

**The Personal Experience
of Chronic Benign Low
Back Pain: An
Interpretative
Phenomenological
Analysis**

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Abstract.

This thesis is a qualitative study of chronic benign low back pain (CBLBP). Psychological factors play an important role in the genesis and maintenance of CBLBP but the processes involved are poorly understood. The meaning of the pain for the sufferer is considered to be important and more research into this area that takes an idiographic approach is recommended in the literature. Three empirical studies are reported which employ Interpretative Phenomenological Analysis (IPA) to explore the personal experience of CBLBP. A range of themes are discussed that capture the meaning of the pain for the sufferer and help to understand the dynamic relationship between the pain sensation, distress and disability. The first study is exploratory, the participants' struggle to make a coherent sense of their pain is revealed along with the related personal and social implications. In the second study the experience of pain itself is focused on more closely in the context of a simple intervention. Descriptions of the pain are given which reveal its threatening aspect and suggest that the participants' self-appraisal in the face of this threat is important. The factors underlying change are discussed and the contribution of contextual factors is emphasised. The first two studies indicated that the self-concept was worthy of further study and it became the explicit focus of the third study. The relevance of the self was highlighted and it was shown to be indivisible from the lived experience of CBLBP. The three studies reveal the multi-dimensional complexity of CBLBP and highlight how its inherent 'unpleasantness' represents more than a noxious sensory experience but unfolds within a dynamic personal and social context. The emergent themes are reviewed and discussed in relation to the literature and implications for further research and clinical practice are suggested.

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Chapter One.

Introduction.

The Personal Experience and Meaning of Chronic Benign Low Back Pain.

The aim of this thesis is to explore the lived experience of chronic benign low back pain, that is to describe and articulate it from the perspective of the sufferer and go some way toward divining the meanings that it holds for them. In doing so it is hoped to develop our understanding of the subject and explicate some of the processes involved in the complex relationship between chronic pain sensation, distress, disability and organic damage.

Chronic benign low back pain is a considerable problem to western industrialised societies and despite substantial research directed toward both understanding and treating it, it remains elusive. Chronic pain of all kinds and benign low back pain in particular is typified by its unpleasantness, unpredictability and idiosyncrasy.

Psychological factors have been shown to have an important effect on the ultimate experience of chronic pain and it represents a major challenge to psychological research. It represents one of the most intriguing and fascinating subjects for a psychologist to explore. It can be both a symptom and a condition in its own right. It is deeply personal but also universal and exists as a multi-dimensional phenomenon that has social, cultural, physical and historical elements.

Chronic pain defies a simple description and yet there is such a social and cultural consensus about it that if you said you had it, almost everyone you met would know what you meant to some degree. The non-verbal expression of pain is perhaps even more universal, it stands in contrast to the subtlety and variety of language that is employed to achieve its description, but often considered by the sufferer to be inadequate in that regard.

The focus of this thesis will be benign chronic low back pain. That is pain that has persisted for over six months (chronic), where all the associated organic tissue damage is considered to have healed and no active disease process is in place (benign) (I.A.S.P., 1986,1994). Key to the phenomenon and definition of chronic pain is that it feels like acute pain but it cannot be cured and despite everyones' best attentions, it persists. The primitive and behavioural components of pain, to escape and protect the individual from its unpleasantness, are not satisfied and the sufferers are compelled to escape their pain, but never do. As if in room 101 from George Orwell's '1984' (Orwell, 1949), they are trapped with it until they have developed a whole new repertoire of pain management strategies to palliate the situation. This may seem overly dramatic and not everyone in chronic benign low back pain suffers such a degree of pain sensation, distress and disability, but a significant number do, they are considered to have chronic pain syndrome (IASP, 1994) and they are the participants in the studies in this thesis.

The approach adopted in this thesis will be qualitative, and in particular the method will be exclusively Interpretative Phenomenological Analysis (IPA) (Smith, 1995b).

IPA is a psychological method and is dedicated to articulating and learning from the individual's personal view of the subject and its social, cultural and physical connectedness. IPA has recently developed a tradition of research in health and social psychology and displays considerable utility and value in this area. It is ideal for the study of dynamic, multi-dimensional phenomenon where the individual inter-relates with a range of physical, social and cultural processes and it is the meaning inherent in the experience that is important.

The call for idiographic and phenomenological research into chronic benign low back pain does not just come from advocates of the qualitative approach, but is present in the conclusions and recommendations of many quantitative studies that argue it is an important area to develop if our understanding of chronic benign low back pain is to progress.

In chapter two 'The Psychology of Chronic Pain', chronic benign low back pain and the problems it causes are described in depth. The literature on the psychological components of chronic benign low back pain is reviewed, including a brief history of the development of the definition of pain which highlights the puzzle pain has always posed. The relevant psychological theories are summarised and the argument for attending to the personal meaning of pain is developed.

In chapter three 'The Qualitative Approach', the background to the qualitative approach is described and it is contrasted with the mainstream quantitative method. The intention in this chapter is not to dismiss the value of quantitative research, which has already revealed much about chronic pain, but to develop the argument for the

value and importance of using qualitative methods that offer an alternative perspective on the subject. Qualitative research methods are not reviewed encyclopaedically as it is not a unitary approach. It is typified by the wide variety of methods that can be employed and four examples are described, the phenomenological method, grounded theory, IPA and discourse analysis. IPA in particular is shown as an approach that can both complement and relate well to the extant chronic pain literature and this will be evident in the range of other studies that are referenced throughout the thesis.

Chapter four, 'Existing Qualitative Research on Chronic Pain', reviews the limited number of empirical qualitative studies that have been published and shows how little has been done to date. That which has been written is either sociological in focus, or researches other chronic illnesses and this reinforces the pressing need for more qualitative study in this area.

In chapter five, the method that is employed in each of the three studies is described in detail. The method of IPA is given here in as much detail as possible to help the reader understand how the final write-up emerged.

The three study chapters then follow, which are:

Study One. The Personal Experience of Chronic Benign Low Back Pain.

This study was an initial reconnaissance and exploration of the individual sufferer's experience of pain to see what psychological themes emerged as central to their experience.

Study Two. The Personal Experience of Chronic Benign Low Back Pain: Chronic pain and the change in its meaning before and after a simple hypnotic pain management exercise.

The aim of this study was to explore the participant's experience of chronic pain from a different perspective by examining it as it changed whilst they went through a simple hypnotic pain management exercise. The efficacy of the intervention was not the focus of the study, which was to explore how a change in the meanings related to the participants' pain informed us about the nature of their pain.

Study Three. Chronic Pain and the Self.

In the first two studies it appeared that the impact of the chronic pain on the sufferer's sense of self, or self-concept was important and worthy of further study. As a consequence the third study focused on how their experience of their pain had influenced the way they defined or saw themselves.

In each of the studies the important themes are reviewed and discussed in relation to the extant literature. The aim of this thesis is to explore the patient's experience of chronic benign low back pain and by taking such an idiographic approach to see how this develops our understanding of the experience of chronic benign low back pain, and the complex relationship between pain sensation, distress and disability.

Although this may have clinical implications, and these will be discussed, the focus will be on getting close to and explicating the participants experience of their pain, rather than defining the utility of any clinical interventions. The findings from this thesis will be discussed within each of the study chapters and in a final brief discussion chapter at the end.

Chapter Two.

The Psychology of Chronic Pain.

Review of the Literature.

A range of approaches were applied to reviewing the literature over the life time of the thesis and in response to the emergent themes in the analyses of the three studies.

Principal in these were regular formal literature searches which began using PsychLit on CD-Rom, progressed to using the BIDS facility and finally the Web of Science online database. In addition other publications were reviewed on an ongoing basis.

These included:

The journals - Pain, Spine, British Journal of Health Psychology, British Journal of Clinical Psychology, British Journal of Medical Psychology, Sociology of Health and Illness and Social Science and Medicine.

All new health and pain related publications by - International Association for the Study of Pain, British Psychological Society, Open University Press, Guilford Press, Sage, Wiley and Routledge.

Conference reports from - British Psychological Society (BPS), BPS Division of Health Psychology, International Association for the Study of Pain and The Pain Society.

The main focus for the literature searches was 'chronic benign low back pain' and 'chronic pain', this was extended to include other terms such as 'chronic illness', 'qualitative health research' and other key words related to the themes that emerged from the empirical studies.

What is Pain?

Pain is notable for its paradoxical and elusive nature. Although it does serve a primitive protective function at times this does not apply. In certain situations significant injury to the body produces no pain, whilst at others severe and crippling pain can be present in the absence of any disease or acute tissue damage. Pain is a universal phenomenon but also one which is private and subjective. It is fundamentally unpleasant and experienced in a wide variety of forms. Pain cannot be measured directly but is inferred and interpreted from the sufferer's observable behaviours, self-reported cognitions and affect. Although there is a broad consensus with regard to its description and sensation in that most people know what you mean when you say you have pain, it is typified by its idiosyncrasy, variability and a weak correlation between the pain sensation, distress, disability and any objective measures of peripheral tissue damage.

One of the challenges of pain is how to understand something so ubiquitous, so universal and yet due to its personal, individual and changeable nature so difficult to access or describe. The list of English words that could be used as pain descriptors is extensive and runs into the hundreds yet despite this range of options sufferers often struggle to find the words that they feel would do justice to their pain and the

language of pain has been found to serve no useful or stable diagnostic function (Melzack and Torgerson, 1971).

Most pain is associated with a disease process or tissue damage. When this happens it signals the presence of such damage or the threat of injury, triggers a range of escape or protective behaviours and affect and subsides as the related organic damage heals. This is not always the case however. In some instances pain persists after the peripheral healing process is complete or emerges in the absence of any disease process and ceases to function as a warning of an ongoing biomedical problem.

Pain has always been a puzzle that has not conformed to a bio-medical model that treated it solely as an alarm mechanism. In 60% of cases of chronic benign low back pain there is no recognisable organic pathology. There are also other types of pain such as causalgia, neuralgia and phantom limb pain that can either persist for months after the original tissue damage has healed or are triggered by non-aversive stimuli i.e. that which does not cause any tissue damage (Melzack and Wall, 1988). In the case of phantom limb pain the sufferer experiences pain from a part of the body that no longer exists and this supports the case for the importance of higher cortical processes related to pain.

The considerable variability in the perception and expression of pain is such that it can change over time despite no evidence of parallel or contemporaneous organic change and can appear to be very different between people with the same injury. Beecher (1956) in a classic study showed that, despite suffering extensive tissue damage soldiers, wounded in battle required less analgesia than their civilian

counterparts with similar organic pathology as a result of surgery. Beecher's observations showed how the context and meaning of the pain to the sufferer was an important mediating factor in their pain experience and one which at times was more pivotal than the bio-medical factors involved. Put crudely, the battlefield casualties in his study were relieved not to be dead and looked forward to going home away from the conflict, whilst the civilian surgical patients felt no such relief and did not welcome their convalescence in the same way. The experience of pain symbolised a very different future to the two groups, one positive for the soldiers and one more fearful for the civilian patients. Similarly, the two groups regarded themselves differently. The soldiers saw themselves perhaps as healthy men who had been injured whilst the civilian patients saw themselves as unhealthy with a more uncertain future. Each appeared to appraise their pain within a markedly different historical and social context.

The Development of a Definition and Theory of Pain.

Pain has proved hard to define over the years but this is not because as an experience it is uncommon. On the contrary, with the exception of a few rare cases where people are born impervious to pain and suffer due to the absence of its protective function (Melzack and Wall, 1988), each person has experienced pain to some extent with varying degrees of sensation, distress and disability. It's notable that despite this universality a definition of pain that encompassed its complex nature successfully was not established until relatively recently IASP (1986, 1994).

Pain has been recognised and written about since historical records began and reference to it was recorded on Egyptian papyrus in 4000BC (Rey, 1993; Gatchel, 1999). At the time of Aristotle, it was considered to be discrete from the five senses and classed as a 'passion', something related to the soul. This was very much in line with the thinking of the time which considered the relationship between the body and the mind to be fundamental in medicine. Eventually these holistic ideas were overhauled as a result of the technological and philosophical developments that took place during the Renaissance. The mechanistic approach of modern medicine emerged and adhered to a more Cartesian and dualistic division between the mind and the body. Pain was defined in purely stimulus-response terms and considered to serve as a warning signal of actual or potential harm to the body. It was confined as a phenomenon to the body and a direct and an unmediated pathway was thought to run directly from the source of the damage to the brain.

During the nineteenth century an increased sophistication in physiology led to the developments of theories such as Von Frey's Specificity Theory and later on other theories such as Pattern theories (Goldscheider, 1920). These attempted to explain pain phenomena as the result of specific nerve impulses that culminated in a cortical event and were then perceived as a sensation of pain. This introduced the idea of pain as a phenomenon that involved several stages and different processes of transduction, nociception and perception. It discriminated between the peripheral and central nervous system but still could not explain the presence of any pain that was not a direct index of injury or disease.

Historical definitions and their related explanatory models developed our understanding of pain but failed consistently to explain all of the different kinds of chronic pains, the variability of acute pain or how certain serious disease processes could give rise to very little pain. Sternbach (1968) continued the evolution of the definition of pain and summarised it as a phenomenon consisting of three things, which were; a stimulus indicating tissue damage, a sensation of hurt and a collection of behaviours designed to defend the organism from further harm.

This definition introduced the concept of pain as a multi-dimensional phenomenon i.e. something that included a protective behavioural and affective component as an integral part of the experience of pain. It also established it as a subjective 'personal' and 'private' experience. Still however there remained the need for a definition that allowed both for the presence of chronic or phantom pains where peripheral damage was not present and for when disease or injury did not produce pain.

Subsequent to the acceptance of Gate-Control Theory as the central theory of the pain system (outlined below) the current pain definition encompassed both the psychological dimensions of pain and its individual variability. The International Association for the Study of Pain, (I.A.S.P., 1986) stated formally that:

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. (p s217)

In this definition although pain was still defined in relation to organic pathology it was recognised that it could occur in the absence of any ongoing peripheral tissue damage.

The I.A.S.P (1986) also made an important distinction at that point and stated that:

Activity induced in the nociceptor and nociceptive pathways by a noxious stimulus is not pain, which is always a psychological state, even though we may well appreciate that pain most often has a proximate cause. (p. s217)

This allowed pain to be conceived as a psychological experience, not a physiological event and represented a challenge to psychological research to help develop the understanding of pain more fully. Nowhere is this more necessary than in chronic benign low back pain as it is these cases that organic pathology is notable for its absence and a medical cure is unavailable. Chronic benign low back pain is sometimes called colloquially 'medically resistant pain' as it persists despite the best attention and therapies of the medical profession who have admitted readily that complete pain relief is not always possible:

the medical profession has had to come to the unpalatable conclusion that its innate capacity for providing analgesia is severely flawed. (p. 63)
Budd (1993)

The definition of pain remains the focus of debate and it is likely it will continue to evolve. Price (1999) was dissatisfied with the IASP definition of pain as he felt it was not grounded in the experience of pain enough. To him it remained unclear whose point of view defined the association between tissue damage and pain sensation. This ambiguity meant it could still be possible to declare that if an observer could not determine this relationship then the experience was not pain. Anand and Craig (1996) were also critical of the accepted definition as they felt it was too reliant on self-report and description and so could not be applied to living organisms that were incapable of

communicating in such a way. To Price (1999) the association between sensation, suffering and tissue damage in the current definition was still too strong and he proposed a definition where there was no need for the observer to determine the presence of any actual or potential tissue damage. The modified definition he developed retained the primacy of pain as a psychological experience and pain was determined as:

A somatic perception containing (1) a bodily sensation with qualities like those reported during tissue-damaging stimulation, (2) an experienced threat associated with this sensation, and (3) a feeling of unpleasantness or other negative emotion based on this experienced threat. (p1)

Current definitions and models encompass the wide variety of pain phenomena and acknowledge it as a multi-dimensional phenomenon that involves processes of mediation, perception and appraisal that take it beyond a simple biological stimulus-response mechanism. The 'puzzle' of pain that has been referred to earlier and was highlighted by Melzack and Wall (1965) is perhaps only a puzzle if explained using a reductive, bio-medical model. Melzack and Wall changed the name of their classic text from the 'The Puzzle of Pain' (1965) to 'The Challenge of Pain' (1988) perhaps to reflect the progress in our understanding over the time that had passed, much of it due to them.

What has been retained throughout the history of the definition and explanation of pain and is key to appreciating the nature of pain is its inherent 'unpleasantness'. This term helps to convey the discomfort of pain, that it hurts, is noxious or 'physiologically offensive' (Fernandez and Turk 1995) and so demands of us an escape or protective response. The term 'unpleasant' does not perhaps capture how

extreme pain can be but it establishes it as something antithetical to functioning or quality of life.

Gate-Control Theory of Pain (Melzack and Wall, 1965a, 1965b)

Possibly the single most significant development in the understanding of pain in the last century was the gate-control theory of pain. The paradoxes and anomalies of pain that have been detailed above led Melzack and Wall (1965a, 1965b) to develop a theory which remains the most popular for our understanding of the various aspects of pain. They viewed pain phenomena as something consisting of several components that were discriminable in space, time and intensity and had an essential aversive cognitive and emotional component that led to behaviour designed to escape or avoid the stimulus.

Different physiological mechanisms were described for each system and the subjective and psychological nature of pain was considered to be an integral part of the whole pain process.

Gate-Control theory proposed that the action system responsible for a pain experience involved a 'gating mechanism' based in the spinal cord which, when open, transmitted a signal to the brain that would be perceived and interpreted as pain. The gate was triggered when the integrated firing level of the dorsal horn T-cells in the spinal cord reached or exceeded a critical threshold. This triggering threshold was mediated by the dynamic relationship between three inputs:

- (i) Descending central inhibitory control processes from the brain.
- (ii) Large, myelinated fibres (which normally transmit innocuous sensory information).
- (iii) Small, nociceptive afferent fibres.

With this theory it was now possible to explain how certain information could be 'gated out' and the experience of pain blocked or how the gate could remain open such that the pain became magnified or chronic. In Gate Control Theory the experience of pain is not mediated by a single disease process or peripheral injury but in part by the degree to which the pain gate is open or closed.

More than any other theoretical approach gate-control theory emphasized how psychological variables could influence the individual's experience of pain via a descending inhibitory control pathway from the cortex. Melzack and Wall showed that descending efferent fibres could influence afferent conduction at the earliest synaptic levels of the pain system and that it was possible for brain activities related to attention, anxiety, depression, anticipation and memory for pain to exert some control (albeit unconscious at times) over the contemporary experience of pain.

Melzack and Wall postulated the concept of a 'central control trigger' (based in the dorsal column projection system of the spinal cord) that mediated the activity of the pain gate. This trigger defined the degree to which the gate was open and the message transmitted to a higher cortical level. In this process signals from the body would be identified, evaluated in terms of prior and contemporary experience,

localised and if necessary inhibited or enhanced before the action system responsible for pain perception and response was activated.

There is evidence that if the gating system is subject to a particular and persistent level of nociceptive input, then the central control triggering mechanism can become sensitised or 'wound up' and activate the pain gate on a persistent basis creating chronic pain (Jessop, 1993; Davies and Lodge, 1987). As a consequence persistent pain could occur that was resistant to medical treatment, existed in the absence of any peripheral tissue damage and changed over time independent of a disease process. The challenge is to understand what psychological factors maintain the pain system in this hyper-sensitive state and how it can be influenced.

Evidence for the physical existence of a gating mechanism is not conclusive and reflects the difficulty of imaging structures in the spinal cord in action but it represented a substantial development in the explanation of pain and informs much of the research and clinical activity that is undertaken today.

Subsequent to developing the Gate-Control theory Melzack (1999, 1990), looked at the relationship between the pain-gate and the higher cortical areas and developed the Neuromatrix theory of pain. This proposed that, at a higher cortical level to the pain gate, pain was produced by a characteristic 'neurosignature' pattern of nerve impulses that were generated by a widely distributed neural network, termed the 'body-self neuromatrix', in the brain. The particular nature of pain that was experienced at any one time was produced, mediated and maintained by the output of a widely distributed neural network in the brain that related to the pain-gate. This development reinforced

the importance and relevance of psychosocial factors in the experience of pain and highlighted the sophistication and fluid dynamism of the pain system.

What is Chronic Benign Pain?

Chronic pain is any pain that has persisted for longer than 6 months (I.A.S.P., 1986). This is the period of time after which it is considered that all relevant peripheral tissue damage will have healed. Acute pain refers to any pain that has been experienced for under 3 months, or 6 months (sub-acute). Chronic benign low back pain refers to any pain located in the lower back that is not related to an ongoing disease process but is the result of the 'wind-up' and sensitisation of the central nervous system structures related to the pain system. It can be related to a precipitating injury or disease but most often simply emerges over time for no acute reason.

In acute pain the pattern and presentation of the pain most often indicates the underlying organic cause in the form of an injury or disease. With chronic pain this is not the case, chronic pain lacks this functional element or 'biological utility' (p413) (Gatchel and Epker, 1999) and is not diagnostic.

An important fact of chronic benign low back pain is that, although painful, in the majority of cases there is no peripheral structural damage to the spine that would be exacerbated by movement. Movement may well promote further pain and usually does but it would be unlikely to cause any damage as it might in an acute situation where rest and temporary immobility would be recommended. Chronic benign low back pain is incurable and to treat it as acute pain would be destructive. To restrict

movement often creates the conditions that can exacerbate the chronic pain and sufferers are at risk of more serious problems if strong analgesics, extensive convalescence and inactivity are prescribed (Main and Spanswick, 2000; Hanson and Gerber 1990).

Despite such a contrast in acute and chronic pain, to the sufferer the sensation feels the same and compels them to respond in the same manner, to protect and escape from the pain. Chronic pain emerges from an initial six month acute episode during which disease or injury may well have been present or implicated. It will appear to the sufferer as the seamless persistence of their acute pain as there would have been no distinguishable discontinuity between the acute and chronic phase. This can be a source of confusion.

As they develop chronic pain the sufferer endures a persistent pain, one that has been resistant to a medical cure and may well make no biological or diagnostic sense to them. Most notably it will not have responded in the manner they might have expected from acute pain in that rest and other escape or protective behaviours will not have secured relief. Chronic and persistent pain cannot be escaped but the inherent motivational and behavioural components of pain toward escape remain. This primitive urge to seek relief and protection does not succeed and is frustrated constantly.

Chronic benign low back pain is one of the prime examples of the complexity of pain. There is considerable individual variability in chronic pain according to its context and the meanings it holds for the sufferer (Hanson & Gerber, 1990; Turk & Flor,

1984; Holzman & Turk, 1986). It is typified by its unpredictability over time as it can switch in intensity and quality at any point to give the sufferer a range of experiences from 'good days' to 'bad days' Charmaz (1991).

The challenge in chronic benign low back pain is to understand the relationship between pain sensation, distress and disability, which is neither linear nor causal but dynamic and multi-dimensional (Waddell, 1987). Chronic benign low back pain is not synonymous with psychological and physical dysfunction as many people with frequent pain continue to work and rarely seek health care assistance (Turner and Romano, 1984). Even though chronic pain can cause inactivity and disability many people learn to function fairly normally (Doleys et al., 1982). However a significant population of people with chronic pain do report high levels of pain sensation, distress and disability and these cases are often referred to as suffering from Chronic Pain Syndrome (IASP 1994; Hanson and Gerber, 1991). Turk and Flor (1999) identified the inadequacy of a biomedical model to explain the interaction between these elements and why there is this difference in the experience of chronic pain:

from the biomedical model it would be predicted that there would be a highly significant if not isomorphic relationship between objective pathology and disability, yet this is patently not the case. (p19)

The dynamic nature of chronic pain has highlighted the importance of the personal psycho-social factors involved and they have been recognised to have a major mediating influence in the person's ultimate experience of their pain sensation, distress and disability (Melzack and Wall, 1988; Waddell, 1987; Turk and Gatchell, 1999).

The consistent struggle to both treat chronic pain successfully and explain its presentation, coupled with the development of the application of Gate-Control theory and other mainstream psychological research led to the development of the biopsychosocial model as an alternative to the traditional bio-medical approach (Turk et al., 1983). This established the importance of the psycho-social elements that had been implicated in the genesis, maintenance and treatment of chronic benign low back pain (Waddell, 1987; Waddell et al., 1984, 1992).

The bio-psycho-social model emerged as a better way to understand the phenomenon of chronic pain and develop ways of helping to treat it (Turk et al., 1983). It proposed that for each individual there were pre-disposing, precipitating and maintaining biological and psychosocial factors that interacted to establish and maintain chronic pain and disability. It posited a link between affect like fear, distress and the somato-sensory cortex and established a link between pain experience and the physiological processing of pain (Turk and Rudy, 1988). The bio-psycho-social model outlined by Waddell (1987) and Turk, Meichenbaum and Genest (1983) incorporated psychological, social and cultural factors and encompassed both the complexity of chronic pain and its fluid relation to distress and disability. It provided a vehicle for exploring further how the processes that influenced the pain-gate and the chronic pain experience might operate.

Chronic benign lower back pain is a major health problem and single largest cause of time lost at work in western society. It produces a demand on the medical health services which cannot be satisfied as 85% of cases are not amenable to a neat medical diagnosis, 60% of low back pain cases would not benefit from the attention of a

medical consultant and only 2-3% would qualify for surgery (Clabber Moffat et al., 1995; Waddell 1987).

It's incidence has been described as having reached 'epidemic' proportions in western societies and as it is predominantly a mid-life, not a late-life condition it affects people during their most economically active years. It is the single largest cause of disability in the UK and represents a major source of morbidity and distress (Rosen, 1994). Maniadakis and Gray (2000) estimated that the direct economic cost in the United Kingdom in 1998 in terms of health care costs, informal care and loss of production was £1632 million. For those experiencing back pain the aggregate yearly cost to the U.S. economy was in the region of \$80 billion (Bonica, 1990).

The simple epidemiological statistics that establish the prevalence of chronic low back pain and its status as a public health problem are compelling. In any one year 60% of the working population will have an episode of some kind of back pain. Fortunately 95 % will resolve within 6 weeks, leaving 5% at risk of developing a chronic problem. At some stage of our lives 80% of the population will endure back pain (Waddell, 1987). It could therefore be considered statistically to be a 'normal' part of life. Although not all those who suffer pain seek help for it (Smith et al., 1996) for those people who develop a chronic pain problem it can leave them, their families and associates feeling significantly distressed and disabled.

The Impact of Chronic Pain: Affective and Cognitive.

To the sufferer chronic benign low back pain can be a significant problem. Bonica (1974) described chronic pain as exclusively 'malefic' as despite the ability of people to manage it constructively, it was inherently and powerfully destructive and had no redeeming features. Chronic pain serves no protective function, disrupts daily activities and functioning, interferes with sleep and promotes distress in its sufferers, their carers and family and the professionals who set out to help them (Von Korff, Le Resche and Dworkin, 1993; Gatchell 1996). Chronic pain appears to have the potential to disable most functioning but the mediating processes involved allow for a considerable degree of heterogeneity and variability in that regard and are not well understood.

Concomitant to chronic pain sufferers also report many other difficulties (IASP Task force on Taxonomy, 1994) as they respond to the demands of their pain. People with chronic pain often present with fatigue, immobility and disability and sleep problems, social isolation and family relationship problems can also emerge and the relationship with social and medical services can deteriorate as the sufferer continues to seek help but most often receives failed medical treatments that compound their situation (Gatchell and Turk, 1996, 1999; Hanson and Gerber, 1990; Main and Spainswick, 2000).

Chronic pain is related to emotional problems as the sufferer struggles to manage their situation (Jensen et al., 1991; Robinson and Riley, 1999). It can be associated with high levels of pain-related fear and disability (McCracken and Gross, 1993), other

more social and interpersonal anxieties (Asmundsen et al., 1996), self-criticism and depression (Haythornthwaite et al., 1991), anger (Fernandez and Turk, 1995) and frustration (Wade et al., 1990). Chronic pain is associated strongly with negative emotions (Robinson and Riley, 1999) and the destructive effect of the fear and anxiety related to chronic benign low back pain can be significantly disabling. Emotions that have been associated with chronic benign low back pain include anxiety, fear, anger, guilt and frustration (Craig, 1994; Gaskin, et al., 1992; Kuch et al., 1993; Okifuji et al., 1999). Depression has been associated strongly with chronic pain and has been related to decreased pain tolerance (Romano and Turner, 1985) and self-criticism but the evidence suggests that although chronic pain can cause depression, the reverse is not true and depression is not a causal factor or precipitant for chronic benign low back pain (Skevington, 1995; Gamsa, 1994). Turk and Flor (1999) in a review of the research suggested that 40-50% of chronic pain patients suffered clinical levels of depression. Whilst from a clinical perspective, accommodating to loss and coping with depression was considered by Hanson and Gerber (1990) to be the major task presented to some-one having to endure chronic pain.

With regard to anxiety, authors such as Vlaeyen and Linton (2000) and Crombez et al. (1999, 1998) have argued that the role of fear in chronic pain was critical. The fear itself could be such that it promoted a phobic response to specific movements that caused more disability than the pain sensation itself. Such a high level of arousal was also considered by Melzack (1990, 1999) to be detrimental to both functioning and general health. In his work on the neuromatrix he highlighted its close relationship and sensitivity to prolonged stress. The two interacted in a synergistic fashion that perpetuated both and caused the related homeostatic mechanisms to dysfunction. In

the long run this led to a heightened experience of pain, hyper-arousal and the breakdown of muscle, bone and neural tissue.

Anger and its related hostility and aggression has been associated closely with chronic pain and was described by Fernandez and Turk (1995) as 'one of the most salient emotional correlates of pain' (p165). Anger is a common emotion experienced by chronic pain sufferers (Okifuji et al., 1999) and has been associated with increased pain intensity as well as depression and other pain behaviours. Although cognitive mediation was a factor in the experience and expression of anger, Berkowitz (1990, 1993) suggested that the noxious nature of pain and its intrinsic unpleasantness meant that the anger response was to some extent sub-cortical and not mediated by any cognitive processing. Berkowitz conceived of anger as integral to pain rather than just reactive to it.

The denial of anger, or self-blame was considered by Fernandez and Turk to be destructive and was implicated by them in increased pain and distress. Along with the inhibited expression of anger it has been shown to be a variable in poor physical health in general (Pennebaker, 1989, 1992). Pain sensation alone is not the sole source of anger for the sufferer and Fernandez and Turk listed many reasons for a chronic benign low back pain sufferer to become angry and frustrated in response to the personal and social implications of their situation.

All pain, acute and chronic has been shown to disable cognitive functioning. This can result in difficulties with concentration, attention, short term memory as well as problem solving and other cognitive tasks (Kewman et al., 1991; Smith et al., 1994;

Schnurr and McDonald, 1995). Sufferers also struggle to understand their chronic pain and the reason for its presence and this mysteriousness, incongruity and resultant confusion can compound the distress and cognitive problems that arise (Eccleston et al., 1997; Morley and Wilkinson, 1995; Williams and Thorns, 1989).

The role of attention and anxiety in chronic pain has grown in prominence over recent years, in particular the implications of the capacity for pain to interrupt and capture attention, the process by which we select the information required for action (Eccleston and Crombez, 1999). Eccleston and Crombez (1999) defined the inherent characteristics of pain that enabled it to do this; namely its intensity, novelty, unpredictability, association with threat and the related fear and catastrophising that promote hypervigilance.

Attention, tension and anxiety are also thought to influence the experience of pain by both increasing the levels of somatic tension and mediating the perception of pain. Arntz et al. (1994) proposed two psychological processes in the relationship between attention, anxiety and pain. An attributional one in which the pain-relevance of the anxiety was the essential factor and an attentional one, whereby the focus of attention was more critical. Pain-relevant anxiety was assumed to increase and mediate pain if the arousal experienced due to the anxiety was itself attributed to the source of the painful sensation and integrated into the pain experience. With attention the important factor was the degree to which the inherent nature of pain enabled it to command the sufferers attention, disable their functioning and cause secondary problems such as rumination, pain pre-occupation, emotional distress and more pain.

As anxiety is also a factor in focusing attention through the priming of the attentional processes it is likely that the two processes inter-relate. Pain-related fear can also interfere with cognitive functioning and cause the sufferer to become hypervigilant to threatening stimuli and less able to divert their attention from pain-related information (Asmundsen et al., 1997; Crombez et al, 1998) or apply more adaptive coping strategies (McCracken and Gross, 1993).

Eccleston (1995a, 1995b) argued strongly for the need to direct research toward the relationship between central attention structures, anxiety and chronic pain. This was prompted by research that showed the efficacy of distraction techniques and cognitive strategies for managing chronic pain to be equivocal (Eccleston, 1994; Skevington, 1995).

Eccleston's research focused on the fundamental nature of the relationship between pain and attention. He argued that pain, through its noxious and fluctuating nature, was able to access our consciousness very successfully. It could both interfere with our cognitive processing and secure the lions share of the finite resources that were available for all cognitive functioning. Eccleston concluded that as this was the case any attempts to divert attention away from chronic pain were futile in the long term and that to be constructive attention should be directed toward the pain. This would then facilitate a more adaptive attribution of the pain experience into something less fearful and less painful.

The evidence appears to show that affective distress is an important factor in the experience of chronic benign low back pain and that it can operate within it in a range

of ways, although the causal or maintenance mechanisms are not well understood. Longitudinal studies have indicated that affective distress is more likely to result from chronic pain than precipitate it (Gamsa, 1990; Radanov et al., 1996). In addition psychological disturbance has been found to be as great in patients with an organic basis to their pain as in those with no organic diagnosis (Benjamin et al., 1994) and pain sufferers pursuing litigation do not report significantly higher pain or distress than those who do not (Skevington, 1995). Both of these cases undermine the argument for purely psychogenic pain.

Psychological Processes and Theories of Chronic Pain: The maintenance of Chronic Pain and Chronic Pain Syndrome.

Gatchell and Turk (1999) in the preface to their book 'Psychosocial Factors in Pain' (p. xiii) defined four important points in the recent development of the study of pain, each one of which involved a significant step forward in the role of psychological factors and theories. In brief the four points were:

1. Melzack and Wall (1965), formulation of the gate-control theory of pain which emphasised the role of central nervous system structures in pain and the primacy of cognitive and affective factors in the experience of pain.
2. The work of Miller (1969) and Basmajian (1963) which demonstrated that psychological factors could influence physiological activity in the muscular and vascular systems implicated in pain.

3. **Fordyce's (1976) study of the role of learning and conditioning factors in communication and pain behaviour.**
4. **The work of Turk, Meichenbaum and Genest (1983) to integrate the above findings into a cognitive-behavioural model of chronic pain and its treatment.**

Chronic benign low back pain presents a different profile of symptoms and signs to the sufferer than that of acute pain. Although it may be associated with some form of injury or accident at first once any related tissue damage has healed after three to six months the symptoms are often hard for the sufferer to understand as they are generally unpredictable, vague, ill-localised and lack any relationship with time or physical activity that could be predicted from a simple or 'common-sense' knowledge of anatomy and physiology.

Mainstream social-cognition psychological theories of chronic benign low back pain have focused on either the contribution of dysfunctional beliefs and behaviours associated with it, or the coping or adaptation responses to it. Most research in chronic pain is applied and directed at either how to modify particular maladaptive behaviours or beliefs, or toward determining the active contribution of particular phenomena with the aim of achieving better therapeutic interventions and outcomes. This situation reflects the imperatives and clinical demands of working with patients who suffer with chronic pain, distress and disability but it could be argued that such an applied focus has skewed research away from the study of pain itself as a discrete phenomenon and that this has constrained our understanding.

The main psychological approaches will be reviewed below. The categorical distinctions, 'Behavioural' and 'Cognitive', are not meant to portray them as discrete or opposing theories but act as a simple device to aid their description. Each approach is also not homogenous and encompasses a variety of different perspectives which, when combined, represents the elements that have been integrated into the mainstream cognitive-behavioural approach.

Behavioural Theories.

Behavioural approaches established the difference between pain sensation and pain behaviour and focused on the relationship between them and the sufferer's external environment. They represented the first formal approach to pain management and targeted behaviour and suffering as opposed to just pain sensation. Chronic pain was viewed broadly in two ways.

Firstly, that it could arise and be maintained as the result of secondary hypertension that is induced by a fear of pain and can cause somatic tension, muscle spasm, ischaemia (restricted blood supply) and an exaggerated pain perception (Flor, et al., 1985; Bortz, 1984).

This respondent model postulates that the avoidance of movement that is induced by pain causes secondary problems as it leads to lower levels of activity, the disuse and deconditioning of the musculo-skeletal system and yet further increases in the levels of somatic tension and pain sensation over time. This situation generalises as it persists and more and more situations elicit pain and immobility as the pain-tension

cycle is intensified yet further.

Secondly, that pain behaviour and as a consequence pain is maintained by a form of secondary gain for the sufferer. This occurs when external reinforcement contingencies, including the behaviour of the sufferer's family or significant others prompts the development and maintenance of the maladaptive pain behaviour and chronic disability (Fordyce, 1976; Romano et al., 1992). In particular the solicitousness and attending behaviour of significant others toward the pain sufferer was felt to be a key factor in the maintenance of their pain behaviour and pain sensation (Flor, Kerns, and Turk, 1987).

This operant model, developed by Fordyce (1976), distinguished between the individual's private pain experience and their quantifiable pain behaviours. The latter being amenable to modification. The theory proposed that during the acute pain phase (the first three months) the pain behaviour would come under the control of external contingencies of reinforcement which prompted the development and maintenance of a chronic problem.

Philips and Grant (1991a, 1991b, 1991c) found evidence to argue that problematic chronic pain behaviours did not emerge as a new kind of behaviour but were the result of the persistence of acute pain behaviour over time, 'there was no evidence of chronic pain evolving and growing, but rather of a persistence of the acute presentation' (p435) (Philips and Grant, 1991b). This indicated to them that the behaviour represented a failure to accept that the pain was no longer acute, that no further medical treatment was possible and that a new way of conceiving and relating

to the pain was necessary. The pain behaviour had now become inappropriate and unhelpful as it was directed toward achieving a cure and solving an acute problem, rather than managing and adapting to the pain as a chronic phenomenon.

The behavioural approach suffers from appearing to be too uni-dimensional. It can be criticised for not taking account of the cognitive or affective factors involved for the sufferer and neglecting the perspective of the other individuals in the sufferer's immediate social network. Not allowing for the internal states of the sufferer or their family. Rowat et al. (1994) reviewed chronic pain in the context of the wider family network and showed how other family members also struggled to manage the chronic pain and how its impact on their collective lives influenced the sufferers pain. This exposed how the concept of chronic pain and pain behaviour as the result of secondary gain or attention seeking related to one discrete individual was too simplistic to explain the chronic pain experience.

Behaviourists would argue in their defence that they have never advocated such simplicity and have been misrepresented, that the focus of the theories they advocate has always been on the subtle and dynamic interaction between the person and their environment and that clinical interventions have abused the method in the past by aiming only to extinguish pain behaviour crudely, rather than understanding its maintenance. Behaviourism is interested in meaning, particularly the impact of threat and fear in this respect and so does not ignore or dismiss the emotional experience of the patient in a discompassionate manner. Nevertheless it remains a reductive approach that treats people as passive and inert respondents to the environment. It does not take account of their active 'internal' or private processes that contribute to

the particular personal construction of meaning that explains why similar environmental events can produce both a wide range of responses in different people and different responses in the same individual at different times.

Cognitive Theories.

Cognitive theorists focused on the individual's private appraisal of their pain and how they made sense of their experience. It represented a shift away from attending to observable behaviour toward an interest in the mind of the person involved. As a consequence cognitive theories placed an emphasis on the importance of the individuals beliefs, attributions, self-efficacy, expectations and acceptance, attention, control and coping strategies in the experience of chronic pain (Weisenberg, 1994; Jensen et al., 1991). The imperative to help people in chronic pain has focused research more on the cognitive aspect of the management of chronic pain and defining processes that exacerbate the experience and promote chronic pain syndrome.

