

**RECLAIMING A SENSE OF WELL-BEING
AS A RESULT OF RECEIVING
THE BOWEN TECHNIQUE**

submitted by

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STATEMENT OF AUTHORSHIP

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis presented by me for another degree or diploma.

No other person's work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any other degree or diploma in any other tertiary institution.

A handwritten signature in black ink that reads "Judith Rayment". The signature is written in a cursive style with a large initial 'J' and a long, sweeping underline.

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August, 1997

ABSTRACT

This study explored the effect of the Bowen Technique on the well-being of seven women suffering chronic low back pain.

Chronic low back pain is a worldwide problem, with myriad accompanying negative effects. At its extreme, it can bring about a loss of the sense of self. Orthodox medicine has found the condition difficult to treat. Increasingly, disillusioned sufferers seek the alternative of complementary therapies to alleviate their pain.

It emerged in this study that the participants were typical of chronic low back pain sufferers in terms of the effects on their lives and their dissatisfaction with orthodox treatment. However, this research discovered that discontentment with treatment also occurred with some highly invasive complementary therapies. The study established that the Bowen Technique (a gentle, non-invasive therapy) was effective in relieving the participants' chronic low back pain where other therapies had failed. The therapeutic relationship with the Bowen practitioners was reported as crucial to this process.

The effectiveness of the technique and the significance of the therapeutic relationship could have important implications for the treatment and alleviation of chronic low back pain should the findings of the study be supported in further research.

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GLOSSARY

AURA

A flow of energy (normally unseen, but sometimes suggested by "seers" to be of different colours) encircling all living entities.

CHAKRAS

Located near the brain and spinal cords are seven principal energy centres called "chakras", (usually invisible).

CHIROPRACTIC

Manipulation of the spine and other areas of the body in order to rectify disorders caused by abnormal functioning of a nerve.

IMMOBILISATION

A therapy that depends on the person being absolutely inactive.

MASSAGE

Treatment involving stroking, rubbing and kneading of muscles and other soft tissues to encourage circulation of blood and lymph and cultivate a state of relaxation.

METAPHYSICAL

Forces or power operating outside the known laws of the physical universe.

OSTEOPATHY

A variety of techniques such as stretching, massage and manipulation of joints to eliminate pain and improve mobility.

ORTHOPAEDIC

Related to the area of surgery involved with the restoration of irregularities of the spine and joints.

SHIATSU

Originating in Japan, this technique employs the use of fingers and elbows on specific points on the body with the aim of restoring the natural flow of energy.

TRACTION

To enable a fractured or dislocated part of the body to heal, a variety of pulleys, splints and weights are used to apply a steady pull to the injured area.

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INTRODUCTION

This study aimed to explore the physical and emotional responses to the Bowen Technique (BT) and its effect on the well-being of seven women suffering from chronic low back pain (CLBP). The study traced their individual journeys as they sought pain relief, the various positive and negative experiences they encountered and the impact this had on their physical, emotional, spiritual and social health and well-being. All participants had seen a number of therapists, culminating with treatments from Bowen therapists. They all reported having excellent pain relief with this last therapy. This study explores why this occurred.

There is no other published research into the effects of this particular technique. Thus, this study may inform a wider audience about the efficacy of Bowen therapy and why the women in this study (CLBP sufferers) experienced such positive results.

Chronic non-malignant pain occurs more often than other types of pain (Howell, 1994a). It should be noted that it involves not only physical, but emotional, spiritual, mental and social responses (Donovan, 1987; Fordyce, 1985; Hanson & Gerber, 1990; Loeser & Egan, 1989; McCaffery, 1989; Melzack & Wall, 1988; Sternbach, 1987; Simon, 1989). For these reasons, Grounded Theory was the methodology chosen for this study as it emphasises the importance of the participants' reported experience (Strauss & Corbin, 1990).

Chronic pain may cause people to feel as if they have lost control of their lives, resulting in feelings of helplessness, hopelessness, depression and, ultimately, loss of self (Corbin & Strauss, 1987; Seligman, 1975; Frank & Frank, 1991; Melzack & Wall, 1982).

The beliefs and attitudes surrounding health, well-being and illness, the meanings individuals ascribe to their suffering, the coping strategies employed, and the encounters with various orthodox and alternative therapists and their respective therapies, can all have a profound impact on the experiences of those with CLBP.

The whole ordeal of suffering with chronic pain can be exacerbated if the pain is not legitimised or validated by the treating therapist. When no organic basis can be found,

physicians may place the CLBP patient's case into the category of 'idiopathic' or 'indeterminate', leaving the sufferer feeling depressed and misunderstood (Borkan et al., 1995; DiMatteo, 1991).

This attitude on the part of some physicians can be explained to some extent by the fact that, historically, there have been two major informing philosophies in medical practice: reductionism (as in orthodox medicine) and holism (currently expressed as 'complementary therapies'). The former clearly separates mind and body, with the belief that health exists once the disease has left the infected body part, while the latter sees mind-body as inseparable, not only from one another but also from the environment. Nowadays, definitions of health and well-being include a much broader range of views than in the past and incorporate different philosophies. There is the belief within holism and other health and healing paradigms that living organisms have the inherent ability to regain their natural state of balance and heal themselves. This dynamic balance involves the physical, psychological and sociological aspects of the individual (Capra, 1983).

Asking why the illness has happened often forms the principal focus in alternative healing systems (McGuire & Kantor, 1987). For example, Lipowski (1970) believes that coping strategies are strongly linked to the meanings ascribed by individuals to certain illnesses. Frankl (1959) states that individuals who have discovered a meaning for their suffering may frequently recover more rapidly.

The philosophy of many alternative healing paradigms is that a 'life energy' flows through the body and may even be transferred between bodies (Capra, 1983). The BT is a relatively new complementary therapy. It is a holistic, remedial body technique that uses a system of muscle and connective tissue movements. The basic principle of the BT is that by re-setting the body to stimulate energy flows using specific moves, the body is able to heal itself, and this may help various acute and chronic problems.

A major factor in the overall healing of the individual is the relationship and interactions that occur between the therapist and the client. Borkan et al. (1995) highlight the physician-patient relationship as being a possible key to better results with CLBP. An outcome of an enhanced

physician-patient relationship may be an actual improvement in the presenting condition because the patients feel better understood by their physicians (Watson, 1985; Kotarba & Seidel, 1984; Finn, 1986; Stewart, 1987; Lloyd & Maas, 1991; DiMatteo, 1991; Drew & Dahlberg, 1995; Baume, 1996).

An understanding of the characteristics of chronic low back pain, its prevalence and some of its effects is crucial to this study. These factors will be discussed in the first chapter.

THE PAINFUL SEARCH FOR VALIDATION AND TREATMENT

Introduction

Chronic low back pain (CLBP) can cause significant distress and is a major social problem experienced worldwide. Borkan et al. (1995) note that low back pain is among the most common pain conditions in the USA, Israel and Europe. During 1995-1996 in Victoria, Australia, the Victorian Workcover Authority's statistical report for this period stated there were 8,525 work-related claims involving back injuries.

The seven women in this study all suffered from CLBP. This chapter will first consider the nature of chronic pain and its social and emotional effects as reported in the literature. The second part of the chapter will explore the question of why sufferers, having tried orthodox treatments, might seek help from complementary therapists, including Bowen therapists.

Pain is a complex subjective experience, involving physical, psychological and emotional factors. There are many definitions of pain. For example, one definition is that of the International Association for the Study of Pain: 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage' (IASP, 1979, in Merskey, 1986). While this definition is excellent for some purposes, it does not acknowledge the multifactorial nature of pain; nor does it affirm individual experience. For this reason, the definition informing this study is from McCaffery (1968, p. 5): 'Pain is whatever the experiencing person says it is, existing whenever it does.'

A common belief is that when pain occurs it signals a warning to the individual; conversely, when the pain stops, the individual assumes all is well (DeGood & Shutty, 1992). This belief may help people adapt to pain when it occurs. However, when pain persists for no obvious reason, the individual may be unable to maintain this view (Williams et al., 1994).

The term 'chronic pain' is used when an individual has suffered pain for longer than six months. Unlike acute pain, chronic pain 'cannot be experienced as ongoing normal pain precisely because normal pain is expected to end within a reasonable period of time' (Hilbert,

1984, p. 367). In some cases, of course, such pain lasts for years (McCaffery, 1989; Howell, 1994a). The stress of being in pain on a daily basis becomes a part of everyday life, but the tension remains.

