity played out in various ways in participants’ narratives. For example, some participants explicitly stated that they avoided complaining and being
“negative.” Other participants would begin conveying their distress, but would then withdraw their comments and provide a more positive interpretation of their circumstances. Further still, certain participants wholly denied the painful nature of their experiences.

In the case of Cynthia, she reported that she exerts a strong effort not to complain. Notably, after describing her frustration related to caring for her daughter’s godson, she softened her words by saying, “This is my life, but it’s all good. We’re happy to help…” This statement is interesting because Cynthia had already explicitly stated that she was decidedly not happy about helping, since the task was exhausting her. Clearly, a disconnect exists between her words and her emotions. Cynthia seems to believe that it is not acceptable to state how she truly feels, and that she needs to continually exhibit a positive and accepting attitude. This theme was continued in the following exchange between Cynthia and the interviewer. Please note this exchange is quoted at length in order to capture important nuances:

_Cynthia_: I don’t have a choice, but hey, I’m not complaining. I’m not complaining, am I?

_Interviewer_: Even if you were [complaining], that would be okay.

_Cynthia_: I’m sorry – am I answering your question?

_Interviewer_: Yes, and anything you say is welcome.

_Cynthia_: I don’t really think about myself that much, but, uh, I don’t know, I just, I don’t know how else to tie it in. (Short pause). I’m sorry.

_Interviewer_: Sorry about what?

_Cynthia_: I feel like I’m not getting to the meat of it.
Interviewer: No, no, you’ve encapsulated it eloquently and articulately, so there’s no need to apologize at all.

Cynthia: I just don’t like talking about myself much. I don’t like to complain.

The above exchange illustrates how apologetic Cynthia is when she believes she is complaining, or when she fears that she is disappointing someone.

Similarly, Nancy seems to feel guilty about “complaining” during the interview – even though the very purpose of the interview was for her to examine her experiences. At various points during the dialogue, she contemplates that perhaps she is “overreacting,” and that her problems are no worse than other people’s issues. However, her comments are not particularly credible, since they are stated after she makes it very clear to the interviewer that she is exhausted and overwhelmed by her circumstances.

Costa also has a strong tendency to downplay the painful nature of his narrated experiences. Despite the cruelty exhibited by his mother, who used to regularly abuse him, he insisted that he has forgiven her. Costa also reported that his mother has “changed,” and so he has wiped the slate clean, pardoning her for her violent acts. Similarly, after recounting how he encountered his father in Brazil and viewed him as a stranger, Costa stated, “But it’s okay. That’s a long time ago.” Furthermore, after describing the manner in which various police officers had threatened to beat him, Costa insisted that he does not hold any ill will toward the police: “[T]here’s a lot of good cops.” It is almost as though Costa wants to deny any vestiges of anger he might hold toward the various individuals in his life who abused their power and violated his trust.
In a very overt way, Tatiana attempted to block the distressing nature of her experiences. She explained that she simply tries to deny the deaths of her mother and grandmother, since it is too difficult to address these immense losses.

Anthony also downplayed the distressing nature of his experiences. Perhaps most notably, after recounting the death of his mother, he declared, “It’s the life, and so I take it.” Although many would argue that Anthony has had a very eventful life, which included the death of his mother, being imprisoned in the army, being forced to escape his country of origin, and then rebuilding his life on a different continent, he does not recall things that way: “I’ve always had a good life,” he stated. It is unclear if Anthony genuinely sees himself as having had a peaceful existence, or if there is an element of denial in his words. It is interesting to reflect on Tatiana’s words: “Some things happen to you, and you deny them your whole life, you don’t want to remember. And then when you realize it happened, you still deny it.” Perhaps, to some extent, this is what Anthony is doing.

Similarly, although Pardis described numerous momentous events – perhaps most notably that he fled Iran and Turkey under the fear of being murdered for being a Christian – he denied that this experience was particularly distressing. “The men who wanted to kill me were acting from ignorance. It wasn’t their fault,” he noted, in an even tone.

It is also interesting to observe that James’s very refusal to expand upon significant events in his life – notably fleeing Somalia due to political unrest – could be evidence of his inability to confront his troubling emotions related to these events.
Metatheme 3: Acting as a Caregiver

Another metatheme identified in the narratives was “Acting as a Caregiver,” which can be defined as a strong desire and/or perceived obligation to act as a caregiver. This metatheme is also characterized by giving scarce heed to one’s own needs while elevating the desires of others.

Numerous instances of acting as a caregiver are found within the narratives. As will be described, these examples are as varied as caring for others’ children in spite of one’s own pain and fatigue; financially supporting one’s parents at the expense of one’s own needs; managing one’s household while asking for little assistance from family members; sacrificing for a sick spouse despite one’s own chronic pain; and continually caring for a mentally ill spouse despite that person’s verbal abuse.

To elaborate: In the case of Cynthia, she agreed to care for her daughter’s five-year-old godson for the next year while the child’s mother is attending school overseas. Cynthia consented to this undertaking, despite the fact that she is dealing with various taxing situations in her life and generally feels exhausted and overwhelmed. Cynthia described a recent situation when she arrived home at 7:30 p.m., and then realized the boy had urinated in his bed. Although worn out after a long day at the office, she needed to strip the bed, wash the sheets, and tend to the child. She stated, “It’s something I didn’t need to go back to at this point in my life... That’s a stress for me.”

In Flora’s case, she had immigrated to Canada with hopes of attending college and securing fulfilling employment. However, her plans never materialized, partly because she placed so much emphasis on aiding her family in the Philippines. She stated, “I wanted to do something different but, unfortunately, I wasn’t able to do that because I
was helping my family back home [financially].” Essentially, she put her own dreams on
hold in order to help her parents have an improved quality of life. Flora worked in jobs
that brought her little satisfaction so she could continue sending payments to them.