The cognitive approach has shown that people develop a set of dearly-held beliefs about their illnesses and that the nature of those beliefs and the 'common-sense' models of illness that they construct out of them have implications for their chronic pain experience, pain behaviour and treatment (Nerenz and Leventhal, 1983; Lau and Hartman, 1983; Leventhal et al., 1980).

It is the dysfunctional nature of certain beliefs and the impact of unhelpful ways of thinking (in the form of coping responses) that are thought to be most important in the maintenance and genesis of chronic pain from a cognitive point of view. Maladaptive

evaluations of the pain experience have been associated with an increase in uncertainty, hopelessness, low self-efficacy and a lack of control (Jensen et al., 1991; Turk and Flor, 1999) which, it is argued, promotes further distress and disability and a subsequent increase in pain sensation. This maintains the pain as a chronic phenomenon through the direct influence on the pain-gate system and by denying the sufferer access to more therapeutic behaviours or ways of thinking.

The nature of the beliefs related to the onset of the chronic pain have also been shown to have an effect on morbidity in chronic pain, although it is not clear quite how this works. They generally fall within one of two broad categories where the sufferer considers their pain is due to a discrete event or not (non-event). Specific events include accidents, illness or surgery that the sufferer feels has led to pain that persists whilst non-event accounts for those situations where the chronic pain has emerged gradually over time for no apparent reason that the sufferer can discern. Adjustment appears to be worse for patients who believe their chronic pain arose as a result of a specific event (Toomey et al., 1997; Turk and Okifuji, 1996; Turk et al., 1996) however the results were not consistent and no causal mechanism has been proven although the role of blame and its attribution may be important (DeGood and Kiernan, 1996; Turk et al., 1996).

An individual's cognitions about an event and their ability to cope with it are hypothesized to affect functioning and behaviour in two ways, through a direct impact on mood and an indirect one through the influence of the selection of coping strategies. Lefebvre (1981) found that the cognitive distortions of chronic low back pain patients were similar to those of clinically depressed patients whilst

catastrophisation, frustration, pessimism, self-criticism/blame and pain pre-occupation have each been associated with poor coping, distress and high levels of pain in the chronic benign low back pain sufferer (Turk & Flor, 1984; Turk and Rudy 1992; Keefe et al., 1992; Holzman & Turk, 1986; Härkäpää et al., 1996; Williams et al. 1994).

Chronic Benign Low Back Pain: Fear-avoidance beliefs

The single most important dysfunctional belief in musculo-skeletal chronic pain is related to the 'fear-avoidance' of the pain. This belief is rooted in the incorrect assumption that the sensation of chronic pain signals the presence of an on-going disease process and organic damage that dictates the need to rest or restrict mobility (Slade et al., 1983; Riley et al., 1988). People with significant fear-avoidance see disability as a necessary part of chronic pain and activity as dangerous. The dominance of fear in this misinterpretation promotes the avoidance of movement and all the secondary problems this generates related to disuse, deconditioning and the maintenance and exacerbation of fear and somatic tension (Vlaeyen and Linton, (2000). Prolonged rest is contra-indicated in chronic pain and fear-avoidance has been shown to be predictive of the development of a chronic pain career (Waddell et al., 1993). The fear of the implications of spinal pain and the associated unwillingness to remain functionally active was at one point as much a result of misinformation concerning the nature of the underlying pathology causing the pain, as an aversion to the pain itself. Sources of misinformation were numerous but health professionals were not innocent in this instance. Despite the fact that no more than two days of bed rest is recommended for episodes of acute low back pain Deyo et al. (1986) patients

were until recently recommended to rest until they got better and told to avoid any physical activity that produced pain.

The research on pain beliefs has highlighted the association of certain dysfunctional beliefs with greater pain sensation, disability distress but has been unable to make more than correlational conclusions. More needs to be known to understand and explain the processes that are involved and the inherent variability over time that so typifies the presentation of chronic pain. The work to date has tended to examine beliefs by treating them as fixed, stable and inert variables in an experiment. As a result it has not been possible to make any statements about how they evolved or were formed and has not been able to address or accommodate them as dynamic or fluid phenomena.

The Concept of Coping.

Contemporary mainstream approaches to the study of chronic pain tends to adopt an integrated cognitive-behavioural approach that acknowledges the importance of both the individual's beliefs and appraisal of a situation and their experience of particular reinforcement contingencies. They are believed to inter-relate in a manner which determines the person's behaviour and can be understood and manipulated through the rational functional analysis of the behavioural and cognitive antecedents and consequences related to particular events such as pain or pain behaviour.

Research into coping strategies has attempted to identify the various ways, both helpful and dysfunctional, that sufferers employed to manage their pain. In brief,

passive approaches that reflected a sense of powerlessness and uncertainty such as 'hoping for a cure', 'resting' and 'catastrophising' have been found to be unhelpful prompting higher levels of reported pain sensation, distress and disability whilst more active strategies such as 'coping self-statements', 'positive social comparison', 'regular exercise' and 'seeking social support' have been shown to be more helpful (Jensen et al., 1991; Boothby et al., 1999). Certain strategies such as 'Ignoring pain', 'reinterpreting pain sensation' and 'distraction' have been shown to play only a minor or equivocal role in good adjustment (Boothby et al., 1999). Reviews of the research into coping strategies to date suggest that the relationship between each particular strategy, pain and functioning is not understood at all clearly and much more study is required.

Lazarus and Folkman (1984) defined coping responses as 'constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person' (p. 141). Much of the literature on coping views pain as a source of adversity that places a demand on the person that might exceed their resources. Pain is seen as the stressor and coping the response to it. The research has tended to focus on the reaction to the presence of the sensation of pain rather than any of its other emotional, behavioural or social elements.

Keefe et al. (1992) argued that it was difficult to determine whether it was pain or the lifestyle changes that were the most salient source of stress for pain sufferers. Turner et al. (1987) asked pain sufferers to indicate the major sources of stress in their life but only analysed the data on those patients identifying pain as the main stressor and

ignored the rest of the population. It is conceivable that people's coping responses have different effects in different contexts.

The review by Jensen et al. (1991) presented a mixed picture of the relationship between coping strategy and functioning although there were methodological problems with the grouping of studies. The review failed to distinguish between patient populations in its analysis, grouping studies using malignant pain (where a disease process was present) and benign chronic pain together. Chronic pain is not an homogenous condition and it cannot be assumed that each pain syndrome has the same set of biopsychosocial and contextual factors and processes at play. This can also be the case within particular single conditions. In chronic benign low back pain the incidence of catastrophizing and other 'maladaptive' pain strategies was higher in patients whose diagnosis was incongruent with a medical explanation and whose pain was more poorly localised (Hadjistavropoulos & Craig, 1994).

Boothby et al. (1999), Jensen et al. (1994), Dozois et al. (1996) Turner et al. (2000) each reviewed particular coping responses to chronic pain. Their findings for certain particular strategies are reviewed in more depth below although the overall picture with regard to their utility is not clear. The research has tended to focus on clinical populations that by their nature are typified by high distress and disability. The conclusions therefore have tended to emphasise the presence and problems of adopting passive responses to chronic pain and the limited efficacy and resource problems of employing more active strategies. It is not yet possible to divine the role of coping strategies as a discrete phenomenon in the maintenance or management of chronic benign low back pain but the research to date highlights the complexity of this

aspect of the experience of chronic pain. Those strategies which have received the most attention to date are explained and reviewed in more detail below.

Catastrophizing involves the use of exaggerated negative cognitions and attributions in relation to pain. It is the one strategy which has been related most consistently to poor adjustment and functioning in chronic benign patients (Boothby et al., 1999), although how the relationship works is poorly understood. Cross-sectional studies have shown catastrophizing to be associated with high levels of psychological distress (Harkapaa, 1991; Jensen et al., 1992) and pain intensity (Harkapaa, 1991). In agreement with the cross-sectional studies the longitudinal study by Jensen et al. (1994) showed that decreases in catastrophizing from pre to 3 month-post intervention were correlated with decreases in depression. In the more recent study by Turner et al. (2000) catastrophizing again predicted depression even when age, gender, pain intensity, beliefs and other coping strategies were controlled for.

Catastrophizing seemed to be unrelated to disability (Turner et al., 2000). Decreases in catastrophizing over 4-7 months were unrelated to changes in disability over the same time period (Jensen et al., 1994). An earlier cross-sectional study by Jensen et al. (1992) also found no relationship between catastrophizing and disability when pain intensity and duration were controlled.

Cross sectional studies vary but on the whole have shown ignoring pain to have little relation to disability and distress in patients with benign chronic pain (Robinson, 1997; Jensen et al., 1992, 1994). Post treatment physical and psychological functioning were also unrelated to pre-treatment scores on ignoring pain (Dozois et

al., 1996). One exception is Turner et al. (2000) who found ignoring pain to be significantly related to both physical and psychological functioning. The evidence is equivocal and worthy of further research.

Neither the four reviews nor other cross-sectional studies found a relationship between diverting attention away from pain and disability (Jensen et al., 1992) or psychological distress (Jensen et al., 1992; Robinson, 1997; Jensen et al., 1994; Dozois et al., 1996; Turner et al., 2000). On the whole the relationship was inconsistent and suggested that such distraction was similar to 'ignoring pain' and not something that appeared to be effective at managing pain. The problems related to sustaining distraction in the face of chronic pain and its ability to capture attention were reviewed earlier and will be looked at again in more detail in chapter seven, study two.

Employing positive coping self-statements is one of the rarer and more active strategies for coping with chronic pain. In this case the sufferer repeats to themselves consciously phrases that reinforce and describe a sense of optimism, control and self-esteem in an attempt to mitigate the impact of the chronic pain. Again research findings are mixed. Robinson et al. (1997) found more frequent use of coping self-statements to be correlated with higher levels of general activity. However Jensen et al. (1992) and Robinson et al. (1997) found no relationship between coping self-statements and disability or psychological distress. Jensen et al.'s (1994) longitudinal study also failed to find a significant relationship as did Dozois et al. (1996). Turner et al. (2000) found more frequent use of coping self-statements to be related to less depression. With the exception of Turner et al. (2000) the use of self-coping

statements appeared to be unrelated to better functioning.

Praying and hoping are not intended to mean the same thing but refer to a more passive and inert approach to managing pain. Of all the strategies this is one where the definition is the least well defined as little distinction is made between praying as an active religious or spiritual endeavour or as a more passive secular activity. It has been associated with distress and poorer adjustment in chronic pain (Boothby et al., 1999) but again the picture is uncertain and perhaps reflects the fuzziness of the concept.

The mixed picture given by reviews of coping strategies indicates that the concept could be useful but makes it difficult to draw any firm conclusions beyond confirming the maladaptiveness of catastrophising. It suggests that further research is required and highlights how little is known about the processes involved. The strategies as they are currently defined may not relate to the single phenomenon of pain in any consistent or meaningful way. They may say more if reviewed in the wider context of the personal and social situation the person with pain finds themselves in and the resources and demands that are placed upon. Equally, it may be more productive to control more for the intensity of the pain sensation, broad pain type and chronicity in more detail. In a study by Jensen and Karoly (1991) 'ignoring pain' and 'coping self statements' were found to be related to better psychological functioning and they also found 'diverting attention', 'ignoring pain' and 'coping self statements' to be related to increased activity levels. However this was only the case for patients with low levels of pain severity, identifying pain severity as a moderator of the relationship between coping and adjustment. As with the case for the study of beliefs the research

has tended to treat coping strategies as inert and monolithic variables and not as more dynamic or flexible concepts. It is possible that pain sufferers will not adopt one discrete strategy and apply it in a stable and uniform manner at all times but will utilise a whole range of them at different times and in varying degrees, according to different circumstances.

Other Theories of Chronic Pain.

Each psychological approach and theory like cognitive-behaviourism has addressed the problem of chronic pain, its genesis and maintenance at some time in an attempt to understand and explain its presence. Two alternative clinical approaches, Psycho-analytic and Systemic, are reviewed below. Each approach has a strong clinical tradition although not one grounded in the mainstream, social-cognition approach to research. They are referred to here, albeit briefly, to highlight the breadth of interest there has been in chronic pain and the importance of personal and social meaning that is shared by each approach.

Psycho-analytic approaches have described chronic pain as either, a conversion neurosis, a form of masked depression, or a hypochondriacal reaction and are based on the psycho-analytic view (Symington, 1986) that it results from a compromise between the fulfilment of a 'forbidden wish' and its punishment. More recent approaches addressed the metaphorical nature of the pain site and saw it as the somatization or sublimation of powerful personal emotional impulses and intra-psychic conflicts. The rigour of psycho-analytic research has never satisfied scientific criteria and their findings are generally considered to be interesting but not testable.

The evidence of Benjamin et al. (1988) that psychological disturbance has been found to be as great in patients with an organic basis to their pain as in those with no organic diagnosis also undermines the argument for a purely psychogenic pain.

Such an approach could also be criticised for being too uni-dimensional and not relating to pain as a multi-dimensional bio-psycho-social phenomenon. The traditional psycho-analytic approach seeks to explain the differences in reported pain according to the personality of the patient or the presence of a disorder. Patients are subsequently treated in a dichotomous fashion and their pain classified as either 'organic' or 'functional'. If the pain is organic it is considered 'real' and if not, it is defined by exclusion to be 'psychogenic' and explained as a somatoform disorder.

This makes many assumptions:

- (i) That pain measurement is reliable.
- (ii) That current diagnostic methods can detect all possible medical pathology.
- (iii) That there are no differences between people other than psychopathological ones.
- (iv) That pain cannot cause emotional problems, but is always the symptom of one.

These are all crude assumptions based on a reductionist and biomedical model that do not take account of the multi-dimensional nature of pain. Exclusively behaviourist or cognitive approaches, or an integrated cognitive-behavioural one would be equally at fault should they neglect the fact that pain existed and operated within a biopsychosocial context.

Family systems therapists have a clinical tradition of working with people in physical illness (Altschuler, 1997) and the importance of the family in chronic pain sufferer is important (Kerns and Payne, 1996; Kerns, 1999). Theorists believe that the emotional strain linked to pain and illness is related to the communicative nature of pain and that the symptoms of the patient are maintained if they fulfill the collective emotional needs of the family as a unit or social system (Roy, 1986; Patterson and Garwick, 1994). A rigidity in family interactions was considered to lead to the onset of a psychosomatic illness and the immediate precipitation of the symptoms were often caused by a threat to the family homeostasis whilst the maintenance of the symptom was explained by the new stability the symptom provided to the family system (Roy, 1986; Nicassio and Radejevic, 1993).

The implications of systems theory were supported by Smith and Friedman (1999) who looked at how the chronic benign low back pain patients perceived their pain within the context of their family relationships and suggested that the pain acted as a mechanism to regulate the distance and closeness of the sufferer to their family members.

As with the psycho-analytic studies more research related to a systems approach to chronic pain would be helpful, but the conclusions offer interesting avenues to explore and promote the active consideration of the symbolic, social and psychological factors over the physical ones in the genesis and maintenance of chronic pain.

The evidence suggests that it is unlikely that any one prescriptive psychological

theory that neglects to see pain in its bio-psycho-social context will be able to explain the multi-dimensional puzzle of chronic pain successfully and will only repeat the failures of the medical model. That is not to say that for specific patients the two approaches above have not been very helpful.

Chronic Pain Management – Pain Management Programmes.

An argument in support of the primacy of psychological factors in chronic pain is the efficacy and utility of chronic pain management programmes. These are psychological interventions designed to help people better manage their pain and reduce the disability and distress concomitant with it.

Living with chronic pain involves managing more than just the sensation and unpleasantness of pain but also its personal and social impact, including the changes, losses and uncertainty it brings for both the sufferer and their families and carers (Hanson and Gerber, 1990; Main and Spainswick 2000).

The services for people with chronic pain are grounded in the bio-psycho-social model and many studies have been able to show their utility and efficacy (Flor et al., 1992; Morley et al., 1999). These services are in demand as chronic pain is a significant source of disability and morbidity amongst the working population and has been described as a public health problem of epidemic proportions (Rosen, 1994).

Pain management programmes vary according to their composition and approach but most if not all are based on the gate-control theory of pain (Melzack and Wall, 1988).

They attend explicitly to the psychosocial processes involved in the mediation of chronic pain and aim to enhance the individual's ability to manage and cope with their chronic benign low back pain.

Each of the psychological theories reviewed above have contributed to the development of helpful psychological interventions for chronic pain. Although services differ locally in their approaches they each share certain common features, (Turk and Holzman, 1983; Hanson and Gerber, 1990; Gatchell and Turk, 1999) which are:

- (i) **Reconceptualisation.** Providing a rationale of the patients' pain in a way that makes it understandable to them and amenable to modification..
- (ii) **A message of hope and optimism to combat demoralization.**
- (iii) **The individualisation of treatment to suit the patient's needs and take explicit account of their psycho-social situation.**
- (iv) **Active patient participation and responsibility in the quest for improvement.**
- (v) **The acquisition of pain management skills.**
- (vi) **The promotion of self-efficacy.**
- (vii) **The attribution of change to the self.**

Each of these common elements and objectives are shared with other chronic illness rehabilitation programmes (Bennett, 2000) and some psychotherapies (Dryden, 1996). They highlight the benefit of focusing on the personal and psychosocial resources of the individual sufferer in chronic illness, independent of their medical situation.

Pain Management Programmes (PMP) are the most popular group psychological interventions and take a palliative approach to chronic pain. They are not concerned primarily with ridding a person of pain but are focused on helping people deal with, cope and ultimately manage the effects of having chronic pain. People referred to a PMP have generally experienced a significant decline in their social, recreational, vocational and domestic activities and are often experiencing psychological distress (Main and Spainswick, 2000; Gatchell and Turk, 1996; Hanson and Gerber, 1991).

Chronic pain is a broad term that encompasses many different types of pain of which chronic benign low back pain is one of the largest. Similarly, patients who display and endure chronic pain syndrome, that is pain with disabling distress are also not an homogenous group. The previous section on coping strategies highlighted the extensive and complex variety of individual responses to chronic pain and how each one, although described as a strategy, did not appear to serve a single function but was perhaps better described as a multi-dimensional reflection of that persons appraisal of their situation. Turk and Rudy (1988) surveyed a clinical population of chronic benign pain sufferers and found evidence of their diversity and the variation in their clinical need. They distinguished between three distinct profiles of patients which were; 'Dysfunctional' (DYS), 'Interpersonally Distressed' (ID) and 'Adaptive Copers' (AC). DYS patients reported high levels of psychological distress, inactivity and felt a lack of control whilst ID patients felt they had little social support and that their pain was dismissed by important others. In contrast AC patients reported less pain and distress and functioned at a higher level of mobility. These findings were reinforced by Mikail et al. (1993) and were used to show how an enhanced therapeutic effect could be achieved by tailoring interventions to the more specific

and personal needs of chronic pain patients (Turk and Okifuji, 1998; Turk et al., 1998).

A pain management programme format varies from centre to centre. There are both inpatient and outpatient programmes and the amount of patient contact time is dependent on the resources available. Due to the multifaceted nature of chronic pain the team running a PMP is typically multidisciplinary consisting of a nurse, doctor, physiotherapist, occupational therapist and a clinical psychologist.

The psychological therapeutic approach of a pain management programme is based mainly on cognitive-behavioural theory. Although clinical psychologists are divided in the emphasis they place on either the cognitive or behavioural components in therapy it is difficult to differentiate between them in practise. Implicit in cognitive-behavioural therapy (CBT) is an emphasis on helping patients to look after themselves. Bradley (1996) highlighted the four main objectives of CBT when applied to chronic pain patients, which were:

- To help patients to alter their beliefs that their symptoms are unmanageable and teach them to become resourceful problem solvers.
- To help patients to monitor their thoughts, emotions and behaviours so they may realize the relationships between these and environmental events, pain, emotions and psychosocial difficulties.
- To help patients to practice behaviours at certain times to cope effectively with pain, emotions and psychosocial difficulties.

- To help patients to learn and maintain adaptive ways of thinking, feeling and responding that can be used to cope with problems that may arise after the termination of the PMP.

There have been a number of meta-analyses into the efficacy of PMPs. Morley et al. (1999) conducted a systematic review and meta-analysis of the randomised control trials that had examined the efficacy of PMPs. They found strong evidence for the efficacy of cognitive-behavioural treatments in restoring function, mood and reducing pain and disability. Their analysis also found PMP multidisciplinary approaches to be significantly better at achieving positive changes in pain experience, cognitive coping and appraisals and reducing pain behaviours compared to uni-modal treatment approaches. Studies comparing PMPs to waiting list controls showed the same significant differences, as well as significant improvements in mood, affect, activity levels and social role functioning.

Morley et al. (1999) were critical of the research they reviewed and noted that most empirical studies had an over-reliance on self-report measures and not enough direct observational reports. They felt there was a poor representation in the data of measures of health service use, drug intake, uptake of additional treatment and change in work and occupational status.

Due to the nature of a meta-analysis many outcome measures have to be subjectively classified into higher-order constructs to aid the making of generic conclusions. In addition to this the variability between different programmes and the difficulty in standardising the application of the wide variety of cognitive-behavioural therapies

can prevent important effects of a the cognitive-behavioural approach to chronic pain being identified. It can be argued that such a statistical analysis only gives a view of the general efficacy of the most common components of pain management programmes and that little comment on the therapeutic processes involved is possible.

The majority of studies used in the Morley et al. (1999) meta-analysis were designed to compare pre and post adjustment measures to determine contemporaneous efficacy and little long term follow-up data was taken. Other longitudinal designs have however shown long term improvements. One randomised control study followed up an outpatient multi-modal CBT programme over 18 months and found the CBT group to be significantly better than the controls on measures of pain intensity, behaviour change pain coping ability at work (Jensen & Bodin, 1998). A much earlier study by Guck et al. (1985) compared post-treatment patients with controls from one to five years after treatment and found patients reported less pain and depression and an overall increase in quality of life above that of the controls.

Psychologically based pain management programmes, although the treatment of choice and proven to be effective remain only partially understood. Many medical, personal, social and cultural factors are beyond the influence of such interventions and they should not be considered to have failed if they have not produced significant change at every level. However, the mechanisms underlying treatment success have yet to be determined and it is still not clear what works for whom (Tait, 1999). The limits of our knowledge are exposed by the difficulties we have in explaining outcomes and predicting the individual variability of patients' progress through pain management interventions. Turk and Rudy (1991) asserted this view in their

conclusion that it was unclear exactly what people with pain have to do to feel better and that as a consequence compliance, adherence to treatment and attrition from programmes remained a problem. Turk and Flor (1984) and Jensen et al. (1991) when reviewing treatment approaches each concluded that the development of research into the contextual and processual factors in chronic pain was required to improve services in this regard.

Chapter Three.

Qualitative Research and Chronic Pain.

Introduction.

Psychological research has yet to address completely the dynamic complexity of chronic benign low back pain and it could be argued that this is due in part to the limits of the approaches that have been employed to date. Despite the evidence of an acknowledgement of the significance of the meaning and phenomenology of chronic pain outlined earlier, psychological research and treatment has only recently begun to adopt qualitative methodologies to examine it. Little attention beyond the anecdotal accounts of clinicians has been given to the lived experience of people with back pain (Carter, 1999) and this was exposed in the literature review undertaken by Walker et al. (1999) who could not identify any published studies using qualitative methods in any of the journals directed solely to the study of pain.

The research to date has shown much of the multi-dimensional nature and complexity of pain and provided us with a wealth of data about it and the argument for applying qualitative methods does not imply the rejection or dismissal of the findings of quantitative research. Shaw (2001) emphasised this point when making the case for the application of Interpretative Phenomenological Analysis (IPA) in health psychology:

without the invaluable knowledge provided by these traditional studies health psychology and more fundamentally, health practice, would not bare the high levels of sophistication it does today. (p48).

Much remains that defies our understanding of chronic benign low back pain and a phenomenological approach could be utilised to explore more fully the confusion that is left.

There is a need for a different approach, not to replace empiricism, but to complement it:

phenomenological perspective in psychology offers the possibility of reconsidering many established psychological issues and concerns in ways which are original and illuminating. (preface ix) Spinelli (1989)

Although few qualitative studies of the personal experience of pain have been published there are examples of quantitative endeavours to attend to the symbolic nature of pain and the use of language. Melzack and Torgerson (1971) in their preliminary work for the McGill Pain Questionnaire were keen to develop new approaches to the problem of assessing pain and wanted to use words instead of numbers to describe its many forms. This was an attempt to view pain as more than just a sensory phenomenon and explore the wealth of language that was available to describe it. Their ambitions were limited at the time but they hoped to explore the many different ways that pain could be described in an empirical way,. Words used to define pain were brought together and categorised and an attempt was then made to scale them on a common numeric intensity dimension. Unfortunately this maintained the primacy of a quantified view of pain intensity in research and clinical work by taking a rich source of qualitative data and reducing it to a single dimension and a number. The study did, however lend strong support to the notion that pain represents a wide variety of experiences that can be captured, expressed and

accounted for in the sufferer's use of language. They were able to show that the words that were used revealed something about the nature of pain and showed it to be something that involved previous experience, attribution and meaning. They went on to suggest that a detailed analysis of the quality and structure of the pain experience was required, but this has yet to happen in the way they intended. Their experience revealed how the nature of pain will resist any attempts to reduce it to a simple uni-dimensional phenomenon and that the language used to describe pain does not contain enough shared or consistent meaning to work successfully as a diagnostic medical tool.

Rationale for the adoption of a Qualitative Approach in the study of Chronic Benign Low Back Pain.

The qualitative approach and the methods employed within it are reviewed extensively in the next chapter (the Qualitative Approach). Prior to this in the section below a rationale is given for adopting it in this thesis.

Getting at the Meaning of Chronic Pain.

A range of explanatory theories have been developed for chronic pain and these have been criticised for being too reductive (Novy et al., 1995). Novy et al. indicated the need for more

complex theories that could integrate the many multi-dimensional aspects of pain whilst Aldrich et al. (2000) also argued that such theories needed to recognise these elements as dynamic phenomena and not static or concrete. Qualitative methods have been shown to be useful in the study of fluid and rapidly changing phenomena that are not easily measurable.

The inability to quantify pain or its related cognitions and emotions in a reliable and valid way remains a key research problem and one which supports the argument for developing alternative ways of studying pain. This argument is not just based on a critique of the limits of the research that has been done to date, but has emerged out of the conclusions formed from that research and their recommendations for further study (e.g. Price, 1999; Pincus and Morley 2001). A more idiographic approach to the study of pain is recommended and in particular one that privileged the description and interpretation of the personal meanings of chronic pain and articulated the processes by which those whom suffer it constructed and made sense of their experience.

Two examples of the problems of quantifying the chronic pain phenomena are 'straight leg raising' and the 'visual analogue scale' (VAS). Both are accepted widely as quantified measures of pain sensation and disability but claims that they capture the pain experience in an objective or valid manner are problematic. Medical and sensory conceptualisations of pain have led to the use of measures such as 'straight leg raising' (the degree to which some-one can raise their leg from the horizontal) to determine the nature and extent of pain sensation, organic pathology and disability. The interpretations of these findings however rely on the clinical judgement of the clinician and are poorly standardised (Jensen et al., 1991). They also do not allow for the social demand characteristics of the situation, for example, some one in chronic pain could raise their

leg to its mechanical limit once, as long as they were prepared to endure severe pain as a result. That pain would most likely not be contingent on the leg raise but would emerge the next day. Consequently, the degree to which a person with chronic pain can raise their leg is not a measure of their pain but could also be a function of what they hoped to do the next day, or what they wanted the person assessing them to think of them.

A more psychological measure is the visual analogue scale (VAS) to measure pain severity and intensity. Despite its development as a standardised and objective pain measure it also remains very subjective. Sufferers are asked to indicate the severity of their pain by placing a mark on a 100 millimetre line where one end signifies 'no pain' and the other the 'the worst pain imaginable'. This is based on the assumption that pain can be evaluated along one dimension and that 'the worst pain imaginable' remained constant for the individual. This does not allow for the possibility that the person's experience could cause their imagination to change over time and so alter their report of pain.

As some-one's pain can only be inferred from their behaviour and self-report its quantitative study will always be problematic. Quantifying pain and aspiring for an objective and stable measure limits the extent to which it can be viewed as a dynamic or fluid phenomenon that can be different according to context and contain within it paradoxical or contrasting elements. The evidence suggests that pain is more than just an acute primitive warning signal and its complex presentation demands further study.

Quantitative empirical research to date has clarified and classified the psychological nature of chronic benign low back pain (Skevington, 1995). However, although in each case the researchers have identified important constructs, beliefs and behaviours that are characteristic of and associated with chronic pain, they have been unable to address completely how or why such behaviours and beliefs were formed, maintained or interacted. Further research is recommended by a number of authors to gain a greater awareness of the personal meaning of pain to the sufferer and the processes involved in the development of chronic pain (Craig, 1984; Holzman & Turk, 1986; Jensen et al., 1994; Jamison et al., 1994; Flor & Turk, 1984; Gatchel and Turk, 1999). Leventhal (1993) considered that the nature of personal meaning needed to be given a central focus in the study of pain because:

It has long been clear that the meaning given a somatic (pain) experience will play a crucial role in the activation of the emotional-motivational component of the pain system. (p142)

Craig (1984) after acknowledging the extensive expansion of research on the pain phenomenon argued that the developments in our knowledge highlighted the need to gain a greater awareness of both the meaning of the pain to the sufferer and the relationship between a subjective experience and its overt expression. Craig felt that these phenomenon could best be understood as a product of the sufferer's personal background which lends further support to the value of adopting an idiographic approach to research.

Anecdotal Studies

There is a small literature of anecdotal studies about the experience of chronic pain written by experienced clinicians. These did not follow a systematic method but attended to the meaning of the personal experience of their patients. They are reviewed below.

Hubner (1984) in his clinical observations, placed pain at the heart of the individual's experience of their lives:

Pain had posed the ultimate question of meaning; that is, dominated by pain, and distracted by nothing, what did these patients live for? What gave their lives meaning? (p446)

Hubner considered that pain challenged the sufferers' meanings about their life and in so doing isolated them from those around them. To be in pain involved 'being separated, being alone. At no time are we more alone than when we are in the grip of pain' (p447). Bakan (1968) took a similar view and addressed the puzzle of pain by considering it, as did Frankl (1959), as an essential human experience which was indivisible from life and not simply a diagnostic tool of medical science but something which had the destructive potential to challenge the meaning of life.

In LeShan's (1964) work with patients in severe pain of long duration their pain was described as 'utter senselessness' and 'meaningless' but LeShan saw that individuals always tried to give it

meaning. He compared chronic pain with a nightmare as, (i) terrible things were done and worse threatened, (ii) all control appeared to be external, (iii) there was no time limit set. LeShan and Frankl both emphasised that as humans we have a need to find a reason or cause for suffering, a 'will-to-meaning', and that the lack of a perceived meaning in chronic pain or of a culturally understood context made it harder for the individual to cope with. According to LeShan chronic pain did not warn or tell us what to do, it did not help us to act and may be so severe as to disrupt useful activities and habits. He concluded that as we cannot act against chronic pain, but can only bear it, the only adequate expression of this kind of pain was a scream.

The above writings reinforce the concept of pain as a destructive force and described the potential of chronic pain to produce a form of existential frustration in the individual, a noögenic neurosis as Frankl put it where the sufferer felt not just pain but also experienced no other positive value in their life. This conforms with Levi (1987) who's personal account of suffering led him to believe that when enduring abuse and hardship it was the retention of an individual sense of purpose in living that promoted survival in adversity rather than a robust constitution.

During the last 30 years the field of pain control and research has grown at an ever increasing rate and pain phenomena are now considered an integral part of psychological theory, experimentation and clinical practice. Despite this progress however our understanding of chronic pain remains plagued by differences in focus and is typified more by debate than consensus. Psychological research into pain has been criticised for a lack of rigour and the neglect of single case design (Jensen et al., 1991; Morley et al., 1999) and the manner in which it

struggles to answer the contextual and phenomenological questions that have been specified as important in helping take pain research forward.

Much mainstream psychological research has focused on pain management rather than pain and represents an attempt to quantify and measure the experience in order to determine the efficacy of pain control procedures or the relative contribution of certain discrete factors. Large group studies and statistical analyses have not enabled the individual and personal parameters of the participants to be defined and denies the researcher the opportunity to study themes related to the idiosyncratic process of suffering chronic pain.

The extant psychological research suggests that the phenomenology and meaning of pain cannot be ignored and a qualitative approach has been shown to be useful to develop our understanding further. Price (1999) also argued that, as the ontology of pain was subjective, there was a need for new and different forms of study that could address it as such and recommended the application of a phenomenological approach to develop our understanding and knowledge:

A deeper understanding of pain and pain modulation requires that both scientists and healthcare providers directly address the meanings of pain (p210)

Chapman et al. (1999) felt that to develop our understanding of pain further the bio-psycho-social model itself required further development as it did not explain adequately the process of how the person's psychosocial experience affected their brain and body. They proposed that a constructivist perspective would help in this regard. One which acknowledged processes of

consciousness and meaning and assumed that the brain responded to an internal representation of reality, one of pain as a phenomenon, rather than to an objective or external reality.

Chapman et al. identified some key features of human consciousness which they felt were important in the construction of a personal representation of chronic pain (or any other similar phenomenon) for the sufferer. These were; 'coherence', which tended toward the formation of a personal meaning situated in space and time; a 'sense of self', described as an epiphenomenon of the brain's tendency toward that coherence which allows for a point of view or perspective to be established and maintained in a stable fashion over time; and 'purposiveness' which inclines toward survival and adaptation and mediates the allocation of finite resources.

The constructivist view expands on the idea of the importance of cognitive schemata (Dar and Leventhal, 1993; Pincus and Morley 2001) or 'common sense' models in the experience of pain (Leventhal, 1993) and according to Chapman et al. provides for a pathway from the peripheral and biomedical processes of transduction and nociception through to the final and psychological experience of pain.

The review in chapter two of the definitions, theories and psychological aspects of chronic benign low back pain showed it to be a multi-dimensional phenomenon and established the importance of the psycho-social elements within it. Its 'unpleasantness' was evident in the extensive negative affect, cognitive distortion and behavioural dysfunction and disability that was associated with it. Merskey (1984) stated that the management of pain should be based on a clear concept of the nature of pain and that the challenge was to understand the relationship

between pain sensation, distress and disability which was neither directly linear nor causal but personal and psycho-social.

Pain is now both defined and recognised as a subjective experience and this has had important implications in its research, enabling a focus to be directed toward phenomenological and contextual influences (Anand and Craig, 1996; Encandela, 1993; Price, 1999). Despite such recommendations the number of published empirical studies on the personal meaning of pain is limited and research is most often to be found within the medical sociology literature (e.g. Kotarba 1983; Baszanger, 1992; Bury, 1988; Bendelow & Williams, 1995). Carter (1999) concluded that little attention has yet been given in the study of pain to the lived experience of people with back pain.

The review of the body of qualitative research on chronic pain that follows later in this chapter shows that the application of this approach is at an early stage. There is little on chronic benign pain as opposed to chronic malignant pain or chronic illness and even less that adopts a more explicit idiographic approach looking at the individual's private experience of the chronic benign low back pain itself. Much of the work adopts a sociological perspective that highlights the social consequences of having pain and the difficulties that are created within the sufferer's family system, or in their relationship with the health and social services.

The qualitative psychological studies to date, however few in number, have shown that there is a significant advantage to employing a qualitative methodology and gaining access to an area of the individual's experience that could not otherwise be secured. The conclusions of qualitative

study are, by their nature, tentative and help to discern the themes around which the participants order and build an understanding of their experience.

Qualitative research into physical health has been criticised from within for according the socio-linguistic dimension too much privilege such that the material or physical dimension of the experience of illness, the body, has been overlooked or rendered invisible (Yardley, 1997a). In health psychology this takes the form of focusing too much on the discursive nature of experience such that the material or external aspects are neglected and a reductive, dualistic mind-body approach that excludes the body and only attends to the mind is reinforced. The findings and conclusions that emerge from such an approach to research is then at risk of becoming disembodied from the participants' experience and guilty of being equally as unrepresentative and limited in its scope as a quantitative study (Kelly and Field, 1996). The relationship between discourse and physicality is an ongoing source of debate and has led to the development of material-discursive approaches that acknowledge the physical reality of the body and attempt to encapsulate theories which embody the participant's experience and do not relegate the body to a minor or passive role (Yardley, 1997a; Murray and Chamberlain, 1999).

This notion, which has been termed 'embodiment' is an attempt to maintain the idea that we experience things from the perspective of an integrated and 'lived body' (Bendelow and Williams, 1995; Frank, 1990) and as such are more than simply a psyche reacting to and separate from a body. To not adopt this view would represent a replication of the biomedical and dualist perspective that discursive approaches set out to challenge. A more integrated and 'embodied' approach recognises that the physical aspect of experience is equally as responsive to contextual

and discursive processes and an important focus of study. In this way the contribution of more physical phenomena such as dizziness, fatigue, pain, nausea, heat, weight gain or anxiety can be recognised and included within any emergent theory.

Phenomenology, with its primary focus on the personal experience of the participant provides a useful means of achieving such an approach and recent writings have aimed to develop a phenomenological approach to the body and illness which conceptualise it as an embodied, multi-dimensional phenomenon (Murray and Chamberlain, 1999; Yardley, 1997; Borkan et al., 1995).

This Research Project: using Interpretative Phenomenological Analysis (IPA) to examine the personal experience of chronic benign low back pain.

This doctorate represents my contribution to the development of our understanding of chronic benign low back pain and the request that is repeated often in the literature to attend to an aspect of the personal experience of chronic pain in a manner that is firmly psychological in orientation and emphasis.

The particular approach that has been adopted, Interpretative Phenomenological Analysis (IPA) and its theoretical basis are described in detail in the next two chapters.

The research to date about the psychology of chronic benign low back pain is compelling and shows it to be an important and fascinating area of study. In particular it shows that there is a

pressing need to continue to study it from a qualitative perspective and look at its 'lived' experience and personal meaning.

Qualitative research methods are concerned with achieving a descriptive or conceptual account of the data rather than constructing general laws of behaviour and can help to build theory in areas which are difficult to research in more quantitative ways. They can be particularly helpful in making sense of a mass of abstract information or in areas typified by fluidity or change.

The commitment of IPA to an idiographic case-study approach can complement both the extensive quantitative research that has been published to date and add to the very limited body of qualitative research that shows a need for more phenomenological study. The value of IPA is it is data-driven, it employs a method that maintains a closeness to the data and as a consequence is governed very much by the accounts given by the participants. Its flexibility enables the researcher to investigate the personal experience of the participant within a cultural context and make connections between the two, attending to both what is unique and what is shared within the participant's accounts (Shaw, 2001).

A considerable number of health psychology studies have now been published using IPA and although its use is not exclusive to health psychology it has been proven to be particularly useful in this field. The phenomenon under study in health psychology; peoples bodies and the experiences they have of them are ideal subjects for study using IPA as they are recognised to be complex, subjective and dynamic and influenced by contextual factors that are not easily measurable. It is useful for exploring the relationship between subjective perceptual processes

and disease and there is already a growing literature on the use of IPA in a variety of areas in health psychology, including: genetics (Michie et al, 1999; Smith et al., 2000), sexual health (Flowers et al., 1997; Flowers et al., 1998), palliative care (Jarrett et al., 1999), and pregnancy (Smith, 1999a; Smith, 1999b).

The existence of real, material entities such as bodies and disease provides an ideal context for this kind of qualitative research. Smith et al. (1999) summed this up by saying:

Why is IPA relevant to health psychology? It can be argued that health psychology is generally premised on the belief that people think about their bodies and that their talk about these bodies in some way relates to those thoughts. (p219)

Accessing the personal meanings inherent in the participants' experiences is central to this form of study. The aim is to try to understand and illuminate their content and complexity rather than determine any measure of their frequency. As mentioned in the next chapter on qualitative research, these meanings are rarely transparent and emerge via the interpretative process which involves the investigator in a sustained engagement with the data. That is the approach within each of the studies in this thesis and the data are the verbatim transcripts of semi-structured interviews given by the study participants.