Chronic pain can drastically alter an individual's life, resulting in long-term frustration for the affected individual, and for the families and attending health professionals. This frustration can lead people to feel as if they have lost control over the management of their lives. When the pain is not validated by others, feelings of hopelessness, helplessness and depression may occur (Frank & Frank, 1991; Hanson & Gerber, 1990; McCaffery & Beebe, 1989; Melzack & Wall, 1982).

Experiencing *intermittent* chronic pain may cause particular dilemmas and disruption to daily living for sufferers. At times when there is little or no pain, people are able to continue with usual activities. This may mean that they feel more in control of their life. However, when the pain returns, they may be forced to relinquish these activities and even careers they enjoy, thus forfeiting any sense of control (Weiner, 1975, in Bendelow & Williams, 1995). Under these circumstances, everything the person normally takes for granted in terms of a general sense of well-being, even basic bodily movements, becomes unpredictable. This may result in reduced confidence and demoralisation (Kleinman, 1988). It is clear from the literature that consideration of the 'sense of control' issue is crucial to any understanding of the effects of chronic pain.

Effects of Chronic Pain

Loss of Control

Individuals vary in the extent to which they think they have management over their lives (Sarafino, 1990). When there is a belief that successes and failures are dependent upon the behaviour of the individual and are thus within the individual's power, the person is described as having an internal locus of control (ILOC). Conversely, an external locus of control (ELOC) exists when people believe that events in their life are determined by influences viewed as outside their authority; that is, governed by powerful others or by chance happenings (Rotter, 1966, in Harkapaa et al., 1996).

It could be suggested that possessing a strong sense of personal control will have a beneficial effect on health and assist in adaptation to, and rehabilitation after, severe illness and pain (Sarafino, 1990). When people who have historically assumed command over life endure chronic pain and restricted mobility, and are thus deprived of that authority, they may eventually be forced to change their behaviour to accommodate the loss (Skevington, 1983). For example, Borkan et al. (1995) found that farmers who were forced to give up their work because of CLBP suffered a great sense of loss of identity.

There is a popular assumption that individuals who rely on internal, rather than external, control over their illness will display more positive health outcomes (Wallston & Wallston, 1982). It is suggested that 'pain patients' (as they are sometimes called), who have an ILOC may suffer with less depression because of a greater tendency to employ diligent coping strategies (Crisson & Keefe, 1988; Skevington, 1983). As was found in a study conducted by Strong et al. (1990), individuals with CLBP were least affected in their everyday activities when they described themselves as having a sense of being in control.

With respect to locus of control in the health care setting, both Benner (1990) and Gadow (1990) point to the lack of active participation and control people with chronic conditions have over their general health and well-being. They maintain that control over assessment and treatment is governed by health professionals. In particular, Kotarba & Seidel (1984) point to the lack of decision-making participation by patients. This view is supported by DiMatteo & DiNicola (1982).

Where there is chronic pain, another factor is at work which could add to the sense of loss of control. Leder (1984-85) proposes that, on a daily basis, individual's bodies are in synchrony with their sense of self. However, when pain occurs, the body immediately conflicts with this sense of self, causing a sense of dissociation. As Bendelow & Williams (1995, p. 148) state: 'pain reorganises our lived space and time, our relations with others and with ourselves'.

Loss of Self

Charmaz (1983) in her study of chronic illness, proposes that the person with a chronic affliction experiences one of the most basic forms of suffering, a 'loss of self'. This occurs

when they are unable to replace their 'disintegrated' former self-image with a new one that is similarly valued. The term 'loss of self' can be interpreted as loss of body function, fulfillment and confidence in overall health. This may mean loss of self-image and position as an energetic contributor in the community (Watson, 1985).

Not all 'loss of self' under these conditions is permanent. In their paper on chronic conditions and the accompanying changes to the individual's body and identity, Corbin & Strauss (1987) describe how loss of self occurs when people are restricted from performing duties connected with different aspects of their selves. Acceptance of this loss will enable individuals to construct a new identity around the restrictions. The road to acceptance may involve the experience of emotions such as anger, denial, bargaining, grieving what is lost and depression. Acceptance may only begin when the future is embraced; 'hope', a potent life force, is an exigent motivator in this regard (Dubree & Vogelpohl, 1980). Once a person discovers new ways of functioning that add meaning to life, he or she has reached a level of acceptance in spite of the physical difficulties experienced (Stewart, 1987).

People's reactions to their pain and the accompanying loss of self may also vary with the meanings they ascribe to it (DiMatteo, 1991). Sometimes, chronic pain sufferers may feel they have been given an unfair deal.

On this point, in a fascinating study, Beecher (1956, in Sarafino, 1990) compared the experiences of World War II soldiers who had been wounded in battle and as a result suffered pain, with that of civilians. He discovered that being a soldier meant there was an expectation and a degree of acceptance of being in pain. The fact that the soldiers were glad to be alive coupled with the prospect of returning home from the war, increased their optimism and reduced their pain. Conversely, civilians who had undergone surgery for similar wounds to the soldiers, albeit much smaller wounds, reported more pain and a greater need for medication than their military counterparts. The explanation offered for this is that pain may be accepted by the soldiers as a necessary component of war, and their safe return compensation. Conversely, civilians reacting to pain were unable to accept its inevitability and therefore lacked a positive outlook.

As with the civilians in Beecher's study, CLBP sufferers may resent their pain if it has no obvious cause and thus no meaning. Therefore, they may see no hope of getting better. Without a sense of hope, they may feel they have lost control in determining the course of their life.

Feelings of uncertainty (and concomitant loss of meaning) may be heightened if the sufferer does not know why they are in pain (Conrad, 1987). Williams & Thorn (1989) point out the need for individuals to find the cause of their pain to recover and feel better. As Schlesinger (1993) argues, managing pain is doubly difficult when its origins are unknown.

These effects, of course, occur over a period of time. During the process, some sufferers adopt strategies designed, whether consciously or otherwise, to maintain the sense of self. Schlesinger (1993) found in her Pain Management Study that one strategy adopted by women suffering from chronic pain was to declare to themselves and others that they could still carry out the same activities as they always had, when in fact they were finding it increasingly difficult to maintain previous standards. This coping strategy has been termed 'living around the pain', where individuals exhibit a healthy behaviour at work, but once at home manifest their pain (Borkan et al., 1995, p. 983). It is reasonable to assume that such a strategy could succeed only in the short term and that it might in the long term have deleterious effects on both the well-being of the women and on their relationships, with the resultant loss of a sense of self reported elsewhere.

Given these two major effects of chronic pain, loss of a sense of control and loss of the sense of self, it is necessary to consider the mainstream philosophy and practices of orthodox medicine (biomedicine) in treating chronic pain, if we are to understand the experiences of the participants in this study. Comparison will be made with the philosophy and practices of complementary therapies, including the Bowen Technique.

Treatment of Chronic Pain

The Biomedical model

Viewed from a medical standpoint, chronic back pain is often seen as unmanageable and expectations of a cure remote. Health professionals receive inadequate and inappropriate

'indeterminate' are terms often used by physicians when describing CLBP (Bendelow & Williams, 1995; Borkan et al., 1995; Sundblom et al., 1994). Many studies show that when no organic basis can be found for the problem, patients will suffer even more from depression than those who have received a formal diagnosis (DiMatteo, 1991).

This has interesting implications for treatment in the light of the finding that positive emotions may decrease the perception of pain, while negative emotions can have the opposite effect (Turk, Meichenbaum & Genest, 1983; Frank & Frank, 1991). Svebak et al. (1991) in their study on stress and mood states of back pain sufferers discovered that feelings of resentment played an extremely important role in exacerbating the pain. When individuals suffer chronic pain and do not know the reason for their pain and cannot find long-term relief, it is possible that feelings of resentment may occur. Conversely, being able to ascribe a reason for the pain may act as a protective mechanism against feelings of resentment and hopelessness (Priel et al., 1991).

When biomedical practice retains the power to control and does not value patient participation in the relationship, there are few opportunities for the individual to be involved in their care (West, 1984, in DiMatteo, 1991). Research cited in Stretcher (1983) supports patients having a more assertive role that is oriented to their needs instead of the more conventional doctor-centred approach. In the light of the fact that loss of a sense of control is a major effect of chronic pain, it is clear that a key element in the area of control is the need to have reported pain legitimised. However, as we have seen, orthodox health professionals often do not validate chronic pain.