In a slightly different vein, Mary noted that her role as a caregiver to two young
autistic sons has been very challenging for her, due to their unique needs. She tries her
best to be a “good mum,” but she generally feels that she is failing. It is clear that her
sense of responsibility to be a good caregiver is exacerbating her sense of being
overwhelmed. Similarly, Paula was often unable to address her own needs, since she was
a single mother caring for two boys: “[I]t was so hard, a lot of pressure. You had to give
up a lot of your life and the stuff you could have had, to give things to them, especially
when they’re in school.”

With respect to Nancy, the most “momentous” event in her life was when her
husband became injured in a workplace accident. Since that time he has been suffering
from chronic pain, fibromyalgia, and depression. This has meant that Nancy has needed
to care for him. As part of her caregiving role, she has been ferrying him to appointments
and searching endlessly for treatments that might alleviate his discomfort, and has largely
been neglecting her own needs.

Since her spouse is ill, Nancy has also been the primary caregiver for their
daughters, one of whom has suffered from depression, and another who has a learning
disability. However, perhaps even more challenging is that Nancy has become the sole
breadwinner for her family – despite the fact that she also suffers from chronic pain.
Although Nancy has contemplated going on disability, she has the sense it would be
“tak[ing] the easy way out,” and she would not be comfortable with such an arrangement. When asked why she does not have family members help out more, she replied:

I don’t know. It’s making me well up. (Begins crying). I don’t know why I don’t want to depend on anybody. Maybe it’s because I’ve done it for so long on my own? ‘Cause I guess, really, I’ve been on my own.

Nancy is so accustomed to bearing her family’s burdens and not having others help her, it has come to feel natural. It is worth noting that Pardis’s situation is similar to Nancy’s. Even though he also struggles with chronic pain, he is left to care for his spouse, receiving scarce assistance and appreciation from others.

**Summary of Chapter Five**

The three metathemes (Recounting Traumatic Events; Downplaying Experiences; and Acting as a Caregiver) were expanded upon in this section. Furthermore, this section demonstrated how these themes overlap among the participants.

In the following section, these themes will be explored in greater detail. Implications for practice will also be provided, followed by the strengths and limitations of this study, directions for future research, and concluding remarks.
Chapter Six
Discussion

This study was an effort to strengthen understanding of the relationship between chronic pain sufferers’ subjective experiences and the onset and/or perpetuation of their pain. Results of this research were intended to equip psychotherapists and other mental health professionals with increased understanding of the chronic pain population so they can better serve clients who present with this debilitating condition.

This undertaking was guided by the general principles of phenomenology, specifically those related to embodiment. According to Merleau-Ponty (1989) and other theorists, the body is one’s center and carrier of experiences. As such, chronic pain may be a representation of one’s hardships.

To this end, the narratives of 12 participants (eight women and four men) who had been contending with chronic pain for at least one year were elicited. Interview questions focused upon momentous events that had occurred in these individuals’ lives, as well as their subjective experiences of these events. Participants’ narratives were mined for both content and meaning.

Analysis of the data resulted in three emergent core categories: a history of trauma in chronic pain sufferers’ lives; a tendency for pain sufferers to downplay their traumatic experiences; and a propensity for these individuals to elevate the desires of others at the expense of their own needs. These patterns are not currently addressed within dominant treatment protocols for chronic pain sufferers, despite the fact that they appear to play important roles in the development and evolution of pain sufferers’ somatic distress.

This chapter includes a discussion of each of the three themes, along with their
importance to the realm of counselling psychology. The clinical implications of these findings are outlined, along with the strengths and limitations of this study, directions for future research, and concluding comments.

**Recounting Traumatic Events**

A widely held belief is that chronic pain must have objective, measurable causes. This notion, rooted in the biomedical model of illness, has shaped chronic pain treatment, including the practice of psychotherapy. However, a theme identified across all of this study’s participants was a history of trauma. This study seems to affirm an important concept that has been demonstrated elsewhere in the literature, namely that a close relationship exists between a history of trauma and the onset and perpetuation of chronic pain (Rubin, 2005). It is important to note that, to date, this finding has largely been explored through the execution of quantitative studies; however, the present inquiry was able to capture the richness and nuances of pain sufferers’ experiences, since it employed a qualitative approach in the form of a narrative methodology.

The present study also reinforced the concept that, contrary to popular belief, trauma need not take the form of rape, assault, natural disasters, or other major catastrophes for it to have lasting consequences on its victims. Events that may appear less disruptive can be equally seminal. Participants described various key events including, but not limited to, divorce, death of family members, loss of employment, racism, inability to bear children, and separation from parents. In line with common definitions of trauma, these events shattered participants’ sense of security, changed the way they interacted with the world, and resulted in feelings of shock, helplessness, and vulnerability (Epstein, 2013; Herman, 1992).
Participants’ responses corresponded with Herman’s (1992) trauma research, which has found that traumatic reactions occur when action appears futile and when neither resistance nor escape seem possible. Participants generally felt powerless to solve the problems they described.

According to the literature, somatic pain is a natural consequence when individuals endure trauma. Through her writings on the psychophysiology of trauma, Rothschild (2000) appears to support the phenomenological perspective that chronic pain can represent the embodiment of trauma-related subjective experiences. In her aptly titled book, The Body Remembers (2000), Rothschild has stated: “Emotions, though interpreted and named by the mind, are integrally an experience of the body. Each emotion looks different to the observer and has a different bodily expression” (p. 56). For example, individuals might develop chronic headaches, back pain, or other somatic expressions of their trauma (Rothschild, 2000). Frijda (1986) has echoed this concept, remarking that subjective experiences are inseparable from the body: They are “matters of the body: of the heart, the stomach, and intestines, of bodily activity and impulse. They are of the flesh and sear the flesh. Also, they are of the brain and the veins” (p. 5). Frijda seems to be articulating that, though positive subjective experiences can help the body to feel healthy and vital, negative experiences, such as those engendered by trauma, can leave the body aching and depleted. Miller (2006) has also portrayed how the body records all that a person has endured in life and expresses trauma – particularly those traumas that have been suppressed – through somatic symptoms:

Ultimately the body will rebel. Even if it can be temporarily pacified with the help of drugs, cigarettes or medicine, it usually has the last word, because it is quicker
to see through self-deception than the mind. We may ignore or deride the messages of the body, but its rebellion demands to be heeded because its language is the authentic expression of our true selves, and of the strength of our vitality.