This doctorate will attempt to add to our understanding of chronic benign low back pain by going some way to addressing a gap in the extant research which indicates an urgent need for more psychological idiographic qualitative studies to complement the body of quantitative and

sociological work that has been done to date. Chronic benign low back pain represents perhaps one of the best subjects for this kind of research as the evidence suggests it involves the ever-changing interplay of physical, psychological and social elements.

Empirical Qualitative Studies in Chronic Pain.

Studies directed explicitly at exploring the personal meaning of chronic pain are rare in the psychology literature and until recently tended to represent the anecdotal observations of experienced clinicians, rather than the application of a particular empirical method (reviewed in chapter two). Of the qualitative study on chronic pain that there is, the majority has been undertaken within medical sociology and has either focused exclusively on determining the social meanings related to the phenomenon under study or looked more broadly at chronic illness in general.

The impact of a chronic disabling condition such as pain on the individual was described by Bury (1982) as a 'biographical disruption'. Chronic pain and illness was shown to call into question the sufferer's past and future and required them both to rethink each one and renegotiate each of their relationships. Williams (1984) also argued along similar lines that chronic illness had the potential to cause the sufferer to rethink their situation extensively and engage in a 'narrative reconstruction' of their lives. In the absence of other facts, the individual drew upon their lay beliefs to construct an account of the onset of their illness and often this entailed that they reconfigured their biography, past and present. It was essential for the sufferer to construct

an account of their situation and they used whatever beliefs, models or 'facts' that were available to them to serve this process.

Strauss (1984) looked at chronic illness generally and introduced the notion of the 'illness trajectory' to describe the total amount of work undertaken by the sufferer over time to manage their illness. Themes such as uncertainty, intrusion and social isolation were considered by Strauss to be important in defining the individual's particular trajectory which itself was then felt to have consequences for their social roles and identity, how they defined themselves and were defined by others. Corbin and Strauss (1987) later wrote about the active way in which people with chronic conditions endured a process of identity reconstruction as their situation changed and deteriorated and they endeavoured to maintain a continuity with the life they knew prior to their illness.

Charmaz (1983, 1995b, 1999) emphasised the degree of loss associated with chronic illness and how this forced the sufferer to adapt constantly. Charmaz speculated at how the experience of chronic illness disrupted the sufferers social identity and forced them to redefine their place within their social and cultural network. This process of definition took place in the context of social discreditation and produced a sense of alienation in the sufferer as they became dislocated from their previous and preferred social identities. Their identities were not conscious and had been taken for granted by them up to that point, only emerging into consciousness as a result of their loss. Other studies also highlighted the deleterious impact of illnesses that had chronic consequences on the sufferer's self-concept and the problematic contrast between their private sense of self and their public social identity (Yoshida, 1993; Kelly, 1992).

An explicitly qualitative approach to chronic benign pain was undertaken by Baszanger (1992) and took as its focus two different pain centres with contrasting philosophies although the same theoretical base in the gate-control theory of pain. Baszanger focused on the context and setting of a pain clinic, described its characteristics and examined how physicians specialising in chronic pain worked at 'deciphering' pain to themselves and for the patient. The study was not an analysis of the sufferer's experience of pain but that of the professionals who set out to treat them.

Baszanger found that there was no consensus regarding chronic pain that could be used to characterise a patient's pain situation or organise relations between professional and lay persons. This difficulty, 'the problematic factuality of pain and doctrinal debate' (p212) affected physicians' everyday practices and their relations with patients. By using two pain centres with opposite conceptions and practices Baszanger showed the differing ways in which the physicians determined the patient's pain, formulated advice to them and how this involved them in specific systems of relations with patients. This enabled her to draw attention to the use of operational knowledge and the physicians' arrangements of the facts that amounted to the resources they used for organising interventions. She revealed how operational knowledge was central to the medical work that brought doctors and patients together.

A researcher who focused on the social meanings attached to chronic benign low back pain specifically was Kotarba (1983), who underscored how difficult it was for chronic benign low back pain sufferers to function securely within their social settings, free of punitive labels.

Finding an acceptable role or public identity was shown to be difficult and their self-concept suffered as a consequence. Kotarba, like Williams (1984) highlighted how chronic benign low back pain patients did not resign themselves passively to having pain but engaged in a continual sense-making process and showed how they reached out to others in their social world to establish and determine the meanings of their pain. He focused on the loss of self-esteem that could occur when having pain threatened the competent fulfillment of particular social roles, such as the 'good patient', 'good parent' or 'good worker'. The lack of any positive social meanings for chronic benign low back pain was a key part of Kotarba's thesis:

the common reaction among patients is to interpret the term 'chronic benign low back pain patient' as a negative evaluation of self. They see themselves as somehow being blamed for their misery or as having a weak character for not remaining stoic. (p76)

Kotarba highlighted how the experience of chronic pain challenged the individual's definition of themselves and their social worth through the absence and loss of any positive social identities and roles. They showed how sufferers had to defend themselves against the acquisition of negative social labels and struggled to fulfil other more positive ones competently. Chronic pain often meant it was difficult even to be a 'good patient'.

Hellstrom (2001) and Charmaz (1991, 1994, 1999) highlighted the importance of the dimension of time in relation to the individual's experience of their self-concept during a chronic illness..

Hellstrom (2001) adopted a phenomenological method and looked specifically at the problematic relationship between chronic benign low back pain and the self. She emphasised a key task in

chronic benign low back pain of maintaining the consistency of the self and focused on how this unfolded problematically over time. To Helstrom, the self was something that was both stable and malleable and could, as a result of chronic benign low back pain, develop into many different and sometimes unhelpful selves. The participants in Helstrom's phenomenological study described their self-concept in a number of ways. As a nostalgia for a past self, highlighting a significant sense of loss; as a notion of a 'projected self' where they felt defined by others and vulnerable to denigratory labels; and as an 'entrapped self' where they felt isolated in the present, unable to communicate with others or progress and stuck in what Helstrom termed a 'viscous' present where events could not be controlled or predicted. The task of maintaining a consistent self-concept in the face of chronic benign low back pain was highlighted and Helstrom argued how when this led to the development of an unrealistic or 'spurious' self, like the 'fictional self' described by Charmaz, it could compound the problem and prevent the individual concerned adapting constructively to their situation.

Walker et al (1999) also took a phenomenological approach to the study of chronic pain and a prominent theme to emerge was one they termed 'in the system' to describe where patients felt trapped and powerless within the medical, social security and legal systems. In their study personal accounts were collected from chronic back pain sufferers who sought help from a pain clinic and analysed using a phenomenological method. Five themes emerged which were identified as; 'The pain takes over', 'Sense of loss', 'They don't understand', 'Coming to terms' and 'In the system'. Unfortunately they chose to focus on only one theme, 'In the system'. They did not expand on the other four in any detail except to say in summary that the participants told how their daily lives had been changed irrevocably due to their pain and that it lead to a profound

sense of loss that pervaded all aspects of their life. The participants felt misunderstood and stigmatised by their pain and this made it difficult to come to terms with their current situation, they felt pessimistic and could see no positive future for themselves.

The theme 'In the system' represented the main focus of the Walker et al. study and described in detail how those with back pain felt both passive and powerless. The authors argued that they were rendered this way to a great extent through becoming entrapped by the very systems which were designed to help and protect those who were ill, injured or disabled. The participants' experience of both the medical and the welfare systems acted to compound their distress and disability through exacerbating their confusion, limiting their sense of control and discretion and engendering a feeling of stigma. They concluded that this reinforced the relevance of situational explanations for the development of the negative attitudes and perceptions that were often held and reported by chronic pain patients. The social meanings related to chronic pain that emerged in the study confirmed Kotarba's (1983) findings and emphasised the difficulties chronic pain patients had of living with their condition within a social context that conferred it no positive or even neutral value.

The Walker et al. study represented the first exclusively qualitative study to be published in a pain journal. It highlighted the importance of situational processes over individual or intra-personal factors and explored how the physical, personal and the social elements interacted in the experience of chronic pain. Their focus on the one theme 'in the system' however tended to emphasise and privilege the situational and social factors over the personal and physical experience. This echoes the assumption within phenomenology that human experience is too

complex for any one study to capture (Giorgi 1985) and highlights the potential for more research in this area.

Summary of the Literature

Pain is an everyday experience that functions to promote protective behaviour aimed at the escape or avoidance of physical harm. Viewed in this way it has a strong survival function. However, chronic benign pain also has two rather unfortunate and dominant characteristics: first, it is an interruptive and unpleasant experience; and second, it can persist long after its survival value (or diagnostic utility) is spent. It cannot be measured directly but can only be inferred from the sufferer's self-report and behaviour.

Chronic benign low back pain has the potential to disable cognitive functioning and can be associated with high levels of negative affect and disability. It has been described as 'physiologically offensive' (Fernandez and Turk, 1995) and 'malefic' (Bonica, 1974) and in particular the inherent characteristics of pain: its intensity, novelty, unpredictability and association with fear can promote hypervigilance in the sufferer and makes chronic benign low back pain particularly good at capturing our attention and securing a place within our consciousness (Eccleston and Crombez, 1999).

Counter to the notion of pain as a private event it can usefully be understood as a cultural, social, and symbolic event. The advent of the gate-control theory (Melzack and Wall, 1965) and the biopsychosocial model (Turk et al., 1983) established a connection between psychological

factors and the ultimate experience of pain that helped to some degree to explain the dynamic and idiosyncratic relationship between pain sensation, tissue damage, distress and disability.

Cognitive-behavioural theories consider that the suffering, maintenance and causes of chronic pain are the result of maladaptive behaviours, reinforcement contingencies, cognitions and a deficiency of coping skills. In particular, chronic benign low back pain has been related to:

- Secondary hypertension and ischaemia due to excessive guarding and bracing of the pain related parts of the body.
- The avoidance of movement due to secondary gain and social reinforcement that promotes immobility, disability and the deconditioning of the body.
- A phobic level of fear-avoidance of movement driven by the incorrect belief that the pain it caused signalled further tissue damage and peripheral pathology (as would be the case perhaps in acute pain).
- Cognitive distortions such as catastrophisation which prompt further distress, hypervigilance to pain and disability and an inability to adopt any useful coping strategies that might promote better adjustment or acceptance.

Qualitative studies of chronic pain are very limited in number and have highlighted the difficulties related to the process of loss, of preserving a valued social identity, maintaining a coherent sense of self and the problems of relating productively to medical health services.

The focus of much psychological research has most often been on chronic pain management

rather than the pain itself and there is a need for more progress in understanding key aspects of the experience of pain such as the pathway or link between psychosocial factors and the pain-gate, the active therapeutic ingredients of change and rehabilitation and the manner in which chronic pain unfolds and emerges over time following the first acute phase.

Chapter Four.

The Qualitative Approach.

Introduction.

This chapter reviews the qualitative approach to research within psychology, gives examples of some of the main approaches (although not all as this area is characterised by the variety and diversity of the methods that are employed) and argues the case for the utility of qualitative research.

In appearance the qualitative approach is markedly different to the quantitative one although on closer inspection they have more in common than might appear from the contrast in their underlying philosophies and methods. The presence of a degree of overlap and shared ground argues against defining the two approaches in opposition to each other. However, advocates of the qualitative approach are critical of the exclusive application of quantitative work within psychology. To a certain extent qualitative research emerged out of a dissatisfaction with the epistemology and methodologies that characterised the majority of research in mainstream academic psychology (Smith et al., 1995a; Yardley, 1997b). From an historical perspective psychological research has developed extensively over the last fifty years and as a result has moved from controlled laboratory experiments that focused on the manipulation of observable behaviours, to the study of more private, covert and intra-psychic phenomenon. This shift

represented the development of an interest in the activity of the mind of the person under study. Despite this development the ontological and epistemological approach that has been employed has most often remained the same, namely the logical positivism and empiricism of the natural sciences.

The qualitative approach is not easy to define in a concise manner. It did not emerge as a single or unified movement and the inherent variety, diversity and fierce debate within it defies any attempts at achieving a neat summary. The various qualitative approaches that have been applied come from different backgrounds and some are more advanced than others in their development. A broad consensus regarding the themes that typify the qualitative approach is possible however and these include an explicit commitment to; accessing the construction of personal and social meaning for the individual, an interest in subjectivity, using interpretation and description rather than measurement and statistical analysis, the importance of context and an holistic not atomistic approach, examining the process of the phenomena as well as its outcome and viewing the imposition of pre-ordained theoretical frameworks and assumptions as problematic as they constrained the researcher and may have a poor fit with the subjects perspectives. A priori assumptions are considered unacceptable as they interfere with the researcher's main objective which is to attend to the subject's personal perspective.

Qualitative and Quantitative Psychology.

Psychology by tradition is a quantitative and positivist discipline although in recent years there has been a development in the use of new and alternative approaches that have adopted a more constructivist, contextual or discursive epistemology (Smith et al., 1995a, 1995b; Guba and Lincoln, 1994).

Over the last decade the interest in qualitative approaches in psychology has increased dramatically and this has prompted the emergence of a number of publications dedicated to the approach both within psychology in general (Smith et al, 1995b) and in the area of health psychology specifically (Yardley, 1997; Murray and Chamberlain, 1999; Morse and Johnson, 1991). This represents a significant development in a discipline that has been dominated by quantitative study and a dedication to an epistemology and methodology inspired by the natural sciences (i.e. Physics). Smith et al. (1995a) asserted that this development was necessary and perhaps inevitable in order for the discipline to develop and progress in the study of covert, multi-dimensional and dynamic phenomena that require attention to be focused on personal meaning and the mind.

The differences in the two approaches is grounded in their view of several key aspects including; the status of an 'external reality', objectivity as opposed to subjectivity as the goal of measurement and study, how knowledge can be developed and accessed and ultimately, what constitutes human nature and a credible or legitimate scientific approach. A simple semantic

distinction might be that qualitative work sets out to articulate the nature of the constituent properties of an entity whilst quantitative work attempts to determine how much of the entity there is, what its dimensions are and how the component parts relate to each other in a logical or law-like manner as if they were acting in the same way as a physical particle. Typically a quantitative approach transforms a phenomena into a static numerical value in order to analyse it, whilst a qualitative study would focus on acts of speech and language or behaviour and attempt to describe or interpret the personal meanings within it. Qualitative work has an avowed commitment to language and the ways in which people use it. People are seen to engage in the active process of making sense of their world and there is a presumption that we build a representation of it to use as reference and guide action. Quantitative researchers also accept the notion and importance of an internal representation or schema that influences our experience, but study it in a different way, most often by treating individuals as interchangeable variables or subjects within the context of a controlled experiment.

The qualitative approach aims to achieve a detailed and textural interpretation or description of the phenomenon rather than the quantitative measurement of the relationship between hypothesised variables. The orthodox notion of psychological variables is abandoned in favour of seeing them as dynamic constructions located and embedded within an embodied social and biographical context. Meaning and interpretation are privileged over measurement and statistical analysis and explicit attention is given to the social context of the research study itself (Smith et al., 1995b; Murray and Chamberlain, 1999; Yardley, 1997).

Debates between the two approaches are diverse and range from the more conciliatory and utilitarian arguments that attempt to define which approach might suit which question (Bryman, 1988) through to challenging the status of psychology as a science in the traditional prescriptive sense and adopting a separatist distinction that separates qualitative work from psychology as a science.

To portray the two approaches in opposition would be problematic as some representatives of each would claim to occupy part of the middle ground that exists between them. In particular advocates of both approaches would argue that the pursuit of meaning was their goal and quantitative researchers would also assert that the interpretation of results to build a theory was an important part of their work. The approaches are also not mutually exclusive or incompatible and could be employed within the same study to good effect. Yardley (2001) argued that as the value of both approaches was now recognised more and more, there was a need to find an integrative theoretical framework that enabled the discipline to progress in a pragmatic way, rather than maintain a separatist or adversarial debate where each party caricatured and misrepresented the other.

If carried out in their most recognisable forms the two approaches would be distinguished from each other easily and the experience of the researcher and the participants would be very different.

The distinction is clear in the priorities of the different approaches, either toward securing reliable and valid measurement in an attempt to determine a universal and objective 'reality', or the interpretation or description of the individual's subjective sense-making and construction of

personal and social meaning through a focus on their use of language and communication.

Murray and Chamberlain (1999) argued that the emergence of qualitative approaches represented a radical alternative to the mainstream positivist tradition:

Instead of seeking accurate measurement of hypothetically related variables and assessing their relationship statistically, these alternative approaches seek complex interpretations of specifically socially and historically located phenomenon. (p7)

Giorgi (1995) considered that the contrast in the two approaches within the one discipline was so profound as to place psychology at a critical point in its development. It either adhered strictly to the version of science established by the natural sciences or admitted that it was not a science according to that definition and adopted another scholarly label. Many qualitative researchers argue for adopting an expanded idea of science such that their findings can be afforded the status of knowledge (Smith et al, 1995a; Stevenson and Cooper, 1997; Smith, 1996a).

The quantitative approach in psychology privileges the collection and statistical analysis of numerical data in order to determine a 'true', reliable, valid and objective set of outcomes and conclusions about the object under study. It aims to do this through the logical process of statistical analysis, deduction and reasoning. The discrete elements that are believed to constitute the phenomenon are identified and relationship between them is determined by treating them as independent and dependent variables within an experiment. In this way a detached and neutral researcher is able to determine and expose the fundamental laws and patterns that govern how the constituents interact. It assumes there is a stable 'reality' that is independent of the observer or the participant and measurable in an objective way through controlled observations.

The quantitative approach within experimental psychology was appropriated from the natural sciences of the nineteenth century, physics being the prime example. It draws upon the empiricism, positivism and hypothetico-deductive reasoning that are the mainstays of that scientific approach and treats individuals as a physicist would treat a natural material or particle. It was the dominant philosophy of science at the time that psychology was emerging as a discipline and it has been argued that its adoption reflected the need of psychologists at the time to both see themselves and be seen by others as legitimate scientists (Murray and Chamberlain, 1999). This approach informed the early psychological studies which focused on observable behaviours that lent themselves easily to experimentation. As the focus changed over time and moved on to an interest in cognition and the workings of the mind the same experimental and epistemological principles were adhered to (Smith et al, 1995a). It is assumed within a positivist paradigm that empirical and quantitative methods, if applied appropriately, give the researcher access to an objective reality that can be measured and identified (Charmaz, 1995a):

sophisticated quantitative methods gained dominance and beliefs in scientific logic, objectivity and truth supported and legitimised reducing qualities of human experience to quantifiable variables. (p29)

Critique of the Quantitative Approach.

The quantitative approach is criticised as reductive and limiting by qualitative researchers who contend that it does not fit well with the inherent nature of human behaviour and experience, ignores the context of the subject under study and cannot address or identify the processes involved. Whereas the focus of interest has moved on in mainstream psychology to look at more complex and private processes of the mind, the methodology hasn't and struggles to address the way we construct meaning and plan our actions.

The presumption that an experiment takes place within a value-free or neutral context and provides objective outcomes which relate meaningfully to the subjects experience is also challenged. The psychological variables that are assumed by positivists to exist in reality and are measured within such an experimental setting are instead thought to be better understood as constructions or phenomenon that emerge in the interaction between the researcher and subject. Such a challenge does not dismiss the utility of the quantitative approach completely nor deny that there is a considerable degree of meaningful consistency and consensus within and between subjects' experience, but it maintains that the research cannot be independent of the physical and social setting of the study. The data that emerges from such research is not considered to be neutral but as value-laden as the theories or null hypotheses that the study sets out to test. Any claims that the outcomes are 'correct' and an accurate representation of an external reality are challenged.

A qualitative perspective would argue that the complex and sophisticated practice of experimental research is such that it is prey to either the direct effect of personal and cultural value and influence, or the opportunity for it to have an indirect effect through the selectivity and behaviour of the researcher. During an experiment the investigator first selects a theory from which to hypothesise and chooses a question, then selects participants and interacts with them during the study to produce the data. This is followed by processes of selection and interpretation which shape the conclusions and presentation of the analysis including; the inclusion or omission of certain data, the examination of particular comparisons or associations and the explanation of unexpected, ambiguous or inconsistent findings. When the experimental process is described in this way the potential for selectivity is highlighted and this undermines the argument that it is possible to be discrete from the endeavour or treat the material or the findings of the research as an objective and correct record of 'reality' or 'truth' and not the product of a particular social practice.

The logico-deductive model that is employed by the quantitative approach and dictates that theory drives the research and the related analysis is also criticised for limiting the development of our understanding of the processes related to private cognitive and affective phenomena. The application of deductive reasoning stands in contrast to the qualitative approach which does not generally employ any 'a priori' hypotheses and looks for theory to emerge through a more inductive process. Charmaz (1995a) argued that the experimental and deductive approach seldom leads directly to the development of theory in this way.

Exploring individual variability and personal meaning is often suppressed in quantitative experiments. The larger the group the more powerful and general is the statistical outcome and any idiosyncrasy or anomalous outcome is not explored but often either reduced to the status of an experimental effect or excluded as a statistical 'error'. The findings that emerge can then seem dislocated and unrepresentative of the individual experience of the subjects under study.

There is a significant discrepancy between the methodology of a natural science that is obliged to freeze the subject under study in time in order to measure it and the natural phenomenon of human nature that exists in a dynamic form and is typified by its subtle variability and inconsistency. Measurement can be seen to constrain the study of human experience such that the conclusions that are drawn are an incomplete representation of the phenomenon under study.

Equally, the constraints of statistical testing are such that they pare away the ambiguities, unpredictabilities and idiosyncracies that characterise human communication and behaviour. The quantitative approach is criticised for 'reifying' numbers and elevating them to the status of absolute facts rather than recognising their limits and treating them as something that has emerged from a particular point of view (Yardley, 1997b).

Qualitative researchers maintain that human behaviour is meaningful and contains a capacity for intention and anticipation that implies the presence of active and dynamic intra- and inter-personal processes. These processes are designed to make some kind of sense of what is going on, has gone on and might go on around us. The participant in a study is considered to be appraising their situation moment by moment and responding accordingly. The appraisal process draws from

many different sources and represents a powerful process that cannot be controlled for or measured within an experiment and it is thought by qualitative advocates to be an important focus for research in its own right. Many quantitative researchers also share such an interest but the methods that they would prefer to employ are limited in their ability to capture and explore the unfolding cognitive processes that are involved and it has been argued that the application of more qualitative methods is required (Lyons, 1999).

This section has focused on how problematic the prescribed quantitative approach can be. Arguments against such an approach do not dismiss its utility and applicability but highlight its limitations and the need to develop different approaches. Yardley (1997) argued that it is the phenomenon and processes inherent in subjectivity and the construction of 'reality' have been neglected and should now be the focus of psychological study, as aspiring for both objectivity and reliability could not be justified and inhibited further study:

rather than striving for the illusory goal of objectivity, it is more productive to examine the way in which our reality – including the particular version of reality portrayed by scientists – is shaped by the purposes and conventions, aspirations and assumptions, which form an intrinsic part of human life. (p.1)

Qualitative Approaches.

A disaffection with the quantitative approach prompted the development of various qualitative approaches (Guba and Lincoln, 1994; Smith et al., 1995b). They constituted a more discursive form of psychological study that attended to the active role personal, social and linguistic factors took in the mediation and construction of human experience. The criticism that qualitative work fails to meet orthodox scientific standards is matched by the counter accusation that positivism adopts too narrow and prescriptive a definition of science and so limits the scope of psychological study (Stevenson and Cooper, 1997; Smith, 1996a). As the epistemologies of the two camps remain in such contrast it is unlikely that the debate between them will be resolved easily.

Researchers and theorists have addressed this by arguing both for an enlarged definition of 'scientific' psychology that would establish useful criteria for assessing the validity of different types of research (Smith, 1996a), or by pressing the case for a different post-positivist approach that bridged the gap between the two camps (Stevenson and Cooper, 1997). Such an approach acknowledges that there is a form of external reality but accepts that it cannot be represented accurately because of the limits of human perception, interpretation and cognition.

Qualitative research encompasses many different approaches that do not adopt identical epistemologies or draw upon the same philosophical or intellectual traditions. Two important approaches however are Phenomenology and Symbolic Interactionism.

Phenomenology.

Essential to the phenomenological perspective is a commitment to attending to the individuals point of view and the meanings that they attribute to their actions. Human behaviour is conceived as a product of how people interpret their world in their attempt to make sense of their experiences and the task of the researcher is to examine the process of that ongoing construction of meaning, or 'sense-making' Giorgi (1995).

Phenomenology pays explicit attention to the conscious experience of our world and the exploration of subjective experience is an attempt to expose how our consciousness imposes itself upon and obscures reality. The process of interpretation that it is presumed this involves creates a distinction between subjective experience and what is termed objective reality. It calls into question exactly what is real to us and what it is we act upon.

Phenomenology is based on the broad view that real objects in the world exist independently of our conscious knowledge or awareness and that we have direct access to them via our senses.

Critical to this view however is that having translated this sensory information we then experience it as a 'phenomena' in the form of its appearance to us as opposed to the thing itself as it really is in the external world:

The world as we experience it, is a phenomenal world. (p. 2)

(Spinelli 1989)

A phenomenological view of reality considers that the definition of 'something' has as much to do with the individual and the meaning systems that they employ in the interpretation and translation process, as it has to do with the 'thing' itself. The interpretational process is thought to be indivisible from reality and has to be incorporated into any statements about it.

The phenomenological approach argues that adhering to a logical positivist view that adopts the assumptions and methodologies of a natural science ignores the fact that in psychology the subject possesses the same consciousness as the researcher and is actively involved in the research process all the time. This is seen to be one of the reasons behind the discrepancy that can exist between the reductive findings of quantitative studies and the rich and varied experience of the subjects or participants.

According to phenomenology our experience of the world is best considered to be an interaction between the 'raw matter' of the world and our personal mental apparatus. Emphasizing the importance and idiosyncrasy of interpretation and translation does not deny that the process could be a stable one and have a shared social nature that would appear in the form of consistent and predictable behaviour, but argues that the correctness of our interpretations is more a function of social and cultural consensus than any objective laws or facts. Of clinical interest is that phenomenological theory decrees that as long as the explanation that we provide for our experience is acceptable to us, it serves to reduce the concomitant disturbance we experience.

The process by which the mind reaches out into the world in order to translate stimuli into a meaningful experience is termed intentionality. Phenomenologists believe that consciousness is a consciousness of 'something' in that the basic interpretative act is to experience the world in terms of objects and that whatever sense we make of the world is derived intentionally by reaching out to those objects actively. Direct, raw or conscious access to the real world is denied us however as interpretation lays at the heart of our mental experience.

The theories and processes outlined above gave rise to a broadly based phenomenological method. The intention of the method was to peel away the interpretation added to the stimuli as much as possible in order to arrive at a more accurate knowledge of the 'things themselves' :

strip away, as far as possible, the plethora of interpretational layers added to the unknown stimuli to our experience in order to arrive at a more adequate, if still approximate and incomplete, knowledge of 'the things themselves'. (p16)
Spinelli (1989)

It could also be argued that much could be learnt about the nature, structure and processes inherent in the construction of the interpretation itself, regardless of the 'thing' under study. Each qualitative approach appears to vary according to the degree to which they focus on exploring either the individuals process of interpretation, their account of it, or the nature of the thing or external object itself. There is some debate about how much or what one individual's account can tell you about the subject under study and this is evident in the description of the different approaches that are reviewed later in this section.

Spinelli, in the above quote emphasised the focus on learning about the invariants of the

experience as if to learn about the thing itself, whilst Giorgi (1985) quoted earlier in this chapter highlighted the aim of the researcher to examine the process of 'sense-making'. Both would appear to have value and which ever approach was taken would depend on the focus of the researcher and their research question.

Symbolic Interactionism.

Symbolic interactionism shared many of the assumptions of phenomenology but had its roots more in the social science approach to the study of human behaviour. It included a more explicit concept of the 'self' and paid direct attention to the social context within which we operate (Denzin, 1995; Blumer, 1969).

Individuals were seen as existing within a social world and having a social self which consisted of a complex mixture of biological instincts, the 'I' and internalized social constraints, the 'Me'. The self was considered to be the outcome of the dialectic between the I and the Me and this interaction involved a continuous process of mutual interpretation between how we defined our situation and how we believed we would be received.

Symbolic interactionism, like phenomenology considered that action was directed toward things on the basis of their meanings and that these were mediated via a process of interpretation, but believed that those meanings had been determined much more through a process of social interaction.

The goal of Symbolic Interactionism, according to Blumer (1969) was to discover how the process of interpretation sustained and directed the ways in which the participants determined their actions. Like phenomenology it depicted the 'stimulus to act' as undergoing a process of interpretation before a response was forthcoming and the focus of research was also process oriented with the intention being to articulate the process of interpretation.

Symbolic interactionism considers that our social world and the reality of our conscious experience is both complex and multi faceted. It focuses on subjective experience and feeling rather than objective fact and its roots trace back to a tradition of American sociological study based on the works of Mead (1934), James (1907) and Dewey (1927). The approach presumes that we create a world of phenomena and experience for ourselves and reflect upon it as we continue to experience things. Symbolic interaction is seen as the product of self-reflection and social interaction and the basis upon which we conduct ourselves within our social and personal worlds. Communication and its relationship to culture and society, social relationships and self and identity are key elements in symbolic interactionism and as a consequence have assumed a central role within the broad spectrum of qualitative approaches that it has influenced.

Qualitative Methods.

Qualitative psychological research employs many different methods, many of which were derived from the positions outlined above and although they stand in contrast to the quantitative approach there is much debate within this area and it is not a unitary field. Much of the debate focuses on the status of a participant's account of their experience and how much of what people say about something actually relates to the thing itself. Many methods are employed in this area (Guba and Lincoln, 1994; Murray and Chamberlain, 1999; Smith et al., 1995) but the following section will outline the elements of the qualitative approach to research by focusing on four prominent methods; The Phenomenological Method, Grounded Theory, Interpretative Phenomenological Analysis (IPA) and Discourse Analysis.

Phenomenological Method.

In order to study how people experienced their world and develop an understanding of the structure of that experience phenomenological researchers collect exhaustive, intensive and 'thick' (Geertz 1973) descriptions from respondents in an attempt to approximate the participants perspective as truly as possible. The method as described by Giorgi (1985) will be reviewed here.

Certain rules are adhered to in this approach , which are;

- (i) Rule of Epoche, whereby initial biases are set aside (bracketed) in order that an openness can be imposed and only the primary data is attended to. The prejudices of the researcher

are, as much as possible, kept in check.

- (ii) 'Describe, don't explain'. By focussing on the immediate and concrete impressions only it becomes possible to derive an analysis from the individuals experience and not from the researchers or subjects 'a priori' assumptions.
- (iii) Horizontalization. This further enables an open-minded approach, without prejudice, by treating each descriptive episode as equal and not imposing any hierarchical structure.

The method involves four main phases:

1. The researcher reads the participant's entire description of their experience in order to achieve an overall grasp and understanding of the statement, a 'sense of the whole'.
2. The researcher then returns to the beginning of the text and reads it, discriminating passages or incidents in the text that act as 'meaning units' and convey something about the psychological phenomenon under study.
3. Once all the 'meaning units' have been defined they are examined and transformed to reveal the psychological insight they offer.
4. Each of the meaning units is combined and a consistent statement is developed about the participant's experience.

It is considered important in this approach that the discrimination of the meaning units takes place in a discrete step before they are examined further and transformed into a more integrated statement. This is in order to stay as close as possible to the participants' accounts. Giorgi

(1985) stated that different perspectives could be adopted within his phenomenological method and he was explicit both in his acceptance of this diversity and the cautious and tentative manner in which it addresses the conclusions that are drawn. A description of the structure of the participant's experience is preferred above any in-depth interpretation and it is assumed that human experience will always be consistently more complex than any one study or analysis could capture.

Grounded Theory.

Grounded Theory developed within sociology and emerged from a collaboration between Glaser and Strauss (1967) who developed a set of guidelines rooted in the symbolic interactionist tradition. It was developed to provide a method for conducting rigorous empirical qualitative research. It consists of, 'a logically consistent set of data collection and analytic procedures aimed to develop theory' (p27) (Charmaz, 1995a). The number of procedures and practices that are applied as grounded theory is now so extensive that there is no one discrete or easily identifiable method and it has become a broad term (Chamberlain, 1999). The approach is 'theoretical' in that it demands that a theory of the phenomenon should develop and 'grounded' in that it is necessary that the theory emerges from the data as a result of a sequence of inductive and deductive thinking undertaken by the researcher (Chamberlain, 1999; Charmaz 1995a).

Grounded Theory was typified by the employment of a prescribed process of repeated data sampling and coding techniques directed toward the development of an emergent theory. The

process of coding the data according to its content gives the data meaning to the researcher and categories are developed and inter-related until no further categories emerged. At that point the data is considered to be 'saturated' in that it contains no further data that could be contained within a meaningful code or descriptive label. The researcher engages as closely as possible with the data through an ongoing and iterative process of re-reading, line by line coding and memo writing such that levels of abstract analysis are built directly upon the data and refined by gathering further data to the point where the analyst can attempt to capture, describe and theorise about the experience of the subject in a meaningful way. The 'constant comparative method' is often employed where instances and categories of codes are compared continually for similarities and differences to divine as much as possible about the relationships between them. Having coded the data line-by line questions are asked of the data that help to lead to the development of more abstract categories. The data is reduced and a core category is identified which relates to the other categories and unifies the resultant theory (Chamberlain, 1999). Data collection is guided by theoretical sampling whereby participants are selected on the basis of theoretically relevant constructs, rather than for their statistical representativeness within a particular population.

Grounded Theory can be employed to accommodate to either an interpretive or a structured positivist analysis (Charmaz, 1995a). It is not a single entity but it shares within it the adoption of a contextual perspective in the development of an understanding of how that person experiences the phenomenon under study (Henwood and Pidgeon, 1992, 1994).

Interpretative Phenomenological Analysis (IPA).

Interpretative Phenomenological Analysis (IPA) is an idiographic qualitative approach that is rooted in both phenomenological psychology and symbolic interactionism, Smith (1996a). It is particularly committed to understanding and foregrounding the participant's personal perspective. It recognizes that this cannot be accessed completely as the participant's thoughts, beliefs or affect are not entirely transparent, but asserts that it can be achieved to a useful extent through the interpretative analytic work of the researcher. The final report is therefore seen as a co-construction between the participant and analyst in that it emerges from the analyst's engagement with the data. It involves the analysis of verbatim transcripts that are derived from in-depth semi-structured interviews with participants (Smith, 1995) and as it is the preferred approach used in this thesis the method will be covered in fine detail in the method section (chapter five).

IPA has a commitment to the importance of the participants talk and their use of language but it also shares with the mainstream social cognition paradigm an interest and acknowledgement of the chain between someone's account, their cognition and physical state. It does not subscribe to the view that those cognitions are fixed or static in any way but sees them as complex, malleable and dynamic entities that are formed and reformed as the participants' endeavour to make sense of their condition and articulate it to the listener.

A number of studies have been published using IPA which have focused on a range of different topics in both health and social psychology (these are referenced in chapter four). It shares a

considerable amount of common ground with both the phenomenological and grounded theory methods and although there are clear differences between them it would be wrong to define them by what amount to subtle contrasts, or to see them as existing in conflict with each other. They are both data driven and have a commitment to divining the meaning inherent in a persons experience by looking at it from that person's point of view and trying to see how they construct and interpret their world.

The IPA approach endeavours to get close to the participant's private and personal experience and its commitment to interpretation as a means of articulating the person's view contrasts with the phenomenological method that aims more to develop an understanding and description of the structure of the experience. In this way IPA focuses more closely on establishing an idiographic, case-study account of the subject, than discerning its general or shared, 'invariant' structure.

IPA's commitment to interpretation as a means of analysing the data also means there is no formal attempt at 'bracketing' as it is referred to in the phenomenological method whereby the researchers personal biases are set aside. Instead, the researcher is considered to engage with the data immediately and this is acknowledged as key to the analytic process. Bracketing is not rejected as a notion and steps are taken to ensure the analysis remains grounded in the data. The principle of equivalence and horizontalisation are adhered to in that no part of the transcript is excluded as potential data in the beginning.

Both grounded theory and IPA have clear steps in their method of analysis, although grounded theory studies reflect a greater diversity in its application to the extent that there is not a single

grounded theory method (Chamberlain, 1999). Rather than identifying 'meaning units' or coding the data, in IPA a series of stages enables the researcher to identify themes within the data that capture the participants experience and remain rooted within them. The themes are combined into a final write-up and statement where passages and extracts from the transcripts are used extensively to illustrate and argue for the relevance and importance of the emergent themes.

IPA displays a strong commitment to foregrounding the participant's personal psychological experience and to developing an idiographic perspective which captures how the participant processes and internalises their experience. This more psychological perspective distinguishes it from grounded theory which most often adopts a sociological analysis and does not focus on the individual and intra-personal meanings for the participants to such a degree. Its recognition of the link between the participants' accounts and their cognitions also enables IPA to relate more closely to the mainstream quantitative research (Smith 1996a). Unlike grounded theory, IPA does not engage in theoretical sampling as the analysis proceeds, whereby data is deliberately selected later in the study as a means to develop the theory, but sticks within its original homogenous sample. The commitment of grounded theory, inherent in its title, toward the development of theory using a sequence of inductive and then deductive reasoning and theoretical sampling (Chamberlain, 1999) contrasts with IPA, which is more committed to elaborating the emergent themes and developing a rich interpretative account of the participant's experience.

IPA, at present, uses verbatim transcripts of semi-structured interviews as the principal source of data whilst the phenomenological and grounded theory studies also draw upon other sources. It

is difficult to identify this as a critical theoretical difference in the approaches as the development of the application of IPA is at an earlier stage. Just as phenomenological and grounded theory methods could be adapted to look very closely like IPA, it is just as possible that IPA could be applied to other sources of data such as video recordings, personal diaries etc.

Discourse Analysis.

Discourse Analysis emerged from a different tradition to the other qualitative approaches outlined above and stands in contrast with them in its attitudes toward the status and nature of a participant's account and its relationship with the subject under study. Discourse Analysis is sceptical of the claim of a connection between account, cognition and behaviour, preferring to concern itself with how accounts are constructed rhetorically and how language is used to serve social and discursive ends. It represents a move within social psychology that drew from a constructivist, post-modern and post-structuralist sociolinguistic background and views knowledge and experience as something that is produced within a social context and influences our interpretations of reality directly (Potter and Wetherell, 1987, 1994; Edwards and Potter, 1992). It was a significant challenge to the social-cognition approach to research at the time it emerged and regards the use of language and speaking (discourse) as an active social process that is worthy of study itself. Discourse is seen as a mechanism through which multiple forms of meaning emerge and are represented and the reality of a phenomenon to the individual, such as their health and illness, is felt to be evident in the discourses they employ in their talk. Critically, these discourses are not treated as if they are related to internal attributes but are considered to be

culturally and socially specific and representative of phenomena that go beyond the individual.

Key to Discourse Analysis is a focus on how people used language to construct versions of their social world. Realism is rejected and the study of the variation, idiosyncrasy and flexibility in the person's account is the prime focus in the examination of the many different functions, both global and specific, that an individual's language can serve (Lupton, 1992; Potter and Wetherell, 2001).

It involves the close reading and re-reading of text and utilises a form of deconstruction to access the meanings inherent in the accounts (Potter and Wetherell, 1987; Edwards and Potter, 1992).

Discourse analysis is not a unitary approach and this is typified by debates surrounding the relationship between discourse and the real world. These include, whether or not analysts should be politically engaged or whether there are some underlying consistent and 'real' physical and subjective experiences that might be encompassed within a new realist approach in discourse analysis that allows for the presence of both constructed objects and a reality that is not contingent to a cultural frame of reference (Wetherell, 2001).