Holism and Complementary therapies

The term 'holism' was coined by Jan Smuts in 1926 and is now a collective term describing any therapy not employing a reductionist approach. Holism is a term frequently used in nursing because it encapsulates the idea of treating the whole person. More recently, the term 'complementary therapies' has been used to identify therapies that work in conjunction or in place of orthodox medicine (McCabe, et al., 1994). In addition, this name was adopted by practitioners of holistic health as acknowledgment that human beings are both substance and energy, and to describe the physical and non-physical therapies employed (McCabe, 1996).

education about CLBP and many current therapies are unsuccessful (McCombe et al., 1989; Leclere et al., 1990; Cherkin, 1988). Thus, doctors are frequently faced with an inability to diagnose and cure these complaints, and despite referrals to specialists may become frustrated at finding no conclusive evidence for the pain (Hafferty, 1991; Chibnall, et al., 1995).

Furthermore, the physician's interest in finding the cause of the pain may diminish if certain pathological origins are excluded. This may occur because of the biomedical view that pain is only valid as a symptom of pathology. Without established evidence of disease, the existence of the patient's pain may be denied (Goldman, 1991a; Weber, 1979, in Lindsey, 1995). Thus, conventional therapists may be inclined not to legitimate pain. Pain patients may therefore be advised to learn to live with their pain (Kotarba & Seidel, 1984). This proposition is supported by Howell (1994a), who found that when health care professionals cannot diagnose a physical basis for chronic non-malignant pain, the patient may become the problem, thus exonerating the health professionals from alleviating the pain.

Kotarba & Seidel (1984, p. 1396) quote from a pain seminar where one physician made the following comment: 'there is no validity when the patient has no motivation not to be in pain.' Labels such as 'problem patient' and 'low-back loser' are used to refer to those showing no motivation to learn to live with their pain or to recover.

One of the ways in which validation *can* occur in orthodox medicine is when a name is given for a condition. Schlesinger (1993) in her study on 'Pain, Pain Management and Invisibility', found that obtaining any kind of label increased the sense of validation for some people. She suggests that it may not matter what the label is as long as there is a label for the individual's condition. 'Chronic pain syndrome' is one label proposed that might help people cope with their experience of back pain when there is no pathological evidence (Hilbert, 1984).

'Fibromyalgia syndrome' is another label used to describe not only CLBP but also the experience of widespread pain, fatigue, stiffness, poor sleep, and other symptoms like irritable bowel syndrome (Wolfe, 1993).

Pain that continues when no agreed cause can be found (for example, CLBP) and no adequate treatment is available within the biomedical area, is termed 'idiopathic'. Idiopathic and

'indeterminate' are terms often used by physicians when describing CLBP (Bendelow & Williams, 1995; Borkan et al., 1995; Sundblom et al., 1994). Many studies show that when no organic basis can be found for the problem, patients will suffer even more from depression than those who have received a formal diagnosis (DiMatteo, 1991).

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to exist. Drew & Dahlberg (1995) view holism as comprising five major concepts: 'openness'; 'non-reductionism'; 'immediacy'; 'meaning'; and 'encounter'. The authors suggest that 'empathy' and 'rapport' might be suitable words to encapsulate these five concepts.

It is maintained that by focussing on the client's emotional needs, by being non-judgemental, by treating the client as an individual, and by attending to the patient as a person at the time encompasses four of these concepts (Drew & Dahlberg, 1995). Furthermore, the authors believe 'meaning' suggests a caregiver who, above all else, respects and values the import patients attribute to their suffering: Frankl (1959) extends this point by claiming that patients who have discovered meaning for their suffering may frequently recover more rapidly. Asking why the illness has happened often forms the principal focus in alternative healing systems (McGuire & Kantor, 1987).

This account of complementary therapies, which includes the Bowen Technique (BT), suggests that the holistic approach might be more effective than the biomedical in avoiding or alleviating some of the major effects of chronic pain by legitimising and validating the patient's reported experience.

Validation

Validation in terms of pain means being listened to and having the affliction legitimised by others. In the client/therapist relationship, validation may be defined as the therapist acknowledging what the person says about their experience. This acknowledgement of the pain experience may actually reduce the pain by relieving anxiety (Stewart, 1987).

Biomedicine and its separation of mind and body may reduce rapport with patients and increase single-factor analysis of the cause. This lack of validation may lead to patients' distrust in practitioners and subsequent difficulty in living with the pain (Borkan et al., 1995). Ultimately, this may cause further suffering to the patient (Howell, 1994a; Finn, 1986).

In addition, Howell (1994a) in her study of women with chronic non-malignant pain, found that women who possessed limited levels of self-validation (that is, an inability to acknowledge their own pain and suffering), and especially those who received insufficient validation from

health professionals, were more likely to regard themselves as unwell. In contrast, she found that when pain was acknowledged by self and others the women were better able to live with their pain while adopting healthier styles of living. Furthermore, she discovered that when health professionals validated a client's pain and their experience of pain, they were perceived by the patient as more caring.

Understanding why people move from orthodox treatment to try complementary therapies is critical to an understanding of the state of mind of the participants in the study.

Exploring Complementary Therapies

It has been suggested that complementary therapists use a more 'patient-oriented' approach. This means providing as much information on the condition and treatment as is possible, treating the patient as an equal and providing a high degree of acceptance (Hewer, 1983). One of the major difficulties that sufferers experience in their relationship with conventional doctors is that of not being provided with sufficient information about their particular problem (Schneider & Conrad, 1983). 'Knowing about one's illness, especially the prognosis, can be a central issue between provider, family and patient.' (Conrad, 1987, p. 15).

A lack of affirmation of pain may result in some sufferers moving from orthodox medicine to alternative therapies. In a study conducted by Chibnall et al. (1995) on physician frustration with patients suffering from chronic headaches, many of the patients in the study (when reporting their views of physicians), expressed their desire merely to have the genuineness of their pain acknowledged and affirmed by their physician. They also wanted the degree of stress and strain this had caused in their lives recognised.

However, Schlesinger (1993) states that sometimes people find it problematic to adequately articulate the pain in order to have the experience validated. They may be loath to talk about it for fear of being labelled a hypochondriac. She proposes that receiving validation from others as well as possessing internal validation, may increase self-esteem and allow individuals to feel supported and helped.

Explanations for Effective Treatment

There is increasing recognition in health care of the importance of the role of the therapist, in particular the development of rapport with the patient and legitimisation of their problems. The term 'rapport' demonstrates that mutual trust and respect are present between practitioner and client, with the shared goal of attaining the patient's health (DiMatteo, 1991). This relationship can play an integral part in the overall healing process, and Borkan et al. (1995) suggest may have positive results with low back pain patients. Stewart (1987) and Finn (1986) postulate that a lack of care, warmth and understanding by the practitioner may mean lack of patient cooperation (Kotarba & Seidel, 1984). This may ultimately have an adverse effect on the patient's feelings of self-worth (Lloyd & Maas, 1991).

Successful helping may be primarily due to the quality of the practitioner's relationship with their patients or client. The creation of trust, hope and faith can be cultivated by getting to know the patient/client, and their specific phenomenological view of the world, and by demonstrating genuine care and concern for the individual's needs, particularly through effective listening (Watson, 1985; Drew & Dahlberg, 1995). A successful patient-therapist relationship may be the catalyst for a placebo effect.

The Placebo Effect

The placebo effect in healing may be seen to be a result of the patient's response to the therapist. For example, the mechanisms of spiritual healing may be due to a placebo effect, or to the power of suggestion (Lindstrom, 1992). Taylor (1987) observes that the effect of placebo is often used to explain the effectiveness and success of some complementary therapies.

Central to the meaning of placebo is the patient's belief in the therapist and/or therapy, the practitioner's belief in the effectiveness of their therapy, and the various interactions that occur (Rosenthal & Frank, 1956, in Sundblom et al., 1994). It is suggested that the patient's condition will improve if these beliefs exist (Davies, 1980; Peck, 1981; White et al., 1985).

Rosenthal & Frank (1956, in Sundblom et al., 1994) propose that certain healers seem able to produce placebo effects in patients, which is not part of the orthodox physician's training.

However, Capra (1983) proposes the placebo effect and its power to heal may be based entirely on the force with which the patients employ their positive expectations, with the support of a therapist (alternative or orthodox). As Capra (1983, p. 363) states:

‘ the patient’s will to get well and confidence in the treatment are crucial aspects of any therapy, from shamanistic healing rituals to modern orthodox medical procedures.’

How much of the healing is due to the technique and how much to the individual’s state of mind? Weatherhead (1951, in Frank & Frank, 1991, p. 26) points to the evidence of what he terms ‘expectant trust’ as a potent influence in healing. The capability of stimulating expectations of help and hope within patients is believed to be an important component of treatment in alternative therapies. Frank & Frank (1991) postulate that these expectations may occur partly because of the healer’s individual appeal for the patient, and partly because of the therapist’s confidence in their own abilities.

Clearly, there is a possibility that the placebo effect might explain some of the effectiveness of complementary therapies, including the Bowen Technique.