(p. 207)

To explicate, individuals will often try to silence their physical pain, using a variety of substances; however, these remedies are ineffective at resolving the pain, since it is not physically present within the body. Rather, it is an emotional ache that these individuals experience; a somatized memory of wrongs committed against them. Miller proceeded to speak about the importance of confronting these traumas in order to heal. An open exploration of one’s feelings, interpretations and perceptions is required, in order to loosen the ties that bind the body to its past experiences.

To reiterate, the present study strengthened existing research, which posits that subjective experiences – especially those shaped by trauma – can be intimately connected to chronic pain. Although quantitative studies have predominantly been executed to make this argument, a paucity of qualitative research on this topic exists. The present study was able to illustrate this finding through rich, detailed, and highly personal accounts, as provided by participants.

Un fortunately, mental health professionals have failed with respect to educating chronic pain sufferers about the relationship between subjective experiences and somatic pain (Piran, 2010). The trauma-chronic pain connection is rarely included in treatment plans for chronic pain sufferers. Instead, these individuals are taught methods to assist them in coping with their physical discomfort. Scarce attention is accorded to examining events in clients’ pasts, which may have contributed to their chronic pain.
As Eriksen, Kirkengen, and Vetlesen (2013) have written, pain sufferers have usually been extensively “scanned, x-rayed, and measured,” (p. 592) and medical efforts have been solely centered on objective evidence. Once chronic pain sufferers reach the psychotherapist’s office, they often lack understanding that their physical problems can be anything other than a biomedical issue. Thus, it is the psychotherapist’s task to teach clients that a trauma history and related subjective factors may play an important role in the onset and prolongation of their somatic distress.

**Downplaying Experiences**

Another theme identified in the participants’ narratives was a tendency to downplay traumatic experiences, as though they were afraid to take full ownership of these events and their troubling effects.

This finding appears to be a new contribution to the chronic pain literature. Though researchers have previously posited that trauma victims have a propensity to minimize their distressing experiences (Herman, 1992), this trend has not previously been attributed to chronic pain sufferers. However, it seems plausible that a connection exists between unprocessed subjective experiences and the onset and prolongation of pain patients’ somatic symptoms.

The study’s participants appeared almost saint-like in the way they spoke about their trials and the manner in which they absolved their persecutors of wrongdoing. That being stated, it is understandable that these individuals tried to minimize the severity of the distressing events they endured. Fully acknowledging losses and mourning these losses can seem like an impossible undertaking. According to Herman (1992), the “descent into mourning is at once the most necessary and the most dreaded task ...
Patients often fear that the task is insurmountable, that once they allow themselves to start grieving, they will never stop” (Herman, 1992, p. 188). Certainly downplaying experiences, sometimes through feigned forgiveness, can serve as a survival tool.

Individuals may attach positive meanings to traumatic situations, since this approach is more manageable to them than actually confronting and addressing the negative events in their lives. Minimization (Guerrero, Andersen, & Afifi, 2014), as it has been labeled in the realm of social psychology, is a form of cognitive distortion; individuals avoid acknowledging and addressing negative emotions by reducing the importance and impact of events that gave rise to those emotions.

It should be noted, however, that participants’ reluctance to fully validate their emotional experiences can also be explained a different way: Their hesitancy seems to be in line with modern society’s conviction that grief, despair, and other “non-productive emotions” are unacceptable. By extension, negative emotional responses should be quieted or ignored.

To illustrate, it was evident that Renata did not allow herself to express her full range of emotions. With respect to not having known her biological parents, she stated, “I would have liked to know who they were, I would have liked to live with them, but if it doesn’t happen, it doesn’t happen.” Regarding her husband’s untimely death, she stated, “I would like to be with him, but things have happened, and I cannot be.” There is flatness to her expression, as if she were carefully weighing each word as she described her emotional state. She seemed reluctant to disclose the level of sorrow that resulted from these momentous events, even though her vocal tone seemed to betray a great deal of sadness.
According to Moncrieff (1997), although variation in mood is a characteristically human way of responding to circumstances, unhappiness has become taboo. Society’s disdain for “negative” emotion diminishes the legitimacy of grief and discontent, therefore reducing the repertoire of acceptable human emotional responses. Rather than being encouraged to explore their internal state and to subsequently understand what is happening to them in more meaningful terms, people frequently feel flawed when their emotions are intense, confusing, or prolonged. A *New York Times* article (2015), which refers to women in particular, states: “We have been taught to apologize for our tears, to suppress our anger, and to fear being called hysterical.” Tellingly, Cynthia stated the following: “I don’t have a choice, but hey, I’m not complaining. I’m not complaining, am I?” Cynthia, among other participants, seemed fearful of being perceived as someone who protested, as though vocalizing distress was a sign of weakness or an indication of being flawed as a person.