The rejection of a relationship between the participant's account and their thoughts or feelings toward an object means that discourse analysis contrasts with approaches such as IPA in its attitude toward the value of the personal description of experience. Radley and Billig (1996) for example stated that illness accounts said little about the illnesses themselves and that 'people use health beliefs to make themselves accountable to others and to articulate for others their own position in the world' (p222). The IPA approach does not dispute that this is a part of what

people do when giving their accounts of health and illness but argues that it is neither the only nor the most important thing that they do.

The qualitative approach encompasses within it a diverse range of perspectives that sometimes adopt contrasting approaches and epistemologies that lead them to study things from very different perspectives. The advantage of this is that there now exists a range of options for study that reflect the complexity of the subject under study and can be selected according to the research question and the focus of the researcher.

Chapter Five.

Method.

Introduction.

The studies in this thesis took an idiographic, case-study approach using IPA to study small groups of participants drawn from the patients that attended the chronic pain out-patient clinic at Montague Hospital, Mexborough, South Yorkshire. The data set for the studies consisted of transcribed semi-structured interviews.

As the studies were qualitative the participants were not regarded as exemplars of the ‘chronic pain patient’ or expected to speak explicitly for their peers, but rather to provide specific instantiations of the psychological experience of chronic benign low back pain.

Personal Background to the Research.

This research was conducted as part of a larger initiative to evaluate the needs of patients attending a chronic back pain clinic. The object of this thesis for myself was to learn as much as possible about both the personal and ‘lived’ experience of chronic benign back pain and the qualitative approach to psychological study.

In addition to being the researcher, I was also the clinical psychologist attached to the clinic. I had a limited experience of working with chronic pain sufferers and was keen to develop it

by exploring their experience from a perspective that was not common in the literature. In this way I felt I could both develop my understanding of what it was like to endure pain on a daily basis and make a contribution to the study of chronic pain that complemented the literature and appeared to be in demand. The research provided an excellent vehicle for continuing my professional development and developing my interest in Health Psychology. Chronic pain represented an enigma to me which I was keen to understand as much as possible. I hoped that the thesis would help me to do this and also learn about more general aspects of human experience, illness, duress and good health.

I had no experience of qualitative work prior to this thesis and valued the chance to learn more about it, to develop my ability to use it and broaden my understanding of research in general. Although the nature of qualitative work precludes any a priori hypothesising I was keen to restrict the focus of the work to only those people with chronic benign low back pain as opposed to all chronic pains in general so as not to treat chronic pain sufferers as an homogenous group.

Prior to and during the thesis I had no personal experience or family history of chronic pain, or any kind of severe acute pain. My interest was not rooted in any personal illness experience but an interest in pain, illness and the value of studying the personal and subjective view of an experience. The enigma of pain and how exploring it could help us to learn more about human nature in general is something that I have always found quite compelling. Pain is something which is both universal and idiosyncratic, it helps to define our lives but at the same time, for all its ubiquity, it often defies any simple description or explanation. As such, perhaps understanding pain could also tell us more about ourselves in

general.

As a Clinical Psychologist employed to help people in pain I felt it was vital to understand the experience of pain from the perspective of the sufferer and at the time I began this research this was not too evident in the literature. The following three studies explore some of the themes which help define the meanings of chronic benign low back pain for the sufferer and although this was not intended to be a clinical thesis, I found the research very useful in my clinical work. It helped me to gain a better appreciation of the personal nature of chronic pain and how best to support people who endure it on a daily basis. In particular I feel I am now a more empathic psychologist and it has reinforced my belief in the importance of the psychology of chronic pain and of always viewing it within a personal, social and moral context. I discuss this in more detail in the final chapter.

Participants.

Each participant had been referred to the Pain Clinic, Montagu Hospital, Mexborough, by their General Practitioner. Each was considered on assessment by the members of the pain clinic team to have chronic benign low back pain with no treatable peripheral organic pathology and significant distress and disability. From a clinical point of view their pain behaviours and symptoms and signs were considered 'inappropriate' according to the criteria described by Waddell and Main (1984) and were recognised to be an index of their distress and a communication of their broader pain experience (Waddell, 1987; Waddell et al., 1992).

They were part of a particular group of chronic pain patients who reported high levels of distress and disability with little organic peripheral pathology and as a result are often termed

to have 'Chronic Pain Syndrome' (IASP, 1994).

The participants were all from the local area of South Yorkshire and in each case they were:

- European Caucasian.
- Described by themselves as coming from a working class background.
- No longer in paid employment.
- Aged between thirty-five and fifty-five.

Each of the participants had also:

- Endured their pain for a minimum of five years.
- Experienced a variety of bio-medical assessments and treatments during that time which had achieved little therapeutic effect.
- Been informed that bio-medical treatments were no longer considered to be appropriate or effective for their condition.

Each participant had been informed that the services that were now available to them were palliative in focus, designed to help them with symptom control and to manage their chronic pain in the best way possible. Part of this service could involve the attention of a clinical psychologist or attendance on a pain management programme at some point in the future.

The participants were approached to take part in this thesis at an early stage in their attendance at the clinic. They were all new patients to the clinic and as such had no prior

contact with any similar service. The studies were part of a broad evaluation of the clinic and participants were asked if they could help the clinic team to develop their understanding of the experience of chronic benign low back pain by being interviewed as part of a qualitative psychological study.

Certain exclusion criteria were applied in the study to both try to minimise the influence of other diseases or mental health problems in the participant's experience of their pain and to recruit participants whose experience had not yet been influenced by prior contact with a formal therapeutic rehabilitation service. The criteria were:

- No other serious physical problems or diseases.
- No history of psychiatric difficulties or record of anxiety problems.
- No previous contact with clinical psychology services.
- No previous contact with chronic pain rehabilitation services.
- No ongoing litigation or compensation cases involved
- No ongoing acute diagnostic medical investigations for their pain.
- No evidence of regular abuse of strong opiate medication or daily use of physical aids such as motorised wheelchairs. This was very rare but was included because patients with these difficulties were referred on to in-patient services immediately and it was felt unethical to include them and important not to cause confusion for them by discharging them from the clinical service but maintaining contact for research reasons. Similarly, the presence of opiate abuse and a dependence on aids often caused other medical and physical problems that would exclude the participant.

Ethical Approval.

Ethical approval was granted by the Doncaster Royal Infirmary and Montagu Hospital NHS Trust Local Research Ethics Committee as part of a multi-dimensional and multi-disciplinary evaluation of the service for patients with chronic benign low back pain (see appendix for file copy of approval letter, patient consent and information forms).

Participants were informed that the object of the study was to help us at the pain clinic to understand their situation in more detail through recording and analyzing their accounts, given in their own words, of their experience of chronic benign low back pain. It was stated explicitly that participation was voluntary, separate from any clinical contact they might have with the clinic, that they were free to withdraw their participation at any time without giving a reason and that this would have no influence on the service that was available to them at the clinic. The measures that would be taken to guarantee confidentiality and anonymity were also illustrated.

The participants' names along with any other identifying information were changed or deleted from the transcripts to preserve their anonymity and guarantee confidentiality. Having transcribed the tape of the interview and removed any identifying information the tapes were either returned to the participants or erased, according to their wishes. Participant consent was secured prior to conducting any interview in the studies.

Data Collection.

The semi-structured interview procedure followed that described by Smith (1995). It involved the construction of an interview schedule that outlined the areas of interest to be discussed during the interview. The schedule was not intended to be prescriptive but to act as a guide for the interview and not dictate its exact course. Participants were asked to talk as freely as possible about their experience of chronic pain and were told that there were no right or wrong answers as it was their experience that was important.

In each study an interview schedule was developed which involved up to ten main questions directed toward the area of interest. The schedules are illustrated at the appropriate point within each of the empirical chapters. Each main question had two or three shorter questions that could be used if the participant struggled to understand it and would help to 'funnel' them towards the subject. The main questions would be open-ended, not closed and invite the participant to say whatever they felt was important about the subject in the question. An example of a main question would be, 'can you tell me about your pain?', this is perhaps the most obvious question to ask but if it was too open or broad for the participant to answer the funnelling questions would be 'how long have you had it? What does it feel like? How did it all begin?'

The interview was semi-structured in that the researcher followed the lead of the participant and only referred to the schedule to guide the interview toward the main research interest if

necessary. The interview schedule did not dictate the interview but served to ensure that as many of the important areas of focus were attended to. The early questions would be introductory and designed to both gain a description of the participants pain and help them to feel at their ease and become comfortable with the process of being interviewed. During the interview questions were adapted in response to whatever emerged and the researcher probed any interesting issues that arose at the time. The interviews took place at the pain clinic, were taped and lasted between 60 to 90 minutes. The tapes were then transcribed and served as the raw empirical data for the studies.

The aim of the interview was to facilitate the participant telling their own pain story and not to check the investigators preconceptions of pain. The verbatim transcripts of the interviews served as the raw data to be analysed using the interpretative phenomenological method described in the previous chapter (Smith et al., 1999; Smith et al., 1997).

The transcription notation that will appear in some of the extracts used in the analysis is as follows:

...	-	Pause
[]	-	Elision
[text]	-	Clarificatory information

Maintaining Quality within the Analysis.

A range of criteria have been published to evaluate qualitative studies and these are reviewed in more depth in the final chapter with regard to the thesis as a whole. Particular criteria were employed in each of the analyses in this thesis as guidelines for auditing quality. They were drawn from those recommended by Yardley (2000) and Smith (1996b).

Two guidelines outlined by Smith (1996b) were observed closely, these were: 'internal coherence' and 'presentation of evidence'. 'Internal coherence' referred to the need to concentrate on whether the argument presented in the study was internally consistent and justified by the data, i.e., if the emergent themes relate meaningfully to the participants' talk, whilst 'presentation of evidence' demanded that sufficient verbatim evidence from the data should be presented in the write up of the analysis to allow the reader to interrogate it.

Yardley (2000) also suggested other criteria in addition to those described by Smith. Similar to Smith, Yardley recommended providing sufficient empirical data to allow the reader to make judgments and for evaluating the persuasiveness of the write-up. In each study both my supervisor and a colleague acted as auditors to check for the coherence of the emergent themes and the degree to which they were grounded in the data. Yardley also recommended the use of triangulation, where a number of different sources of data are used within an analysis to help form a statement and as a means to enhance its power and persuasiveness. In the analyses in this thesis this was observed where ever possible by drawing on more than one participant's account to establish the case for adopting a theme rather than using data from other sources outside of the verbatim interview transcript.

Interpretative Phenomenological Analysis: the process of analysis.

This section will articulate the step by step process that was undertaken in the analysis of the data from each of the three studies in this thesis. As described before IPA is an idiographic, case study approach. It is data-driven in that it focuses on the analysis of the verbatim transcripts of semi-structured interviews and places the participants accounts of their experience at the centre of the study and development of theory.

In summary, the analytic process proceeded as follows:

1. **Looking for themes in the first case.** Interview transcripts were read and re-read a number of times to ensure a general sense was obtained of the participant's account. During this stage notes were made in the left hand margin of potential themes and the process was informed by the researcher's experience of the interview itself. Returning to the beginning, the text was then re-read and any emergent themes identified and tentatively organised in the right hand margin.
2. **Looking for Connections.** Attention was then focused on the themes themselves to define them in more detail and establish their inter-relationships. The focus was on the psychological content of the phenomenon under study and the data was now being condensed.
3. **A Table of Themes.** The shared themes were organised to make consistent

and meaningful statements which could contribute to an account of the meaning of the participants' experience that was grounded in their own words.

4. **Continuing the Analysis with Other Cases.** The process was then repeated for other transcripts, using the first table of themes as a guide to look for further instances of the themes that have already been established and to highlight the emergence of any new themes.
5. **Writing Up.** The themes were translated into a narrative account that conveyed, hopefully, the interesting or important things in the participants experiences.

In this way, the analysis that followed was organised around themes that emerged from the transcripts, rather than constructs predicted in advance. These themes were then considered in relation to the extant literature in the discussion sections.

To illustrate the process more completely a worked example now follows using some of the data from study one in this thesis 'The Personal Experience of Chronic Pain'. In showing the method in such detail is hoped to help the reader understand the analytic process in as much depth as possible. Providing this evidence, presenting a case for the research method and establishing the researchers commitment to the project are considered to be important criteria in the evaluation of qualitative studies (Yardley, 2000; Elliot et al., 1999).

1. Looking for Themes

The process began by looking in detail at the transcript of one interview first before incorporating others. This followed an idiographic approach to analysis, beginning with particular examples and slowly working up to more general categorization or theory.

To begin with the transcript was read a number of times, using the left hand side of the margin to note down anything that was significant or important. The transcript was read and re-read closely in order to become as intimate as possible with the account as each reading had the potential to throw up new insights. Some of the comments were attempts at summarizing or paraphrasing, some were associations or connections that came to mind and others were preliminary interpretations.

In the following example the notes in the left margin focused on how the participant, Linda, struggled to understand the chronic nature of her pain and how the implications for her self-concept began to emerge:

shoulds, ideals, expectations, age appropriate
own age
frustration, bothered
other people
mobility, restriction, trapped
watching others, comparing with others

compared to sisters, family context/reference
compared to past, biography reference
when fit/strong
ideal past/doubt, 'I thought' not 'I was'
adjustment, shock
big loss/change

I. What's it like being in pain?

L. I'm only 50 and I should be doing this and that and the other cos they say life begins at 40 but I can't and I s'pose it does bother me. it's frustrating that people of my own age are, you can see them flying their kite and you feel as if you can't, well you can't.

I. You can't

L. No which is so stupid, I just think I'm the fittest because their are girls (her sisters) and I'm the middle one and I thought well I'm the fittest and I used to work like a horse and I thought I was the strongest and then all of a sudden it's just been cut down and I can't do half of what I used to do.

The other margin was then used to document emerging theme titles, using key words to capture the essential quality of what was found in the text. At this preliminary stage the key words were not considered to be definitive, but helped to articulate something about the concept that was identified.

I. What's it like being in pain?

L. I'm only 50 and I should be doing this and that and the other cos they say life begins at 40 but I can't and I s'pose it does bother me. it's frustrating that people of my own age are, you can see them flying their kite and you feel as if you can't, well you can't.

Loss, of ability, of future?
social comparison – others

I. You can't

L. No which is so stupid, I just think I'm the fittest because their are girls (her sisters) and I'm the middle one and I thought well I'm the fittest and I used to work like a horse and I thought I was the strongest and then all of a sudden it's just been cut down and I can't do half of what I used to do.

social comparison – family
nostalgia – selective recall
sudden loss vs chronic condition
sense of self

This process was continued through the whole interview, making preliminary notes in the left margin first and then proceeding to abstract theme titles in the right margin afterwards. At this stage all of the transcript was treated as potential data and no attempt was made to omit or select particular passages for special attention.

2. Looking for Connections

On a separate sheet the emergent themes were then listed and connections were made between them. Some of them appeared to cluster together, whilst others were regarded as more super-ordinate concepts. At this stage it was also possible for new super-ordinate themes to emerge that helped to pull together a number of the initial categories that had been identified.

In the table below is the initial list of all the theme titles from the right hand column of the transcript of Linda's account, including those from the extract above at the beginning:

- Loss, of ability, of future?	- Implications for the self-concept
- Social comparisons – others	- Confusion and anger
- Social comparison – family	- Self-critical
- Nostalgia – selective recall	- Self-doubt
- sudden loss vs chronic condition	- Social comparison with self before the pain
- Sense of self	- Loss
- Anger and pain	- Bereavement and shock
- Struggle to accept self and identity – unwanted self	- Mobility/physical restrictions
- Lack of control over self	- Adjustment
- Responsibility, self vs pain.	- Planning activity
- Shameful self – struggle with unwanted self, fear of judgement	- Social problems
- Unwanted self rejected as true self	- Social withdrawal
- Attribution of unwanted self to the pain	- Embarrassment
- Defence of original self	- Guilt
- Ranking duress, self vs pain	- Pacing
- Shame of disclosure	- Concealment in public
- Searching for an explanation	- Confusion
- Response to uncertainty	- Unpredictability
- Lack of understanding	- Lack of control
- Fear of feeling out of control	- Withdrawal
- Frustration	- Expressing anger
- Surprise at own feelings	- Burdening others
- Trying to make sense	- Avoiding social contact
	- Hostility
	- Judgement
	- Fear of rejection

The list was then reviewed, reduced to remove any redundant or unrepresentative theme titles and the remaining themes were clustered together in the following way:

- Trying to make sense
- Searching for an explanation
- Response to uncertainty
- Lack of understanding
- Frustration
- Unpredictability
- Confusion and anger
- Hostility
- Anger and pain

- Implications for the self-concept
- Sense of self
- Self-critical/self-doubt
- Loss, of ability, of future
- Sudden loss vs chronic condition
- Loss/bereavement and shock/adjustment
- Social comparison
 - others
 - family
 - with self before the pain
- Nostalgia - selective recall

- Mobility
- Physical restrictions
- Planning activity
- Pacing

- Social
- Identity problems
- Embarrassment
- Guilt
- Avoiding social contact
- Burdening others
- Fear of rejection
- social withdrawal

As the clusterings of themes emerged these were checked back to the transcript to make sure the connections worked for the primary source material. This form of analysis involved a close interaction with the text. The attempt to understand what the person was saying drew upon the researcher's interpretative resources as themes were selected to create some order from the array of concepts and ideas that had been extracted from the participant's responses.

3. A Table of Themes

The next stage was to produce a super-ordinate list or table of the themes, ordered coherently. The process had identified a certain number of major themes which seemed to capture most strongly the respondent's concerns on this particular topic. As before, care was taken to check back with the data to ensure that each theme was represented in the verbatim transcript. At this point certain themes were renamed if it was felt a different title described the theme better, or dropped completely, for example a theme related to 'planning activity', which was present in the first theme list was deleted as it neither fitted well into the structure of themes and sub-themes, nor was it very rich in evidence within the transcript. An identifier was added to each instance to aid the organisation of the analysis. This indicated where in the transcript instances of each theme could be found by giving key words from the particular extract plus the page number of the transcript. It also helped to code the instances in the transcript with an identifier. A sample of the table of major themes from Linda's transcript is given below. The three super-ordinate themes that emerged are shown, plus a few examples of the sub-themes that related to them. As the whole list of related sub-themes is extensive only a few are given here to illustrate the process, (note - 2.9 = page 2, line 9).

1. Searching for an explanation

Response to uncertainty	2.9	No idea
Frustration	4.15	Can't do it
Anger and pain	2.20	Mad

2. Self evaluation and social comparison.

Social comparison – others	10.12	Other people
Social comparison – family	11.3	Fittest of all
Nostalgic – selective recall	11.7	Like a horse
Index of loss/bereavement	16.20	Used to be

3. Social problems

Embarrassment	23.14	Embarrassed
Fear of rejection	24.7	Rejection
Social Withdrawal	24.12	Stay in

Some of the themes were linked to the semi-structured interview schedule whilst others were at a higher level, acting as pointers to the respondent's more general beliefs or style of thinking and talking. For example, in study one in this thesis the topic under discussion was the participants' experience of their chronic pain but a theme emerged that was not anticipated involving a broader exploration of the utility of social comparison in self-appraisal and evaluation. These emergent themes prompt the researcher to think about the focus of the project and can take it in a slightly different direction.

4. Continuing the Analysis with Other Cases

A single respondent's transcript could be written up as a case study in its own right or, as in the case of the studies in this thesis, the analysis can move on to incorporate interviews with a number of different individuals. The super-ordinate theme list from interview one was used to begin the analysis of the second interview, looking for more instances of the themes that were identified from interview one but identifying new ones that arose. New themes that emerged in subsequent interviews were tested against earlier transcripts.

This system works well with studies that employ a small sample size of up to about ten participants, such as those in this thesis. The number of participants is small enough for one to retain an overall mental picture of each of the individual cases and the location of themes within them.

In this worked example, the super-ordinate list from Linda's account was used to inform the analysis of the other transcripts. By remaining aware of what had come before it was possible

to identify what was new and different in the subsequent transcripts more easily and at the same time to find responses which further articulated the extant themes.

As each transcript was analysed following the interpretative process a final list of super-ordinate themes emerged. From the analysis of the study used in this example, four main themes emerged. A new theme 'Not being believed' emerged from subsequent transcripts and on checking back to Linda's transcript instances were found that related to it. In the example below, the identifiers shown to the right of the sub-themes are taken from the accounts of only two out of the nine participants and not all the sub-themes are shown. In practice, each participant was represented. The four super-ordinate themes, with examples of instances within the transcripts, are shown below:

1. Searching for an explanation.	Linda	Nina
<ul style="list-style-type: none"> - response to uncertainty - participants' explanatory models - bio-medical dominance - self-criticism 	<p>2.9</p> <p>2.20</p>	<p>3.15</p> <p>5.9</p> <p>9.17</p>
<p>2. Comparing this self with other selves</p> <ul style="list-style-type: none"> - with others - with self in the past - with self in the future - nostalgic recall of self - upward and downward comparison - equivocal coping strategy - index of loss and threat 	<p>10.12</p> <p>11.7</p> <p>12.11</p> <p>16.20</p>	<p>7.12</p> <p>7.15</p> <p>12.3</p> <p>14.18</p>

<p>3. Not being believed</p> <ul style="list-style-type: none"> - Invisibility of chronic pain - assumptions of others about pain - understandings/expectations of others - implications for identity/pain roles - judgements of others 	<p>10.4</p> <p>22.13</p>	<p>31.15</p> <p>31.21</p> <p>34.12</p> <p>33.2</p>
<p>4. Withdrawing from others</p> <ul style="list-style-type: none"> - private experience vs social appearance - shame and embarrassment - misunderstandings - fear of rejection - stigma 	<p>23.14</p> <p>24.7</p>	<p>11.12</p> <p>28.6</p> <p>30.17</p> <p>34.18</p>

5. Writing Up

The final section was concerned with moving from the master themes to a write-up and final statement outlining the meanings inherent in the participant's experience. The division between analysis and writing up is to a certain extent a false one, in that the analysis continues during the writing phase.

This stage was concerned with translating the themes into a narrative account. The results can take the form of a presentation of the typology of responses that emerged during the analysis, or represent a theory to explain the participants' answers. The table or index of themes was the basis for the account of the participants' responses which, each time, took the form of the argument interspersed with verbatim extracts from the transcripts to support the case. Care was taken to distinguish clearly between what the respondent said and the

analyst's interpretation or account of it. The write-ups can be found in the following three empirical chapters

In each of the studies in this thesis the thematic account was prioritized in the write up and used the verbatim extracts to elucidate or exemplify each theme as part of a constructed narrative argument. Each study presented the themes together in one analysis section while a separate section was devoted to exploring and discussing their implications in relation to the existing literature. A final discussion section will review the three studies and draw together the themes and observations that relate them into a broader statement about the personal experience of chronic benign low back pain.

Chapter Six.

Study One.

The Personal Experience Of Chronic Benign Lower Back Pain.

Introduction.

The aim of the first study in this thesis is to explore in a very broad sense the personal and lived experience of chronic benign low back pain using Interpretative Phenomenological Analysis (IPA). In the absence of other studies of this kind in the literature this represents an initial reconnaissance of the area that adopts a qualitative, data-driven idiograph approach and looks to achieve an understanding of the 'insiders perspective' (Conrad, 1987) of chronic benign low back pain. If the individual and personal meaning of chronic pain is to be explored fully then such an intensive qualitative approach would complement the extensive body of research that has been published to date.

The reviews in chapter two (Psychology of Pain) and chapter four (Chronic Pain and Meaning) in this thesis describe compelling evidence of the inherent psychological nature of chronic benign low back pain, its significance as a major public health problem and the limits of our understanding of it. It shows how much more there is to learn about how chronic benign low back pain unfolds over time and what mediates its characteristic unpredictable, idiosyncratic and unpleasant nature.

Explicit in its definition is the unpleasant and offensive nature of chronic benign low back pain

which has a damaging and deleterious effect on both those who endure it and the people around them. Pain has been associated with an extensive range of negative affect, cognitive dysfunction and distortion, maladaptive behaviour and disability. For each individual, this profile of sensation, distress and disability is unique in both its intensity and quality. What is needed is a better understanding of the personal meaning of the individual experience of chronic pain.

Most psychological research or clinical intervention into chronic pain is based on a broad cognitive-behavioural approach. It probably represents the largest body of health psychology research into a single illness and has established psychology as a key discipline in the study of pain (Jensen et al., 1994; Jamison et al., 1994; Gatchell and Turk, 1999). The limits of quantitative cognitive-behavioural research has been pointed to earlier in the thesis, as has the case for applying more qualitative approaches to develop our understanding of the area. The personal and subjective meaning of pain has been identified as an important avenue of study (Leventhal, 1993; Price, 1999) and qualitative methods have been shown to be potentially very helpful in this regard so far.

In chapter four of this thesis (Chronic Pain and Meaning) the qualitative study of chronic pain was reviewed and it showed how very few data-driven or empirical qualitative studies have been published in the psychology literature on chronic benign low back pain. There remains a pressing need for further studies that take a psychological and idiographic focus and work to explore as much as possible about the personal experience of chronic benign low back pain.

This study is concerned explicitly with articulating the personal experience of chronic low

back pain. It adopts a phenomenological approach and if the meaning of pain to the patient is to be fully explored then it could be argued that such an intensive idiographic approach that is firmly rooted within a psychological tradition is required. Due to the paucity of qualitative studies in this area it was appropriate for this first study to be an initial exploratory reconnaissance of the subject, looking to see what substantive themes emerge that capture the conscious and subjective experience of the participants and reviewing them in the light of the extant literature.

Method.

The method employed in each of the studies in this thesis is outlined in detail in chapter five. To avoid unnecessary redundancy it will not be repeated here and only factors specific to this study will be described.

The first nine participants that matched the criteria and agreed to take part in the study were recruited as an homogenous sample group and interviewed at the pain clinic. In this study they were all women, although men were not excluded from the sample. I presented myself to them as a psychologist studying the personal experience of chronic benign low back pain and they were also aware that I worked in another capacity as the Clinical Psychologist at the clinic.

Each of the interviews with the participants was based on the same semi-structured interview schedule, they were then transcribed and analysed in series according to the procedure outlined in the method chapter (chapter five). Once this was complete it was felt that there

was sufficient data to write up as a meaningful statement. A further group of participants could have been recruited in the same way if it had been felt that more data was required.

The data set for this study consisted of transcribed semi-structured interviews with nine women who attended the out-patient pain clinic. They are all white, european caucasian women from a working class background who no longer worked in paid employment due to their pain. Their ages and length of time in chronic pain are tabled below.

Anonymised Name	Age	Pain duration. (years)
Linda	50	10
Alice	35	9
Becky	46	8
Gail	52	6.5
Ruth	48	5
Nina	37	12
Nelly	46	15
Mary-Ann	53	8
Rachael	49	7.5

The interview schedule was as follows:

1. Could you, to begin with, describe your pain to me in your own words please?
 - what does it feel like?
 - How long have you had it?
 - Does it change in any way?
2. How did your pain start?
 - How long have you had it?
 - How did it come on?
 - Has it changed over time?
3. Does anything affect your pain?
 - Does anything make it better?
 - Does anything make it worse?
4. Do you know why your pain persists?
 - What causes your pain?
 - Why hasn't your pain been cured?
5. Has your pain changed things for you at all?
 - Is anything different now?
 - Do you do anything or feel differently since you had the pain?
6. Why do you think that has (or hasn't) happened?
 - How has pain affected things for you do you think?
 - Why do you think those changes happened?
7. What do you think pain is?
 - How would you explain pain to some-one?
 - Why do you think we can feel pain?
8. What's the most important thing about your pain from your perspective?
 - What do you think of first when you think of your pain?
 - How would you sum up your pain?
9. Has your pain affected you at all?
 - Has it affected the way you think or feel or behave?
10. Why has that happened do you think (if it has)?
 - Why do you think you think/feel/behave that way?

This study was exploratory in focus and the questions were chosen to encourage the participants to talk as extensively and in as much depth as possible about their experience of their pain. No specific aspect of pain was privileged over any other and the questions were designed to be as open as possible to avoid restricting the participants' answers to particular themes.

The transcripts were analysed using Interpretative Phenomenological Analysis. At each stage of analysis in this study my supervisor reviewed the themes to ensure that they appeared to be grounded in the transcripts and well represented within the data by adequate examples. A work colleague also reviewed the analysis to check for the coherence and clarity of the themes and whether the themes were represented well in the data.

Care was taken after each interview to provide time to address any anxiety or distress that the participant might have experienced as a consequence of the interview. In this study none of the participants reported feeling unduly distressed at the end.

Analysis.

This section presents the four super-ordinate themes that emerged from the analysis, which were:

- Searching for an explanation
- Comparing this self with other selves

- Not being believed
- Withdrawing from others

The first theme 'Searching for an explanation' sets the scene for those which follow as it articulates the participants' attempts to understand what is happening to them and is a prerequisite for the subsequent self-reflection. Because such questioning recurs throughout the analysis, it is only presented briefly at the outset.

Searching for an Explanation.

The participants showed a strong motivation to understand and explain their situation, to know 'why?':

I just keep asking myself why the pain is there and I haven't got an answer. I don't know how I should feel really it's just that I don't think it should be there why should I have it? I would have thought that after all this time it should have eased up and gone away but it hasn't.

(Linda)

Participants regularly stated they simply could not 'believe' that nothing more could be done to relieve their pain. There was a marked contrast between their pre-occupation with their pain and their inability to account for its chronic presence. Despite their long history of pain and extensive contact with the health service they neither felt informed about their condition, nor able to influence it. Their pain was often felt to act of its own volition. 'it just comes and goes when it wants really (Alice).'

Linda's account of her situation suggested that despite wanting to understand why she had chronic pain, she could not, to her it was 'unbelievable really'. This was not a simple account of ignorance but a profound state of bewilderment as she failed consistently to understand why she should be suffering, or being punished despite not having done anything wrong. As the best efforts of others had failed, she felt she could only blame herself:

I'm sort of mad at myself I start banging things and getting so aerated with myself that it's there and I can't get it to go away.

Becky also had no answer as to why her pain remained, except to imagine the presence of

physical damage or deterioration:

Well I always thought you had pain to tell you when there was something wrong.

Participants could not explain the persistence of their pain in any manner which was meaningful to them beyond the notion that 'there was something wrong', something bio-medical which demanded attention. Their disbelief and bewilderment prompted frustration, anger and in Becky's case, despair:

But I don't know why you have to keep suffering it and suffering it and suffering it for ever and ever.

Each participant rejected the judgement that their pain was 'unreal' i.e. psychogenic but could not explain its reality in a manner that was meaningful to them. Their accounts revealed their attempts to cope with their pain despite a profound lack of either understanding or information. This uncertainty and ambiguity pervades their experience and will continue to appear as an important factor in each of the following three sections.

Comparing this Self with other Selves.

As participants described their pain they compared themselves with other people and with themselves both in the past and projected into the future.

This creative process of comparison captured the pernicious impact of their pain. One participant, Linda, appeared to reach out to what she saw and by comparing her present

situation with selected events she had witnessed, used those comparisons as benchmarks:

I'm only 50 and I should be doing this that and the other cos they say life begins at 40 but I can't and I s'pose it does bother me, it's frustrating that people of my own age are you can see them flying their kite and you feel as if you can't.

Linda could not do the things she felt she 'should' be able to do like other women of her age who were active and enjoying life. Her comparison was not just of reduced mobility but of the denial of pleasure in activity. Others her age could enjoy their life and celebrate it free from pain 'you can see them flying their kite' and this emphasised her feelings of loss. In one passage Linda recalls a description of her pain-free self set amidst her immediate family:

I just think I'm the fittest because there are 3 girls and I'm the middle one and I thought well I'm the fittest and I used to work like a horse and I thought I was the strongest and then all of a sudden it's just been cut down and I can't do half of what I used to do.

Linda's description of her loss was exacerbated by the recall of an idealised past where she was not only fit, but the 'fittest' and worked not just hard, but 'like a horse'.

As she anticipated the future Linda was afraid that she could only worsen progressively. She could not predict her future and emphasised her pessimism by her comparisons with two people, her mother and a school friend, who both died in distressing circumstances. She admitted that neither of them had chronic pain but her uncertainty meant she that could not guarantee she would not share their fate:

She was a school mate and she was 15 month older than me and it was last year she started, I don't know what she died of she was getting these aches and pains I just don't want it to be any worse as I don't want to be pushed round in

a wheel chair.

Gail also described her situation as one where continual pain had eroded her mobility but responded differently to the comparisons she made with others:

When I see all of my friends, I saw one running for the bus the other day I thought Oh my God it's ages since I had a good run or a good walk, you know. So for about 5 minutes I felt sorry for myself and then I saw somebody else in a wheelchair so you know, I'm not quite as bad as that.

Through comparison, participants often ranked themselves against others and this served to highlight their loss or disability. Linda felt demoted within her family whilst, for Gail, although she felt better off than some-one in a wheelchair she became embarrassed when considered alongside her 81 year old mother-in-law:

You think oh well can I make it over there or shall I say no we'll leave it for another day. I feel so stupid especially when my mother-in-law is 81 and she's trotting about and I am hobbling.

Other participants related similar comparisons. Their sense of social order had been disturbed and in attempting to re-establish their personal status, participants, like Gail, also took refuge in thinking of those in a worse situation than themselves:

I try to tell myself I'm luckier than a lot of people, you know I haven't got cancer.
(Ruth)

The use of others as an aid to resisting the sense of decline and loss that pain provided was equivocal and in some cases detrimental, serving only to exacerbate and define their distress. Participants' uncertainty in their prognosis handicapped any compensation that a 'worse-

world' offered. When Linda witnessed those more disabled than her she felt she may be looking at herself in the future 'I just don't want it to be any worse as I don't want to be pushed round in a wheel chair'. Nina also admitted that, although she looked at others in a worse position it could not compensate for her own sense of deterioration and only increased her fear for the future:

I've done heaps more things than other people have done so I think well, I would, you always think well there's loads of people far worse off than you you know so you try to think of other people who are permanently in wheelchairs and it's supposed to make you feel better which in a way it does but basically its frightening.

The comparison with others who were more unfortunate was intended as a strategy for enhancing self-esteem but often turned into a reinforcer of despair. Chronic pain promoted distress in each participant when they recalled how they were before it began and a sense of grief pervaded their accounts. Although a few took pride in their ability to cope, they often defined themselves as bereaved.

Nelly believed she had lost everything, her comparisons were global and catastrophic, whilst Mary-Ann was more operational and explicit about the change she had experienced and revealed how her pain frustrated her personally:

It's stopped everything, its stopped my life completely.

(Nelly)

I can't do what I used to do I'm not one for staying in house if I can get away with it I go out I don't like stopping in house.

(Mary-Ann)

As with Linda, when participants reflected on their situation they often recalled a better time, a nostalgic time associated with a better sense of self. Memories were recalled to help maintain some morale in the present:

When you don't feel you have a future, you live in the past. (Rachael)

Participants often referred to a past where they were as they had always wished to be, fit, active, able to stay slim, interesting and sociable. Alice grieved for her personality, she wanted to be the 'old Alice', the Alice who could exercise regularly to keep her weight down, do and eat what she liked and feel confident and happy:

Well my personality's gone, I used to be right bubbly and lively and you know, but its, that's gone and even my mum says that I've changed, she never really says in what way, she says I've got more snappy and more nasty you want the old Alice back but you can't.

The nostalgic recall of the past provided some comfort but was again a comparison that proved to be equivocal. The idealised accounts of the past served as a painful index of what had been lost and what now had to be endured on a daily basis, rather than as a haven of reassurance and source of self-regard. The strength of their loss was accentuated by the fact that the past self was often considered to represent the real self, replaced irrevocably by a new but false persona:

You feel like just not particularly giving up but you don't feel the person that you are that you're capable of feeling or capable of doing basically. It makes you feel a bit down and a bit miserable.

(Nina)

'The person that you are' is the person Nina was in the past, the person without pain.

Through their selective use of social and personal comparison participants highlighted the impact of their pain on their self-regard and the equivocal nature of their attempts to cope with its imposition. Pain denied them the chance to be who they once were and preferred still to be. Their contemporary self-regard contrasted with a nostalgic recall of their past and those around them and their comparisons served almost inevitably as an index of their sense of threat and loss. Attempts to buttress self-esteem by comparison with those more unfortunate often proved counter-productive and served only to remind participants of their own gloomy prognosis.

Not Being Believed.

Apart from their behaviour, the participants' condition revealed no visible signs that would give credence to any of their claims to suffering or disability. The participants, who themselves endured a profound sense of uncertainty regarding the aetiology or legitimacy of their pain, felt vulnerable to the judgements of those around them:

It's like anger building up in you. It's like if you're talking to people you're forever, its as though you've got to try and convince them that there's something wrong with you, that get's you down.

(Alice)

The participants felt a continual need to justify their pain as 'real', that is not in any way psychogenic which was synonymous with 'mad or bad':

It's quite embarrassing because its not something that you can see and I do feel guilty, I know that my back really does hurt and I'm not making it up and I feel sort of angry that I can't do it and I think well I wish I could just prove to them that my back really

is bad and that I really must not do it, because if I do I put myself back weeks.
(Nina)

In the absence of any recognition that their pain could persist, participants were by default required to be defensive about their condition, but were unable to make use of any credible explanatory story and as a consequence were often frustrated:

You feel as though no-one believes you, unless people who have got bad backs, it's only them who'd believe you.
(Alice)

Pain had caused a shift in the participants' social roles and relationships and denied them the opportunity to be the kind of daughter, grandmother, or lover that they, or others, might wish them to be. Ruth and Gail were well aware of the potential problems of being mis-understood by their lovers and parents:

I mean you don't look ill, you're not flat on your back, so you know, is it an excuse, oh I've got a headache, do you know what I mean [not too have sex with her husband].
(Ruth)

She [mother-in-law] wanted her house decorating the other week. I said I can't even do my own and I feel guilty that she's going to have to pay somebody to do it.
(Gail)

Each participant's account exposed their awareness of the threat of rejection, not just because they were a burden and unproductive but because they might be disbelieved. In Gail's case, the lack of credible evidence prompted a feeling of guilt that others suffer too.

Mary-Ann was concerned with being judged as 'useless' because she could not look after her family. This was a judgement she endorsed herself as, in common with Nelly and other

participants, she felt uncomfortable at being the recipient of care, unable to reciprocate:

I know I am ill, but I think well why should I have to put that on to somebody else's shoulders I don't want people to look after me and I know they love me but I don't want it. It's degrading.

(Nelly)

The difficulties of feeling believed had a paradoxical effect on the behaviour of participants as a healthy appearance was considered by those around them to be incompatible with any claims of chronic pain, suffering or disability:

If I went round with no make-up and bags hanging down my face or something and just look really badly they'd probably think well yes, but you can't see pain so they don't know do they so they automatically assume that there's nowt wrong with you.

(Alice)

Appearing healthy or mobile whilst remaining in pain was problematic and participants felt obliged to appear ill and disabled to satisfy the requirements of others. Unfortunately, appearing ill left them feeling equally as prey to the consequences of pity as condemnation. Pity to Nelly was a stigma. It degraded her, challenged her place in her social world and was incompatible with how she wanted to view herself or be seen by others:

I just want to say 'hello', you know, 'how are you' and I go 'alright thanks'. Not look at me as though I'm a cripple. I'm not a cripple.

The ambiguity of pain behaviour and the lack of understanding in others left the participants feeling vulnerable to being mis-judged or rejected. The suspicion they felt they were under often drove them to appear more in pain than they needed to and in each case they felt their

pain denied them the opportunity to relate to others free of its influence.

Withdrawing from Others.