Summary

In this chapter, I have discussed the fact that chronic low back pain is a major social problem, causing immense distress and demoralisation for individuals, resulting in feelings of depression, hopelessness and helplessness. Chronic low back pain can create loss of self worth and self esteem through loss of work, and loss of control over daily life events. Furthermore, it has been shown that depression is greater when no organic basis is discovered for the problem.

Validation, especially from practitioners, is seen as a key to individuals feeling in control of their lives. Thus, conventional doctors may find it difficult to legitimate pain without pathological evidence, resulting in the patient becoming the problem rather than their condition. When no organic evidence is present, having a label for the condition reinforces the individual’s sense of validation.

Complementary therapies are seen as effective because of their acknowledgment of the emotional response to a physiological phenomenon and because establishing empathy and rapport are seen as fundamental to holism. The client-therapist relationship is viewed as more oriented to the patient. Some complementary therapies provide more care, compassion, explanation and communication than orthodox medicine. These factors may induce individuals to favour complementary therapies.

Many individuals with chronic pain pursue complementary therapies in their quest for long-term pain relief and for greater understanding of their suffering. This move away from biomedicine may be a response to its more mechanistic approach and its focus on the physical body. The move toward complementary therapies is believed to be partly because of the holistic perspective some therapists take in their approach to health care.

Although research in the area of complementary therapies is limited, anecdotal evidence suggests that many therapies are successful. Apart from the efficacy of any one technique, this success may be due to factors such as the relationship between the therapist and client, the placebo effect, and the overall holistic approach. Since the Bowen Technique is the particular complementary therapy that is the focus of this study, it is described in detail in the next chapter.

THE BOWEN TECHNIQUE

Introduction

The Bowen Technique (BT) is a complementary therapy that utilises remedial techniques involving a system of muscle and connective tissue movements. The precise locations have been closely correlated with acupuncture points and myofascial trigger points. The basic principles of the BT are that by re-setting the body to stimulate energy flows using specific moves, the body is better able to heal itself. In addition to back, neck and shoulder problems, some conditions treated by BT include asthma, arthritis, tension headaches and menstrual difficulties.

The women in this study all sought Bowen treatment following unsuccessful treatments by both orthodox practitioners and other complementary therapists.

Historical background

Thomas Ambrose Bowen (usually referred to as 'Tom Bowen'), the creator of the BT, was born in Australia in the early part of this century, and lived and practised for many years in Geelong. Bowen began practising his therapy from home in the 1950s, and opened his clinic in Geelong in 1959. His therapy became so popular (with Bowen eventually treating between 13,000 and 14,000 individuals per annum), that his practice was included in the Victorian government investigation into the increased use of natural therapies by the general public (Victorian Parliamentary Committee of Enquiry, 1973). Oswald Rentsch, a student of Bowen, began teaching his interpretation of Bowen's work, and named it the 'Bowen Technique' after Bowen, who died in 1982.

As far as can be established, Bowen received minimal schooling and no medical training whatsoever. Some anecdotal evidence indicates he was completely self-taught, while other evidence maintains that during time spent as a prisoner of war in Japan during World War II, he became interested in and gained knowledge of remedial body work. The source of Bowen's

knowledge remains unknown; however, it is likely that Bowen utilised his exceptional abilities of observation and perception to develop the technique.

Overview of the background to vibrational energy therapy

The BT is considered by some Bowen therapists to be a vibrational energy therapy operating on similar principles to acupuncture, trigger points, auras/chakras, and therapeutic touch. Russell (1994, p. 88), when referring to the BT, states, 'energy is moved through the body much in the same way as during acupuncture'. Anecdotal evidence from acupuncturists states that the BT works directly on many of the points used in acupuncture. For example, the first two moves on the lower back of the BT correspond directly to Acupuncture Point Bladder 24. Both moves aim to regulate or balance the energy in the lower back, and help back pain, among other conditions.

Over the course of the last 5,000 years, the Chinese developed the Meridian Theory within Traditional Chinese Medicine (TCM). This theory asserts that 'Qi', (pronounced 'chi' - the Chinese word for 'energy') is transported to all parts of the body by an invisible network of channels. The meridians are considered essential for maintaining a harmonious balance within the individual and should not be confused with blood vessels (Kaptchuk, 1983; Ding, 1992; Jayasuriya, 1981). In addition to other therapeutic effects, the Chinese learnt that by pressing certain points on the body, pain was reduced or completely eliminated. This led to the concept of the 'therapeutic point' and, eventually, 'acupuncture point', as utilised in acupuncture, acupressure and shiatsu (Ding, 1992). According to TCM theory, meridians link the acupoints on the body's surface and the internal organs. They assist organs in performing their function and maintaining normal physiological activities (Ding, 1992; Gach, 1990). As Gach, (1990, p. 6) states:

They are thought to be part of a master communication system of universal life energy, connecting the organs with all sensory, physiological and emotional aspects of the body. This physical network of energy also contains key points that we can use to deepen our spiritual awareness as we heal ourselves.

Jayasuriya (1981) states that scientific research has proved that these acupoints do exist, and are described as areas of low electrical resistance on the skin. This is supported by Lidell et al. (1984) who highlight that these points have lower electrical resistance than the surrounding areas.

Acupoints, also known as 'tsubos' in China, (and often erroneously referred to in the West as 'trigger points'), stimulate the muscle to contract or relax. Tsubos are believed to work in a more subtle way than trigger points, and are 'activated'; that is, 'tonified' or 'reduced' to rebalance the energy flowing through the meridians. It is believed trigger points are formed as a result of acute injury to the muscle. This injury causes sustained muscle contraction due to tension and poor posture. The primary aim is to work on 'inactivating' the trigger point; that is, providing more strength to the muscle by removing the source of discomfort (Lidell et al. 1984; Rachlin, 1994). When pressure is exerted on either tsubos or trigger points, individuals may experience intense pain. Rachlin (1994, p. 461), when referring to acupressure and shiatsu, states that:

Although the theory behind these techniques is based on an ancient Oriental view of the body quite different from the model accepted by Western medicine, the points used in treatment have a high rate of correspondence to the points defined as trigger points.

According to Baldry (1993), approximately 85 percent of classical acupuncture points are in exactly the same location as trigger points. Moreover, with the addition of extra acupuncture points not located on meridians, the overlap of location increases to around 90 percent.

Bowen therapy uses a transverse fascial move on a trigger point. For example, trigger points on the lower leg gastrocnemius muscles and on muscles in the neck are in exactly the same locations as those utilised in the BT (Travell & Simons, 1983).

To understand the theory of energy fields, it is important to discuss vibrational energy therapy. Vibrational energy therapy is based upon the Einsteinian paradigm that the universe and all matter (that is, everyone and everything) is primarily made up of energy or vibration. Gerber

(1988, p. 39) refers to the concept of 'vibrational medicine' where human beings are seen 'as networks of complex energy fields that interface with physical/cellular systems'. It is postulated by the author and other Bowen therapists that the BT works in this way as it endeavours to heal the body by rebalancing energy fields which assist in regulating cellular physiology.

Davis (1991, p. 12 - 13) maintains that:

Therapies which may be described as vibrational healing aim to restore harmony by subtle means, by using what we might think of as gentle persuasion to nudge discordant, and therefore dis-eased cells back into their original pattern of vibration, thereby restoring health.

By inserting needles or fingers on acupoints, the acupuncturist or acupressurist aims to influence the flow of energy in the meridian. Through this, the person's energy is altered, and this energy acts upon the physical body to bring about healing. Thus, the common aim of vibrational healing is to alter vibrations or energy patterns in what is called the 'subtle body' before disease presents in the physical body (Davis, 1991).

In ancient Indian medicine, the Ayurvedic tradition uses the Sanskrit word 'prana' meaning 'life force/vital energy'. Within this and other Eastern philosophies like TCM, the subtle bodies are composed of energy fields that surround all living things, and are commonly called 'auras', within which lie the 'chakras', or energy centres. The role of the chakras is to receive and distribute vital energy between the physical body and the subtle bodies of the aura (Lidell et al., 1984). The locations of the chakras are closely aligned anatomically to the path of the central nervous system (Page, 1992; Gerber, 1988).

It is postulated that the BT works by aligning with the meridians, and influencing the chakras to bring about homeostasis, thus rebalancing the auric field. For example, it is believed that by performing specific moves on the coccyx, the chakra around this area is 'lightened'. It is also maintained that using other BT moves restores energy and balance to the fascia around the muscle.

Western philosophy deals with the concept of a universal life energy via field theory. In this theory, all living systems are vibrating fields of energy, acting as transmitters and receivers within the universe (Burr, 1972).