It is important for mental health professionals to determine whether the chronic pain sufferers with whom they meet have a propensity to minimize, rather than process, their negative subjective experiences. Certainly, avoiding one’s challenging emotions can prove detrimental for one’s physical health, whether the motivation behind this action is to avoid mourning the effects of trauma or due to a misguided attempt to appear positive, and not to burden others with sadness, grief, or anger. Chronic pain sufferers should be encouraged to articulate their subjective experiences – particularly if these experiences are of a painful nature. According to Miller (1997), “In order to become whole, we must try, in a long process, to discover our own personal truth, a truth that may cause pain before giving us a new sphere of freedom” (p. 1).
It is necessary to clarify that it is far different to simply speak about traumatic experiences while intellectualizing them, than it is to fully experience the entire range of emotions that accompany an event, without censure. Indeed, some of this study’s participants appeared to acknowledge the presence of their negative emotions, but shied away from delving more deeply into them. In fact, research shows that a critical dimension of coping with trauma is the degree to which individuals can psychologically confront emotional upheavals after their occurrence (Herman, 1992; Pennebaker, Colder & Sharpe, 1990).

James Pennebaker has extensively studied the health benefits of disclosing trauma through the process of writing or speaking. His research began in 1986 when he and Sandra Beall demonstrated that writing about a traumatic event could be advantageous to participants’ health. Participants in their study who wrote about how they felt about a traumatic or stressful experience made fewer subsequent visits to the campus infirmary than did students who wrote about a neutral topic.

Pennebaker and Beall’s (1986) work spurred a great deal of interest in emotional disclosure, and today there are more than 200 studies related to its value. Although the majority of outcomes observed are health benefits (both physical and psychological), other benefits such as reduced absenteeism, improved college grades, and faster re-employment, have been noted (Range & Jenkins, 2010). These benefits have been observed in a wide variety of populations, including healthy individuals, those with medical problems, and those with psychiatric or psychological problems (Frattaroli, 2006). Moreover, disclosure has been tested in a variety of settings, including clinical and non-clinical settings and in various countries (Range & Jenkins, 2010).
Numerous researchers have hypothesized what the mechanism might be by which disclosing stressful events results in various benefits. One theory is that writing about one’s trauma may act as a form of exposure therapy. Exposure theory is the theoretical basis of posttraumatic stress disorder and phobia treatments, where the goal is to reduce avoidance of the feared stimulus, enable people to repeatedly confront and describe the trauma and, in essence, re-experience and learn to process thoughts and feelings about the trauma. Typical exposure instructions ask participants to disclose their traumatic event repeatedly over several days, which is similar to Pennebaker’s disclosure paradigm (Pennebaker & Chung, in press).

Another proposed theory is that disclosure about one’s trauma assists with self-regulation. Disclosure allows people to observe themselves expressing and controlling their emotions, and may subsequently give new or stronger self-efficacy for emotional regulation. Participants may feel that their trauma, stress, or challenges are more controllable, which could reduce negative affect and lead to other improvements. Furthermore, disclosure tasks may work by allowing participants to explore sources of emotion, make sense of the event, clarify goals, and rectify self-regulation. In this way it can enhance feelings of being in control of oneself (Pennebaker & Chung, in press).

When researchers have asked participants who had reported benefitting from disclosure to explain why they thought it helped, most revealed that this process allowed them to “gain insight” into what had happened to them (Pennebaker, Colder, & Sharp, 1990). This finding may suggest that confronting previously unprocessed information helps participants to mentally organize and integrate upsetting experiences. This explanation resonates with the phenomenological perspective. Seeing as the human body
is not only a biological organism, but also a person’s embodied point of view on the world, it is essential for people to confront, clarify, and reassess their distressing experiences, and examine how their related beliefs might have shaped their relation to the world.

This finding is important because it illustrates the importance of gently probing pain sufferers to learn more about their life experiences, while being conscious that these individuals may try to downplay, or even deny, events they have endured. Moreover, it is important for psychotherapists to help clients to “own” their experiences so they can begin to heal from them.

**Acting as a Caregiver**

Assuming the role of caregiver and placing others’ needs above their own is another pattern that was noted among the present study’s respondents. Rather than stopping to nurture themselves participants sought to ease others’ discomfort, seemingly rejecting the validity of their own emotional and physical needs.

The relationship between habitual caregiving and chronic pain appears to be a new contribution to the chronic pain literature. Although much has been written about how caregiving creates physical and psychological strain over extended periods of time (Schulz & Sherwood, 2008; Vitaliano, Zhang, & Scanlan, 2003), scarce literature is available related to the susceptibility of caregivers to develop chronic pain. That being stated, schema theory, developed for persons with chronic psychological problems who fail to make significant gains in cognitive therapy, may help to clarify this connection. Schema therapy describes a “self-sacrifice schema,” which involves a sense of over-responsibility for others. According to Rafaeli, Bernstein, and Young (2011), it is
common for individuals who match this schema to have psychosomatic symptoms such as musculoskeletal pain, headaches, gastrointestinal problems, and fatigue. Rafaeli, Bernstein, and Young (2011) argue that physical symptoms may provide these individuals with a way to bring attention to themselves without having to ask for it directly, and without conscious awareness. They may feel that experiencing these maladies gives them permission to decrease their care for others and possibly even to receive care themselves. Literature related to the self-sacrifice schema also indicates that these persons exhibit common behaviours, such as listening to others rather than talking about themselves; taking care of people, yet having difficulty doing things for themselves; focusing attention on other people, yet feeling uncomfortable when attention is focused on them; and being indirect when they want something, rather than asking for it directly (Rafaeli et al., 2011). By extension, the interviewer experienced the sense that the participants did not want to “take up space,” and sometimes felt uncomfortable discussing their experiences at length, since it was uncommon for them to do so.

The relationship between habitual caregiving and chronic pain might also be explained by the stress these individuals place on their bodies by giving so much, while receiving little in return. In essence, caregivers may be giving such a great deal to others that they, themselves, become hurt in the process (Eriksen, Kirkengen, & Vetlesen, 2013; Rafaeli et al., 2011).