Rather than endure their chronic pain and continue to meet the demands of their social world, the participants tended to withdraw from public view:

I just want to be on my own. I can't stand anybody, I'm mardy and I'm mardy with everyone else. You know what I mean. I'd rather just take off upstairs.
(Mary-Ann)

They felt a burden to other people and there appeared to be no agreed way of relating to others that they could employ. It was easier for them to conceal their condition than to rely on the understanding of others. For Gail, rather than explain that it was her pain that caused her to avoid social events she found it easier to lie and risk appearing unsociable:

If anyone asks me if I am going anywhere, come on, no. Rather than tell them why [the discomfort of pain] I just say I can't be bothered they probably think I'm a bit of a misery it's better than going out with them and spoiling their fun.

Misery and being boring with little to talk about except pain was felt by the participants to be unacceptable in company and they withdrew from social contact to avoid the potential for any embarrassment or rejection:

But I mean we just don't go, we won't go anywhere now because of that I get too embarrassed and I just hate being in company and you always get onto that subject [pain]. And if you're out for social evening the last thing people want to hear is what your misery is, so I just, that's why we don't go out that often.
(Becky)

There was a tension between the participants need to withdraw from other people and their fear that this would leave them isolated or abandoned. They felt their relationships were at risk and were aware of the limits of others' compassion. Ruth admitted how before her pain she used to avoid any-one who appeared unwell as she could not tolerate their misery and she now hides her own distress so as not to prompt others to reject her:

I've been around poorly people all my life and I think I get a little bit naffed off myself and I cross the road cos I've thought, oh gosh, I can't stand Mrs so an so today and she may be a really poorly woman, this is why I don't want to burden anybody else because they must feel just the same as I do.

When in public, Linda not only felt easily irritable but also conspicuous and now prefers not to go out. Her social world could not accommodate people who had chronic pain and required supportive chairs or who needed to move constantly or lie down if necessary. Her disability was in part mediated by social acceptability and appearances:

I didn't even go out Christmas or New Year because I knew what it would be like, there'd be no sitting down because it would be all packed and theres no way I'd like to stand up and if there were a seat I'd have to get back up so I can't remember the last time we went out.

Participants felt that when in public they could neither afford to show their distress, nor appear healthy and mobile. Their social world which, prior to their pain, they recalled nostalgically was now transformed from a sanctuary and supportive network to something aversive and threatening. Regard and respect had been replaced by a perception of disgust or pity.

Participants felt trapped, unable to secure the understanding of others and retreated to the

safety of their own company, effectively cutting themselves off from any benefit of social support.

Discussion.

Searching for an Explanation.

The 'sense-making' process that is often referred to in qualitative research was revealed in the participants accounts in this study through their drive and wish to understand why they should have chronic pain and their inability to achieve that understanding. The ongoing and active process of constructing understanding that is a key element of both the phenomenological and cognitive approach was present in the participants accounts and took the form of an ongoing, unfinished search. They remained confused as the personal models of their pain that they had constructed failed consistently to match their experience.

The participants were pre-occupied with their pain but despite frequent contact with the health services they remained confused. They were convinced that something bio-medical was wrong with them, could not understand why their pain should persist and reported despair that given this was the case no-one appeared to be doing anything medical to help them 'there must be something wrong but nobody seems to want to help (Becky)'.

Uncertainty is an important experience in chronic health conditions and has been identified as a key factor in its related distress (Radley, 1994; Härkäpää et al, 1996). The degree of information that is available to the chronically ill to assist them in their understanding is often

sparse, or in a form that they cannot utilise (Bury, 1991; Locker, 1991). Uncertainty has been shown to correlate with distress, helplessness and reported pain intensity (Williams and Thorn, 1989; Idler, 1993; Jensen et al., 1991) particularly if it is believed to be due to chance, to endure with no relief or to be mysterious in origin. Similarly, Baszanger (1992) described the 'problematic factuality' of chronic pain and emphasised how difficult it was for health professionals to 'decipher' chronic pain to their patients as it did not adhere to a simple explanation and was different to acute pain.

According to one form of attribution theory, seeking an explanation which establishes a cause is a typical response to uncertainty (Brewin, 1988). No one particular attributional style has been linked to distress in pain and chronic illness (Radley, 1994) and for the participants their frustration and hopelessness appeared not to be consequent upon a discrete attributional category but to follow from their more fundamental inability to attribute any cause at all. Brewin (1988) concluded that 'explanation is almost certain to be an integral part of any reaction to adversity' (p108) and for those in benign chronic pain it appears to be especially difficult to establish any form of useful explanation.

In the absence of facts they can understand patients with chronic illness often use whatever 'common-sense' concepts they have to hand and construct their own meaning and representations of their illness (Leventhal and Diefenbach, 1991) such concepts appear to serve the sense-making process which appeared to unfold relentlessly for the participants despite their resources. Holzman and Turk (1986) recognised this process in their chronic pain patients:

Patients will behave during illness in ways that are consistent with the

conceptualizations they hold about their symptoms ... When information is ambiguous they rely on general attitudes and beliefs based on prior learning. These beliefs determine the meaning and significance of the problem. (p5)

The participants in this study were grossly dissatisfied with their understanding of their illness and exposed the inadequacy of their own, primarily medicalized, illness representations. There was a contrast between the reality of their chronic pain and their lack of any useful framework to explain its chronic nature. Despite the well established presence of the gate-control theory of pain and the bio-psychosocial model, very little of this had become available to the participants although where the obstacle to this understanding was is not clear from their accounts alone.

The participants' frustrations highlighted the dominance and essential weakness of the application of a purely biomedical model in their attempts to conceptualise their situation. Such medicalization of our understanding of our bodies is referred to extensively in the medical sociology literature (Bendelow and Williams, 1995; Frank, 1990) and is shown in this study to be a major impediment to the participants' endeavours to understand and accommodate to their pain. To date their efforts to understand the ambiguity and uncertainties of their pain had had only punitive and disabling psychological and social consequences. Without an explanation they could understand they could not establish any basis for taking therapeutic action, retain a sense of control, or establish and defend the credibility and legitimacy of their illness or themselves.

Comparing this Self with other Selves.

The participants evaluated their situation by using comparisons with others and themselves in the past, present and future. This often revealed their sense of loss and threat in relation to their chronic pain and the debilitating impact of their experience on their self-concept. To them, their pain had imposed change upon them and denied them the opportunity to be who they once were and wished still to be. Any contemporary self-regard was poor and stood in contrast to a nostalgic recall of a past when they described themselves at their very best, in an idealised form.

As part of coming to terms with and accommodating to the demands of their chronic pain it has been argued that an individual must interpret and repair the disruption such pain causes in such a way that it makes sense in the context of their life story (Williams, 1984; Bury, 1988). The participants showed through their comparisons only partial fragments of such a reparation and despite lengthy pain careers remained pre-occupied with a sense of confusion, loss and threat. Their accounts were similar to those related by Charmaz (1983) who described how the chronically sick suffered in a constant struggle to lead socially valued lives and maintain definitions of the self which were positive and worthwhile:

A fundamental form of suffering is the loss of self in chronically ill persons who observe their former self-images crumbling away without the simultaneous development of equally valued new ones. (p.168)

The need to reconstruct or reshape a self-concept in the face of the impact of a chronic illness has emerged as a theme in several studies on a wide range of chronic conditions and these

were reviewed earlier in chapter four (Existing Qualitative Work on Chronic Pain). For the participants in this study any positive self-image had faded to become the stuff of nostalgia. They often retreated into their past to maintain some self-regard in the face of their experience of chronic pain, however, the focus on an idealised past only appeared to amplify their sense of loss and disabled their ability to adapt to their situation constructively. Helstrom (2001) related how the participants in her study also described their ideal selves as those from their past and how this often prevented them contemplating any productive progress into the future.

Comparison with others is considered to be instrumental in the formation of attitudes (Festinger, 1954) and utilised to cope with uncertainty and anxiety when information is limited, as in the case of chronic illness (Molleman et al., 1986). Festinger's theory suggests that people need to have stable appraisals of themselves and will use social comparison as a means to achieve this, particularly in the absence of more objective measures.

Studies have suggested that downward comparisons with those considered to be in a worse-off situation or with an imagined 'worse-world' can promote positive affect and well-being in individuals under stressful conditions by enabling them to resist the erosion of their self-regard and optimism (Taylor and Lobel, 1989; DeVellis et al., 1990). However other studies such as those by Buunck et al., (1990) and Hemphill and Lehman (1991) have suggested that the relationship is neither strong nor direct and that the comparison with those in a 'worse-world' can also promote negative affect under certain conditions. The downward comparison with 'worse worlds' has been identified as problematic in a number of chronically ill populations (Affleck et al., 1988; Blalock et al., 1990). Jensen and Karoly (1992) showed that comparative evaluation was really only effective in those with short pain careers and of little

use in long-term chronic pain. The anxiety inherent in the physical condition itself has also been shown to play an important mediating role (Vanderzee et al., 1995).

In this study the participants' comparisons stood in contrast to the argument that views them solely as a beneficent coping strategy. They found no sanctuary in being better off than those who were in a wheel-chair or dying of cancer and were often more frightened as a result. Their uncertainty denied them any guarantee that their own condition would not deteriorate and that one day they might not inhabit the 'worse-world' already inhabited by others they compared themselves with.

The participants employed a wide variety of comparisons with themselves in other situations and with other people around them in their attempts to describe and evaluate their situation. They compared themselves downwards with 'worse worlds' and upwards with better ones interchangeably and no one single form appeared to serve a particular or discrete function. To be understood best each comparison needed to be seen in its personal context and it was in their complex network of comparisons that the individual's sense of their situation was revealed. Overall, comparison was an equivocal coping strategy and served best as an index of the participant's view of their situation. It revealed their attempts to manage their distress and uncertainty and helped to expose the personal meaning of their chronic pain.

Not Being Believed.

To the participants, the awareness and understanding that other people had of their chronic pain was poor and being believed and judged appropriately could not be guaranteed. Having pain regarded as 'real' is a major cause of concern for those taking time off work (Tarasak and Eakin, 1995; Pinder, 1995) and the need for this kind of 'legitimation' of the illness has been identified as an important aspect of the social experience of being ill (Kotarba, 1983). Bury (1991) described the problems that could arise if the validity of a chronic condition was brought into question. He stated that having a 'real' illness was important to:

re-establish credibility in the face of the assault on self-hood, personal integrity and threat to social status. (p456)

Bury (1988) emphasised the lack of any social stability for the chronically ill as each of their relationships was put at risk 'relationships do not guarantee particular responses' (p92). He emphasised how unstable the social environment was for those with a chronic illness and how as a result they could not assume they had retained any positive or valued social identity.

In common with the experiences of people with chronic cardiac illness that were related by Radley (1994) the participants in this study endeavoured to continue to live in their social world of healthy people, often appearing and trying to appear healthy themselves but failing habitually to live up to the expectations and responsibilities they felt were implicit in that world. As a consequence they were often both self-critical and defensive. Unable in their uncertainty to justify to others or themselves why they should remain in pain they felt vulnerable to criticism and disapprobation.

Expressive pain behaviour has been described in the past as a form of attention seeking maintained by secondary gain (Fordyce, 1976; Heaton et al, 1984) and the aim of some clinical interventions has been to extinguish such behaviour by not responding to it or rewarding it with any kind of attention. The participant's behaviour in this study argues against taking such a simple stimulus-response perspective and shows how the participant's behaviour takes place within a dynamic social setting. They felt obliged to appear ill as any appearance of good health was considered by others as evidence of unreal, invalid pain or malingering. Rather than seeking attention, the participants appeared to be trying to both deflect any potential criticism and conform to the expectations that others had about the appearance and identity of those who claimed to have pain. No reward or understanding was felt by those whom, whilst remaining in pain, improved their health, appearance or mobility, instead they felt more vulnerable to misunderstanding.

There was an ongoing tension between their private experience of their bodies and their social identity and Kelly and Field (1996) maintained that this was at the core of the everyday and distressing experience of people with chronic illness. For the participants in this study the invisibility and day-to-day variability of their chronic pain left their appearance unchanged, whereas the restrictions and intense unpleasantness of their body eroded their private experience of their quality of life. Consequently, overt and visible distress and disability was often the only currency or vocabulary that was available to them to establish the legitimacy and 'reality' of their pain to others although this was also difficult given the confusion of chronic benign low back pain, what Baszanger (1992) referred to as the 'problematic factuality' of chronic pain. The participants struggled to achieve or agree a collective or social

understanding of their chronic pain that was either stable, valued or 'real' i.e. legitimate.

Withdrawing from Others.

To the participants, their chronic pain was problematic as it was an invisible and private experience but had profound social consequences, some of which have been outlined in the previous section. They were required to reconcile the restrictions of their pain with the demands of their social network and more often than not this was too demanding and resulted in their withdrawal from social contact. Their accounts showed how the utility of social contact and comparison for self-affirmation and support was negated by their fear of misunderstanding and rejection.

The tendency to seek out others for support when under stress has been shown to decrease under certain conditions (Buunk and Hoorens, 1992). Charmaz (1987) and Kotarba (1983) also described how feeling discredited by others and unable to reciprocate social support or fulfill the obligations implicit in past role-relationships were important factors in the suffering and subsequent social withdrawal related to chronic illness and pain.

In common with the experience of sufferers of rheumatoid arthritis (Bury, 1988) the participants in this study felt their pain affected their relationships with those around them. They had no 'role prescription' in their social network to guide their social interaction. They were unable either to perform ordinary activities in socially appropriate ways or explain why they could not and found it easier to be alone.

In a study on a similar sample of patients with benign pain Rose (1994) identified a four-stage process through which the participants in the study had proceeded as they accommodated to their pain. Similar to those in this study each participant had found it hard to make sense of their condition and in their failure to do so had developed a strong sense of emotional and social isolation, loneliness and alienation. They had found it hard to exist in their social world and safer to retreat from it, returning only after having re-established some form of self-regard. In each case they re-entered their world in a different place to that occupied by their previous, pain-free life-style.

The accounts of the participants in this study highlighted how their experience of chronic pain was closely linked to a sense of stigma and apologetics. Chronic pain left them anticipating and fearing misunderstanding and rejection and while the lack of social contact was mourned, the personal costs associated with the engagement with others meant that on balance they preferred to withdraw from that social world.

Strengths and Weaknesses of the study.

The particular strength of this study lies perhaps in the perspective it provides into the experience of chronic pain. The participants were able to give rich accounts of their experience of their pain and these highlighted and reinforced its multi-dimensional and personal nature in a way which complements the extant quantitative research. In particular it reinforced the degree to which chronic benign low back pain existed within a dynamic personal and social context.

The study was limited in various ways. To begin with the sample was only women with chronic pain syndrome and how much the themes apply to men or people with chronic benign low back pain but lower levels of distress and disability can only be speculated. Similarly, the interviewer was a male clinical psychologist and the interviews took place within a hospital setting. The impact this would have had on the participants is hard to gauge. Although no explicit reference was made to this factor by the participants during the interview, it cannot be ignored as something that could have influenced and inhibited the participants' accounts. Reviewing this issue specifically at some point within the interview could have gone some way toward addressing or evaluating the nature of its effect. The study also used quite a narrow source of data. It was drawn from one interview and so limited the opportunity for using triangulation within the analyses. Additional sources of data, perhaps using repeated interviews with the same participants or diaries or journals could have added strength and depth to the analysis.

Conclusions.

Mainstream empirical research highlights the 'puzzle of pain' and the lack of concordance between pain sensation, disability and organic pathology but has been criticised for being too correlational, able only to speculate on the processes involved in a patients pain career (Jensen et al., 1991). Through adopting the phenomenological approach it was possible in this study to access the individual, 'insider's perspective' (Conrad, 1987) of living with chronic pain and focus on some of the underlying processes involved in a way which complements the extant research.

The accounts of the participants in this study revealed the multi-dimensional nature of their experience of chronic pain. They shared an inability to explain the persistent presence of their pain or reconstruct any contemporary self-regard. In their uncertainty, despite having a benign condition, they feared for their future. They could not establish the legitimacy of the chronic nature of their pain either to themselves or to others in their social world. As an appearance of good health or activity was generally considered to be incompatible with any claim to remain in pain, the participants felt obliged to appear ill to satisfy the requirements of others. By default participants treated their own pain as a stigma and tended to withdraw from social contact.

The participants accounts highlighted how their pain frustrated both their need to attribute a cause for its chronic presence and to attain a stable appraisal of their situation from which they might establish a sense of control or positive self-regard. They felt a pervasive sense of loss and as they failed consistently to understand or explain why their pain should persist they also felt threatened, unable to guarantee themselves a benign future, free of chronic pain or social rejection. They employed many different forms of social comparison and it appeared to serve as an equivocal coping strategy. It served best as a window into the participant's view of their situation. It revealed their attempts to manage their distress and uncertainty, appraise their situation and helped to expose the personal meaning of their chronic pain.

The themes which emerged in this study highlighted the need to attend to the psychological processes and constructs that the patients in chronic pain live through and bring to a pain clinic. This initial study emphasised how the participants experienced their chronic pain not just as a simple sensory phenomenon that produced cognitive and behavioural reactions but as

something that was embedded within a powerful and dynamic social and historical context. Their chronic pain experience was connected to their ongoing appraisal of their bodies, their social worlds and their biographies and it appeared to defy their attempts to make sense of it in any benign or useful way.

Chapter Seven.

Study Two

The Personal Experience of Chronic Benign Low Back Pain: The change in its meaning during a simple hypnotic pain management exercise.

Introduction.

The themes that emerged from study one underscored how the participants experience of their chronic benign low back pain was embedded deeply within a personal and social context. To follow on from this study two focused more closely on the private description of the pain itself in order to try to explore it more fully as an object of reference in its own right and examine the ways in which the participants described, appraised and related to their pain as a discrete 'thing'.

To focus on the pain in this way the participants experience was studied before and after a simple pain management exercise that was designed to palliate their experience of the pain. By exploring their experience of pain as it changed (or not) it was hoped to learn more about the nature of that experience.

The pain literature indicates strongly that people experience their chronic benign low back pain as a composite, multi-dimensional phenomenon. The services to help people with such pain reflect this and are most often grounded in the biopsychosocial model. Many studies have shown the utility and efficacy of pain management programmes (Flor et al, 1992; Morley et al., 1999) in helping to change and improve the experience of chronic benign pain for those whom attend. Pain programmes vary according to their composition and approach but it is likely that virtually all are based on the gate-control theory of pain (Melzack and Wall, 1988) and include the use of some form of attention-based pain management and relaxation exercises (Gatchell and Turk, 1996; Hanson and Gerber, 1990; Main and Spainswick, 2000).

Tension and anxiety have been identified as important factors in the chronic pain experience and attention and attribution have been identified as potentially key elements in the mediation of the influence of anxiety on pain (Price, 1999; Arntz et al., 1994).

This process was reviewed in chapter two of this thesis where it was shown that although attention appeared to be the key factor in acute pain, in chronic pain it appeared that both attribution and attention were likely to play a critical role (Eccleston and Crombez, 1999). Eccleston (1995a, 1995b) has argued strongly for the need to direct research toward the relationship between central attention structures and chronic pain.

Eccleston's research argued that the ability of pain to access our consciousness automatically was so strong due to its noxious and fluctuating nature, that any attempt to divert attention away from it was futile in the long term. To be constructive and

therapeutic attention needed to be directed toward chronic pain and not away from it so that a more adaptive attribution of the pain experience and its meaning can develop.

An approach that has the facility to employ both attributional and attentional processes in chronic pain is clinical hypnosis and a range of hypnotic techniques for pain have been developed and published (Hart and Alden, 1994; Syrjala and Abrams, 1996). During hypnosis the participant is taken through a process of induction and deepening toward a state of highly focused attention, at this point suggestions are given that are directed toward either altering their perceptions or sensations of pain or achieving some other therapeutic effect. Chaves (1994) in a review of hypnosis and pain management concluded that in order to maximise outcome, the attributional and contextual elements which defined the meaning of the pain had to be incorporated into the suggestions.

A cognitive exercise that is complex enough to challenge the sufferer's pain for the finite resources of central attention is the use of imagery (Skevington, 1995). Although imagery is not essential for hypnosis it has been identified as a powerful therapeutic agents in pain management (Turner and Jensen, 1993; Fernandez, 1986).

Imagery can also, if focused on chronic pain, reveal the meanings of the pain to the sufferer in the form of the descriptions, attributions and anxieties that they hold about it. Fernandez (1986) proposed a classification system for cognitive coping strategies for pain. These were (i) imagery, (ii) self-statements and (iii) attention-diversion. Imagery strategies were similar to applied hypnotic techniques and revolved around the

production of particular images with pain-attenuating potential. These were either imagery associated with events that were inconsistent with pain or, transformative imagery that sought to modify specific features of the pain. Although quantitative studies of the effectiveness of imagery are criticized for a lack of rigour they often report an increase in the client's ability to cope with pain that is consonant with the Fernandez classification system (Barber, 1986) and could help us to understand better how chronic pain and attention inter-relate.

This study was set up to explore the participants' descriptions and experience of their chronic benign low back pain as they went through a simple imaginal hypnotic procedure. The objective was to analyze how the participants experienced their chronic pain in the process of change and to see whether adopting such a perspective helped to gain a different insight into its lived experience. The pain management procedures were informed by the Fernandez classification of imagery, using either transformative imagery where the suggestions were directed explicitly toward altering the pain experience or incompatible distractive imagery where the experience of a pleasant, relaxing scenario was suggested to counter the aversiveness and unpleasantness of the pain.

Method.

The data for the study consisted of the transcribed interviews with ten participants taken before and after a six-week course of either hypnotic transformative pain-imagery or relaxation imagery. The participants were allocated randomly to either group by a colleague who was blind to their identities, each participant was allocated a number and these were divided into two groups.

As in study one the participants had attended the pain clinic for an initial assessment appointment and been informed that their pain was not amenable to any aggressive or curative medical treatment and was chronic in nature. They were then referred internally to one of the options for chronic pain management. Whilst they were waiting to receive an appointment they were approached by myself to ask if they would like to take part in a study into the personal experience of chronic benign low back pain. The information they were given was the same and given in the same way as outlined in the method chapter (five).

Ten participants were recruited in a short space of time and once they had agreed to take part in the study they attended the clinic once a week for six weeks for the pain management exercise which was also recorded to enable them to practice the exercise at home. The research interviews took place one week before and one week after the course of sessions.

Five participants followed a course of hypnotic induction, deepening and suggestion directed toward inducing a state of somatic relaxation that was incompatible with the tension related to their pain. During the session no other suggestions were given and no reference was made to the participant's pain, their attitude toward it or their self-concept.

The other five participants followed the same course of hypnotic induction and deepening but the suggestions were directed at transforming their personal sensation of pain toward a more tolerable state. The suggestions were agreed prior to the intervention and based on the imagery elicited from the participants at interview. For example, for one participant the suggestions were directed toward helping transform the pain into something 'further away' whilst for another the suggestions were directed toward turning the pain into something less aggressive or 'belligerent'. No other suggestions were given and no other suggestions were made about the participants or their pain.

The ages of the participants plus the length of time they had been in pain is listed on the next page. As in study one they were all white, european caucasian, from a working class background and no longer worked in paid employment due to their pain. This study used a mixture of male and female participants, their anonymised names, ages and length of time in pain are tabled overleaf:

As with study one the first ten participants who fitted the criteria and agreed to participate in the study were recruited. In this study there was a mix of men and women. The interviews were conducted in the pain clinic, transcribed and then analysed in the manner

described in the method chapter. Sufficient data emerged in the analysis of this batch of participants to proceed to the final write-up. A further group would have been recruited in the same way had it been clear that more data was required.

I presented myself as the researcher in the same manner as in study one, as a psychologist researching the personal experience of chronic benign low back pain. In addition I explained that I would be the person administering the brief intervention in this study. They were aware that I worked as a Clinical Psychologist in the pain clinic but that I was not otherwise involved in their care in any way.

Anonymised Name	Age	Duration of Pain (years)
Adrian	42	10
Paul	38	5
Lily	51	9
Jim	54	11
Jo	39	13
Monica	43	7
Annie	52	6
Tim	42	10
Henry	55	15
Brenda	37	7

My supervisor monitored the development of the themes throughout the process of analysis and a work colleague reviewed the analysis its overall clarity, coherence and presentation of evidence.

The pre-intervention interview schedule began in the same way as study one and then focused more on the particular experience that was of interest in this study, which was to focus more closely on the participants' description of the pain itself. Following some broad non-directive introductory questions where the participants were asked simply to talk about their pain, questions were then chosen to encourage the participants to talk as freely as possible about the imagery they associated with their pain, what was different about their experience following the intervention and what factors they felt might have influenced that change. To avoid asking leading questions which restricted the response options of the participants the questions were open ended as much as possible.

1. Could you describe your pain to me in as much detail as possible in your own words please?
 - What does it feel like?
 - How long have you had it?
 - Does it change in any way?
2. How did your pain start?
 - How long have you had it?
 - How did it come on?
 - Has it changed over time?
3. Does anything affect your pain?
 - Does anything make it better?
 - Does anything make it worse?
4. Do you know why your pain persists?
 - What causes your pain?
 - Why do you think your pain hasn't gone?
5. Can you control your pain in any way?
 - What makes the difference between good days and bad days?
 - How do you cope with it?
6. What makes your pain change?
 - what happens on a bad day/good day?
 - what causes a flare-up do you think?
7. When you think about the pain itself what comes into your mind?
 - How do you relate to your pain?
 - What would sum up your pain?

Post-intervention the participants were asked the same questions plus additional ones asking them to comment on any changes that might have occurred as a result of the exercise. These were:

1. Have you noticed any change in your pain due to the exercise?
 - Does your pain feel any different now?
 - If it has, how has it changed?
2. Have you noticed any other changes since the exercise?
 - Is anything else different?
 - Have you noticed anything new?
3. What do you think caused the changes to happen (if any)?
 - How do you think it helped?
 - What made it work do you think?
4. Why don't you think it helped (if it didn't)?
 - If everything is the same why do you think it didn't change?
 - Why don't you think it worked?

Care was taken to leave time at the end of each interview to attend to any distress that might have emerged for the participants during its course. In this study none of the participants reported any undue anxiety following the interview.

Analysis.

Pre-Intervention

In the pre-intervention interviews the participants were asked to describe their pain in as much depth as possible. Their accounts clustered around three broad themes, which were; 'Pain Taxonomy', how each participant classified the various sensations related to

their pain; 'Mechanisms and Causes', the metaphors used by the participants to describe the processes related to their pain; and 'Intrusion', the perceived impact of the participants' pain on particular domains of their quality of life.

Pain Taxonomy.

Each participant had developed a personal classification system, which they employed to rate and rank their pain's variable quality and intensity. To describe their pain they each focused on it as if it took two broad forms, pain at its worst and pain at its best. Each participant employed their own particular criteria to define the differences between the two. There was a uniformity about the quality of the participants' 'pain at its best', related to its chronicity and persistence. Accounts of the pain 'at its worst' however, revealed the personal and individual nature of each participant's fear and distress related to their pain.

Adrian described his pain in two discrete forms, which he labeled an 'ache' and a 'pain', '...there's a difference between back ache and back pain, to me it feels different.' His everyday ever-present chronic pain was an 'ache' and he reserved the term 'pain' for that which was capable of producing an overt display of distress:

To me pain is, making me crying, you know, I was just laid on the floor and I used to be crying in agony and I mean crying.

Although it was not considered pain, Adrian was careful to emphasise the aversive nature of his 'ache', '..Oh I can get terrible with it, I start sweating with it sometimes and get annoyed..' His ache was notable not for its intensity, but for its persistence. It endured with no respite and left him feeling unable to know what to do for the best:

Its all day really, not being able to settle.

When it's bad it's just there and I just don't know what to do with myself.

Adrian's 'ache', although it remained a hurtful and unpleasant sensation, was restricted to a feeling of irritation and frustration rather than the despair he associated with pain:

It's like dull, that's why I call it. its more annoying than anything else, it's really annoying to me, but it hurts.

The other participants also conceived their pain in two polarised forms, a mild and a strong form. In contrast to Adrian it remained for them a 'pain' at all times as Paul describes:

only two [types of pain], that's not too bad and the very bad indeed, It's always the same pain all the time.

At its best their pain was similar to Adrian's 'ache'. It was marked by its persistence, its intrusion and the associated feelings of frustration and irritability:

It's just annoying, niggling, when it is like it is now its maddening because you know its not that bad but you know its there and its interfering with your life all the time. (Lily)

As with Adrian's 'ache', Lily's pain at its best, although not intense appeared to offer no respite, no possibility of a relief or a cure:

Lily. It's annoying, you know you could have your toothache out but.

Int. you can't have your back out?

Lily. No.

For Lily, at its worst, the pain was typified by a disabling, dissociated and withdrawn psychological state:

Oh its terrible, I feel sick, I'm in a world of my own, I don't hear or see anybody. I'm just shut off into my own little cave, I'm like a zombie.

The continuum upon which Lily placed her pain was related to a sense of proximity. At its best it was 'distant', whilst at its worst it felt closer, more intrusive, 'it gets nearer and more intense.'

Other participants' accounts defined their pain according to cognitive and affective dimensions rather than simple sensory intensity, but retained the polarised taxonomy.

Jim's account described the pain as if it were a social or interpersonal phenomenon. The pain was defined by how intimidating and afraid it made him feel:

Jim. It comes in two flavours
Int. Flavours ?
Jim. Yeah, two kinds ?
Int. How do they differ ?
Jim. They make you feel different, one is vicious, scares you
shitless, its like it's after you like. The other one can't have
you like, its irritating and it won't leave you alone but it's
not like, after you.

There was a concensus amongst the participants in their accounts of their pain at its best, where it was considered more bearable but notable for its persistence and relentless, unending quality 'it just won't go away what ever you do' (Jo). Monica described her pain when at its best as, 'peaceful, but its not like being able to move into another room where you can't hear it, its there all the time'. The concept of pain as 'peaceful' contrasted with the aggression and anger she felt it was like when it was at its worst.

The participants' pain was at its most personal and idiosyncratic when described at its worst. Annie felt her pain at its best was 'bearable' and equivalent to a 'moan', but at its worst it revealed its personal meaning to her, her fears for the future and her inability to predict how she would end up:

Its [the pain] somebody screaming, the agony, the despair, I do imagine what I think I am going to be like when I'm sixty, how bad is it going to get, am I going to be able to stand it.

Each of the participants revealed the individual nature of the distress they felt in relation to their pain when they described it in its worst of two forms. For example, Adrian was physically crippled, doubled-up and in despair at what to do for the best, Lily withdrawn,

dazed and nauseous and Jim and Annie were both frightened either for the future or as if they were in danger of being assaulted.

Mechanisms and Causes.

In addition to describing and categorising their pain, the participants' imagery also focused around what they imagined caused their pain and its associated distress.

Adrian maintained his distinction between a 'pain' and an 'ache' in his use of causal imagery. In each case they were associated with descriptions of on-going organic pathology and a memory of an episode of intense acute pain. The 'ache' was associated with an exposed nerve:

Like my nerve showing, I mean when I had that tooth out at the back there, it were an hole I'd got in it like and it, but I don't call that pain.

To qualify as 'pain', Adrian required more active organic pathology:

What I call pain is when my disc were out of place and it were wrapped around, apparently it were wrapped around the sciatic nerve and it were gradually doubling me up like that.

Like Adrian, Lily associated her pain with a memory of a painful episode and with aversive images of active organic pathology. The memories were traumatic and the imagery both dramatic and impossible. Adrian imagined his vertebral disc as if it were

'wrapped around' his sciatic nerve, whilst Lily associated her intense pain with an image of her back as if it were splitting in half:

I get that tingling and then it feels like, along the bottom that it's going to crack, that's how I had when I passed out. It was terrible...if I bent either way I feel as though it would split.

When her pain was not at its worst and more like the 'ache' Adrian described, Lily pictured her back being damaged and physically eroded, in a less traumatic way:

Even when they gave me that rocking exercise to do, I could hear it like grinding, something grinding.

Jim described his worst pain in the form of nerve damage, but it was more metaphorical in content, related to his feelings of intimidation, powerlessness and the fear of assault:

Its as if some-ones got hold of you and is ripping at your back, its torture and all you can do is lie and wait for them to stop.

Jo's account was more mechanical than neurological and conveyed his sense of immobility and the hopelessness of feeling as if he was on the 'scrapheap':

When its bad I'm rusted solid, there's absolutely nothing you can do about it. My hips will just seize, go stiff and everything comes to a halt, scrap heap.

Jim and Jo's descriptions of their pain bridged between the aversive images of severe biological damage and those of more metaphorical or abstract concepts. Jim considered

his pain at its worst to be an aggressor, intent on assaulting him and damaging his spine, whilst Jo described his with the finality and immobility of a rusted and seized engine.

Many of the other participants shared Jim's account of their pain being the consequence of a violent and brutal assault that they felt helpless to resist. For example Paul described his pain at its best as being like, 'somebody has just got their knuckles in middle of your back, just giving it a little dig', whereas, at its worst his pain was like an assault, 'a good kicking' and one which seemed to continue endlessly:

its like somebody punching, but its constant , its a constant pain, its like somebody punching but its a punch which never comes off [never stops] ... as if somebody's got top and bottom and they've twisted it, twisted it round.

Other participants continued the theme of helplessness in the face of assault and specified the type of damage inflicted, as if by a knife:

You get like a shock through your system, through my back and down my legs, its like its just like somebody putting a knife in you. (Tim)

The theme of assault was extended by Annie to include what she imagined it would be like to be struck by lightning:

It's excruciating like being struck by lightning, it's like my back all tightens up and like somebody's shoving a knife up me.

Participants also used more abstract and purely psychological terms to describe their pain. Lily saw the pain as a malignant force, as evil, 'a red devil with great big horns on', which she associated with a feeling of nausea, 'something gets you in a knot and you feel a bit sickly'. Annie echoed Lily's account of the malignancy of her pain and described her own situation as if her pain was involved in a parasitic process, draining her of any motivation:

It feels like something's attacking your body isn't it ... I'm always tired, when it's bad it's like everybody's plugged into my back and all the energy's gone, it's dead ... all sucked out.

In a similar vein Jo and Paul described their pain as 'vindictive' and 'cruel'. To them it was senseless and appeared to act only out of malice, existing only to prevent them from doing what they wished to do and to deny them pleasure:

It's mean, vindictive, I get to the point where I can do things and then it just comes in and spoils everything just so I can't, I can do nothing, it hates me. (Jim)

It doesn't seem to be giving me a chance at all just lately ... it's like somebody's got their hand inside your spine and every time you think about doing something they just give it a little squeeze. (Paul)

Whether physical or more metaphorical in description the participants' imagery for their pain, like their taxonomies, reflected more the quality of their distress, their sense of despair, powerlessness and frustration than the technical level of their understanding of the processes of chronic pain.

Intrusion.

Each participant considered their pain to have had a profound impact on their quality of life, but varied according to the quality and degree of this intrusion.

Adrians's pain had changed his life extensively, but he felt that its effect had been restricted to only certain domains:

It's changed my life 90%, my lifestyle but it's changed my lifestyle 90% but me actual home life and personality, it hasn't changed me that way.

Adrian felt no sense of shame or responsibility for his pain and felt that its persistent presence did not reflect upon him as a person, or influence his personality or self-regard:

I don't think I've changed as a person because I'm not disappointed in myself if you get what, I've done nothing wrong and I can accept that, you know, I've done nothing wrong and I've not, It's just...how I actually did it I don't know I'm not like annoyed with myself that way because it's just one of those things.

Lily described a similar reduction in her levels of activity, '...it ruins my life really...it does it sort of cuts your life in half...', but in contrast to Adrian, her pain not only restricted her life, but pervaded both it and her sense of self, '...it's part of me now...' It was associated with a sense of permanence and powerlessness as it intruded into her view of her future where she imagined it would persist endlessly:

At least with a toothache you can go to the dentist and have it out, can't you, with a back you're stuck with it, forever.

For Henry, the intrusive and pernicious nature of his pain extended yet further, to the point where he felt his pain defined him as an individual:

It's so bad it takes over my body, it takes over my mind, it makes me short-tempered you know, talking about the pain I've got, it makes me a pain, it's that feeling of knowing that I must be a pain to others. I'm a bother. On a daily basis it's destroying me, it's stopping the pleasure of my life.

Tim and Jo both ascribed qualities of malice and cruelty to their pain and felt this was directed toward interfering with their relationships by making them both intolerant and hostile. Similar to Henry, but in contrast to Adrian they felt their pain had intruded into their personality and that they and those around them suffered as a consequence:

It's made me into a monster, sometimes, Jekyll and Hyde. Made me full of hate, so no one wants to know me. I've lost people cos of who I am now. (Jo)

Tim's pain was associated with a significant degree of somatic tension and he saw pain management as a dual task which he felt he often failed to achieve and which, like Jo, had changed his identity:

I tense up with my back pain the rest of my body is going haywire you see, you're not just coping with back pain, you're coping with the rest of your body ... it's made me a different person, I'm usually really placid, up to getting this I could cope with anything, I've never been stroppy and short-tempered and snappy like I am now.

Lily related a similar process whereby her experience and response to her pain interfered greatly with her social relationships. But in contrast, rather than becoming aggressive in the face of her pain, she was prompted to withdraw into a state where she dissociated herself from her surroundings. As Lily retreated, in fear, from the pain and the memories of past pain episodes she also became estranged from those around her:

Nobody can get through to me when it's like that. I'm just in my own little world...I just tend to shut off from it [the pain] when it gets so intense I get frightened cos I know from when I passed out with it, it wasn't very nice at all, horrible, I've never had pain like that and I don't want to have it again.

Annie felt that coping with her pain drained her of energy and the ability to feel pleasure, 'you've lost the vitality of life'. For Tim coping with such ever-present and persistent pain represented a test of stamina. His pain remained within his consciousness and often caused problems with fatigue:

It's always there and its at the back of my mind, eventually it gets through to me, you know I can keep, what is it, I can't keep switching off, you tend to like think I haven't got it, but you can't do it all the time.

Many participants, like Jim described how the simple physical restrictions associated with their pain, '...you can't do anywhere near as much as you could.'. However Jim also emphasised how his pain's intimidating quality also dictated his disability:

When it's bad, that's when its out to get you and you're afraid to do anything in case it does.

The participants' disability was as much a function of the degree of apprehension they held in relation to their pain, as of its physical restrictiveness. Their lack of confidence in their ability to predict or withstand a severe flare-up of pain when they were away from their home regularly restricted their mobility. Paul felt this quite acutely:

I haven't got the confidence to go out without my stick, I haven't got the confidence just to go around the corner to shop.

For Paul his pain was omni-present, dictatorial and persecutory, actively disabling him:

It never goes away, its like somebody's got their hand in and every time you think that maybe I can do this, you start something and it gives you a kick, you always pay for what you do.

Each participant, having defined the unique meanings and qualities that typified their pain also described how this intruded into specific personal and public domains of their lives and lifestyle. The participants' experience of pain extended beyond an unpleasant sensation or restriction in movement to influence directly their self-concept, self-efficacy and relationships.

Post – Intervention.

In the participants' accounts following the intervention each groups appeared to have received a similar therapeutic benefit that was independent of the style of the intervention. For each of them their pain remained the same and the benefits were not related to the explicit content of the intervention. Pre-intervention the participants described their pain in personal and contrasting ways and this variety was also reflected in their report of the outcomes of the intervention.

Pain Taxonomy and Mechanisms and Causes.

The participants reported, post-intervention, that their pain remained unchanged. The same pain taxonomies and causal beliefs they applied prior to the intervention were retained. Adrian emphasised his distinction between a 'pain' and an 'ache':

I class pain as, what can I say, like sharpish, you know to be sharp, where as my back problem, I wouldn't say it's sharp, it's dull.