This energy field can be altered (or balanced) by the employment of a variety of therapeutic techniques, for example acupuncture. It is believed the BT works along these lines. There is also an assumption that the BT is related to TCM through its correlation with some of the points utilised in acupuncture. Furthermore, since some of the moves used in the BT correspond to those used in trigger point work, it is thought there may be a relationship between these two therapies. It is in these areas that the BT might be described as working on a physiological as well as a metaphysical level. However, despite these possible connections, the mechanisms of the BT are not clearly understood.

Virtually no literature specifically relating to this technique is available for review, due to the paucity of research conducted to date in this area. However, an unpublished research project was undertaken in 1993 by Pritchard at Swinburne University, Melbourne. This quantitative study looked at how mood state, heart rate and muscle tension are affected by the technique. Pritchard (1993, p. 11) found that:

‘An impressive and encouraging result of the present study was the consistent increase in the psychological well-being in individuals after the Bowen Technique therapy was employed. It appears the Bowen Technique can enhance an individual’s feelings of well-being by reducing tension, depression, anger, fatigue, confusion and anxiety.’

However, the results cannot be considered reliable owing to Pritchard’s very small sample size of ten subjects.

Dixon, a chiropractor, wrote an unpublished case report in June 1995 on the effects of the BT on ilio-tibial band friction syndrome, a condition involving thigh/knee pain caused by injury from repetitive strain of the area. His report focused on himself and one of his patients who presented with the same syndrome. It was during his training in the BT that he experienced considerable relief for this particular problem, and reported no pain at all in the next four years.

One week after his training, he applied the technique to a 25-year-old female patient experiencing the same problem. According to Dixon's report, this female reported no recurrence of the problem in the following four years.

Dixon (1995) utilises a physiological explanation for the success of the BT and speculates that the technique normalises some aberrant musculo-skeletal behaviour through the activation of the muscle spindles and the golgi tendon organs. These receptors provide the feedback link between the muscular and central nervous systems. However, as Dixon's findings are very limited, they cannot be regarded as substantiating evidence of the positive effects of the BT.

Russell (1994, p. 88), states: 'The Bowen move stretches the muscle, activates the golgi tendon apparatus, and sends a signal to the brain, all of which produce muscular relaxation'. As a registered nurse and practitioner of various complementary body therapies, including the BT, Russell (1994, p. 88) has found that 'it seems to improve the quality of life for clients with chronic illnesses, such as Parkinson's disease, multiple sclerosis, arthritis, and strokes, by balancing their energy and assisting them to have a feeling of well-being'.

Summary

The BT was established by Tom Bowen, an Australian, who may have developed and adapted his therapy partly as a result of being a Japanese prisoner of war during World War II. It is also possible that this was enhanced by an outstanding talent (reported by colleagues) for observing and understanding the body.

It is believed the BT is based on an energy theory in much the same way as some other complementary therapies, for example, acupuncture. By working on certain points on the body, it is postulated the BT stimulates energy flows thus promoting healing to occur within the body. There are very few studies to substantiate the efficacy of the BT, apart from one unpublished research report and some unpublished case reports.

This chapter has given a brief history of the BT and how it works. This study endeavours to expand the knowledge of the BT; the methodology used for this purpose is outlined in the next chapter.

RESEARCH METHODOLOGY

Introduction

A two-step approach, requiring two methodologies was used for this study. First, a preliminary, national survey of Bowen therapists was conducted. This was followed by a qualitative study involving in-depth interviews of seven women receiving the Bowen Technique (BT).

The national survey was conducted to determine the most common problem treated by Bowen therapists and this informed the selection of participants for the in-depth qualitative study. The national survey also sought information about the therapists themselves, including: qualifications, experience, procedures, and number of visits per client. The intention in gathering this secondary data was simply to establish a profile of Bowen therapists and their practice in the absence of any research in the field.

Survey method

Since no information was available on Bowen therapists or their clients, no data was found regarding the most common presenting complaint of Bowen therapists' clients or on the results of the technique. The design of this section of the study involved the use of a questionnaire as the most efficient tool for gathering the data and to ensure anonymity.

Steps in survey:

- Research design: draft questionnaire
- Pilot studies of questionnaire
- Modification of questionnaire
- Selection of survey sample
- Distribution of questionnaire for nation-wide survey
- Analysis of survey data

Pilot Survey

Before the nation-wide survey, the draft questionnaire was piloted with six Bowen therapists. As a result of their feedback, modifications were made and the questionnaire re-piloted by telephone with the same therapists.

Selection of Survey Sample

Two hundred (200) Bowen therapists were chosen by systematic, randomised sampling, taken from the membership directory in the 'Bowen Hand's' newsletter, published quarterly by the Bowen Therapy Academy of Australia. This publication is the only comprehensive source of Bowen therapists.

For the nation-wide survey, two hundred (200) questionnaires were sent and of these, one hundred and twenty-eight (128) were returned, five (5) of which were not used because the therapists had stopped practising. (see Appendix A)

Ethical considerations

Coding was used on the questionnaire to ensure anonymity of survey respondents.

Questionnaires were sent to respondents with a covering letter explaining why the survey was being conducted. (See Appendix A).

Survey results

The survey sought to establish the most prevalent condition of BT clients, the main procedures used to help this condition and the number of visits required. Other modalities that might have been used to treat the problem were also investigated. In addition, details about the respondents such as number of years as a Bowen practitioner, other recognised health-related qualifications and anatomy and physiology training were established. (See Appendix A).

Back pain proved to be the most common presenting problem of BT clients and thus this condition formed the basis of the major study.

Qualitative study

A qualitative, inductive methodology was chosen for the second phase of this study. Such an approach is appropriate to an analysis of subjective experiences such as the experience of pain and the concept of well-being. Pain is subjective and when a person's experiences are reported and recorded as data the results are more likely to be fruitful in generating hypotheses (in the absence of earlier research) than a more "objective", quantitative methodology. Conrad (1987) supports this approach by suggesting that the examination of the experience of illness from the patient's subjective perspective is a patient-centred view of illness and therefore desirable. Furthermore, it allows for an exploration of the lived experiences of participants suffering CLBP and not simply the symptoms of the condition.

The 'insider's' view focuses on the manner in which individuals feel their affliction has altered them, not only from their own but also others' perspectives, and how this affects their feelings of self-worth (Conrad, 1987). Finally, the inductive approach allows for a deeper understanding of the relationship participants have with their therapists and is in accord with the philosophical stance of this researcher.

Why Grounded Theory was chosen for this study

Within qualitative research methodology, Grounded Theory was the most appropriate choice for this study because it provided rigour in that it is a detailed and systematic method of analysis. Since the method allows theory to emerge from the data rather than from preconceived notions, it is especially suitable to a field of study lacking in research.

What is Grounded Theory?

The essence of this methodology is that the theory must be grounded in the data, that is, the theory emerges from the data. The aim is to extend the narration of a particular phenomenon through the recognition of categories and the associations between them, with the desired goal of building a theory of the phenomenon through identification of the context and process (Becker, 1993).

The collection of data, the analysis and the emerging themes are seen as inseparable and therefore become intertwined; that is, the whole process is in a constant state of dynamic

motion. Rather than hypotheses, broad, open research questions are employed, with the intention that a theory emerges that will clarify and account for the phenomenon experienced by the participants.

Concepts, categories and propositions are three basic elements of this methodology. Concepts are identified by analysing the qualitative data for similarities and differences and describing phenomena, events and incidents. Clustering concepts together into a higher rank builds a more complex concept which forms a Category. Propositions involve postulating or testing conceptual relationships between concepts and categories in order to clarify further the emerging theory (Becker, 1993).

Initially, analysis involves a process called 'open coding', used to record the significance and frequency of identifiable categories. This is followed by a process called 'axial coding', that is, refining, developing and making connections between categories. This process is achieved by including the phenomenon, causal conditions, context, intervening conditions, actions/interactions and consequences (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Chenitz & Swanson, 1986).

The following example describes the process of analysis before the women received the BT. The participants (all of whom were women) suffered from chronic low back pain. During their search for a 'cure', they sought help from a variety of therapists (context). Frequently, in their association with these therapists, the women's condition and their debilitating pain was not acknowledged by the therapist (action). This resulted in a sense of alienation and hopelessness in the women (interaction). They typically changed therapists or ceased seeking therapy (consequence). The persistent lack of validation of their pain by treating therapists and the failure of the therapies caused the women to feel demoralised (outcome). All the women experienced different degrees of lack of validation from their therapists and family and associates (intervening conditions). Out of this process emerged the phenomenon of loss of well-being.