Eriksen et al. (2013) also propose that chronic pain can be a demonstration of self-neglect; the results of both overwork and overwhelm. They present the example of “burnout” (p. 597) to elucidate their theory. Eriksen et al. (2013) explicate that when a person develops burnout, it is not a single event, but strains over time, often with various
causes that eventually manifest as somatic pain. A strong tendency to act as a caregiver, rather than to tend to one’s own needs, can result in feelings of exhaustion and pain as the body deteriorates and falls into disrepair.

Eriksen et al. (2013) posit that chronic pain and its sister, chronic fatigue syndrome, can be viewed as a “defense speech from the depths of our humanity” (p. 596), signaling that the body requires increased rest and care, and that a person’s current living conditions and activities are not sustainable. Their explanation could very plausibly relate to this study’s participants and their chronic pain, since each described an accumulation of hardships in their lives. According to Desjarlaisi and Throops (2011), the body is a locus from which one’s experience of the world is arrayed. As such, both overwhelm and unworthiness are actively experienced through the flesh.

This finding – that chronic pain sufferers have a history of acting as a caregiver – suggests a weak sense of self. These individuals deem others’ needs to be more important than their own. This belief may lead pain sufferers to overextend themselves and to make sacrifices that have adverse emotional and physical effects for them.

It is important for this finding to be incorporated into treatment plans for chronic pain sufferers. Psychotherapists must assist these clients to honestly appraise their actions, in order to determine if they have invested an unhealthy portion of their resources into caring for others’ needs at the expense of their own physical and emotional health. Clinicians should also help pain sufferers to set boundaries so they can focus appropriate time and energy on listening to and heeding their own needs.
Implications for Psychotherapy

Though a commonly held belief is that chronic pain is a purely corporeal phenomenon best addressed at the physical level, such a conviction has been detrimental to the treatment of this incapacitating condition. The present study has contributed to the growing body of research, which suggests that psychological factors (in the form of individuals’ subjective responses to trauma and the resulting patterns in their behaviour) may be related to the onset and perpetuation of chronic pain. These findings have important clinical implications. As will be described, treatment plans for chronic pain sufferers should reflect the possibility that these clients have a history of trauma, which they may minimize, and that these individuals may also have a propensity to act as caregivers at the expense of their own health.

The first step when commencing any form of psychotherapy is to develop a secure space for the client. To create a space safe, Crossman (1966) developed the “3 P’s” (Permission, Potency and Protection), which remain a valuable resource even decades later. (1) Permission involves giving clients space to feel their feelings, speak their truths, and be themselves. (2) Potency is about becoming more powerful than the patient’s inhibiting, damaging beliefs. For example, clients may feel they are unable to speak openly because if they honestly express their anger they will be rejected or abandoned. The psychotherapist’s role is to show that he/she will give all necessary support against being abandoned. (3) Protection involves creating a confidential space with appropriate boundaries, which keeps the patient safe from harm.

Another key to successful psychotherapy is showing clients that they are truly heard. The term “therapy” is derived from the Greek word *therapeia* – “attendance.” The
skill of attending, in this context, involves staying with the client rather than interjecting with advice, problem-solving, or the suggestion of completing a cognitive behavioural “thought record.” The experience of being listened to in a concentrated and focused way, of being heard, seen, and witnessed can be transformative. When clients truly feel attended to, they come to know that they have important things to say and, by extension, that they have worth (Finlay, 2015). The more a person feels valued, the more he or she will be willing to share with the psychotherapist.

Once a sense of safety has been established and clients feel their words are valued, it is important to share research with the client, which illustrates the correlation between trauma and chronic pain. However, this message must be delivered in a gentle manner so that pain sufferers do not interpret the clinicians’ words to mean their pain is not real or is “all in their head.”

Subsequently, Van Houdenhove, Luyten, and Egle (2009) recommend tactfully questioning chronic pain sufferers about adverse experiences in their own lives. These researchers have suggested the following statements to commence the dialogue:

I would like to know somewhat more about you as a child. How was the family atmosphere at home? How was the mutual understanding between your parents, and between you and your brothers and sisters? Was there someone who used to drink too much alcohol, use drugs, or was physically violent? Did someone in your family have long-standing mental problems? Did your parents show understanding and support when you were worrying about something or had emotional difficulties? Was your privacy respected at home? Have you been
bullied at school? Have you ever been a victim of physical assault or been forced to do sexual things? (p. 53).

In this way, psychotherapists can open the lines of communication and convey that it is safe to speak about past experiences, rather than concealing them. As Herman (1992) has emphasized, disclosing distressing events, and unpacking them, is the prerequisite both for the restoration of social order and for healing.

It is necessary to offer the following caveat: Research suggests that many pain sufferers staunchly support the dominant biomedical model of illness, and cleave to diagnoses (e.g., chronic pain and fibromyalgia) that place attention on the physical body alone (Dow, Roche & Ziebland, 2012). By extension, they may believe that interpretations about illness should be confined to the material body, as a means of eliminating inappropriate moralizing and discrimination, and in order to relieve affected individuals and their families of responsibility (Lock & Nguyen, 2010). As such, clinicians may face resistance when introducing the idea that subjective factors may play a role in the onset and perpetuation of illness. That being stated, the majority of participants involved in this study acknowledged the connection between their emotional responses, their interpretations of traumatic events, and their somatic symptoms. As such, it is plausible that an increasing number of pain sufferers are receptive to the idea of exploring how subjective experiences may be related to physical illness.

The psychotherapist should also have a candid discussion with chronic pain sufferers about “self-care.” If applicable, the clinician should help clients develop a new way of perceiving themselves as individuals who have the right to feel comfortable, safe, and worthwhile. Making sure basic needs are met is the foundation of self-care (National
Domestic Violence Hotline, 2014). These basic needs include getting sufficient sleep, eating nutritious meals, and engaging in regular physical activity. It is also important for pain sufferers to incorporate activities into their schedules that bring them pleasure and relaxation (National Domestic Violence Hotline, 2014).