Adrian's 'ache' continued and it's persistence and demand for attention remained a central problem, as it also did for Tim:

It's just there, it's I don't know whether it's just, it's in your brain all the time. (Adrian)

It grinds you down, it goes on and on and on and on and on, you can't ignore it forever. (Tim)

Post-intervention the participants reinforced the focus on the persistence and perceived endlessness of their pain when it was at its best:

Its still there, it won't let up, even when its not too bad its still there and you think, its going to be here forever. (Jo)

I've got the same pains, most of the time its just there bugging you, not scaring but bugging you and you can't imagine what its like without it. (Jim)

Similarly, post-intervention none of the participants changed their descriptive imagery as it related to their ideas about the causes of their pain. All but one of the participants reported that their pain had not changed. They felt it continued to persist and that the processes related to its presence had not been altered or modified. However, each also felt more able to manage their pain, 'the pain's the same but I'm better in myself' (Brenda). The participants reported an increase in the degree of self-confidence they felt in the face of their on-going pain. In asserting that their pain remained, the participants highlighted the change they felt had taken place:

its still like vicious, no difference, but I think I can deal with it a bit better, like I'm not running away, I'm stronger. (Jim)

One participant was an exception, Lily, who had employed more descriptive rather than causal imagery reported that her pain had moderated in that, pain post-intervention, it had become more 'distant'. It remained a pain which 'nagged', but one which did so from further away, palliating its effect:

It's [the pain] still there but its, as I say its distant, it seems further away than, not as incessant as what it normally is you it's always there nagging, but its not bothering me at all.

Intrusion.

The change in the degree of intrusiveness and impact of the participants' pain on their quality of life and self-concept emerged, from the participants' perspective, as the primary effect of the intervention. It now disabled them less.

Adrian's ache remained a widespread sensation that influenced his perception of his whole body rather than one discrete part of it:

You get because you can feel it. You feel it and all your body like seems to know about it, you know what I mean. Er, what can I say, your brains telling you you've got pain...my head can feel the pain.

Following the intervention Adrian described the continuing presence of his pain but an improvement in his ability to tolerate it and reduce its influence over his mood:

It's not actually getting rid of your back pain, or even helping. Its not like having an injection or something to get rid of the pain or something like that, its just mentally wise, I feel better, I feel a lot better for it.

The other participants' accounts of their pain showed that although it persisted within their body as it did for Adrian, it was no longer as intrusive as it had before the intervention. Jim, for example reported how he now felt less afraid of his pain. It retained the potential to assault him, but he felt more able cope with it:

Its still there and its still mean, but I reckon I can handle it better now, it won't get me as much.

Lily's distress receded as she felt her pain intrude less:

It used to spoil a lot of things. So yeah I feel a lot better, I'm aware of it but that's it, it was over-powering at times.

As she felt better, Lily's disability improved, she was able to resume some of her social activities and feel more in control of her every-day life:

I look after my granddaughter a couple of days a week. I can cope better with that, when she's a bit grumpy, I just can cope with life better, I feel a lot better in myself.

The participants recounted how their pain no longer intruded upon their mood as much as before and that as a consequence they felt more able to contain their emotions. Jo felt he had become more predictable and better able to manage his social life:

It's still there, the pain, no different, but I'm different, I'm calmer, I'm not so ballistic. I can have the pain and not be so hateful, I'm still in pain.

Other participants also described how they felt better able to manage their pain and its effect upon them:

Its still there but I'm better in myself, not so ugly, monster, I can cope with it and its not winding up my body like it was. (Tim)

I don't think the pain as such is any better, I reckon its all worn out and rusted and the tape hasn't kind of lubricated that way, but I can stop it being so mean, spoiling things. (Jo)

Paul considered that his pain had worsened marginally during the time of the intervention, but he felt that the process of deterioration had been slowed and that he could manage his pain better. He put this down to an improvement in his mood:

It's [the pain] a little bit worse, but I seem to be a lot happier now than I was. Being happy seems to lessen it or slow it down, I was finding myself more relaxed and I started to sleep easier.

The experience of empowerment and increased self-confidence in the face of pain were similar in both groups. For example, like Paul in the transformative group, Henry and Annie in the incompatible relaxation group both felt their pain had not improved but that they had become able to manage it better and control their depression and anxiety:

As I say it's definitely slightly worse but I've not been getting so depressed, I try to relax, I mean you panic, I don't get so much you know, what I did in the shops, that definitely works, I don't get so panic-stricken. (Henry)

I think your mood has a lot to do with it yeh, I'm a lot happier now, but er, you know the pain is still as bad, I think I'm coping with it better. (Annie)

The participants' accounts showed that their situation had changed most, post-intervention, in the degree to which their pain intruded upon and influenced their particular social worlds and their sense of self-regard or self-efficacy in relation to their pain.

Active Ingredients and Processes.

Each participant described how they felt a beneficial change as a result of the intervention. However, this was not related to the explicit content of the intervention. In the respective groups their pain had not been transformed and there was no report of a significant decrease in somatic tension. Although no suggestions had been included in either intervention toward developing greater self-efficacy, or self-regard, it was in these areas that the participants perceived an improvement. Contextual factors, particular to both groups such as the relationship with the therapist emerged as the important therapeutic ingredients for the participants.

Jo felt that the pain-management context of the intervention, rather than the content, enabled him to manage and endure his pain better by promoting a better sense of self-efficacy and reducing his sense of hopelessness in the face of it:

As I say nothings gone and I don't feel more relaxed but I'm better with the pain, I can ignore it longer and stop it spoiling things for a bit longer and the tape helps you put your mind to it, makes you think its possible, although it doesn't say that like.

Despite not feeling a change in their levels of tension or pain related to the suggestions embedded in the interventions, the participants each felt better able to manage and reduce, the intrusiveness of their pain into their consciousness. This, in turn, enabled them to engage in other activities. By 'blocking' his pain in this way, Henry felt he was able to feel pleasure again:

your really blocked off with it and, eh, I get absorbed that way and I can sort of relax a bit more. I can't say it takes the pain off, but it's a different sort of feeling, you know what I mean, sort of pleasurable.

Paul described how he felt able to dissociate from his pain and imagine he was 'somewhere else'. The pain continued but he could now achieve a degree of control over its intrusion and secure some respite from it:

I think its not being there, you're somewhere else, not in your own house, somewhere you want to be, I think that helps more than anything else.

Adrian felt the exercise assisted him to manage his pain by supplying a form of social contact and support, a therapeutic alliance to help him to endure his pain at its worst and ease the sense of isolation his pain imposed:

Its like another person involved with you. Where as when it's just you, when it's just your back and your brain that's the way I can put it

like...there's just you two like knowing about it and coping with it at the time.

That ten minutes, twenty minutes or half an hour whatever you want to do it like...involves somebody else in your back pain. (Adrian)

Jim and Brenda were explicit about the sense of social support the intervention offered. It provided them with a sense of moral support and gave them a feeling of confidence in the face of their pain, it was no longer as traumatic to them:

It doesn't say it like but the tape, its like a mate and when you've got your mates with you you feel stronger like, so now I feel like its not just me. (Jim)

Having some one else give you the confidence to resist it, not panic like you'd been stabbed but stay calmer and slow down. (Lily)

Each participant referred to the non-specific inter-personal elements of the intervention, Adrian and Jim specifically and Lily more obliquely. For Lily the important ingredient involved taking some specific time out of her daily life on a regular basis to learn to relax and listen to the sound of some-one talking. This helped her to gain a sense of cognitive clarity:

Just taking that half-hour, to yourself and the droll of your voice...it gives you time to gather your thoughts and things really.

In each case the intervention enabled the participants to ameliorate the sense of social withdrawal and estrangement that had accompanied their pain. Adrian received it

directly from the exercise and others, such as Lily and Jo were able to improve their disability through re-engaging in the kind of social contact their pain had denied them access to through its impact on their mood:

I look after my granddaughter a couple of days a week now. I can cope better with that, when she's a bit grumpy. (Lily)

Now that I'm a bit better with people, not so Jekyll and Hyde-y it means I can see people more. I still get tired but I'm not such a miserable git now, better to live with. (Jo)

Discussion.

The analysis of the participants' accounts showed that they felt they had experienced a beneficial change in their pain and attributed the change directly to the intervention. The effect they reported was independent of the style or explicit content of the intervention and more a result of the contextual and non-specific factors that were common to both groups.

The participants' accounts of their chronic pain in the pre-intervention interviews revealed the richness and uniqueness of the imagery they associated with their pain. Their imagery, 'at its worst', provided an insight into the personal nature of their representations and beliefs about their illness. No change occurred in their descriptive pain taxonomies or causal pain-imagery which suggested that their representations and beliefs about the nature of their pain remained the same. Their self-concepts however

did appear to have changed and they reported feeling better able to manage and contain the anxieties they felt in association with their pain at its worst. In each case the participants had re-appraised the degree of personal threat that their chronic pain represented to them.

No explicit suggestions were made to either group during the intervention toward enabling more self-confidence or self-efficacy with regard to managing the fear and anxiety inherent in the participants' pain. However, this was the improvement they felt had occurred. Their attributions and self-perceptions had become more adaptive and as a result their health anxiety was less intrusive, catastrophic or disabling. They were less fearful of their pain despite its persistent and unchanging nature and less disabled as a result.

The results of this study support the findings of Fisher and Johnston (1998) who examined the role of distress and control cognitions on the pain-disability relationship. They found little support for the mediating role of control cognitions and concluded that it was emotional distress that mediated the pain-disability relationship. In a similar study Sullivan et al (1998) examined the relationship between catastrophisation, a particular cognitive distortion related to anxiety in pain patients and distress and disability. They defined catastrophisation as an exaggerated and negative response to a pain experience and their results showed that it was associated with heightened levels of pain, disability and unemployment. In particular, rumination, the intrusion of health anxiety cognitions was most strongly associated with disability.

The participants' accounts of their pain at its worst revealed the personal nature of their most fearful and catastrophising cognitions about their pain. At the post-intervention interview their accounts of the nature of their pain were unchanged but its personal implications and consequences for them were less catastrophic. They reported that the resultant reduction in ruminative and intrusive cognitions enabled them to improve their disability and functioning. Crombez et al (1998) were able to show this effect in both an experimental study and with a clinical sample (Crombez et al, 1999). They examined the impact of catastrophic thinking on attention and concluded that catastrophisation appeared to amplify somatosensory information and prime fear mechanisms that rendered the sufferer unable to divert their attention away from pain.

Leventhal et al (1980) proposed that each person actively assembled their own cognitive representation of their illness using their lay beliefs and 'common-sense' models. This representation had six main dimensions of which 'consequences' was one. The pre-intervention powerlessness and anxieties that the participants in this study felt in the face of their worst pain appeared to have improved. Their representation of their pain, according to Leventhal's model perhaps was that it now had different consequences, a different meaning with regard to its threat and their future quality of life. Their pain did not threaten them as much and its reduced level of intrusion enabled them to feel less pessimistic. They were able to retrieve some of the activities they had lost or surrendered due to either their fear of movement or social withdrawal and felt more hopeful.

The participants' accounts support Eccleston's (1995b) recommendation that pain management was best facilitated, not by avoiding conscious thought about the pain, but by 'directing attention toward the pain and engaging in a meaningful and positive adaptation of the pain thought'. Both Eccleston (1995b) and Skevington (1995) asserted that simple distraction if it was not associated with an adaptation of the meaning of the pain to the sufferer could only serve as a short-term and equivocal coping strategy.

There is further support for this hypothesis in Kleinman's (1988) anecdotal account that he related in the preface of his book. The patient in particular had to endure a regular and very painful procedure and his role, as a junior doctor, was to support her during it. At first he struggled to do this until he elected to ask her to focus on her pain:

angered by my own ignorance and impotence, uncertain what to do besides clutching the small hand and in despair over her unrelenting anguish, I found myself asking her to tell me how she tolerated it,...she told me. While she spoke, she grasped my hand harder and neither screamed nor fought off the surgeon or the nurse. Each day from then on, her trust established, she tried to give me a feeling of what she was experiencing ... the little burned patient seemed noticeably better able to tolerate the debridement. (pp xi-xii)

Kleinman abandoned his attempts to simply distract the patient and began to ask her to relate her experience to him. This in turn enabled him to begin to form a relationship with her which she seemed to find helpful. The experience had a significant effect on him and he concluded that:

it is possible to talk with patients, even those who are most distressed, about the actual experience of illness and that witnessing and helping to order that experience can be of therapeutic value. (ppxi)

Kleinman's account and those of the participants in this study suggests one of the possible therapeutic ingredients, that is through the act of 'witnessing and helping to order that experience' (pxi) and in particular through directing conscious attention toward the source of the threat in the situation, the distress of the pain sufferer could be eased. The relationship between the patient and the health professional and their joint focus on the patient's pain and situation appears to be an effective therapeutic ingredient. From the participants' perspective it was an integral part of helping them to develop their self-confidence in the face of their pain. Adrian, Jim and Brenda each provided examples of how that contact empowered and helped them: 'it's like another person involved with you...two like knowing about it and coping with it at the time' (Adrian), 'it's like a mate and when you've got your mates with you you feel stronger' (Jim) and 'having some-one else give you the confidence to resist it, not panic like you'd been stabbed but stay calmer and slow down' (Brenda). Brenda's account highlighted how the intervention helped her to stay calm in the face of her pain, not catastrophise or panic as she had done in the past.

The primacy of the contextual non-specific factors in an intervention was echoed in a study by Koutanji et al (1998). They also found no difference in the comparative benefits of a relaxation exercise versus an hypnotic technique for pain management, suggesting that the active therapeutic agents were those that were implicit in the interventions and common to both.

The participants in this study identified both the relationship with the therapist and the pain-specific context as the most important factors to them. Through the rapport they established with the therapist they felt better able to manage their anxieties about their pain. Similar processes have been identified in psychotherapy research where widely different therapies have been found to be broadly equivalent due to the over-riding effects of common factors (Stiles et al., 1986). Of those factors the facilitative conditions and the therapeutic alliance from the perspective of the patient have been shown to relate most positively to outcome (Barkham, 1996; Bergin and Garfield, 1994).

Psychotherapy practitioners have focused explicitly on the importance of the therapeutic relationship as a vital ingredient in the helping process. Malan (1997) defined rapport as 'the degree of emotional contact between the patient and the therapist' (p21) and identified it as the critical on-going measure of therapeutic efficacy 'the universal indicator by which the therapist may be constantly guided' (p85). According to Malan, without adequate rapport other therapeutic processes cannot take place. An important one of these is 'containment' which Casement (1985) described as the process of enabling the client to cope with their most unpleasant and difficult feelings, anxieties which up to that point they had struggled to manage. Casement argued that such containment could not be achieved through diversion or the provision of technical reassurance or information alone but took place within the context of a good therapeutic alliance. What was required and sought after by the individual was a relationship with some-one, 'a person', who was available to help. Through focusing on and identifying the patient's most uncomfortable feelings within the therapy session they could then

begin to overcome and re-appraise them. The accounts of the participants in this study appear to support this argument and showed evidence that this phenomenon also takes place within a simple brief pain-management intervention. The therapeutic relationship that had developed had, in part, helped them to focus on the most difficult and uncomfortable aspects of their pain at its worst and adapt the meanings they had attached to that situation.

Brewin and Power (1999) reviewed the role of such transformation of meaning in different schools of psychotherapy. They argued that the success of any psychological therapy lay in its ability to transform the meanings that the clients had attached to their symptoms, relationships and life problems. In particular they highlighted a small number of themes that they felt were of clinical significance. Of particular relevance to this study were those that centred around the self including, 'the self as powerless', 'the self as inferior', 'the self as non-existent' and 'the self as futureless'. The accounts of the participants in this study suggested strongly that they had achieved some progress in these themes as a result of the intervention. They felt more confident, less powerless and with more hope. Other themes not related to the self, such as 'the other as hostile' appeared not to change i.e., the participants' pain-beliefs remained stable.

In partnership with rapport and the therapeutic alliance, the pain-management context of the intervention was an important factor for the participants. It distinguished it from other supportive relationships that the participants had, as the following segments illustrate: 'the tape helps you put your mind to it, makes you think its possible' (Jo) and

'it wouldn't work unless it sounded like, this is for the pain, this will help, helps you feel you can do it that way, wouldn't work if you were just encouraging like, or if you went on about gardening and being all nice, it's the pain bit you need' (Jim). This adds weight to Casement's conclusion that a good rapport and alliance is both therapeutic in itself and enables a therapeutic process to occur. In this case the containment of the participants' pain anxieties and sense of threat and powerlessness. Jarrett et al. (1999) found that palliative care patients actually expected this kind interpersonal relationship as part of a therapeutic service. 'Support' and 'someone to talk to' emerged as discrete themes in their study of patients' perceptions of a specialist palliative care team.

Strengths and Weaknesses of the study.

The main strength of this study, as with the previous one, lies perhaps in the nature of the themes that emerged and how they captured and articulated an aspect of the participants experience that would have been difficult to explore otherwise. The analytic process was flexible enough to respond to the themes that emerged and as a result it was possible to explore both how the participants experienced and managed their pain and speculate as to what the active therapeutic process might involve.

As in study one the participants were exclusively those with chronic pain syndrome and how the themes relate to those patients in less distress and disability requires further research. Similarly, the analysed data was restricted to the verbatim transcripts of the interviews with the participant before and after the intervention. Other sources of data, such as journals or pain diaries could have provided a greater opportunity to triangulate

the participants accounts and add weight to the emergent themes. The follow up interview was immediately after the intervention and it would have been interesting to repeat the interviews over a lengthier period of time to see how their experience unfolded and whether the changes they reported were maintained.

The participants' accounts could have been influenced in some way by the context of the study, in particular that the interviews took place within a clinical setting and that the researcher in this study acted both as the therapist for the intervention and was a member of the clinic staff. Separating the therapist and the researcher roles would have addressed that problem and further research to see how this might have influenced the participants accounts would be valuable. At the very least the participants could have been asked to describe how they felt it influenced them.

Conclusions.

The simple interventions in this study made no reference to developing the participants' self-efficacy, confidence or empowerment and it could be argued that a more powerful effect could have been achieved through focusing directly and explicitly on those themes. However, if progress was achieved mainly through the effect of non-specific factors such as the quality of the therapeutic relationship this may not have an effect. Further research would be useful to see whether the processes and factors that have previously been called 'non-specific' would be more powerful if they were identified and made 'specific'.

Employing the approaches and techniques of psychotherapy research may help us understand more about the efficacy of pain management interventions.

The participants' accounts described a positive change in their experience of their pain and the particular nature of the change in meaning that involved. They had re-appraised themselves and now related to their pain differently. They were better able to improve their quality of life and reduced their disability through an increase in their ability to contain their anxieties that were associated with their 'worst' kind of pain. Their pain beliefs remained the same but they perceived themselves as better able to manage the consequences of its presence and its disabling claim upon their attention receded. The explicit suggestions and focus of each intervention did not emerge as an important factor, although the pain-related context was important. The participants identified contextual factors and the therapeutic relationship was the most important ingredients to them. This highlighted the importance of establishing a secure relationship between the patient and health professional wherever possible and suggests that, if this cannot be established, such simple interventions will be of only limited help.

The participants experience of their chronic pain changed in this study although from their perspective it was the same 'thing', or phenomenon. A simple intervention enabled them to appraise themselves in a more positive light. This reduced the degree of active and disabling threat that had been associated with their pain, it intruded into their consciousness to a lesser degree and they were better able to function. This suggests that the manner in which the individual appraises themselves is important in the meaning of

their experience of their chronic pain, the nature of its unpleasantness and the process by which it disables the person suffering it.

Chapter Eight.

Study Three.

Chronic Benign Low Back Pain and the Self.

Introduction.

The themes that emerged from the first two studies suggested that the meanings of the participants' chronic pain were not related solely to the beliefs they held about their disease but also to their sense of self. The participants made several references in each of the first two studies to the impact of their chronic pain on their personal evaluation of their self and their self-definition.

For example:

You feel like just not particularly giving up but you don't feel the person that you are that you're capable of feeling or capable of doing basically. It makes you feel a bit down and a bit miserable.

(Nina - Study One)

It's so bad it takes over my body, it takes over my mind, it makes me short-tempered you know, talking about the pain I've got, it makes me a pain, it's that feeling of knowing that I must be a pain to others. I'm a bother. On a daily basis it's destroying me, it's stopping the pleasure of my life.

(Henry – Study Two)

These changes were associated strongly with the participants' pain and were evident in the participants' accounts in their complaints and discomfort at

experiencing and displaying particular emotions or sentiments such as hostility, irritability, withdrawal, alienation, pessimism, frustration and anger. They interpreted such behaviour as a sign of a key change in their sense of self or personality:

Well my personality's gone ... I've got more snappy and more nasty you want the old Alice back but you can't. (Study One)

it's made me a different person, I'm usually really placid, up to getting this I could cope with anything, I've never been stroppy and short-tempered and snappy like I am now. (Tim – Study Two)

The participants self-evaluations had often become self-critical and indicated a deterioration in their self-regard. In some cases this was to the extent that they now described a negative self-concept, defining themselves as having become undesirable, 'a monster' (Jo) or 'I am a pain' (Henry) and revealing evidence of a punitive self-regard:

I'm sort of mad at myself I start banging things and getting so aerated with myself that it's there and I can't get it to go away. (Linda – Study One)

It's made me into a monster, sometimes, Jekyll and Hyde. Made me full of hate, so no one wants to know me. I've lost people cos of who I am now. (Jo – Study Two)

The evidence from the participants' accounts in the first two studies suggested that it would be valuable to explore further the relationship between the self-concept and the experience of chronic pain. In the first two studies this was an emergent element but it was not explored in any depth. It was the aim of the third study to investigate this aspect of the lived experience of their chronic pain in more detail. To see how the

participants' experience of their pain influenced and inter-related with their self-concept and if it was a useful concept in the study of the dynamic relationship between chronic pain sensation, distress and disability.

Concepts related to self and identity have been utilised in a wide variety of ways within psychological research although the explicit concept of 'the self' as a phenomenon has received relatively less attention. The concept of the self is attended to in both Symbolic Interactionism (Denzin, 1995) and Phenomenology (Spinelli, 1989).

According to the symbolic interactionist approach the interpretation process itself which defines the symbolic nature of objects is only thought possible 'by virtue of possessing a self' p12 (Blumer, 1969). With the self-concept an individual can then become an object for their own attention and action and they are able to relate to themselves as well as others. The self as an object and the meanings related to it are considered to emerge through a process of social interaction. The self is viewed as both process and product, continually unfolding and changing yet also organised and resistant to rapid change.

The self is also conceived as an integral aspect of consciousness and a necessary product of intentionality, the sense-making process and drive for coherence that is referred to in the phenomenological approach (Spinelli, 1989; Giorgi, 1995; Chapman et al., 1999). It is considered as a phenomenon in its own right, it enables a

perspective or point of view to be established that aids interpretation and provides a source of continuity over time. The fluid and dynamic nature of the self within phenomenology allows for the presence of multiple selves, for self-deception and for the notion of a self that can be related to.

Concise and consensual definitions of the self are elusive, for example Stevens (1996) outlined five discrete approaches to the study of the phenomena and in doing so highlighted its inherent multiplicity. Definitions have had to be broad to capture the dynamic complexity of the self and not represent it falsely as an inert monolith (Kihlstrom and Kihlstrom, 1997). They most often refer to it as a stable but dynamic collection of core beliefs, constructs or cognitions that are utilised by the individual to define themselves both privately and in their presentation to the outside world (Kelly, 1992; Kelly and Field, 1996; Ashmore and Jussim, 1997).

The self-concept is typified by its many elements, for example; it can be both private (intra-personal) and social (inter-personal) in its structure (Contrada and Ashmore, 1999); it can be rooted in time with a focus on 'past, present and future selves', (Charmaz, 1991; Helstrom, 2001); or differentiated and sub-divided as both subject and process, 'the I' and object and content, 'the Me' as was advocated by James (1890) and more broadly within Symbolic Interactionism (Denzin, 1995).

Ashmore and Jussim (1997) followed James' differentiation of the self into the 'I' and the 'me' where the 'I' (process) organises and manages the 'me' (content). The person

is seen to engage in an on-going process of self-regulation (the 'I') managing the self-definitions, self-standards and self-judgements that make up its structure (the 'me').

The self-concept can also be both social and personal and has the potential to link the two domains together. It includes our beliefs about what others think of us and our perception of the differences between ourselves and other individuals and groups. As such it is a useful concept for exploring the relationship between individuals and larger social systems and between the private and the public domains of our experience.

Authors such as Stevens (1996) have argued that the self has now become a primary source of meaning in contemporary western society. It has a critical influence over our ongoing sense of self-worth or self-definition and provides a form of intra-personal and developmental continuity for us as we live through events over time. Charmaz (1991) emphasised the importance of time in relation to the self and argued how the self-concept provided meanings for the individual and this process unified our subjective experience over time. Both Helstrom (2001) and Charmaz described how that the dimension of time allowed a range of different selves to be organised according to the past, present and future. Particular selves were not necessarily grounded in reality but could be 'spurious' (Helstrom) or 'fictional' (Charmaz) and as such were often dissonant with other aspects of contemporary experience. They could represent a self that did not acknowledge the presence of a chronic condition and would be problematic if they contrasted too much with other contemporaneous experiences or required too great an act of self-delusion to maintain.

Until recently there has been relatively little research into the relationship between concepts of self and identity and physical health or the utility of adopting such a perspective within psychology. The potential utility of this approach was highlighted in a collection edited by Contrada and Ashmore (1999) who concluded that, 'self and identity related concepts can contribute to the understanding of causal processes that underlie physical disease, as well as those instigated by its occurrence' (p8). They established evidence to assert that the self-concept could play a key buffering or mediating role in the relationship between distress, duress and physical health. Examples were drawn from; racial identity and racism (Williams et al., 1999); trauma and recovery (Pennebaker and Keogh, 1999) and living with chronic illness (Charmaz, 1999 ; Leventhal et al., 1999) and in each case the need to maintain, reconstruct or repair a coherent and constructive sense of self was considered to be key to the individuals good welfare and physical health. Idler and Benyamini (1997) found a similar effect when studying their subjects evaluation of their own bodies. Having controlled for objective bio-medical factors they concluded that self-ratings of physical status predicted mortality and disease course. Those people who saw themselves as robust and healthy, independent of their medical health status were in far better physical health over the years that followed.

The importance of the self to physical health was referred to by Taylor (1983) and incorporated into her theory of cognitive adaptation. Taylor studied the process of adjustment to the threat of breast cancer and concluded that three themes were of critical importance, the search for meaning, the need for control and mastery and the

need to maintain self-esteem through self-enhancing evaluations. The process of 'self-enhancement' guided the selectivity of the participants' social comparisons which were selected and interpreted in such a way as to leave the participant appearing to themselves to be well adjusted. Progress in each of the themes defined by Taylor was shown to contribute to better physical health and disease course (Taylor et al., 1998). Taylor's themes and the importance of the self were later echoed by Baumeister (1991) in the four themes he defined as key to establishing meaning in every day life, notably the need for purpose, value, efficacy and self-worth.

Work by Charmaz (1983, 1991, 1995) has been reviewed earlier in the thesis (Chapter Four, 'Qualitative Research in Chronic Benign Low Back Pain' and Chapter Six, 'Study One') and it showed how the loss of social identity was a factor in the distress and disability related to chronic disease. The experience of chronic illness was shown to be typified by feelings of a lack of social value, loss, restriction and isolation that threatened to discredit the individuals sense of self and social identity. Charmaz emphasised the importance of maintaining a socially valued self definition in the management of chronic illness and described how problematic this was for those concerned and their families and friends.

Aldridge and Eccleston (2000) used a Q-methodology to explore the ways in which their participants made sense of their everyday chronic pain. Eight themes were derived and common to all of the accounts was the theme of how pain related to the self and in particular whether pain could change the self. The notion of a coherent and consistent self emerged as something quite central to the participants' process of

making sense and accounting for their experience of pain. Pain was seen as a powerful threat to the self, capable of overwhelming and changing it permanently and for the worse. Living with pain was shown to involve an ongoing and everyday process of both resisting the 'delegitimation' of self and trying to maintain or rebuild the self as rational, competent and endowed with some form of moral worth.

The notion of the self has been neglected in mainstream psychological research although recently there have been developments within cognitive research into chronic pain that show an emergent interest in it as a topic of study (Pincus and Morley, 2001; Aldrich and Eccleston 2000; Chapman et al., 1999).

Chapman et al. (1999) argued that there was a need to develop the biopsychosocial model to include the idea of consciousness and the self. The self was identified as a key feature of consciousness and one that had the potential to link the relationship between the physical and the psychological aspects of pain, providing a pathway from transduction and nociception through to the development of an internal model of the world and the self that informed and guided our actions, intentions and pain. They hypothesised that pain emerged from the complex patterns of a large amount of parallel distributed processing that occurred throughout the brain and the perceiver's model of the self and world. The self was seen as a mechanism that enabled the brain to organise such enormous amounts of information from a coherent point of view and was conceived as a complex phenomenon that could include within it many different versions of the self. Different versions could include; a 'body self' (e.g. Melzack's body matrix, 1990) which allowed a phantom limb to occur and a sense of whole to

remain when a physical part is lost, a private self-appraisal and a higher level of self-organisation related to the roles and identities that defined us within our society.

Pincus and Morley (2001) published a review of studies into cognitive processing bias in chronic pain and suggested that the self, as a schema, could play a pivotal role in the experience of chronic pain. They concluded that patients with chronic pain selectively processed pain-related information in comparison with other types of stimuli. The nature of the bias was unclear from the studies but led them to propose that it could be the product of the interaction between three schemas representing pain, illness and the self. They theorised that the individual experience of chronic pain related to the degree to which the three schemas had gone beyond over-lapping toward a form of enmeshment where the parallel activation of elements from different schemas resulted in elements of one being incorporated into another. Consequently, events that formerly activated one schema would then be capable of eliciting unwanted effects in another and a pathway, via the self, was hypothesized between the physical and psychological dimensions of chronic pain. Pincus and Morley considered that the self schema was particularly important in the enmeshment process and they speculated that it was the degree to which chronic pain disrupted the aspects of the person's schema of the self that determined the focus and degree of enmeshment:

the degree to which the chronically activated pain schema 'traps' negative aspects of the self. As a consequence, the pain experience is viewed in terms of its behaviour and affective implications for the self and not just its sensory characteristics. (p611)

Pincus and Morley argued specifically that more idiographic approaches should be developed to further our understanding along these lines.

Aldrich et al. (2000) reviewed one particular cognitive process related to the competition for attention, that of 'worry', in relation to chronic pain and argued that this too was related closely to the self. Chronic benign low back pain was considered to be particularly suited to generating 'worry', which in turn served to maintain the experience of chronic benign low back pain at a prominent level in the consciousness of the sufferer.

chronic benign low back pain is one environment in which the potential for failed or thwarted problem solving is great, and which provides the conditions for worry to thrive. (p461)

Aldrich et al. argued that in chronic benign low back pain there were many different objects of worry, including some that are social or cultural in origin and that worry was not only directed at aspects of the pain, but also about the self. Repeated attempts to solve an insoluble problem have been shown to provoke frustration and an increase in the negative focus upon the self (Wells, 1994) and Aldrich et al theorised that that chronic benign low back pain patients could become locked into a form of self-perpetuating rumination that maintained a heightened level of vigilance and worry toward pain as a prime threat to the self.

The studies related above explored the relationship between the self and physical illness and showed it to be relevant to the experience of the sufferer and a potential

mediating factor in the course of their disease and quality of life. More specifically Charmaz (1991, 1995) and Eccleston and Aldridge (2000) showed how the experience of chronic illness and pain represented a threat to the self and that managing that threat was a core aspect of coping with the disease. Neither, however, studied benign chronic pain nor adopted a phenomenological approach. Charmaz focused on many chronic conditions from a sociological point of view whilst Eccleston and Aldridge adopted a q-methodology which could not go in any depth into the participants' individual accounts or experience. Further study focusing on benign chronic low back pain and exploring in depth the personal accounts of the sufferers could contribute further to their findings and illuminate the intrapersonal as well as the inter-personal processes involved.

The aim of this study was to explore the nature of the relationship between the participants' chronic low back pain and their sense of self. In particular, to establish how the participants' pain impacted on their sense of self, whether it was a factor in the associated pain sensation, distress and disability and if the participants experience of their pain could inform us about the structure of the self.

Method.

This study involved a single interview with seven participants and followed the same procedure as that used in study one and two and outlined in chapter five.

The same sampling procedure was used as in the two earlier studies. Seven participants were recruited, interviewed and the transcripts of the interviews analysed.

After presenting the draft analysis to both my supervisor and a colleague it was considered that sufficient data was present at this point to enable an internally coherent and persuasive statement which articulated the emergent themes to be written up. Consequently no further participants were recruited. In this study the same importance was paid at the end of the study to the addressing any anxieties that might have emerged on the part of the participants as a result of the interview and in this study three participants reported feeling distressed.

Again, as with the two previous studies, the ages of the participants plus the length of time they had been in pain is listed below. They were all white, european caucasian, from a working class background and no longer worked in paid employment due to their pain. This study used a mixture of five male and two female participants.

Anonymised name	Age	Pain duration (years)
Helen	37	5
Lynette	52	9
Simon	45	11
Frank	51	7
Kevin	36	13
Tony	44	15

My supervisor again reviewed the themes to ensure that they appeared to be grounded in the transcripts and well represented within the data with adequate examples. As in the earlier studies a work colleague also reviewed the analysis to check for the clarity and coherence of the analysis.

In this study the focus of the interviewing was specific to the participants' accounts of their self-concept. Early questions were directed toward engaging the participant in the interview process by asking them to give a general account of their pain. The questions then progressed to those aimed at facilitating as rich and extensive an account as possible of the participant's experience of their self-concept in relation to their pain. To this end and to avoid leading the interview within this area of inquiry, all questions were open-ended.

The interview schedule was as follows:

1. Could you, to begin with, describe your pain to me in your own words please?
 - what does it feel like?
 - How long have you had it?
 - Does it change in any way?
2. How did your pain start?
 - How long have you had it?
 - How did it come on?
 - Has it changed over time?
3. Does anything affect your pain?
 - Does anything make it better?
 - Does anything make it worse?
4. Do you know why your pain persists?
 - What causes your pain?
 - Why hasn't your pain been cured?
5. Has your pain changed things for you at all?
 - Is anything different now?
 - Do you do anything or feel differently since you had the pain?
6. How would you describe yourself as a person?
 - What would sum you up?
 - How do you think/feel about yourself?
7. Has having pain changed the way you think or feel about yourself?
 - Are you any different now as a person after having pain?
 - Do you see yourself differently?
 - In what ways are you a different person now?
8. Why do you think that change has happened (if it has)?
 - What has caused the changed?
 - What has brought that change about?

Analysis.

Participants were asked to talk as widely as possible about the different ways their pain had affected or influenced their feelings, attitudes or beliefs about themselves.

The participants' accounts clustered around four broad themes, which were; 'Living with an unwanted self', 'The social aspect of the self: dealing with other people', 'A self that cannot be understood or controlled' and 'Living with a body separate from the self'. Each of the themes are reviewed in turn below.

Each of the participants related how, as a consequence of living with their chronic pain they had experienced a deterioration in their sense of self and were engaged in a struggle to manage that process. The phrase 'self-concept' was not used by the interviewer, the participants were asked to describe in their own words if they felt living with their chronic pain had affected the way they saw or felt about themselves, 'as a person'. None of the participants reported any problems understanding this concept, referring to it as 'me' and 'who I am'.

Living with an Unwanted Self.

Helen's account captured much of the participants' despair in relation to the deterioration in their self-regard and their struggle to assimilate that aspect of their experience of living with pain into their self-concept. The changes Helen reported were associated with significant distress that, at times, out-weighed that caused by the pain sensation and prompted to her to withdraw from social contact for fear of harsh judgement:

Int. How long has it been like that?

Hel. Since it started getting bad, I was always snappy with it but not like this, it's not who I am its just who I am if you know what I mean, it's not really me, I get like that and I know like, you're being mean now but I can't help it. It's the pain, it's me, but it is me, me doing it but not me do you understand what I'm saying, if I was to describe myself like you said, I'm a nice person, but then I not am I and there's other stuff, stuff I haven't told you, if you knew you'd be disgusted I just get so hateful.

Int. When you talk about you and then sometimes not you, what do you mean?

Hel. I'm not me these days, I am sometimes, I am alright, but then I get this mean bit, the hateful bit, that's not me

Int. What's that bit?

Hel. I dunno, that's the pain bit, I know your gonna say it's all me, but I can't help it even though I don't like it. It's the mean me, my mean head all sour and horrible, I can't cope with that bit, I cope with the pain better.

Int. How do you cope with it?

Hel. Get out the way, [tearful] sit in my room, just get away, look do you mind if we stop now, I didn't think it would be like this, I don't want to talk any more

Helen's account emphasised the distress she felt as she struggled to manage or comprehend her situation. Helen referred to feelings and behaviours she had about herself since having pain, of being 'hateful', that she found disturbing and alarming. They gave her feelings of self-disgust and a fear that if others were aware of them, they too would share that disgust, 'there's other stuff, stuff I haven't told you, if you knew you'd be disgusted I just get so hateful'.

Helen was not explicit about what she does that is so 'hateful', but showed that it was sufficiently threatening to warrant its concealment. Her use of the term 'hateful' was not explicit, but implied that she felt that in being 'mean', she was both full of feelings of hate toward others and also worthy of hate from others.

She showed a need to see herself in a positive light, as a 'nice person', but struggled to do so. This was reflected in her confusion about her sense of self and her attempts to separate the undesirable behaviour from her self-concept and attribute it to the pain, 'it's not who I am it's just who I am if you know what I mean, it's not really me', or, 'It's the pain, it's me, but it is me, me doing it but not me'. Helen appeared to be engaged in an ongoing process of defending her self-concept to retain a sense of self-worth, but she could not reject completely the implication that her 'disgusting' behaviour was not just a function of her pain but also related to her self, 'I know your gonna say it's all me'. The battle to retain a sense of self-worth in the face of her confusing experience of her deteriorating physical and emotional state and disability, was more difficult to bear than the sensation of pain itself, 'It's the mean me, my mean head all sour and horrible, I can't cope with that bit, I cope with the pain better'.

Another participant, Simon, talked explicitly about the difficulties he experienced in relation to the way he felt he had changed. He described the new and different elements of his self-concept, as if they belonged to another person:

It's like living with this guy who follows you around all the time, he never leaves, you're cursed with him and he gets in the way, he embarrasses me. He's unsociable and sometimes downright rude, most of the time he's just a waste of space.

Like Helen, Simon tried to disown the characteristics he associated with the change in his self-concept. Simon attributed them to another person, in an attempt to preserve a positive view of himself. He was aware of this as a conscious coping strategy and this highlighted the importance he attached to maintaining a self-concept that he valued:

Int. This seems to mean a lot to you?

Sim. It does, if I can't be the image that I think I am ... then I'm in trouble.

Int. What kind of trouble?

Sim. I'm not sure now you ask, worse than it is now, I'm sure, when you think about it, it just feels ... horrible. I know when I'm mean it is me, I know there is no 'guy', I'm not mad, but it's not me, that's not me, I'm not like that.

Simon was explicit in his need to retain a desirable self-concept 'if I can't be the image that I think I am ... then I'm in trouble' and as such was engaged in the same process as Helen, albeit more consciously. Helen appeared less aware of the process. She did not distinguish explicitly between different selves, but did make constant reference to a division marking that which was attributable to her, the 'me' and that

which was not, the 'not me', 'me doing it but not me'. Both Simon and Helen referred to the distinction between what was 'me' and 'not me', when relating their conscious lived experience.

Other participants described how they resented and struggled to accept that they had changed, although they varied according to how conscious they were of the process and their resistance to it. Frank, described a similar deterioration in his self-concept and his related frustration and irritation:

Int. have you ever been like this before?

Frk. I was always easy going and I hate the way I am now, I've never been like this before, no, I hate it, drives me up the wall.

Int. what's so bad about it?

Frk. being the bad guy

Int. the bad guy?

Frk. Yeah, being miserable all the time, I used to have a laugh, but it's like there's nothing I can do now, I'm a miserable git.