Finally, a 'core category' was identified through a system called 'selective coding' where sub-categories link the themes and 'make sense' of the data. This core category is the final refinement of the emerging theory, firmly grounded in the data.

Collection of data is directed by a procedure called 'theoretical sampling', that is continuously returning to the participants' experiences and where possible, substantiating these concepts in the literature. Thus, a process of sampling based on theoretically relevant constructs occurs. The asking of questions and the making of comparisons are essential to this type of methodology. Writing of memos and formation of diagrams are other procedures used to direct analysis and assist theory development.

Steps in the Qualitative study

Research design: draft interview schedule

Pilot studies of interview schedule and refinement

Selection of participants for study

Interviews

Ongoing analysis of interview data

Follow-up telephone calls

Final analysis of data

Throughout the study, data was collected using interviews, field notes, telephone calls and discussions with Bowen therapists, as well as an ongoing literature review.

Selection of Interview Participants

Interview participants were people suffering from chronic low back pain, the most common complaint treated by Bowen therapists as determined by the survey. The seven participants were selected from the client base of six experienced Bowen therapists. The criteria for selection were: women suffering from CLBP and having received the BT within the last six months, aged between 38 and 58, and with an Anglo-Saxon background. The reason for the choice of background was that all participants should speak fluent English so that they would be easily understood during the interview and transcription stages.

Participant numbers were limited because of time constraints and the desire for full, in-depth inquiries of the women's individual experiences. A greater number would have provided only superficial interview outcomes. Given the small number of participants, it was decided to limit the study to women.

Ethical considerations

Pseudonyms were used to protect participants' identities and ensure confidentiality. The participants completed informed consent forms before the interviews were conducted. (See Appendix B). It was made clear to participants that they could stop the interview at any stage if it became unpleasant for them. In addition, permission was sought before asking any questions that might have been perceived as insensitive. Ethical approval was granted by the Research Ethics Committee of VUT, St. Albans, for the study to go ahead.

Pilot interviews

The interview schedule was piloted with two clients of other Bowen therapists who fitted the selection criteria. This process helped refine the direction of the initial interview schedule.

In-depth interviews

In this main part of the study, in-depth, semi-structured interviews were conducted.

Before each interview, the researcher made contact with the participant by telephone to confirm her availability and willingness to be a part of the study, and to explain how the interview would be conducted. Once initial contact was made, a date was organised for the interview. All interviews lasted approximately one hour and were conducted in each participant's home. Interviews were tape recorded with permission of participants.

Immediately following the interviews, field notes and memos were made to record impressions of the interview.

In-depth exploration of participants' experiences was promoted through the use of open-ended questions, allowing for a conversational type of interaction. Thus, the interview schedule provided a general guide only and questions were not strictly followed to allow for a deeper and broader scope of discussion. However, interview time constraints of approximately one hour meant this depth of discussion was sometimes limited.

Single one-to-one interviews were chosen on the basis that much of the data collected from participants was likely to be of a highly personal and possibly sensitive nature. Thus, the researcher did not wish to compromise the participants' feelings in any way, and wanted to maximise the information gathered. Throughout the interview, questions were couched in such a way as to induce as expansive a response as possible from the participant.

The first part of the interview explored the problem(s) suffered by the participant, the kinds of therapies they had already undertaken and how they came to learn of the BT. This was followed by an exploration of how they perceived the role of the Bowen therapist, including factors such as the therapist's particular qualities, and how the Bowen technique was applied.

The second part identified the kinds of physical, emotional and spiritual reactions they had experienced during and after the BT. The final part endeavoured to identify the impact the BT had on the participants' general health and well-being. (See Appendix B).

During the data collection phase, the major concepts that emerged from one interview provided direction for further analysis and collection of additional data in subsequent interviews. This process is called 'theoretical sampling'.

Constant comparisons were made between the data from each interview, to search for similarities and contrasts. Sampling to the point of saturation was the desired goal. This was achieved by continuing to sample until all areas of variation were substantiated and no additional concepts stemmed from the data (Strauss & Corbin, 1990).

Analysis of Interview Data

Transcriptions of the interviews were carried out as close to the interview as possible so that all the nuances could be included and the essence of the interview would not be lost in the transcription process. Following transcription, the tapes were listened to again to ensure that what had been said during the interview had been transcribed correctly. Stories were then written of what appeared to be emerging from the data, to give an overview of the women's general experiences. This was an important part of the process preceding 'open coding'.

Open Coding

The process called 'Open Coding' then followed. This began with meticulously reading the transcript, line by line, sentence by sentence and underlining sections or words of data that appeared to encapsulate a particular phenomena, event or incident. Once underlined, a key phrase or word signifying a particular concept was placed in the right-hand margin next to these highlighted areas. This procedure was used for the entire transcript and by opening up the data in this manner, allowed the researcher to see a much broader picture. On completion of this initial coding, a list was made of all the key phrases (concepts). During open coding, a technique of looking for similarities and differences between existing and subsequent interview data allowed for categories to be generated from key phrases and transcript quotes. Thus categories were identified, based on their significance and frequency.

Axial Coding

Using this method, it became clear that certain experiences that could be termed 'negative' and 'positive' were common to all participants; thus a process called 'Axial Coding' had begun. (For example, in the early stages of data collection, an emerging theory was that the client-therapist relationship seemed significant. This theory was explored in all subsequent interviews.) Hence, Axial Coding and Open Coding overlapped at this stage of the analysis. Once these patterns were discerned, relationships were made between categories by refining and placing them into a cycle thus allowing 'selective coding' to occur. (see Fig. 1, p. 33).

Selective Coding

Selective coding commenced once core sub-categories had been identified, which linked all the minor categories in the theory together. This was achieved by analysing the context and conditions under which the phenomena occurred and the outcome of actions and interactions that eventuated. Two core sub-categories were identified: the overall experience of loss the women had endured as a result of suffering with CLBP, and the revitalising experience of the BT. As a result of selective coding, the major 'core category' was named with two minor core categories.

While the **description** of the process of analysis inevitably suggests the development of a hierarchy, the actual process was cyclical as were the participants' experiences. A concept diagram depicting themes in the participants' journeys, (See Fig.1, p. 33) and a 'conditional matrix' (See Appendix C) were used in the final analysis to organise key concepts and identify the central phenomenon (Strauss & Corbin, 1990; Miles & Huberman, 1994). Regular reference to the concept diagram (p. 33) will assist understanding of the findings reported in the following chapter, 'Hoping and Coping Transformed'.

Summary

Two methodologies were required for this research; a survey of Bowen therapists and indepth interviews of people receiving the Bowen Technique. An initial postal survey was necessary to provide information for the major part of the study. A qualitative approach was selected for the second phase of the study, as such an approach provided the broadest means by which to record and analyse the experiences of participants and the phenomena under study. Grounded Theory was adopted since it provides a rigorous method while allowing the theory to emerge from the data rather than from any predetermined beliefs.