Setting boundaries is another issue that should be explored among pain sufferers who demonstrate a tendency to neglect their own needs in favour of honouring others’ desires. According to Glaister (1994), boundaries are the physical and emotional space that a person creates to differentiate himself or herself from others. In healthy individuals, boundaries are strong, yet flexible, and allow for individuality, growth, and development. In dysfunctional individuals, which can include trauma sufferers, boundaries may be rigid or poorly defined. Rigid boundaries impede interpersonal exchange and interaction, and promote secrecy, separation, and isolation. Conversely, those with poorly defined boundaries impose few rules or limits in their relationships.

Gilles (2014) has provided various suggestions to assist with the establishment and maintenance of healthy boundaries. Notably, he has recommended that individuals communicate their thoughts and feelings honestly and clearly to others, and to practice saying “no” when necessary. Applied to chronic pain sufferers, these individuals must be careful not to give too much and not to say “yes” to requests for assistance when to do so would have deleterious effects on their own somatic health.

It can also be beneficial to explore chronic caretakers’ reluctance to heed their own needs and to help them understand any deep-rooted beliefs that may interfere with their ability to participate in an appropriate self-care regime, to respect their own boundaries, and to engage in appropriate psychological and physiological recuperation. The use of
images or metaphors can be a helpful way of achieving this goal (Brazier, 1991). For example, the psychotherapist could say, “I have an image in my mind of you as a rope, trying to hold things together, but beginning to fray. How does that image feel for you?” Clients would then be able to express whether this image resonated with them, or if a different image would capture their distress more effectively. According to Brazier (1991), the introduction of metaphor enables the psychotherapist and client to “play” with the matter in hand and to experiment with it (Brazier, 1991). It is important to note that the process of psychotherapy is constructivist rather than reductionist. Interpretations are not efforts to reduce things to their underlying elements so much as ways to explore their meaningfulness (Brazier, 1991).

According to Bessel van der Kolk (as cited in Ogden, Minton, & Pain, 2006), it can also be worthwhile to invite pain sufferers to attend to their inner sensations and perceptions, and to notice any challenging emotions they encounter. He has noted, “one cannot learn to take care of oneself without being in touch with the demands and requirements of one’s physical self” (p. xxv).

Perhaps a less obvious but equally important requirement of psychotherapy for chronic pain sufferers is to make the sessions as participatory as possible. Pain sufferers have often spent many years passing through the hands of various medical specialists, who were minimally interested in their subjective experiences. Moreover, without being conscious of it, these clinicians may have taken part in a representation of the very conditions that gave rise to the pain-prone behaviour they were observing (Roy, 1998). As such, psychotherapy should be a chance for these clients to regain control over their bodies and their health. Pain sufferers should be encouraged to look within themselves
and to question what their bodies are telling them. Steen and Haugli (2000a) have called for a change in power structures:

A creation of a relationship between two persons is needed, with both as experts; the person with chronic pain on her/himself, and the health professional an expert in helping her/him to search for answers about her/his life situation in her/his painful body through both internal dialogue with herself and external dialogue with the health professional. The meanings of the pain are not necessarily immediately available for the patient, and therefore, of course, not for the health professional. (p. 596)

As Steen and Haugli (2000a) imply, patience is needed to allow new meanings to emerge. There is value in lingering over material, so that associations can form, and insights can surface.

**Strengths and Limitations of the Study**

**Strengths**

A notable strength of this study is its qualitative design. Qualitative methods are instrumental at unraveling and understanding the meanings that people ascribe to their experiences (Polkinghorne, 2005). The current study has contributed to readers’ knowledge of chronic pain sufferers’ subjective experiences and has uncovered various patterns in their behaviour, such as a tendency to invalidate, or at least downplay, their feelings and needs, while being responsive to the feelings and needs of others.

The emphasis on the participants’ narratives, as well as on their felt meanings, allowed for a deeper and more refined exploration and understanding of the phenomenon of chronic pain. Adding to this strength is its conceptualization and execution within the
philosophical realm of narrative analysis. Narrative philosophy holds that individuals
themselves must be allowed to guide the discussion, while the researcher attends to both
what they talk about, and how they talk about it (Riessman, 1993). This study’s
participants were invited to tell their stories about momentous events in their lives that
occurred prior to the onset of their pain. The researcher then noted the emphasis,
tonation, and nuances of the discourse. What respondents chose to speak about, and
how they did so, contributed to the attributions of meaning discovered in this study
(Riessman, 2008). Permitting the participants to dictate their own stories in an unhindered
fashion allowed the researcher to access those elements of meaning that may not have
otherwise been accessible. This was valuable for discovering new information and for
looking at chronic pain in a relatively unexplored way.

Another strength of this research is its wide-ranging content. The ages, ethnicities,
genders, and experiences of participants were diverse, thus making evident that the
findings of this study could potentially be applied to a variety of individuals. Moreover,
the dissimilarity between participants provided a diverse sampling of events that
contributed to the richness of the data.

An additional strength of this study is its important contribution to the chronic pain
literature. Although a fair number of published quantitative studies have explored the
links between trauma and chronic pain, no qualitative studies have examined the
narratives of chronic pain sufferers within a phenomenological paradigm to gain insight
into this connection. Certainly, this study assists with filling a void in the chronic pain
research.
Limitations

This study has several limitations. First, this study is interpretive. The researcher brought her biases, assumptions, and history to this project, which influenced the collection and analysis of data. These influences were monitored by the researcher’s maintenance of a reflective journal, where she endeavored to record any feelings and presuppositions that she noted while undertaking the research. As well, she regularly sought feedback from her academic supervisor, fellow students, and colleagues, who assisted her in making fair-minded connections between the contents of the interviews.