Like Simon, Frank rejected the way his self had developed whilst he had suffered chronic pain. However, unlike Simon, Frank did not distinguish between two different selves or make any attempt to disown the undesirable characteristics he related. Instead he felt overwhelmed by them, as if they now dominated his self-concept.

Simon and Frank's accounts showed a contrast in their response to the way they felt they had changed and emphasised the difference in the degree to which each of the participants were conscious of the changes they had gone through and how much it represented a change to their original and preferred self-concept. Lynette, for example, like Simon, retained a distinction between two different types of self, her self-concept that had not changed and a new self due to her chronic pain:

Int. have you changed at all?

Lyn. I suppose if you ask people who know me then they'd say I had. I'm not so lively anymore, more quieter and reserved. Sometimes I don't want to go out because I don't want to go out. You know, I don't feel like it, its too much bother or I just feel a bit nervy about it. I've lost a lot of confidence out and about seeing people and I used to be quite assured, quite assertive.

Int. how would you describe yourself now

Lyn. that's difficult because I don't think I'm different inside, but I am different, outside, like I just said.

Int. how would you define the difference

Lyn. well, I still think of myself as I used to be and that's still there, inside, but this pain it's a parasite and its causing problems and I end up doing things which aren't me, not really. They don't feel like me anyway but I can't control it very well sometimes.

Lynette tried to define a difference between how she saw herself, which remained desirable and how she behaved and appeared to other people, which she felt was unattractive at times and distressing. Unlike Frank she retained her original, pre-pain self-concept, which hadn't changed, 'I don't think I'm different inside, but I am different, outside'. Like Helen, she attributed the difference to the malign influence of her chronic pain:

Lyn. miserable, it means, I don't know I'm just crap, I'm not worth knowing, no good to any-one...I'm just a cow.

Int. Is that how you see yourself

Lyn. well no not really, but that's how I come across isn't it, miserable, unpredictable, sulky, but that's not me that's the pain.

Int. how would you describe yourself.

Lyn. well I was happy and good to know, but maybe I'm not now. Inside there's someone who loves people and enjoys things but maybe I am a cow, I've become a cow and I'm sure I'm no fun to be around.

Int. but how would you describe yourself?

Lyn. I am a nice person, but the pain takes over and stops it sucks it all out and leaves me miserable and tired ...and those who know me know its not me but I suppose it is and if you didn't know me you'd think I was a miserable cow, so maybe I was a nice person and now I'm a cow.

Lynette's account exposed the difficulties she had in maintaining a distinction between an unchanged self-concept and a newer undesirable pain-self. Throughout her account phrases like 'maybe I was a nice person and now I'm a cow' and 'and those who know me know its not me but I suppose it is' implied that, like Helen her belief in that distinction was not complete and that she struggled to accept the idea that her self-concept now included the undesirable aspects she referred to. Like the other participants, it was important to Lynette to maintain a desirable self-concept and she attributed her undesirable behaviour to the pain 'but that's not me that's the pain'. However, she displayed doubt that this was still so and at times referred to herself very negatively, describing herself more like Frank 'I don't know I'm just crap, I'm not worth knowing, no good to any-one'. Her reported belief that she retained a positive self-concept 'I am a nice person, but the pain takes over and stops it sucks it

all out' was not sufficient to prevent her from having significant feelings of powerlessness and worthlessness.

Another participant, Kevin, accepted that he had changed and now displayed and experienced a range of socially undesirable feelings and behaviours. However, unlike Lynette, he asserted unequivocally that his self-concept had not changed and that his undesirable characteristics were a function of his chronic pain. They were not attributable to any change in his sense of self, that which he termed 'me':

now its me with this bit that doesn't fit, doesn't belong to me, causing all the problems, what you need to understand is that the pain is not me its attached to me, doing it to me, but its but its not me, it's a part of my body which doesn't belong to me anymore, its different .

Kevin described the distress and in particular the anger and aggression he felt in relation to his lifestyle with chronic pain. Kevin attributed responsibility for this directly to his pain, over which he felt he had little control. He was able to articulate particular scenarios where he felt his pain controlled his behaviour and left him with no compassion or concern for others:

Kev. well its like I said, I am me, nice guy, the pain is this but I've now got this pain, it hurts but its evil gives me a nasty head and makes me hateful, irrational. Like, I hate it when they all leave in the morning and I'm left on my own and I hate it when they all come back in the evening, but I've been watching the clock waiting. Waiting for what, so I can be mean when they get in

Int. so you feel things and you do things that don't feel like you

Kev. yeah, if something sad happens to some-one, I'm not sad, sometimes I'm pleased, especially if they do their back in or get a headache, no sympathy, I'm just glad some-one else is miserable and you have these stupid rows about nothing and you know they're stupid but you have them any-way because you get to spray a bit of hate about.

Kevin did not relate having any conscious awareness of endeavouring to maintain a desirable self-concept, as the other participants had. However he disapproved of the characteristics he attributed exclusively to his chronic pain and found them difficult to endure. They were the source of further distress and he was uncomfortable talking about them to the point where, like Helen, he asked for the interview to be terminated:

Int. yes of course we can. You've talked a lot about how having pain has changed things for you, the way you see yourself and your body, apologising, what's the hardest part out of all that, the most difficult to manage on a daily basis?

Kev. the bits that aren't me, I can't be me, the hardest part is the pain obviously, but the fact that I'm like this monster, I get mean, I do things and I think things which are mean, things which I'd never tell anyone and I'll not tell you so don't ask, I get so and I can't stop myself and I hate it and I know it's wrong but I can't do much about it except say sorry afterwards or just keep it to myself, the family understand I know but that's the hardest part now you ask. Its not me to think that, I've had enough now, ... lets stop now

Int. ok thankyou.

Each of the participants had to make sense of aggressive, hostile and socially undesirable behaviour that they experienced through having pain and disapproved of themselves. It was these experiences, those too threatening to disclose in any detail, that represented such a challenge to the maintenance of their self-regard and

compounded other negative feelings of loss and worthlessness they felt due to the impairment of their pain.

Like Helen, Kevin experienced things which he felt were too socially undesirable to disclose, 'I'm like this monster, I get mean, I do things and I think things which are mean, things which I'd never tell anyone'. Kevin also described himself as 'hateful' and directed this at other people, he now lacked compassion or sympathy for the suffering of others and took pleasure in their misfortune, 'if something sad happens to some-one, I'm not sad, sometimes I'm pleased, especially if they do their back in or get a headache, no sympathy, I'm just glad some-one else is miserable'.

Living with feelings of aggression and bitterness were particularly problematic for the participants, most notably the manner in which their anger and resentment had come to dominate their feelings towards others. It was described in various ways i.e., 'I'm like this monster' (Kevin), or by Helen, who used the term 'hateful'. A further example was given by Tony who, over time, had become resigned to the fact that his contemporary experiences were now central to his sense of self. Not only did he think less of himself, but he felt his bitterness and frustration at his own predicament had left him unable to care for other people. This reinforced and confirmed his negative view of himself, as a 'miserable old git', just as Kevin's aggression and pleasure at the misfortune of others had compounded his view of himself as a 'monster':

Int. right, how else has it affected the way you feel about yourself.

Tony. just bitter and you know what, I don't know if anyone else has told you this but you stop caring, if someone else gets a pain you're not sad for them, you're glad that some-one else knows how you feel, you end up being glad that some-one else has got pain too, that's awful, you get like you're pleased if someone else is suffering or miserable too, instead of like, sad for them, you think not just me then, or you don't think anything, you don't care, people come to the door collecting money and you think, why is it never for chronic pain, what about me why doesn't anyone collect for us and you send them away and it might be cancer in children or something but you just think I don't care anymore, I'm not just miserable to know I am miserable, miserable old git.

Int. are those your words

Tony. yeah, wife hates it when I say it but I'm right.

Tony describes above the extent to which his bitterness dominated his feelings towards others at times and how this compounded his critical view of himself. At times Tony only thought ill towards others, he welcomed their misfortune and pain, rejected their need for help or and wished pain upon them. Tony actively felt pleasure at the suffering of others, rather than indifferent and was appalled to have such feelings. He highlighted the extent to which this had gone by emphasising how, when he felt like that, he wouldn't even care for children with cancer and in doing so underlined his view of himself as undesirable and miserable. Helen too experienced both negative feelings toward others and destructive social behaviour, which undermined her attempts to retain or preserve a positive self-view:

Hel. No not really, well, you don't want to think you've changed at all and I don't think about it, you've asked me and I'm trying to think and yeah, I don't want to, but I think. I'm not a bad person, perhaps, yeah, it brings you down and then you end up spoiling things.

Int. How do you mean?

Hel. No one is going to hear this tape right?

- Int. Like we agreed, anonymous and confidential, you get the tape after I'm done.
- Hel. Right ... the pain makes me mean. I don't want to be, but I get like, mean, I don't care about other people, nothings funny and I get mad if they try to be nice, like pity. It's not really me, but it is me if you know what I mean, I don't like it but I do it, do you understand and I end up saying sorry, if I've snapped like, it's the pain it's killing, it does that sometimes.

Each of the participants gave accounts of either overt behaviours or more covert cognitions or affect, that had developed as a result of living with chronic pain and which they disapproved of and saw as indicative of a degradation of their self concept. Some of the participants attempted to attribute this change to the development of a new 'self with pain' that was discrete from their core and original pre-pain, sense of self 'that's who I am when the pain's not around' (Lynette) and responsible for their undesirable behaviour. This was not associated with the absence of any distress however, they remained distressed by the behaviours themselves and the struggle to retain some self-regard was typified by anxiety and confusion.

The Social Aspect of the Self: dealing with other people.

The participants' distress related to their self-regard, was at its most acute when in a social context, either when interacting with other people, evaluating themselves in relation to other people, or considering what other people thought of them. Their uncomfortable feelings about themselves emerged into their consciousness when in the presence of others.

One participant, Tony, identified explicitly how he could manage his situation more easily if he did not have to interact with others, specifically his children. Social isolation appealed to him, not because of the behaviour of others, but because his feelings about himself emerged into his consciousness less and the pressure to portray a particular identity was absent, 'to be away from people and not have to be something else your not, that would be bliss':

Tony. yeah you know that desert island discs

Int. the radio show

Tony. I'd love that, don't get me wrong I'd miss my kids and I don't mean it, but to be away from people and not have to be something else your not, that would be bliss

Int. you'd be happier that way

Tony. yeah, no well , no I'd still be a miserable old git but it wouldn't matter, its only when other people come around that it matters, if you can just be yourself it doesn't matter what you do, I'd probably shout and swear all day but it wouldn't matter I wouldn't have to put on that front so it'd be easier

Int. so a lot of how you feel depends on who's around

Tony. I suppose it does, but not the pain, that just happens. Dealing with the pain I suppose is different. You could say if I didn't have kids I wouldn't be like this.

Tony described the pressure he felt to behave in a particular way when in company, specifically, to conceal his distress and be sociable, or to model socially desirable behaviour to his children. He saw this as a separate task to managing the sensation of pain 'not the pain, that just happens. Dealing with the pain I suppose is different'. Managing and living with himself in different social contexts was to Tony, as with the other participants, an additional and more distressing task 'I wouldn't have to put on

that front so it'd be easier'. As before, the participants' struggle to manage the assault upon their self and identity and function within a social context, was more problematic, more disabling, than tolerating the pain sensation.

Tony's overt behaviour was, to him, not a reflection of how he felt about himself privately, but the expression of an alternative self. He described it as 'putting on a front' and 'not being the real me' and found it exhausting when he socialised to the point that he now dreaded the prospect of meeting and having to engage with other people:

Tony. yeah, you're just bitter and disappointed you had all this to look forward to and not now and you end up just dreading everything, I used to be all optimistic and look forward to things but not now you just wish you didn't have to do things and when you go out you end up like you can't wait to get home, back to base, like a real party pooper, people ask you or invite you and you think oh god do I have to and then you think of the wife and you think well I should make the effort so you put a front on and you go out but all the time you're looking at your watch and thinking about when you can go home and go upstairs and lay on the bed and get some relief, get a break.

Int. what do you mean by 'putting on front'

Tony. its all just happy go lucky, smiley happy, how are you, I'm fine, no problem, just being sociable, no more just being normal and making sure no-one knows you're in pain or agony so it doesn't spoil things for everybody and you don't have to talk to people about your pain, so you look normal.

Int. is that easy to do

Tony. oh yeah you get used to it, its second nature and it's a lot easier than telling people the truth which they have no idea what to do with you just go into the act, its easier

Int. but you said you dread going out and having to do it

Tony. yeah, its easier not to see people at all

Int. so you'd rather not put the front on

Tony. no you do it cos you have to, to get through it, but because you have to do it and its knacking you can't wait to stop and you count down the minutes before you can leave, like I said there's no point having me around I'm not good company, I'm miserable.

For Tony, social contact was now aversive, threatening and tiring. Masking his private experience when in public had become an automatic and tactical necessity, 'you do it cos you have to, to get through it', 'its second nature and it's a lot easier than telling people the truth' and the cause of much distress as it undermined his sense of self 'there's no point having me around I'm not good company, I'm miserable.' and the effort involved left him physically exhausted 'and its knacking you can't wait to stop'.

More specifically, as a result of his pain and the associated disability Tony felt he had become a poor role model to his children, 'I'm embarrassed to be around, you should be someone your kids can look up to'. Tony felt he could not fulfil his role as a father and found this distressing. It was at its most unbearable when his children were around, to the extent that he avoided them when he could. The way he now saw himself was brought into focus when he described how he imagined his children saw him, as inferior and somehow broken, as 'a bit of a man'. This was self-critical, Tony gave no indication that his children shared this view, 'I can't bear to have them see me like this, its pitiful'. Tony's critical view of himself was at its most unbearable in the presence of others, his children. Where possible, in their presence he tried to over-compensate for self-criticism and become very active, despite the resultant increase in his pain:

Tony. no its just how I feel, like I`m some waster, they should have someone who`s impressive, to look up to but how can they look up to me with what I do all bad tempered and crippled, dossing about lying down every 10 minutes. All they see is a bit of a man

Int. how does that make you feel

Tony. terrible, I try and keep out of their way or when they`re around I make sure I try to do lots so at least they have something to look up to, but I can`t bear to have them see me like this, its pitiful

I. what do they see when they see you

Tony. like I said, pitiful really, a dosser, nothing to be proud of like, when they get older they`ll probably want to hide me.

For Simon, the distress related to the change in his sense of self was also at its most acute, to the point of being unbearable, when he interacted with other people. He found contact with other people aversive and intimidating and as a consequence managed his behaviour and his environment in such a way as to remain as isolated as possible. Like Tony he made no reference to the behaviour of the people he met, but articulated the discomfort he felt about himself, when with others and the way this compelled him to behave:

I just can`t do it. It makes me sick to be around them and look them in the eye. If I stay in the house, in the garden I`m ok, you should see my house, it`s like Fort Knox, if some-one came to the house they wouldn`t think any one was in, I`ve set it up that way even the postman puts the letters in a box on the wall, I don`t answer the phone. (Simon)

Other participants, like Frank below, also related how they had retreated into their house and had become anxious at the prospect of talking to anyone as this triggered the emergence of their most punitive thoughts about themselves:

Frk. I don't go out, I don't answer the phone, I live at the back of the house and I dread it when the postman comes.

Int. why's that?

Frk. cos I don't know what to say, or anything, I just feel embarrassed. You just think what do they think of me

Kevin found it necessary to defend himself constantly against the notion that he was in some way inferior to others, or responsible for his predicament. This left him feeling insecure about the social consequences of others knowing he had pain and frustrated and angry that he should be judged in that way. To him, this was a key element in his experience, it was a form of persecution:

Int. so how does that leave you feeling?

Kev. a bit like I need to be careful about people and a bit worried about what's going to happen to me, are we all going to get rounded up and taken to a camp somewhere and then really angry

Int. angry

Kev. yeah angry, for fuck's sake when can I stop apologising.

Int. how do you mean?

Kev. apologising all the time for being in pain for being in pain, for not being able to work, for not being able to kick a ball, going on holiday, going upstairs.

Kevin felt the need to conceal the true nature of his pain from others for fear of suffering severe social consequences. He likened it to a persecution and a delegitimising of people in pain, his choice of metaphor suggesting a comparison with those sent to the concentration camps during the Holocaust. These were not paranoid delusions as Kevin did not feel in fear of his life to that extreme, but he used it to emphasise the magnitude and ubiquitous nature of the distress and threat that was associated with his pain.

Kevin's insecurity regarding the judgement of him by others left him angry and resentful. His account of his rage and the powerful use of metaphor suggested he was engaged in an ongoing and daily struggle for legitimacy and found it difficult not to judge himself as inferior too. There were things he felt an habitual need to apologise for, as if he too found it difficult to make sense of his situation in such a way that he could reject the notions of inferiority or culpability completely.

Each of the participants felt in some way that having pain or an aspect of their experience of being in pain left them feeling inferior to others. Frank, unlike Kevin, did not feel as if other people saw him as guilty of having pain but he found his disability and the way it denied him the opportunity to fulfil his social roles distressing. To the extent that he described himself as a burden, having no social value:

- Frk. I'm just useless, I can't help out my mother, can't kick a ball in the garden with the kids. I'm just a burden
- Int. a burden
- Frk. yeah, putting on everybody all the time, people have to do things for me
- Int. why is that so bad do you think
- Frk. its just bad what's the point if you can't contribute, you may as well not be there, everyone is missing out because of me.
- Int. do people make you feel unwelcome
- Frk. oh no its me not them, although I'm sure they get tired, its me feeling pointless because I can't do my bit, so you think what s the point why be there, there's no point if you can't do your bit, its only right. Now I need people, but they don't need me, in fact their life would be easier if I wasn't there, they'd have less to do, so I'm a burden.

A Self that cannot be Understood or Controlled.

The participants not only found it difficult to accommodate to the presence of new and undesirable aspects of their self with chronic pain, but remained confused and distressed at the lack of control or discretion they had over the processes of change involved. They felt they could not explain why their self-concept had changed, or predict how it would develop further. Whether their self-concept had changed, or a new 'self with pain' had emerged, their new selves appeared to be outside of their conscious control. This compounded their distress and sense of powerlessness. Achieving control over the self was seen by the participants to be a separate task to pain-management and stood itself as a significant and sometimes dominant source of their distress.

Each of the participants were asked what they thought had caused them to change.

Kevin typified their responses, describing both confusion at why he should think and behave the way he did and feelings of powerlessness to do anything about it except:

I hate it and I know it's wrong but why it is who knows, I don't and I can't do much about it except say sorry or just keep it to myself, you wonder sometimes, what the hell is going on.

For the participants this was a difficult aspect of their chronic pain to cope with. In the extract below Tony highlights his unsuccessful and daily struggle to manage and understand his destructive behaviour, 'I wake up and pray in the mirror, 'today I will not shout at the kids', you keep it up for a while and then you just don't, you get tired and your pain head goes on'. He remained mystified about why he had become like this and apprehensive at his own destructive potential:

Int. that's what its like now?

Tony. Yeah, sometimes ... can you tell me why? Because I don't know why, how ever much you promise yourself on a good day that you'll try harder and not be so sad and think positive and all that stuff ...I wake up and pray in the mirror, 'today I will not shout at the kids', you keep it up for a while and then you just don't, you get tired and your pain head goes on and well.

Helen expressed a similar inability to understand or exert any influence over the development of her self-concept. Like the others, this evoked feelings of powerlessness that complicated and compounded her distress. She became tearful talking about it during the interview, underlining both her despair at being unable to

control or predict her feelings or behaviour and her astonishment at the process of change in her sense of self that this reflected:

Int. do you know why you feel that?

Hel. I'm just full of it at times, but why?, no, I get like I want my doctor to have pain, I want you [becomes tearful] to have pain, sorry ...you just think, who are you? whats going on?

The participants' perceived failure to influence the progression of their self-concept, resonated with the distress related to the uncertainty over the genesis of their chronic pain. They neither knew why they had pain, nor why they should have changed in the way they had. They separated the two phenomena, 'its bad enough having the pain, but to watch yourself turn into this [pause] into this, 'git' and be able to do nothing about it, its horrible' (Simon). They did not feel able to control themselves and managed the situation by reacting to it as they went along, making amends after episodes or outbursts of destructive behaviour that occurred due, in their eyes, to the dominance of their new selves.

Lynette and Frank each described how they now lived without much control or understanding of their self-concept or it's expression. Living with pain now involved tolerating and managing their new potential for destructive and anti-social behaviour. Neither could predict how they would behave, or which aspect of their self-concept would dominate at any one time, ' Jeckyll and Hyde, which one's going to turn up today' (Lynette). Like the other participants, although they rejected and disapproved of the anti-social aspects of themselves that they displayed, they felt powerless to

influence them, 'they say why do you do it and I say if I knew, I wouldn't do it'. The participants felt they now had to manage the destructiveness and unpredictability of their self-concept, just as they did their pain:

Lyn. No when I do stupid that brings me to my senses and I can step in and do all the 'oh I'm really sorry stuff and try and make up for it.

Int. so what do you think happens?

Lyn. I don't know I snap, something builds up and I don't know it, something inside gets to a point where you only have to get in my way and I'll blow, I'll lash out doesn't seem to matter what or where, I don't get to decide, that's not me I'm not like that ...people say what's happened to you, Jeckyll and Hyde, which one's going to turn up today, they say why do you do it and I say if I knew, I wouldn't do it.

Frank appeared to engage in an ongoing dialogue or commentary on his behaviour and appeared more aware than Lynette of his emotions building up, but he also felt unable to stop them being expressed:

Int. why do you think this happens?

Frk. My wife summed it up, she said 'what are you like?', she wanted to know who was this bloke she was living with, the one who goes upstairs when people come round and doesn't seem to have any sense of humour and I say I don't know, nobody tells you you get like this, [pause] you don't want to be and you get into these rows or you get your pain head on and you're thinking 'here we go again, off on one' but there's nothing you can do about it and you think, what is going on.why can't I just be like I was?

Life in chronic pain for the participants involved a struggle for understanding over the processes defining their self-concept. For example, Kevin here expresses his mystification and frustration at being aware of the inherent destructive paradoxes in

his behaviour, but unable to influence it at the time. In his situation it compounded and exaggerated the uselessness and loss he felt due to the physical limits imposed by his pain:

you know you get full of it, what you can't do and being such a waste of space, so instead of being nice to make up for the fact that you can't cut the grass, you're mean, clever eh?

The uncertainty and lack of influence over their feelings or behaviours left the participants pessimistic about the future. They could neither predict the course of their chronic pain, nor the development of the destructive aspects of their sense of self. This left their future threatened by the prospect of further physical, personal and social injury:

Int. how does that affect you?

Frk. You worry, what's going to happen?

Int. whats going to happen

Frk. Yeah, no-one will tell me why I've got pain, I've no idea why I'm like this, well it's the pain, but I don't know what to do about it, so you worry.

Int. about anything in particular?

Frk. What do you mean

Int. what are you afraid will happen?

Frk. It will just get worse I suppose and you know, what can you do about it, how long will people put up with it.

The inability to influence their self-concept left the participants in fear that, as a result of their behaviour, they would suffer socially, be rejected and ultimately end up alone.

Their lack of a significant sense of self-control, left them fearing the social consequences of being in chronic pain in addition to any physical deterioration:

Int. why do you think this is happening?

Sim. I wish some-one could tell me because I'd like to know, it's not me that's doing this, it is but its not, its him [self-with-pain], I'd like to know how to control it because its spoiling things and I don't want it to.

Int. how does that affect you?

Sim. It just adds insult to injury, its bad enough having the pain, but to watch yourself turn into this ... into this, 'git' and be able to do nothing about it, its horrible. I think I can live with the pain, but I'm not sure I know what to do about this.

Int. how do you mean?

Sim. What I just said?

Int. sorry, how does that affect the way you see things going

Sim. Well its dismal, I don't feel as if I know how to start turning things round. So who knows its hard to imagine it could get much worse, but who in their right mind would put up with me.

Simon, like the other participants, found it increasingly difficult to find any value or regard in his contemporary self-concept. This was highlighted in his critical assessment of his social desirability and value, 'who in their right mind would put up with me'.

The participants confusion regarding their sense of self was a significant factor in their experience of living with pain and an important factor in their distress. They struggled to comprehend or feel in control of themselves and this compounded their feelings of hopelessness, fear and pessimism about their future. Their experience of

themselves was typified by uncertainty, they could neither predict their pain, nor how they might respond, think or feel at any point in the future. They had become unreliable and unpredictable and as they felt they no longer had executive control over themselves the participants could not guarantee that they might not cause themselves more and worse problems in the future. This experience of themselves resonated with their experience of the pain sensation itself, as a confusing, uncontrollable and destructive phenomenon and, as in earlier sections, could become the primary source of distress, over-riding the concerns about the pain as a sensation.

A Body Separate from the Self.

The inability to exercise control over parts of their body contributed to the participants feelings of distress and powerlessness. However, the relationship between their self and their bodies was not straightforward. Their accounts showed the extensive degree to which their self-concept had been affected by the change in their bodies and the pain they endured, but the internal workings of the body was most notable for its exclusion from the conscious appraisal of the self. The participants' lived experience of their bodies in relation to their self emerged as a form of dualism, where any dysfunctional or painful part of the body was placed outside of the self and felt to be 'not me' and those parts of the body which functioned normally and therefore silently, were taken for granted and given little attention. Each participant reported giving little conscious attention to their body prior to the development of their pain, but had now become aware of it where it related to the pain.

For Lynette her body had changed from something she had only considered previously with regard to its appearance, but not its inner workings, to something that she was now aware of consciously on a daily basis. This was only the case for those parts of her body involved with her pain, it had not generalised to other parts of her body which she treated as she always had:

Int. ok has your pain changed the way you see your body?

Lyn. Sorry?

Int. has it changed the way you see your body, think about it?

Lyn. I suppose its made me think about it, before I thought about what it looked like, whether I was putting on weight or what make-up to wear, but never about what was going on inside, never gave it a thought, I still don't about the bits that don't hurt, but I know I've got a back now and a bum and left leg, because it hurts and you can feel it like a solid thing like something that's gone wrong.

Int. a solid thing?

Lyn. Yeah, like a mass a bit of leather, in your back getting in the way, you know where your back is all the time, this thing you carry with you now, giving you hassle and getting in the way.

When Lynette described her body she retained the distinction referred to above between an original self and that which had emerged due to her pain, rejecting the notion that anything associated with the pain was a part of her original and preferred self. That which she termed the 'real me':

Int. so your body is different now

Lyn. Oh yeah, its in two parts, the old good bit and the pain bit, which has gone wrong.

Int. how do they vary?

Lyn. One bit works, the other doesn't, like a section has gone wrong, when it's bad and I can't move properly, its like its not part of me, it won't obey

Similarly for Simon and Kevin, the parts of the body that were now associated with the pain and were no longer as easy to control, had become a discrete part of the body and something that was now carried around by them and not a part of them:

Sim. I never thought about my body before, I just abused it I suppose, now I feel it and bits of it feel really weird, as if they're not part of me any more.

Int. which bits?

Sim. The numb bits and down the leg where it hurts and I can't move it like I could, they're somehow separate now.

For Kevin, the parts of his body that were no longer considered part of him were those that felt different and could not be controlled automatically but required conscious effort:

Int. and after the pain?

Kev. now its me with this bit that doesn't fit, but its but its not me, it's a part of my body which doesn't belong..

Int. how is it different?

Kev. well it feels different, you know about it, it tingles and burns some times, back and down my legs so you can isolate it, you can tell the part that doesn't belong to you, like its been infiltrated or somethinglike at the dentist, not just the pain but all the tingling and numbness and the fact it doesn't work as well,

I can lift my arm, no problem but you have to work harder to get the legs to do stuff, you have to make them.

Int. you have to make them

Kev. yeah, kind of because they're not me so I have to kind of make them

Lynette, Simon and Kevin each described a fractured experience of their bodies, excluding from their self-concept the parts of their bodies that were now in conscious awareness or could not be controlled automatically, 'its not me, it's a part of my body which doesn't belong' (Kevin), 'bits of it feel really weird, as if they're not part of me any more' (Simon) and 'its not part of me, it won't obey' (Lynette). Those parts of their bodies that were unaffected continued to play no conscious role in their self-concept, i.e., 'never gave it a thought, I still don't about the bits that don't hurt' (Lynette). Their accounts highlighted the contrast between the significance of the chronic pain on the participants' sense of self and the exclusion of the painful parts of their bodies from their conscious account of that sense of self.

Other participants did not perceive any division in the way they saw their bodies. To them the body remained unified, but with pain. It was however, discrete from their sense of self. They had paid little attention to it prior to the development of their pain and continued to regard it the same way afterwards.

Frank and Tony's descriptions of their bodies were consonant with those of their self-concept and reinforced their unitary but negative view of themselves. Tony did not consider the distinction between the parts of his body that hurt and those that did not,

as important, but viewed the whole body as essentially the same thing that now had pain, whilst Frank saw himself as a 'crock' and his body in the same way. It acted as a symbol of this decline:

Int. do you think of your body in a different way now

Tony. no not really, it hurts but its still the same body, a bit gone wrong and painful but you never know it might put itself right. You don't think about your body unless it goes wrong and I used to think about it but I don't know, I think about the pain but not my body, no-one has shown me anything about my body that says anything all the xrays and tests are normal they say, which doesn't help you just give up on thinking about it

Int. has it changed the way you see your body.

Frk. not really, I'm just a crock now, it hurts now when it never used to but I don't see it much different, except its broken and no-one can fix it.

The participants' accounts of their experience of their physical bodies suggested that they played a paradoxical role in their self-concept, both influencing it in significant ways but remaining excluded from it. When with pain the associated parts of the body were felt to be alien and excluded from the self, whereas those parts of the body that functioned normally were given no attention.

Discussion.

The emergent themes from this study confirmed the indications in the previous two that the self was a valuable focus for research into chronic benign low back pain and played an important role in its lived experience.

As a consequence of living with their chronic pain the participants' self-concept had deteriorated. It continued to endure further assaults in the form of undesirable involuntary impulses and cognitions that could not be accommodated into any personal or shared social notion of a valued self.

The participants described how their self had fractured and now involved the emergence of an additional 'self with pain' that contained the new undesirable elements which were so incompatible with their preferred self, something they termed 'the real me'. Participants varied according to the degree to which they perceived that the new 'self with pain' dominated the preferred 'real me'. To preserve their preferred self it had to be estranged from the newly emerged behaviours and impulses and either placed in conflict with a new self, or left as something from the past. The new aspects of their self-concept that the participants rejected and assigned to their new 'self with pain' were those that they perceived to be both socially undesirable and unattractive. They were abhorrent to the participants and intruded into their conscious awareness most acutely when within a social or relational context.

The participants were confused and distressed at their lack of understanding or control over the processes related to their self-concept that they described. They could not explain why they had changed or predict how it would develop. This experience contributed to their sense of powerlessness and compounded their hopelessness in the face of their chronic pain.

Their accounts indicated that their bodies played a complex role in their conscious appraisal of their sense of self. Their pain had affected their self, but they gave little conscious attention to their bodies when it was not in pain and the parts of their bodies that were in pain were excluded from the core sense of self.

The participants perception of the changes in their self-concept was an important element in their experience of chronic benign low back pain and one which at times was more difficult to manage, or 'unpleasant', than the pain sensation itself.

Adopting a phenomenological approach provided a useful way of exploring this aspect of their lives with pain and highlighted some of the processes involved. In particular, the assault of chronic pain upon the self and what having chronic pain revealed about the nature of the self.

Living with an Unwanted Self : The assault on the self.

There is evidence in the literature that supports the participants' accounts of the deleterious impact of their pain on their sense of self. Contrada and Ashmore (1999) explored the relationship between the self and physical health and argued for a key role for the self in the experience and quality of physical health. Pennebaker and Keogh (1999) and Leventhal et al. (1999) each concluded that the self could mediate the relationship between distress, chronic illness and disability. They emphasised the need to maintain or re-establish a coherent, valued and stable self-definition in order to best manage a chronic condition or endure trauma and duress and argued that where this was not possible and the self came under threat, the individual endured increased distress, disability and poor physical health.

The experience of chronic benign low back pain for the participants was intertwined with their experience of their self. In study one in this thesis the work of Bury (1982, 1988) and Williams (1984) was reviewed and emphasised how the disruptive nature of chronic illness obliged its sufferers to renegotiate their relationships and, in doing so, to review their biographies as a whole, sometimes rewriting their view of themselves in the context of their past and their illness. Kelly (1992) found this was also the case with regard to adjusting to radical surgery and contrasted the difference between the private experience of the self and the more public and inter-active phenomenon of social identity . Although the two phenomena are linked this

distinction helps to describe and explore the phenomenon and asserts the importance of the private self as well as social identity.

The emergent themes in this study echoed those from the Aldrich and Eccleston (2000) q-sort study which highlighted the threat to the self that was inherent in the experience of everyday pain. Key to each of the factors that emerged in their study was how pain related to the self and its potential to change and overwhelm it. Pain represented a threat to the legitimacy of the self as rational and competent and introduced the possibility that control over the self could be lost due to the pain. To Charmaz (1983, 1991, 1999) the chronic illness sufferer's disability and limited lifestyle often left them unable to re-establish a valued self and exposed the degree to which, for some, the self was predicated on social values related to action and productivity. In contrast, Cuthbert (1999) rejected explicitly any implication that such a process was inevitable and gave many examples of chronic illness sufferers who had managed very successfully to maintain high levels of self-regard, action and productivity, despite their condition.

Each of the studies described above highlighted the negative impact of chronic pain or illness on the sufferer's sense of self and how the self was implicated in the relationship between the disease and the associated distress and disability, but they were unable to explore how the intra-personal processes might unfold. The participants in this study gave personal accounts of their ongoing struggle to re-establish or defend any sense of a contemporary and valued personal self-definition and the further problems this caused. The themes 'living with an unwanted self', 'the

social aspect of the self: dealing with other people' and 'a self that cannot be understood' revealed their struggle to retain control over their self and to continue to see it as something positive in the light of their new experiences.

Since developing chronic pain the participants had experienced a variety of distressing, anti-social and aggressive involuntary impulses and behaviours that they felt unable to comprehend or control and which were incompatible with a positive self-concept. They were unable to assimilate or accommodate many of the new involuntary impulses, feelings and behaviours into their pre-existing self and appeared to reject them as a contemporary self that was not real, not the 'real me'. To accept it as the self involved adopting a critical and negative set of self-definitions. Some of the participants did this and those who did often retained their past self as their preferred self in the form of an historical 'real me'.

The participants appeared to be engaged in an ongoing process of defending their self concept. They varied as to the extent to which the new 'self with pain' dominated but it remained at all times unwanted and a private source of pressure. The lack of understanding or feeling of control over the new behaviours, affect and cognitions that threatened their positive view of themselves compounded their distress and left the self in the future at risk. The struggle to achieve Taylor's (1983) three tasks, that of achieving meaning, control and self-esteem to manage threatening events and illness progression (Taylor et al., 1998) and the descriptions by both Charmaz (above) and Kotarba (1983) of the struggle against a loss of a valued social identity were each evident in the participants' accounts. This was not just due to disability, to the

problems of an immobile body or being actively rejected or discredited socially, but also due to their difficulty assimilating and accommodating their chronic pain experience and the behaviours inherent in their chronic pain into a positive contemporary sense of self.

A Self that cannot be Understood or Controlled: maintaining a coherent self.

Maintaining a consistent, coherent self has been identified as an important theme in chronic illness and this was a task the participants in this study struggled to achieve. Corbin and Strauss (1987) referred to a process of identity reconstruction that took place during an individual's chronic illness trajectory that was directed specifically toward maintaining the continuity of the self that was known prior to the illness. As in this study they found that the experience of a chronic condition obliged the sufferer to integrate new experiences into their self-concept and to experience a different kind of self or selves. Yoshida (1993) referred to a similar process in spinal chord injury whereby the individual had to incorporate new 'identities' with their former self and often struggled to do so, swinging in a pendular fashion between rejection and accommodation over time. These studies emphasised the resistance of the self and identity to certain kinds of change and its primacy in the individuals experience of their illness.

Kotarba (1983) described how in chronic pain the self could become not just negative but uncertain and incoherent, 'hopelessly unmoored' (p202). Charmaz (1991, 1995) also argued that the self tended to resist dramatic change and as a consequence could become out of step with contemporary experience in chronic conditions. 'Fictional

selves' would then emerge which were not reflective of the current situation but ensured that the preferred (usually past) selves remained unchallenged and preserved. This was problematic if the individual's everyday impairment clashed too much with the expectations linked to the 'fictional' selves and the person attempted to do things that were no longer physically or mentally possible. The struggle of the participants in this study to establish any form of stable contemporary self appraisal supports this notion of their self-concept being 'unmoored', not just persecutory but fragmented, incoherent and dissonant with their everyday experience.

Helstrom's (2001) phenomenological study also underscored the task of maintaining the consistency of the self over time when in chronic benign low back pain. In common with the studies reviewed above and this study the participants in Helstrom's phenomenological study described their self-concept in a number of ways. As a nostalgia for a past self, highlighting a significant sense of loss; as a notion of a 'projected self', where they felt defined by others and vulnerable to denigratory labels; and as an 'entrapped self', where they felt isolated in the present and unable to communicate with others or progress, stuck in what Helstrom termed a 'viscous' present where events could not be controlled or predicted. The primacy of establishing a stable and valued self-concept in the face of chronic benign low back pain was reinforced and Helstrom argued how when this often led to the development of an unrealistic or 'spurious' self (like the 'fictional self' described by Charmaz and the 'real me' described by the participants in this study) which compounded the problem and prevented the individual concerned adapting constructively to their situation.

The participants in this study worked to construct a private sense of self that they could both manage and relate to in a helpful way but their preferred self, the 'real me' that they had experienced little conscious awareness of before the onset of their pain emerged as a separate phenomenon. It now lived with a range of other selves similar to those described by Helstrom and others above and was often the sole preserve of any valued or positive meanings. It was alienated from much of the participants contemporary experience of being in pain and was an impediment to any change or adaptation they might make to that pain.

The Social Aspect of the Self: dealing with other people.

The participants' experience of their self when in pain revealed it to have a critical social dimension and their experience was best understood in a social and primarily relational context. The theme 'the social aspect of the self: dealing with other people' showed how the participants distress was at its most acute and disabling when in the social domain and the involuntary impulses and behaviours that they experienced as incompatible with their self were inherently anti-social in definition. As a consequence they struggled to live with themselves and minimised their contact with others.

The accounts of the participants showed their chronic pain and self-concept to be very social in nature. Radley (1999, 1994) has published extensively on the social nature of health and illness and argued that the personal nature of an illness was such that it

was more than a biomedical disease, but was an experience situated within an historical, social and cultural context. He distinguished between a disease as a biological phenomenon and an illness as its more holistic, lived experience. In particular, Radley emphasised how, for the sufferer, the demands of a chronic condition for the sufferer involved resolving the conflicting demands of the body and its impairment with those of society (as embodied in role expectations and relationships). This conflict can cause problems of 'discrediting definitions of the self' (Bury, 1991), stigma (Goffman, 1990) and a struggle for legitimation, not just for the illness but for the person. Maintaining and securing a sense of personal virtue has been shown to be important in chronic illness (Williams, 1993) and highlights how much a chronic illness is a social and moral condition as well as a biomedical one (Kugelmann, 1997). Radley (1994, 1999) identified that one of the distinguishing features of chronic illness is that the sufferer is obliged to continue to live in a world defined by healthy people and will be judged or defined in some degree according to their 'normality'. Becoming discredited involved the threat of being defined and judged dominantly according to the illness and seen as 'less of a person' (Williams, 1993). The notion of normality was described as being enshrined in obligations of behaviour and expectations about roles and it was in this way that the participants in this study struggled as, in addition to their disability, the hostile and anti-social elements of their experience confused and surprised them and left them feeling abnormal and vulnerable to judgement. The struggle to be acceptable and normal in chronic illness is heightened when it takes place within a culture that values independence, productivity and beauty (Douglas, 1978). Radley (1999, 1994) and Charmaz (1983) argued that adjustment to chronic illness was a function of loss and the retention of social engagement or participation (Radley and Green, 1987), but in

contrast, the participants in this study revealed how they also experienced a significant degree of active threat related to the self in a social context. They lived in disabling fear of being judged poorly, abhorred or pitied by both others and themselves. They struggled to relate to themselves in a constructive or positive manner and were influenced by their perception of how others thought of them. This was often to the extent that it dictated their behaviour and prompted them to either withdraw or over-do their activity according to the situation. The way they lived in the minds of others often pre-occupied their thoughts and influenced their behaviour.