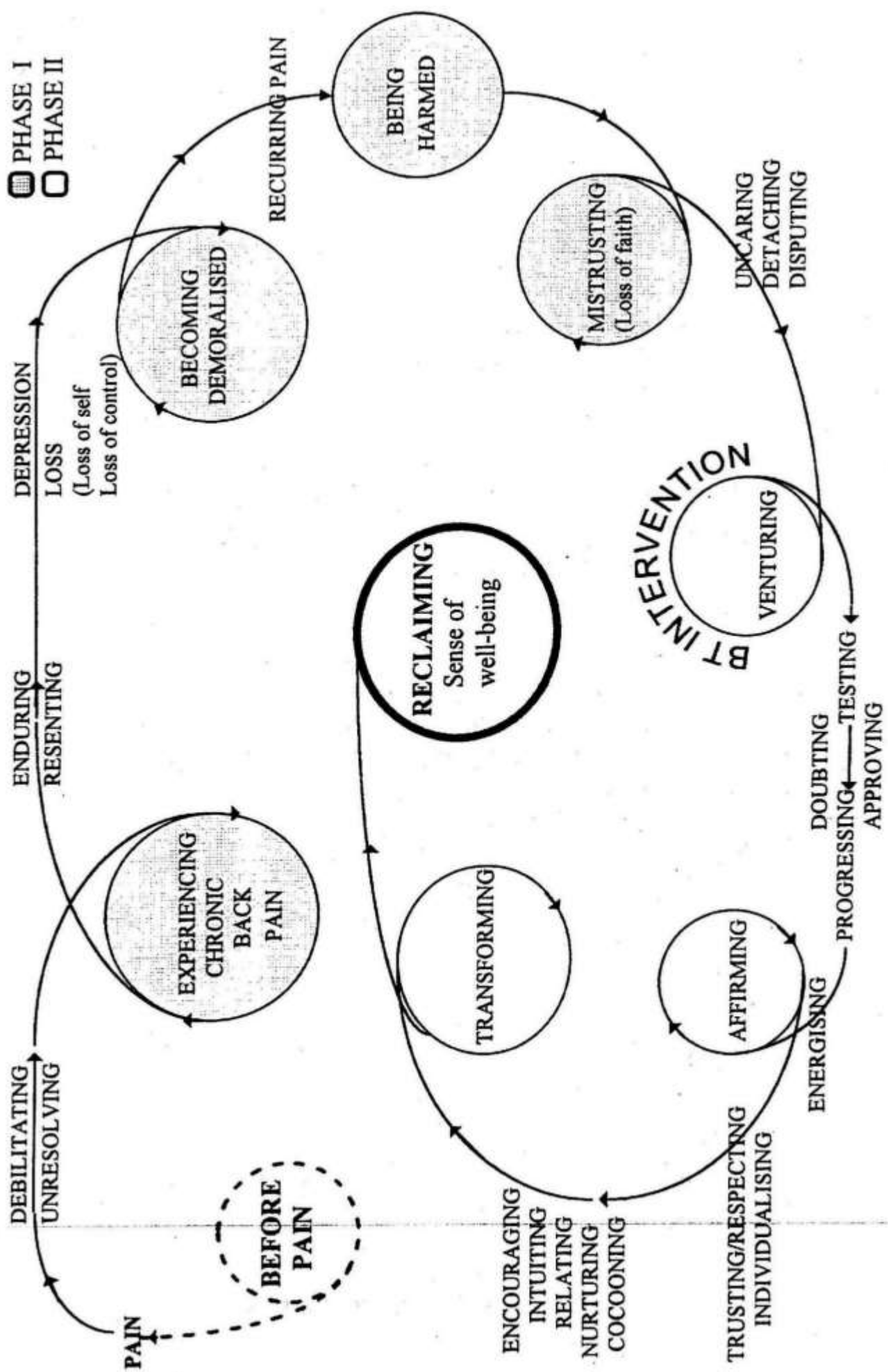


Figure 1 - PARTICIPANTS' CYCLE - Associated concepts

HOPING AND COPING TRANSFORMED

Introduction

Two methodologies, quantitative and qualitative, were utilised in this research and the findings are therefore presented separately.

The major finding is that all the women suffered debilitating effects on their lives as a result of their chronic low back pain (CLBP). Further, in seeking pain relief, they each had similar experiences in dealing with orthodox and complementary therapies. Finally, all of the women found considerable pain relief with the Bowen Technique (BT).

(A) Findings from the nation-wide survey

Only findings relevant to the main study are reported here. For other findings (not central to the main study) to do with background, qualifications, length of practice and frequency of client visits, see Appendix A.

The main purpose of the questionnaire was to identify the most common presenting problem of clients for the BT. The following table shows the results for this item. (n = 112)

Condition	Frequency	Valid Percent
Back	63	56.3
Neck/shoulder	34	30.4
Arm/hand	1	.9
Hip	2	1.8
Leg/knee	4	3.6
Jaw	2	1.8
Headaches/migraines	4	3.6
Arthritis	1	.9
Other	1	.9
Missing	11	Missing
TOTAL	123	100

Table 1 - BT clients' most common presenting problem

This table shows clearly that back pain was the most common presenting problem for Bowen therapy. This is a significant finding, since it is the first survey to be conducted on the BT. The second most common condition to be treated were neck and shoulders.

(B) Findings from Qualitative study

Presenting condition of participants

The seven clients selected for the study had all suffered from back pain for at least six months; thus the actual condition under study became CLBP. Participants were located through the client files of experienced Bowen therapists.

Profile of participants

The seven women who took part in this study were: Sally (age 38; CLBP for four years), Joan (age 39; CLBP for four and a half years), Anne (age 40; CLBP for eight years), Sarah (age 46; CLBP for eleven years), Susan (age 47; CLBP for seventeen years), Carol (age 55; CLBP for thirty-eight years) and Mary (age 58; CLBP for forty-four years). (Pseudonyms are used to ensure anonymity).

In-depth interviews

Interviews explored the effect that the BT had on the women's sense of well-being; also, their experiences of living with pain and seeking its relief. This involved inquiry about the various therapies they had tried and the therapists from whom they had sought help. The study examined what motivated the women to seek the BT, what their experiences were of this technique, how this affected their CLBP and their general health and well-being.

Before presenting details of the findings from the interviews, a brief overview is given in the interests of clarity. It emerged that a particular succession of experiences had occurred for all the women. This took the form of a cyclical development from a position of having no pain, to a position of experiencing chronic pain with the concomitant effects on the participants' well-being. After the application of the BT, they experienced a transforming process where the experience of pain lessened considerably and they gradually regained control over their lives and were again able to engage in previous activities. A central finding of the study is that all

the women reported a revitalised sense of self and well-being that was at least as positive as before.

Before experiencing the BT, the participants had tried a range of therapies from orthodox medicine to chiropractic, osteopathy, remedial/relaxation massage and other complementary therapies. This ongoing search left the women feeling demoralised and depressed. In time, they suffered a loss of self worth and sense of control over the management of their lives. Finally, a distrust of health professionals developed and a belief that their pain could not be 'cured'. Dr. Patricia McGrath, (in an interview with Goldman, 1991b) believes that individuals suffering chronic pain will have very low expectations of a new treatment working if they have already tried a number of therapies for the problem. This is supported by the fact that the participants reported varying degrees of ambivalence toward trying yet another therapy, the BT.

Findings are divided into two phases that reflect this cycle. The analysis of the experiences leading up to the loss of well-being (Phase 1) is followed by the analysis of experiences resulting in the reclamation of their well-being (Phase 2). Figure 1 on page 33 clarifies the findings.

RESULTS FOR PHASE 1 (BEFORE THE BOWEN TECHNIQUE)

Open Coding

The terms used to report the results of the first analysis of the data (open coding), are deliberately 'active', since the experiences of the participants consisted of dynamic movement rather than static stages.

Based on their frequency and significance within the transcripts, the following stages were identified before the BT: being debilitated; lack of pain resolution; enduring; resenting; being depressed; losing; suffering recurring pain; being harmed; feeling uncared for; feeling invalidated.

Each of these stages constitutes an initial *concept*; they are elaborated below.

Being debilitated / Lack of pain resolution

The women's experience of pain and of various therapies which they tried, show a commonality in terms of unresolved pain and subsequent frustration and loss of hope when the therapies failed. The experience of CLBP without effective treatment or affirmation of the pain resulted in some participants abandoning orthodox treatments; instead, they elected to undertake complementary therapies in their quest for pain relief and acknowledgement of their suffering.

All the women discussed the profound effect that chronic pain had on their lives, including their work. Sally, the youngest participant, owned and ran a fruit and vegetable shop. Four years ago, she suffered a prolapsed disc, and this has since caused her chronic intermittent pain in her lower back. She has sought help from a number of practitioners including chiropractors, osteopaths, orthopaedic specialists, general practitioners and remedial massage therapists. She could not carry anything or walk any distance, thus making it impossible to do any physical exercise. Her debilitation meant that she had to give up working in the shop. It also severely limited her ability to undertake home duties and look after her husband and two children. 'I've tried various different ways of treating my symptoms for my back...however, nothing gave any sort of lasting relief...'

Joan gave up her job as a photographer to look after her newborn baby six months ago (her third child). She began experiencing problems when she had a fall during the pregnancy with her second child, four and a half years ago. This caused ongoing pain in the lumbar, sacral and pelvic areas of her back and referred pain down one leg. She received treatment from chiropractors, osteopaths, massage therapists and shiatsu therapists. '...I've had so much hands on...' Despite temporary alleviation of the pain, she endured frequent frustration when there was no real improvement in her condition.

Anne, a part-time nurse, has had back problems for many years and experienced chronic pain for approximately eight years. She described the problem as 'nurse's back' and had received assistance from a range of physiotherapists and eventually a remedial massage therapist. She

reported that as neither of these therapies gave any kind of permanent relief for her CLBP, she frequently felt extremely dejected and debilitated.

Sarah, who works part-time in a plant nursery, experienced back pain for about eleven years; it began when she moved a very large carpet without assistance. She sought treatment from chiropractors and general practitioners, '...I've seen quite a few chiros over the years...', but the relief she gained was temporary. Much of Sarah's back pain was kept under control while she was on a methadone program; however, once that stopped, the pain and its associated difficulties returned. As reflected in the literature, a paradox exists for those rehabilitating from drugs when drug treatments, for example, narcotics, are used to relieve chronic pain (Aronoff et al., 1986; Kanner, 1986; Reuler, Girard & Nardone, 1980).