Second, this is a descriptive study that explores and relates the experiences as dictated by the participants. As such, it cannot make causal attributions. The study was not an experimental one intended to measure the relationships amongst the variables, so the data cannot speak to the issue of cause and effect. As a narrative study, the findings here are not intended to be generalizations, and the results cannot be attributed to the population as a whole. That being stated, findings presented here can be utilized to generate testable hypotheses regarding the potential relationship between trauma, the downplaying of trauma-related emotions, neglect of personal needs, and the onset and perpetuation of chronic pain.

A third limitation is that this study is retrospective in nature. Participants depended upon memory when recounting their stories. It cannot be known for certain whether events transpired as the participants described, and so this study does not make claims of validity. According to Riessman (1993), “[t]he historical truth of an individual’s account
is not the primary issue” (p. 64). Rather, the truth of participants’ stories lies in their credibility, plausibility, intelligibility, and trustworthiness.

**Directions for Future Research**

The present study is an exploratory one that has provided the field with valuable information regarding the subjective experiences of chronic pain sufferers, as well as other patterns in their lives (i.e., a tendency to downplay the severity of their experiences, and a propensity to neglect their own needs in order to tend to others). Findings presented here can be employed to generate testable hypotheses with respect to the potential relationship between experiences of trauma, minimization of trauma-related emotions, neglect of the self, and the onset and perpetuation of chronic pain. It is also worth noting that, should this relationship be strengthened by further research, comprehensive assessment tools/questionnaires could be developed. This would assist mental health clinicians in determining the patterns with which they are working before a treatment plan for chronic pain sufferers is developed.

Further research could also be focused on the relationship between immigration and the onset of chronic pain in an effort to better determine whether immigration, or difficulties with acculturation, predisposes individuals to develop chronic pain.

Moreover, despite the frequent co-occurrence of chronic pain and posttraumatic stress disorder (PTSD), limited research has explored this relationship. It seems imperative that future research is concentrated on the possible comorbidity between chronic pain and PTSD; it is plausible that, rather than being distinct disorders, chronic pain and PTSD are closely connected.
Concluding Comments

Within the traditional biomedical model of illness, which remains dominant in Western society, health and disease are reduced to the basic components of organs and biochemicals (Kato & Mann, 1996). Non-biological factors, including momentous life experiences and the general way that individuals relate to the world, are often ignored and given minimal attention when trying to decipher the factors underlying a person’s chronic pain. Instead, diagnostic testing is normally viewed as the primary method of analysis, and medication is the most widely prescribed treatment. When psychotherapeutic interventions are employed, CBT is the commonest modality; this type of therapy is in line with the Cartesian belief in duality and the positivist premise of a single reality.

The present inquiry, which employed a narrative methodology, involved a theoretical shift from the body of biomedicine to the “lived body,” which is described by the phenomenological theory of embodiment. This study led to the development of an emergent model of factors that may result in the onset and perpetuation of chronic pain, as well as ways that these patterns can be addressed within a psychotherapy context.

Placing the biomedical and the phenomenological model in an either/or position is too simplistic. Both models are important and can assist with the achievement of improved health. That being stated, psychotherapists must understand that health care involves more than the alleviation of pain though biomedical means or assistance coping with it. Rather, it must involve a journey of discovery, which goes above and beyond assistance with biological pain concerns. Moreover, students training to become psychotherapists should receive education about the potential connection between
subjective factors and chronic pain, so that the cycle of focusing primarily on objective evidence can be interrupted.
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Appendix A: Recruitment Notice

TELL ME ABOUT YOUR LIFE BEFORE YOU DEVELOPED CHRONIC PAIN...

I am a doctoral student (Ed.D) in Counselling Psychology at the Ontario Institute of Studies in Education of the University of Toronto (OISE/UT).

I am studying chronic pain sufferers’ life experiences prior to the onset of their illness. I am interested in learning about pain sufferers’ emotional responses to these experiences and the way they make meaning of them. I am also interested in learning if participants see any connection between their significant life experiences and the subsequent onset of their pain.

If you are an English-speaking adult who has struggled with chronic pain for at least one year and is willing to talk about significant experiences in your life before you developed chronic pain, I encourage you to take part in this psychological research.

You would need to be willing to spend approximately 2-½ hours participating in a one-on-one interview. As well, you must be willing to have your interview recorded.

If you would like more information about this study, please contact me:

Kate Peplinskie, M.Ed., 416-558-7060

My research supervisor is Dr. Charles Chen, of OISE/University of Toronto, cp.chen@utoronto.ca
Appendix B: Telephone Screening Form

Thank you for your interest in participating in this study. As you know, I am researching chronic pain sufferers’ life experiences, prior to the onset of their illness. I am interested in learning about pain sufferers’ emotional responses to these experiences, as well as the way they make meaning of them. I am also interested in learning if participants see any connection between their significant life experiences and the subsequent onset of their pain.

May I ask you a few questions to determine your suitability for participation?

Screening Questions:

1. How long have you had chronic pain?

2. Are you open to discussing significant experiences in your life, that you believe to have been especially momentous, prior to the development of your chronic pain?

3. Would you be willing spend about 2-½ hours talking to me about your experiences and how you believe these experiences shaped your life?

4. Would you be okay with me recording our discussion? I would transcribe the recording and then delete it.
Appendix C: Informed Consent Letter

CHRONIC PAIN RESEARCH STUDY:

INFORMATION/INFORMED CONSENT LETTER

Kate Peplinskie, Principal Investigator. 416-558-7060

Dr. Charles Chen, Research Supervisor. 416-923-6641, ext. 2485

Dear Participant: I am a doctoral student in the Department of Counselling Psychology at the Ontario Institute for Studies in Education of the University of Toronto. My research is centered on possible patterns between chronic pain sufferers’ significant life experiences, their interpretations of these experiences, and the development of their illness.