Ashmore and Contrada (1999) and Jussim and Ashmore (1997) emphasised the multiplicity of the self and how many of its essential elements were social. The position of symbolic interactionism also argues that it is through social interaction that we define the meanings that we use to define the self and our actions (Denzin, 1995). These include the beliefs of what others think of us and our perception of the differences between members of social groups that we do and do not identify with. Ashmore and Contrada asserted further that the fundamentally social nature of human beings could be both a source of support and threat and as such had important implications for damaging psychological stress and health behaviour. The experience of the participants in this study would support that conclusion. Jussim and Ashmore further subdivided the social self to include the idea of multiple selves as opposed to that of a single identity and asserted that the social aspect of the self contained within it as many selves as there were important others in the person's life.

The participants endured the kind of self-definitions and self-judgements that made social contact and intimacy aversive and threatening and prompted them to withdraw from relationships and conceal their private experience of living with pain. They judged themselves harshly and feared the consequences of the opinions of others. In addition they could not guarantee sufficient self-control or regulation to predict their behaviour in public. In this way they appeared to endure a significant degree of shame in relation to their experience of living with chronic pain. They were both ashamed of themselves and feared the judgements of others.

The concept of shame is a useful one in this regard as it places the private experience of the individual within a social context. It has been described as the 'affect of inferiority' and is associated with major disturbances of the self (Kaufman, 1989).

Shame has been defined as the anxiety derived from beliefs that create a negative self image in the eyes of potential evaluators (Beck et al., 1985). Lewis (1987) proposed that self-other comparisons were central to shame whereby in shame one saw oneself as inferior. Gilbert (1989, 1992) added to this by broadening the concept to relate it to a pre-disposition toward rank and status judgements and the consequences of such judgements. Lewis (1987) argued that self-other relationships were central to shame and it was this particular aspect, how they believed they would appear in the minds of others that was important and threatening for the participants. Gilbert et al. (1994) defined the threat inherent in shame as:

In shame one sees oneself in the inferior position. Shame is characterised by the self being unable, the helpless object of another's ridicule, scorn or punishment. (p25)

Shame-prone individuals feel inferior, powerless, bad in comparison to others, vulnerable to punishment and unattractive. Shame promoted concealment and resentment and has been shown to be related to distress and social anxiety Gilbert (2000). It incorporates the individual's evaluation of their relationships with others, their appraisal and anticipation of the beliefs of others about them and their evaluation of themselves in relation to others. It places the individual's self-judgements and definitions firmly within a social context and shows how that can be inherently threatening and distressing for the individual.

The participants' accounts in this study showed how in addition to the loss of social value there was a significant degree of shame inherent in their experience of their chronic benign low back pain. This was not just because they could no longer do things or fulfil particular social roles but also because their involuntary experiences left them vulnerable to feelings of shame that were, at times, more uncomfortable and unbearable than enduring the simple sensation of pain.

The concept of shame is useful as it enables the participants' experience to be described as something that is private and personal, but also set within a social context and it provides a bridge between the two. Crandall and Moriarty (1995) found that diseases that were perceived to be severe or under personal control were most likely to lead to social rejection. Kotarba (1983) referred to this as 'victim blaming' and it represents another example of the negative implications of chronic

benign low back pain for the self in that it can also be held responsible for the cause and maintenance of chronic benign low back pain.

On this theme, Eccleston et al. (1997) showed in a q-sort study that responsibility, blame and the protection of identity were important themes in chronic benign low back pain. The sufferer emerged as feeling blameworthy and described a need to resist personal responsibility for the presence of chronic benign low back pain both to themselves and healthcare professionals. Making sense of a condition with no clear or socially agreed biological utility or value shifted the focus of responsibility toward the person whose social identity was then challenged, weakened and at risk of being shamed. Kugelman (1997, 1999) also focused on this aspect of chronic benign low back pain and emphasised how difficult it was for some-one to relate to their pain without having to defend themselves from accusations of responsibility or culpability. Having pain was exposed yet further as more than a biological disease, but a social and moral condition which had the potential to place the self in jeopardy.

The participants' anxieties about their socially undesirable and destructive behaviour, their social withdrawal and self-criticism suggested that they were both ashamed of themselves, embarrassed about their situation and felt vulnerable to criticism and punishment as a result of being in chronic pain.

Living with a Body Separate from the Self: The self and the body in pain.

The experience of the participants in this study suggested that their body and the chronic benign low back pain located within it was fundamental in their experience of their self, but their lived experience was such that the relationship between them was defined by alienation and exclusion, rather than any conscious sense of integration.

When free of symptoms the participants' body disappeared to them and was not a source of criteria used to define the self, beyond, possibly, its functional capacity or image. Retaining a self that contained only that which was useful, functional, coherent and valuable emerged again as a key task in the endurance and management of chronic benign low back pain as any part of the participants body that was associated with the pain was placed outside of the self and termed 'not me'.

The participants in the studies by Helstrom (2001) and Kleinman (1988) had also developed a dual relationship with their bodies, viewing them as something both strange and separate from their self. Additionally, Vrancken (1989) described how pain could produce a split within the person that added to the fragmentation referred to above and caused the self to be divided in two, into an 'I' and 'an it' (the body).

Kelly and Field (1996) argued for a more 'bodily' approach to chronic illness as they felt biological facts were neglected and of critical importance to the self. They advocated a movement to 'bring the body back in' and not exclude it from the

individual sufferer's experience. Williams (2000) also made an interesting distinction between the bodily 'disappearance' in the absence of pain and the bodily 'dys-appearance' when in pain, whereby the body only entered the consciousness in the event of it dysfunctioning. This was the case for the participants but what remained constant was that whether present or absent the corporeal body was almost always excluded from the self.

This separation and dislocation between the body and the self was also explored by Bendelow and Williams (1995) in their argument for a more embodied account of peoples' experience of illness. They noted how although the study of pain required the application of a multi-dimensional model and a level of thinking and analysis that went beyond any kind of dualism, by contrast at the experiential and subjective level the lived experience of pain actually reinforced those dualisms. This left the sufferer aware consciously for the first time of a contrast between their body and themselves. Bendelow and Williams (1995), like Williams (2000), described how the experience of pain challenged and disrupted the unconsciousness of the body and its 'disappearance' in everyday life. As a consequence pain could render the body 'disharmonious' from the self and contributed to the kind of fracturing of the self that was evidenced by the participants accounts in this study. To the participants the painful parts of the body were separate objects, things that were no longer part of them or the 'real me' as they referred to themselves and had become estranged and alienated from the self. Unfortunately for them they were forced to live within the limits imposed upon them by their bodies and an ongoing source of conflict persisted as they were unable to transcend their bodies. This relationship between the body and the self was inherently problematic as the participants had to live according to their

bodies and not their preferred selves which appeared to exclude any reference to a painful or impaired body.

Strengths and Weaknesses of the study.

As with the two previous studies this study highlighted the value of adopting an idiographic response and the manner in which it provided a contrasting perspective on the experience of chronic pain that complements other research approaches. It is limited by its focus on one source of data and one interview per participant which, it could be argued, gives a narrow view of the personal experience of the participants.

As with the other studies, the influence of the dual role of the researcher as clinic staff member and of conducting the interview in a clinical setting are areas in which the work could be advanced and improved.

Conclusions.

The notion of the self emerged in this study as a valuable element in the experience of chronic pain sensation, distress and disability. It was an important factor in the lived experience of the participants and served as a useful vehicle to reinforce yet further the multiplicity and multi-dimensional nature of the participant's experience of pain.

Chronic pain assaulted and undermined the participants' sense of self and the process of losing a valued sense of self was, at times, more distressing to them than enduring

the physical sensation of pain. The assault on the self involved the participants' difficulties in assimilating the involuntary impulses, behaviours, affects and cognitions that they experienced into a valued contemporary sense of self. These experiences were abhorrent, incompatible with their pre-existing sense of self and a source of significant feelings of threat, shame and self-criticism.

The participants' experiences highlighted the inherently social nature of the self and the utility of adopting a relational and social perspective to the self, which emphasised its connectedness to other social and cultural domains. The way the participants related to themselves and perceived the opinions of others towards them was problematic and a factor in their disability and distress. The emergent behaviours they found difficult to manage and which were incompatible with positive self-judgements or self-definitions were all inherently anti-social or socially undesirable.

The participants felt in danger of being judged as inferior by others and they saw themselves as inferior and vulnerable to rejection and punishment. They lived negatively in their own minds and in the minds of others and as such endured significant intra- and interpersonal distress, withdrawal and disability. The presence of such chronic fear, shame and sensitivity to punishment or rejection emphasised the degree to which their pain was laden with an ongoing sense of threat to the self.

Chapter Nine.

Conclusions and General Discussion.

The participants' accounts in each of the studies revealed the complexity and individual variety of their chronic pain experience. Despite their struggle to understand it they gave rich and thick descriptions of what it was like to have chronic benign low back pain, as evidenced in the extracts used in the analyses.

In study one the ongoing confusion of this type of pain emerged. Despite exhibiting a strong drive to understand their situation and construct an acceptable sense out of it, the participants shared an inability to explain its persistent presence in any way that was meaningful. Although they had suffered pain for a considerable time, sometimes up to fifteen years, they were not experts in their condition and did not know what to do for the best. This absence of clarity was evident in the many different kinds of social and personal comparisons they employed to give an account of their situation. The particular social comparisons that were selected gave an insight into their personal appraisal of their situation but served poorly as coping strategies. In the context of this 'senselessness' the participants were unable to establish any legitimacy or shared understanding of the chronic nature of their pain. Their attempts to make progress, to do more or look better whilst still in pain often created confusion and was problematic. By looking 'ill' their pain was acknowledged more easily as 'real', i.e. medical and physical, but displaying pain behaviour was also difficult as this left them vulnerable to feelings of pity or rejection. As a result of this situation, despite its

omnipresence and disabling dominance in their lives the participants avoided talking about their pain, masked it as much as possible and tended to withdraw from social contact.

In the second study the aim was to examine the personal experience of chronic benign low back pain from a different perspective and look at the pain itself in more detail by exploring it as it went through a process of change. In contrast to the previous study the participants described their pain as a discrete object in more depth and employed imagery and metaphor that revealed a range of additional meanings related to their pain.

Each participant had developed a personal classification system which they employed to rate and rank the variable quality and intensity of their pain. Each system described the pain in two broad forms; 'pain at its worst' and 'pain at its best'. There was a uniformity about the quality of the participants' 'pain at its best' related to its chronicity and persistence, but accounts of the pain 'at its worst' revealed the personal and individual nature of the fear and intimidation they felt in relation to their pain.

The participants' imagery for their pain reflected more its threatening meaning, rather than the level of their technical understanding of any causal processes. It extended beyond an unpleasant sensation or restriction in movement toward something that influenced their self-concept and inter-personal relationships directly.

The participants described a beneficial change in their experience of pain after the intervention, although this was not related to its explicit content. No change occurred in the participants' taxonomy or causal pain-imagery indicating that their

representations and beliefs about their pain remained the same. Although no suggestions had been included in either intervention toward developing greater self-efficacy or self-regard, it was in these areas that the participants perceived an improvement. Their attributions and self-perceptions had become more adaptive and as a consequence their health anxieties were less intrusive or catastrophic and they were less disabled. The therapeutic effect was independent of the specific content of the intervention, although the pain-specific context of each was important. The non-specific elements shared between the interventions emerged as the most active therapeutic ingredients.

The first two studies in this thesis indicated that the participants' sense of self was an important element in the lived experience of their pain. This became the focus of the third study and the themes that emerged suggested that the participants' sense of self was indivisible from their experience of their pain. Their accounts showed that as a consequence of living with their pain their self-concept had deteriorated. It now contained new elements that were uncomfortable to tolerate and a source of distress. Their experience was of an ongoing struggle to defend and maintain a preferred and valued self-concept and this had a disabling effect on their everyday lifestyle. Making sense of and evaluating themselves was a key and potentially mediating factor for the participants in their experience of their pain.

Employing IPA helped to illuminate the different ways in which chronic benign low back pain operated as a dynamic and multi-dimensional phenomenon and emphasised the importance of the interaction of the personal, social, cultural and physical

elements involved. Chronic benign low back pain is an example of a dynamic, multi-dimensional experience that exposes the inherent process of sense-making and the construction of knowledge particularly well. The emergent themes in this thesis emphasised the various different ways that pain could be unpleasant, senseless and social. It revealed its disruptive nature and the manner in which it frustrated the attempts of those who endured it to divine some coherent meaning within it from which to select action. In this context, 'senselessness' referred to the absence of any coherent personal or social value to the experience; the participants' pain did not lack palpable meaning but was notable for its threat, loss and confusion.

Many of the themes described in this thesis underscored how chronic pain was not confined by medical and personal parameters but was also social and relational. The 'socialness' of the participants' pain emerged throughout the thesis; social comparison, the presence of shame, withdrawal, difficulty being believed and the social nature of the self emphasised how much of its meaning and experience unfolded within a social and cultural framework.

For the participants, their condition was medically benign but from a personal and social perspective the experience was of a malignant process involving a significant degree of threat to the self. The notion of the fear-avoidance of movement in chronic benign low back pain has been identified as a causal factor in its disability and the sensitisation of the pain-gate system. The complex and dynamic nature of the threat to the self within the participants' chronic pain experience suggests that it could also play a similar role in its disruptiveness, senselessness and unpleasantness, promoting

a heightened vigilance toward the pain and reinforcing its place within the consciousness of the sufferer.

The themes and conclusions in the three studies in this thesis can be related to the broader literature on pain in a range of ways. They highlighted the senselessness and uncertainty of chronic low back pain and how it frustrated the participants' need to establish a coherent understanding of it. They emphasised the social component of the pain experience, the manner in which its unpleasantness was more than just a sensory or discrete psychological phenomenon and how chronic pain exists within a social context (Radley 1994). Viewing chronic benign low back pain from the participants' personal experience emphasised the degree to which it operated within a symbolic, moral and cultural framework and reinforced the value of adopting a multidimensional, biopsychosocial framework and model to explore it (Gatchell and Turk, 1999).

From a cognitive-behavioural perspective, in addition to the more pain-specific beliefs described in the literature, the beliefs the participants held about themselves, their self-concepts and how they felt others saw them also appeared to play an important role in their pain experience. Similarly the lack of a shared coherent, constructive or socially-valued understanding of chronic pain within the participants' social network influenced their everyday interpersonal interactions in a manner which compounded their pain and disability. The 'common-sense' models (Leventhal, Meyer and Nerenz, 1980) that they and those around them held about their pain failed habitually to explain their illness. The participants' pain behaviour was as much a reflection of their struggle with the confusion, uncertainty and misunderstanding of

their pain, either within themselves or those around them, rather than the product of a particular pain-specific belief or discrete reinforcement contingency. For example although they were fear-avoidant of movement (the incorrect belief and anxiety that movement caused tissue damage and rest was required) they would often engage in excessive and painful activity, in defiance of this belief, as a result of their appraisal of the demands of their social situation and other beliefs about themselves.

Much of the qualitative work on chronic pain highlights the loss associated with it and the problems of achieving or maintaining a valued social identity over time (Charmaz, 1983; Kotarba, 1983; Hellstrom, 2001). The participants' accounts in this thesis echo those findings but also introduced the notion that the experience of chronic benign low back pain also involved a significant degree of threat. The threat of movement inherent in fear-avoidance (Crombez et al., 1999) was matched by the threat inherent in both social rejection and a persecutory self-view. Self-criticism is a cognition or attribution that has been associated with chronic pain (Haythornthwaite et al., 1991) along with the problems caused by catastrophisation and other cognitive distortions or passive coping strategies (McCracken and Gross, 1993) related to low self-efficacy, low self-esteem or an external locus of control (Gatchell and Turk 1999). The nature of the individual's self-concept and the related self appraisal could be a factor in the selection of particular responses or coping strategies and in the degree to which they are able to accept or adjust to the presence of their pain.

The notion that chronic benign low back pain contains within it an additional source of threat could both reinforce the ability of pain to capture the attention of the sufferer and maintain the levels of fear, worry, rumination and hyper-vigilance that have been

reported in association with chronic benign low back pain and which operate to retain and consolidate the pains position in the consciousness of the sufferer (Aldrich et al., 2000). The study of the self and how it is maintained over time have had little prominence in the study of chronic pain and it represents perhaps the most significant contribution of this thesis. Recently, Pincus and Morley (2001) proposed the idea that a key feature of the presentation of chronic pain is the extent to which self and chronic pain can become enmeshed and interact. They argued that a core process in the maintenance, successful relief and management of chronic pain was to enable a separation of the self from pain. The participants' accounts of their self-concept in study three and their wide and varied use of social comparison in study one showed evidence of their struggle to retain a stable or coherent self-concept that was not overwhelmed by their pain. One particular process, social comparison (Festinger, 1954), which has received considerable attention as a potential coping strategy was shown to be equivocal in that regard and appeared to be best seen as a core self-appraisal process rather than a useful pain management tool.

Quality in Qualitative Work.

It is important that the criteria by which a qualitative study is judged is appropriate. Some of the qualitative approaches adopt different epistemological viewpoints to each other and they each contrast with those of the mainstream quantitative approach (Smith et al, 1995b; Murray and Chamberlain, 1999). The rejection of the notion of a stable, measurable and objective truth means that the outcomes of qualitative research cannot be validated using constructs from the natural sciences and different criteria

are required to establish the value and quality of qualitative work (Yardley, 1997a, 2000; Smith, 1996b).

A number of authors outlined ways in which the validity of qualitative research can be assessed (Smith, 1996b; Conrad, 1990; Stiles, 1993; Lincoln and Guba, 1985; Guba and Lincoln, 1994; Yardley, 2000; Elliot et al., 1999). Smith (1996b) suggested several criteria to assess the internal validity and reliability of qualitative research and they were adhered to closely in this thesis. Two important ones were 'internal coherence' and 'presentation of evidence'. 'Internal coherence' referred to the need to concentrate on whether the argument presented in the study was internally consistent and justified by the data, whilst 'presentation of evidence' demanded that sufficient verbatim evidence from the data should be presented in the paper to allow the reader to interrogate the analysis.

Other authors have also suggested similar criteria that could be used to assess qualitative studies (Lincoln and Guba, 1985; Guba and Lincoln, 1995; Elliot et al., 1999; Yardley, 2000).

Yardley (2000) offered perhaps the broadest range of criteria that can be applied to evaluate a study. They were divided into five main areas:

1. **Sensitivity to Context** - showing evidence of a theoretical grounding, relevance to extant literature, the presence of adequate empirical data, a recognition of the socio-cultural setting, commitment to the participants perspective and a respect for ethical issues.
2. **Commitment** - showing evidence of a prolonged engagement with the topic, competence and skill in the methods used and an immersion in the relevant data.

3. **Rigour** - related to the completeness of the data collection and analysis, triangulation (using a number of different sources of data to form a statement) and the presence of sufficient data to allow the reader to make judgments.
4. **Transparency** - in the form of clarity and cogency as evidenced in the rhetorical power and persuasiveness of the write-up and the degree to which all relevant aspects of the research process were disclosed.
5. **Impact and Importance** – including the utility of the study and impact on the beliefs or actions of other people. This was considered by Yardley to be a decisive criterion.

It is hoped that the research presented in this thesis observed each of the criteria outlined above.

The measures that were taken during the research for this thesis are described below in relation to the Yardley guidelines:

1. **Sensitivity to Context.** Evidence for this shown in the introductory chapters which aim to establish the position and commitment of the researcher both to the subject, that is exploring the participants' personal view of the topic and the approach that was adopted. The analysis is presented in such a way as to highlight the value given to the participants' words and in each of the discussion sections care is taken to evaluate the findings in relation to the literature from a wide range of research approaches.

2. **Commitment.** Care was taken in these chapters to show that this was not a casual research interest but a serious attempt to: develop our understanding of chronic benign low back pain through a focus on its subjective experience; establish the case for adopting IPA as a method; explain the reasons for the specific focus of the research and show evidence of an in-depth understanding of the area. Describing the research process and method in detail is also intended convey the depth of immersion and level of engagement with the data this involved. The findings from the studies were related closely to the extant research from both quantitative and qualitative studies to reinforce their applicability and highlight the utility of the approach.

3. **Rigour.** The use of triangulation and the presentation of sufficient data to support the statements in the studies were important criteria within each of the analyses and a valuable audit tool for quality. Triangulation took the form of showing evidence for each emergent theme in the transcripts of several different participants. By using the accounts of different participants the variation within each theme could also be explored and articulated. IPA studies are notable for their commitment to using extensive examples of data within the analysis and that principle was adhered to in each of the three studies in this thesis. The step by step process of the analysis ensured that at each point the themes could be related back to the transcripts and the notes were available to my supervisor and colleague to help explain how particular themes were selected and provide material for an internal audit of the process.

4. **Transparency.** To ensure that the emergent themes were both coherent and grounded in the data the transcripts were looked at independently by both my supervisor and a work colleague during the analysis. With my supervisor we discussed our readings of the interviews and came to an agreement on the theme categories before the analysis proceeded. The second reader acted as a check on the emergent analytic account, particularly to monitor for clarity, persuasiveness and the degree to which the themes were evident in the data that was presented. Making the analytic process transparent was also the reason, in part, for describing the analytic method in detail and providing extensive examples of data in the analysis sections of each of the empirical study chapters.

5. **Impact and Importance.** To support a case for the impact of this research the emergent themes in this thesis were related to the findings from a broad range of approaches to chronic pain research. The aim was to show the relevance and applicability of the findings and to emphasise the degree to which it offered a new and useful perspective on the subject. The utility of the research is also evident in part in the section below which discusses the implications of the findings for further research and clinic work.

Personal Reflection on the Thesis.

A notable aspect of this thesis is that although all the data was collected by mid-July 1996, it has taken a long time to finish. Study one was finished by the end of 1994, the analysis for study two was in its first rough draft by the end of 1995, and the

interviews for study three were recorded in the first half of 1996. After that, progress was slow. Much of this was due to the competing pressures of home and work, changing jobs and having babies. However, my experience has been that it takes time to develop your ability and confidence with qualitative research and I'm not sure this thesis and the themes within it would have been the same if I had done it any faster. The research has tracked the development of my clinical work with people in pain and although this thesis is not a piece of clinical research, it has been very informative and influential in that regard.

At the start of the thesis I was beginning to work with people in chronic pain in a clinical capacity. The research offered me an opportunity to gain an insight into chronic pain that was not available from the literature and to learn about the qualitative approach to psychological research. Up to that point I had little experience of qualitative methods, had not come across phenomenology in any of the formal teaching I had received and had been actively dissuaded from using the approach during my training.

I found the experience of researching chronic pain in this way invaluable and challenging in ways I had not anticipated. Gaining a working knowledge of qualitative research that helped to demystify it was satisfying but applying it showed me how much more, in contrast to statistical analysis, it constituted a test of self-confidence. The researcher's personal interpretative potential is integral to the analysis and rather than relying on the statistical properties of the data to establish its power and quality, it was my ability to produce a coherent and selective interpretation that was tested. This felt much more personal and intimidating to begin with and was

replaced in time with a confidence in the method and in the data. It also took time to develop the confidence that the themes themselves would actually emerge and to suppress the experimental urge to look for things based on an 'a priori' hunch. The number of themes I found myself attending to which, at the beginning, I would not have predicted proved to me that themes do emerge in this approach. I had not anticipated at the outset that I would focus on social comparison (study one), non-specific factors in reducing the threat of pain (study two), or the emergence of the self as themes in the personal experience of chronic benign low back pain.

At the time I began this thesis it felt as if qualitative research still had to prove that it was both psychological and scientific. I approached the data in this context and at first this was also quite paralysing as it felt that the pressure was on to produce something exceptional immediately. As if each analysis had to produce a grand unifying theory, find something revolutionary and relate it in a lyrical and entertaining way. This was not the case, but it disabled the analytic process at first as there was the compulsion to snatch at the analysis and jump to grand but superficial conclusions too early, rather than build up a rich interpretative account. This receded as the richness, value and power of the participants' accounts became clearer. The qualitative approach to research also appeared to become more accepted within psychology over the same time period. More qualitative publications appeared in mainstream psychology journals and the first qualitative study (Walker et al 1999) was published in 'Pain', the journal of the IASP. In parallel, more qualitative papers were presented at annual conferences and it felt as if the tone of the debate between the two camps was becoming more conciliatory. The criteria for evaluating quality in

qualitative research were defined more clearly and as a consequence the requests as to how one could establish the 'validity' and 'reliability' of qualitative work dwindled.

Another issue of relevance to the process of analysis was the influence of the relationship that was developed with the participants. It was much closer than in quantitative work and a factor in enabling them to talk about their experiences comfortably. The participants become important to me and I recalled their voices as I read their transcripts. At first it was difficult to address themes in the data if I felt they might cause offence to the participants should they be taken the wrong way, particularly as at the time many applied psychological theories of chronic pain were quite persecutory toward the sufferer. Good supervision and peer review was essential to avoid the problems of 'going native', whereby feelings toward the participants dominated and obscured the analytic process as you were unable to step away from the data enough to give an analysis that was grounded in the data.

With hindsight many of the difficulties I had in the research may have been avoided had I better appreciated the demands of the work. Were I to go back and do it again I would focus more at the beginning on developing my expertise in the research rather than focusing on the subject. This would have been frustrating but a stronger grounding in qualitative analysis and an appreciation of the history of phenomenology and symbolic interactionism earlier in the process would have been valuable. Having a clinical background was helpful to a certain degree but I found that a qualitative health psychology research interview was very different to a clinical one. Your clinical instincts have to be contained and you have to learn to develop a different style of enquiry, one that facilitates the participant telling their story rather than

guiding them toward particular areas. Therapists have often suggested to me that their experience and training qualifies them as a qualitative researcher but I found that not to be the case. There was a danger that if you were wedded too much to a particular model or theory it could restrict the focus of the interview and analysis.

Were I to repeat the thesis I would also not attempt to do the work based on only one day per week. The competing demands of clinical work and research were difficult and using the last day of the week for research was problematic as it caused problems of fatigue. The work was not exhausting in a dramatic sense but it made it difficult to maintain the required level of attention and quality.

I found IPA to be very useful in this research and its idiographic focus suited my aims. My experience would support the conclusions drawn by Shaw (2001) that an IPA study could reflect the breadth and diversity of the topic under study and its interactive multi-dimensional nature:

both the subjective unshared aspects of experience, i.e. those that are internal and unique to an individual, and the shared aspects of experience, i.e. those that are constructed by external forces within a culture or sub-culture' p50.

It is difficult to draw clear conclusions about the limits of IPA as it is so early in its development and embraces a wide variety of perspectives within the analytic method. Certain areas could perhaps be developed to see if IPA could uncover yet more from the data. A commitment to the words people use means that IPA has tended not to focus on other aspects of a transcript such as the things people do not say, the absences in the data and the themes which are embedded within much lengthier

passages in the transcripts. A focus in IPA on the lived and conscious experience of the participants could be seen to limit the analysis of more unconscious processes that might emerge from a focus on, for example, the patterns of dysfluency or dissonance in the participants talk. This is not meant to imply that IPA should transform and become a kind of discourse analysis but to suggest areas where it could be expanded.

Strengths and Weaknesses of the Thesis.

The particular strengths and weaknesses of each study were reviewed in the respective chapters and those that relate to the thesis as a whole will be reviewed here. The commitment to articulating the participant's personal experience and the flexibility of the inductive and idiographic approach enabled both new themes to emerge which were important in the experience and management of chronic benign low back pain and provided a useful perspective on established concepts. The findings could also be related to a wide range of other studies into chronic pain and illness and this reinforced the value of integrating and adopting IPA and the qualitative approach further in the study of chronic pain.

In confining itself to one method of data collection, (the individual interview), one researcher and one method of analysis (IPA), the thesis could be criticised for adopting too narrow an approach to the study of the personal experience of chronic benign low back pain. Equally it would have been valuable to interview pain sufferers other than those considered to have chronic pain syndrome and this is mentioned in the section reviewing the implications for further research. Utilising a broader source of data, possibly including pain diaries or journals could have added

weight to the analyses and increased the opportunity for triangulation. With the exception of study two the studies were cross-sectional and had it been possible it would have been useful to take a more longitudinal focus that could explore the participants' experiences over time. This would also have provided for the intriguing possibility of engaging the participants in the research process by giving them feedback on the emergent analyses and inviting them to collaborate in the study, or by exploring the utility of theoretical sampling as employed by grounded theorists and using the emergent themes to guide subsequent interviews. A contextual difficulty was the dual role of the researcher as clinic staff member and, in the case of study two, also as therapist. This could have had an inhibitory or biasing effect on the participants' responses during the interview and it would have been helpful to either have had a greater level of independence as a researcher or, more importantly, to have paid more explicit attention within the interviews to the participants' awareness of this theme and its influence upon them. None of these difficulties invalidate the findings of the studies but represent potential limits to the thesis and areas which, with hindsight and had resources allowed, could have been addressed.

Clinical Implications.

The studies in this thesis highlighted how the experience of chronic benign low back pain was typified by its senselessness, an assault on the self and the related personal and social problems that this could cause. Each of these themes could be attended to usefully in a pain management intervention and would complement the focus on pacing, goal setting and fear-avoidance that typify the pain management approach.

The idea that the self is important in chronic benign low back pain and that such pain could represent a chronic threat to the self is not one that has received much attention in the development and application of psychological interventions for chronic benign low back pain management. The close relationship between the self-concept and chronic benign low back pain that emerged in this thesis suggests that the status and appraisal of the self would be an important thing to assess in patients that were referred for help. The development of interventions that address the difficulties people might endure in their attempts to maintain an acceptable self when suffering chronic benign low back pain would be useful.

Chronic benign low back pain develops out of an initial six month period of acute pain (IASP 1986, 1994) and much could be done before that transitional phase to highlight the potential for problems to develop. Better patient information and good counsel in this regard to help people understand the multi-dimensional and disruptive nature of the experiences that constitute chronic pain could be beneficial. Teasdale et al. (1995) described this as helping the patient to cope with their situation as well as possible by developing and nurturing their 'mindfulness' or therapeutic appraisal of their experience. In this way the manner in which chronic benign low back pain sufferers felt and thought about their situation would then be as constructive as possible. Patients would not pathologise their own experiences or see them as an indication of a weak or inferior self, but as the product of an individual doing their best to manage an unpleasant and unfortunate situation.

This approach has been described as the development and application of a 'normal psychology of pain' (Eccleston, 1997) which takes into account the inherent

disruptiveness and unpleasantness of pain. To do otherwise would be a reflection of the kind of 'victim blaming' that Kotarba (1983) described and an institutional form of the 'actor-observer' effect (Brewin, 1988) whereby the cause of someone's misfortune or adversity was attributed exclusively to the person. Ogden (1995) expressed a similar concern that the development of a focus on the intra-personal self within a society that valued self-reliance and independence could lead, in error, to the sufferer being held responsible for morbidity that was more a function of a complex biopsychosocial process. The potential for further shame in that context is considerable and anti-therapeutic.

Adjustment (Kerns, 1997; Jensen et al., 2000) and acceptance (McCracken, 1998) in chronic benign low back pain have been identified as important constructs in pain management and each could be enhanced by incorporating an understanding of the self. The research to date into both areas has not identified the processes involved that help people to make therapeutic progress. The implications of the findings from this thesis suggest that such progress requires the maintenance of a stable and secure self and that any change, however useful, that involved a perceived threat to the self would be resisted.

It has been acknowledged that although chronic benign low back pain management programmes are effective our understanding of what works for whom and what the most active ingredients are in general is limited and in need of further study (Morley et al., 1999; Gatchel and Epker, 1999). Brewin and Power (1999) (referenced in study two, chapter seven) argued that particular themes related to the self were important in the therapeutic transformation of meaning in psychotherapy and there is reason to

speculate that this could also be the case within a pain management intervention.

Making more of an explicit reference to the nature of the senselessness and impact of chronic pain on the self during a programme would be very helpful. It has the potential to improve the levels of adherence, attrition and rapport throughout the programme as a key aspect of the patients' experience would be addressed and not ignored.

In assessment prior to the programme it would be valuable to review the patient's situation with regard to their understanding, self concept and the degree of shame and threat they felt in relation to having chronic benign low back pain. Pincus and Morley (2001) considered this was particularly important with regard to self-worth, although as the self is inherently idiosyncratic it would be important not to be too restrictive or prescriptive about what dimensions to review:

it seems to be important to separate patients with chronic benign low back pain who are distressed about the situational constraints consequent to the pain from those who have the additional burden of believing that the negative consequences of pain mean that they are flawed and worthless. (p613)

Study two in this thesis showed that the social context of an intervention was an important therapeutic agent. Addressing the relationship between the patient and the professional more explicitly could increase the power of a therapeutic service, enable a greater degree of the patient's most difficult fears to be contained (Casement, 1985) and guard against pain professionals compounding a patient's sense of shame and inferiority inadvertently. It also emphasises the importance of including as many of the sufferer's family members and associates in the therapeutic endeavour as possible.

The participants' pain involved a significant sense of ongoing threat and arousal. This raises the question as to whether techniques and approaches from the field of psychological trauma, such as eye-movement desensitisation and reprocessing (EMDR) (Shapiro, 1995) or critical incident stress debriefing (Mitchell, 1983) could be applied usefully to the management of chronic benign low back pain to mitigate its intrusive nature. Vlaeyen and Linton (2000) in addressing pain fear-avoidance as a phobic phenomenon have shown the added value of using cognitive behavioural techniques such as graded exposure and cognitive rehearsal, in addition to the simple graded exercise programmes used in pain management programmes to address the disabling fear in chronic pain directly.

Future Research.

It appears to be in the nature of qualitative research that it highlights the inherent diversity and complex nature of the subject under study and generates an exponential number of further research questions. Each theme in this thesis could be followed in finer detail and used as the starting point for further interviews. One question in particular could be to look more in-depth at the nature of the 'senselessness' of chronic benign low back pain and how that related to the other personal and social themes that unfolded.

It would also be very useful to explore the relationship between the self-concept and chronic benign low back pain much further. Ashmore and Contrada (1999) concluded that the concepts of self and identity were powerful causal, mediating and moderating

agents in the pathway between disease and illness but hesitated to conclude too strongly about how this process unfolded as the study of self and identity in this context was undeveloped and at an early exploratory stage.

The limits of this study are that such that it has not been possible to take a longitudinal view of the participants' experience of their chronic benign low back pain, or review the contribution of other related biographical experiences that might contribute to the participants' ongoing struggle to retain or reconstruct their self-concept and manage the social problems related to their pain. Both of these aspects could be explored further.

The idiographic approach employed in this study has shown that the personal and subjective experience of the chronic benign low back pain sufferer is a valuable area of study and highlights active elements of fear, threat and shame that could contribute to the ongoing activation and sensitisation of the pain-gate. Further study to explore whether freedom and relief from shame and self-denigration left the individual in less pain would be fascinating.

It would be interesting to explore the nature of the relationship between pain and the self in people who felt they had made significant and long term progress with their chronic benign low back pain and see if this involved a similar contemporaneous development in their self. Similarly, to see how those who reported lower levels of pain sensation, distress and disability described their experience of their self-concept. One option might be to revisit the work of Turk and Rudy (1988) who defined particular sub-populations of chronic pain patients according to the profile of their

pain, distress and disability. Three profiles emerged which were: 'dysfunctional' (DYS), 'interpersonally distressed' (ID) and 'adaptive copers' (AC). It would be interesting to see whether the concept of shame or the self might help to differentiate meaningfully between the different groups.

Conclusions.

The accounts of chronic benign low back pain in this thesis showed it to be a complex, multi-dimensional and dynamic phenomenon that operated within a biographical, social, cultural and physical context. Using IPA to articulate the participants' personal experience of their pain gave a valuable insight into its idiography and phenomenology that would not be possible using more quantitative methods. The unpleasantness enshrined in the definition of pain was shown to be more than a noxious sensory or physiologically offensive phenomenon but one which was experienced in a wide range of personal and social forms. The participants' pain was typified by its senselessness, its social nature and the manner in which it was intertwined with their sense of self.

Despite having endured their pain for a minimum of five years with no relief, the participants' attempts to construct any helpful or coherent understanding of it remained frustrated. This left them disabled in their ability to control or predict it, to relate to others about it, select a clear or helpful course of action to manage it, or maintain a stable and valued self-concept. The 'senselessness' of the pain represented the absence of any positive personal or social meaning to the behaviours, impulses, cognitions or affect that marked its presence in their consciousness. Their pain was

associated with a significant degree of both social and personal threat and confusion.

This served to maintain the participants at a level of fear and vigilance to pain that ensured and reinforced its place within their consciousness and compounded the relationship between their pain sensation, distress and disability.

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APPENDIX.

The following three pages include:

- **Copy of ethical approval letter. Unfortunately the original letter was lost during relocation. The copy attached was kindly supplied by the secretary of the Doncaster LREC.**
- **Patient information sheet.**
- **Patient consent form.**

DONCASTER LOCAL RESEARCH ETHICS COMMITTEE

Medical Teaching Centre, Doncaster Royal Infirmary, Armthorpe Road, DONCASTER DN2 5LT

Secretary: Mrs C Cooper Tel: 01302 366666 Ext: 3704 Fax 01302 553113

E-mail: chris.cooper@dbh.nhs.uk

Hours of Work: Wed 8.30 - 4.30 Thurs 8.30 - 10.30 a.m.

CHAIRMAN: Mr N Thomas .

With Compliments

From: Chris Cooper
Secretary
Doncaster LREC

26 November 1993

Mr M Osborn
Research Clinical Psychologist
Psychology Department
Doncaster Royal Infirmary

Ext: 3583

Dear Mr Osborn

I am pleased to tell you that the Ethics Committee has studied and approved your project no. 93/41 entitled "Evaluation of a multi-disciplinary back pain clinic". This is for patient inclusion into the study up until July 1995.

Yours sincerely

Dr J R Lambert
Chairman
Local Research Ethics Committee

JRL/WMJ

Patient Information Sheet

We are constantly trying to improve the care that is given to patients with your condition to offer you the best treatment that is available

To do this it is necessary for us to understand as fully as possible what it is like to have chronic pain and how having back pain affects people.

At present we are running an evaluation of the service for people with back pain and as part of that evaluation we are interviewing people about their personal experience of their pain, to get an idea of what it is like in their own words.

We would be grateful if you would agree to take part in one of these interviews.

Your involvement is voluntary. Should you decide not to take part in the study your treatment by and relationship with the clinic staff will not be affected. Should you agree to take part you may withdraw your consent at any time, without jeopardising your future treatment.

The interviews will be confidential and anonymous. They will be tape recorded and transcribed (written out in full). Anything in the transcript that identifies you will then be removed to guarantee your anonymity and the tape will either be erased or returned to you according to your choice.

Consent to Inclusion in Research Study

Patient name.

Address.

I have read and fully understand the patient information sheet.

The nature of this study, its objectives and treatment options have been fully discussed with me by

I understand that refusing to take part in this study or withdrawing from this study at any time, for any reason whatsoever, will not prejudice my further treatment.

I agree to voluntarily participate in this study and I understand that this consent may be withdrawn by me at any time.

Patient signature

Researcher's signature

Date