I will be speaking to adult individuals who have been struggling with chronic pain for at least one year. I would like to individually interview approximately 15 people who are willing to talk about their significant life experiences prior to the onset of their chronic condition.

As a volunteer participant you will be asked to take part in an interview lasting approximately 1.5 hours. I will be speaking to you about significant life experiences prior to the onset of your chronic pain. You will be asked to describe how these experiences shaped your life, how you make meaning of these experiences, and whether you see any connection between these pre-pain experiences and the subsequent onset of your chronic pain. The interview will be recorded and later transcribed. These recordings will be erased once they are transcribed. Your name, and any other information that may identify you, will not be used on the transcripts or final written materials. Instead, codes will be used to mark information, and pseudonyms will be used in the final write-up. All materials will be kept secure in a locked filing cabinet, to which only the principal investigator and the research supervisor have access. Materials will be kept for seven years after the completion of this study, and will then be destroyed. It is possible that information from this study will be used in future publications and presentations, but confidentiality will be maintained. No names or identifying information will appear on any such materials. Participation in this study is entirely voluntary. Should you wish not to discuss a topic raised in the interview, you are free to decline to speak about it. You may refuse to answer any question during the interview. You are free to withdraw from the study at any time, either during the interview or to request withdrawal of your data from the study after the interview, without consequences. It is possible that talking about your life experiences may bring up unexpected or unwanted emotions. If you decide at any time during the interview that you do not wish to continue to participate or answer any questions, you are free to terminate the interview and/or withdraw your information. The investigator will understand and there will be no negative consequences. If necessary, the investigator will provide information for supportive services in the community, and should you choose to seek counselling, she will assist you in finding a counsellor.

Participating in this study is unlikely to provide any direct benefits to you. However,
some people have found that participating in interviews allows them a space and opportunity to talk freely and openly in a non-judgmental atmosphere about their experiences and, in doing so, to appreciate and understand their own experiences in a different light. In addition, the knowledge gained through understanding your experiences may contribute to a richer and more meaningful understanding of your self and the impact that events may have had on your life. Your confidentiality will be protected at all times; however, there are exceptional circumstances that require me to break this agreement. These circumstances are as follows: 1) If you indicate that you are going to hurt someone, or yourself; 2) If you advise me that you are aware of a child being abused or neglected or in danger of being hurt; 3) If you report that you were, or are, being sexually abused by a registered health care professional.

Should you wish to participate in this study, you are requested to sign two copies of this form. You will keep one copy of the signed form. Any questions about this study may be addressed to Kate Peplinskie at 416-558-7060, or Dr. Charles Chen at 416-923-6641, extension 2485.

This study has been reviewed and accepted by the University of Toronto’s Ethics Review Office, which oversees ethical conduct in research. If you have any questions regarding your participation in this study or about your rights as a participant, you are invited to contact their office by telephone at 416-946-3272, or via email at ethics.review@utoronto.ca.

I have read the above information form and agree to participate in this study.

Name: ______________

Signature: ___________

Date: _______________

Are you interested in receiving a final synopsis of this study?

Yes ____           No____

If so, the researcher will forward the synopsis to you at the following:

Email address:

Postal address:
Appendix D: Debriefing Form

Thank you for your participation in our study! Your participation is greatly appreciated.

Purpose of the Study:

We previously informed you that the purpose of the study is to learn about important events in participants’ lives before they developed chronic pain. We also want to learn about participants’ emotional response to these experiences and the way they make meaning of them. The goal of our research is to identify possible connections between types of life events, people’s subjective experiences of these events, and the onset of chronic pain.

We realize that some of the questions asked may have provoked strong emotional reactions. As researchers, we do not provide mental health services, and we will not be following up with you after the study. However, we want to provide every participant in this study with a list of clinical resources that are available, should you decide that you require assistance at any time. Please see information pertaining to local resources at the end of this form.

Confidentiality:

You may decide that you do not want your data used in this research. If you would like your data removed from the study and permanently deleted, please contact the principal researcher:

Kate Peplinskie, M.Ed., 416-558-7060

Final Report:

If you would like to receive a copy of the final report of this research (or a summary of the findings) when it is completed, please feel free to contact Kate Peplinskie (listed above).

Useful Contact Information:

If you have any questions or concerns regarding this study, its purpose or procedures, or if you have a research-related problem, please feel free to contact Kate Peplinskie (listed above), or the research supervisor:

Dr. Charles Chen, OISE/University of Toronto, 416-978-0718

If you feel upset after having completed the study, or find that some questions or aspects of the study triggered distress, talking with a qualified clinician may help. If you feel you would like assistance, please stop by the main reception desk as you leave today to schedule an appointment with your psychotherapist. You may also contact Toronto
Distress Centre, a telephone helpline, which offers 24-hour support: 416-408-4357. In the case of an emergency, please call 911.

*** Once again, thank you for your participation in this study! ***
Appendix E: Interview Protocol

To begin the interview process, the researcher provided the following description to participants: “The purpose of today’s meeting is for me to learn more about the life experiences of chronic pain sufferers prior to the onset of their illness, and the way they make meaning of these experiences.”

The following questions were used, as needed, to assist with the narrative exploration:

1. Tell me about events in your life that you deem to have been particularly momentous prior to the onset of your chronic pain.
2. How did these experiences affect you?
3. If you were to try to help someone understand the impact these events had on you personally, what would you tell them? What images or metaphors or phrases could you use to help them understand?
4. How were you coping with these events around the time of the onset of your chronic pain?
5. If you had to provide reasons for these events, what explanations would you offer?
6. Do you see any connection between your pre-pain experiences and the subsequent onset of your pain?