Problems for Susan, a word-processing operator, began when she developed osteoarthritis seventeen years ago. Although the major problem area is in her lumbar spine, she also experienced referred pain in one leg. There were times when she was extremely debilitated because she could not stand, sit or walk; lying down flat was the only option to relieve the pain. She tried chiropractic, osteopathic and shiatsu treatments for the pain. However, none of these therapies was able significantly to reduce her pain. She became frustrated by her lack of mobility and inability to do everyday activities.

Carol, a retired factory worker, had problems with her spine and suffered chronic back problems since falling on her head at age 17. The stiffness and pain in her joints became progressively worse, making it difficult to sleep at night and rise in the morning. She consulted chiropractors, general practitioners, specialists, physiotherapists and relaxation massage therapists for the pain. '...Over the years, I've tried everything that's been available...' There were times when she really thought she had found the therapy that worked for her. Ultimately, however, she became depressed, disillusioned and debilitated as each therapy failed.

The oldest participant, Mary, a full time teacher, has a long history of back problems beginning at age 14. The original cause of her pain was unclear, but she remembered pulling and hurting her back. From age 20, she began receiving traction, immobilisation and manipulation under anaesthetic. Eventually, she entered a long course of physiotherapy. By her late 20s, she

decided to stop consulting therapists, because she became wary of all the seemingly invasive techniques used on her body; nor had she been given any positive assurance that a 'cure' could be offered. For the next ten years she opted to suffer the pain rather than tolerate interminable treatments. Finally, she recommenced physical therapies with a succession of chiropractors. During the past forty years, the pain has been intermittently crippling; at times she was barely able to move without agonising pain. She experimented with a variety of techniques, often on an ad hoc basis. '...when it got bad, someone would tell me something that was worth trying...I'd try it and that would be it, so there was no logical progression...' However, she did not find anything that gave long-term relief from pain.

Enduring

Four of the seven women described how they would generally endure the ongoing pain, so that it became a part of their life: '...here you are living with this pain, and you lived around it...' 'I'd put up with it a lot of the time.' '...you just put up with it and readjust.' '...tended to just accept it...as a weakness, just something that you lived with...you work through it...Decided that I'd cop it...copped it...for [the] next ten years or so...'

Mary and Sally described the coping strategies they employed in order to endure the pain and show others they were still able to function. '...I can remember stages where I'd have to go into a back room at work and lie down flat on the floor for five minutes to just be able to physically keep going...I was teaching in a classroom, you can't just say, oh sorry, I've got a bad back, goodbye...you work through it...' '...it was my own business...with the customers...in the shop, walking around and being seen rather than sort of every half hour or so sort of staggering out the back and collapsing in a chair and wishing that you were at home, lying in bed.' This adjustment had the additional effect of denying these participants recognition from others; people were unaware of their pain and therefore could not acknowledge it.

Mary decided to endure the pain rather than take medication. 'I always had an abhorrence of interfering with my own body's workings in anything that I thought was a dramatic way.'

Resenting

While four women expressed a stoical attitude, the other three expressed a sense of resentment about their pain; a finding reflected in the literature. One study of back pain and the experience of stress, efforts and moods found that feelings of resentment played a significant role in aggravating the pain (Svebak et al. 1991). Chronic pain can cause long-term frustration for families, friends and caregivers, as well as the person who is suffering the pain (Hanson & Gerber, 1990; McCaffery & Beebe, 1989; Frank & Frank, 1991; Melzack & Wall, 1982).

The issue of resentment arose in connection with this frustration. Sally, the youngest woman, expressed the impact of chronic pain on her relationships: ‘...when I was in pain all the time and in poor health, your mental well-being is...wrecked...you feel very frustrated and teary all the time, very...angry that you can’t do little things...you’re annoyed with yourself...you think everyone else is annoyed with you...’

With a young family of three children, Joan felt resentful because she could not engage in normal activities. ‘...I’ve got a life I have to get on with and live...’ Sally, also trying to run a home and bring up two children, had to forego many activities because of the constant pain. ‘...I’m still fairly young and I’ve got a young family, and I can’t do anything with them.’ Carol, although much older than the other women, resented the impact of pain on her life. ‘...I just kept feeling that I was too young to have something that was there with me all the time.’ The frustration the women expressed in living with their pain-imposed limitations led them to ask ‘why me?’

Being depressed

Carol consulted a variety of therapists but none was able to supply her with an explanation for her constant pain; nor could any clinical basis for her pain be established. The lack of physical evidence for her condition meant that she experienced doubt and uncertainty about her own distress and felt vulnerable because friends and family could not ‘see’ her pain. She reported that people tended to deny the existence of her pain. ‘I was very depressed, because I didn’t know what was wrong with me, and I didn’t know what the final outcome was going to be...my biggest worry, that I would...go so far down...I might never be able to pick myself up

again...' Lack of knowledge about her condition and what was actually wrong with her resulted in Carol feeling fearful, depressed, hopeless and helpless.

Similarly, Joan expressed a loss of faith in the possibility of ever being well. '...very depressing...so emotionally I was just coping, and when your whole body is in so much ...[pain]... and you're trying to deal with it, it's very stressful...'

Losing

The changes brought about by progressive pain and loss of body function may result in a loss of confidence in health generally (Watson, 1985). All the women suffered loss; loss of jobs, loss of self esteem and self worth, loss of ability to perform general tasks, loss of involvement with family and friends, loss of ability to play sport, and loss of the management of their lives.

Susan, aged 46, stated that when she was faced with the loss of her mobility, '...I had gone through a period of grieving my mobility, accepting that at this stage of my life, I wasn't going to be able to do things that I thought I would be able to...'

Despite intensive physiotherapy for her back, the continuing physical restrictions meant that Anne felt compelled to give up her profession. 'There were times when I just felt like giving up...it didn't matter what exercises...what physio did, me being careful at home, it didn't make any difference...I gave up nursing for five years...'

Recurring pain

The recurring episodes of pain caused the majority of the women to cease chiropractic treatments. As Carol explains, 'Up until about five or six years ago, I found that the chiropractor just wasn't doing anything for me...I'd go, it would be all right for a few days, and then it would come back again.' This was a typical experience for all seven participants, which resulted in loss of hope.

In addition to chiropractic, three of the women also received osteopathic treatment but discontinued treatment because of recurring incidents of pain. As Joan explains, 'The osteo

had alleviated it, but I was finding I was getting very frustrated because...it wasn't actually improving...I started to lose faith...that nothing was ever going to work for me.'

Being harmed

Some therapies were felt to be potentially harmful and all of the women felt their pain and loss of well-being were exacerbated by some therapies that were at best unhelpful. Among other therapies, six of the seven women had received treatment from a variety of chiropractors.

There was a strong antipathy expressed by each of the women for high-velocity manipulation and a real fear that the therapy harmed the body in some way. '...sometimes you come out feeling like you've been beaten...' '...I've always had an abhorrence of violent movement of the spine...the chiropractic manipulation is something I've never been 100 per cent comfortable that it's not having a long-term adverse affect.' '...I really didn't like their bone crunching technique.' '...get on the bench, crack, crack, off you go, and you came out feeling very fragile...' The experience of chiropractic techniques resulted in these particular women developing a real aversion to and mistrust of the methods employed.

Feeling uncared for/Detaching

All of the women experienced a sense of lack of care from some therapists. These experiences are described by five of the women. The frustration at the lack of improvement and the subsequent loss of faith was particularly poignant for Sally. Her consultation with a locum osteopath resulted in her being hospitalised and in traction for eight days. The treatment had been careless and negligent. '...I think it was partly his fault that he aggravated it, partly not knowing me as a patient.' Sally was not able to communicate the severity of the pain and felt this situation would never have happened with her regular osteopath. '...I was confident that he knew my body, he knew what my pain levels were at different times...'

Susan felt a sense of powerlessness and dissatisfaction at the way she had been treated by osteopaths. She felt they were too busy to listen or even care, and this created significant problems for her. As they did not clearly explain what they were going to do, she felt as if she was just another number. '...I felt like a lump of meat...they sort of just brushed me aside and said you'll be right, and I wasn't...if someone is in pain, then you should have a treatment program that suits you, not something that suits them...' Susan felt discarded and uncared for,

and that she played no part in her treatment. Stewart (1995) proposes that an overt demonstration of care and respect by the practitioner will ensure that within the therapeutic relationship, the patient's autonomy in the decision-making process is recognised as important. Susan's reported experience contradicts the generally held belief that all complementary therapists show genuine care and concern for their clients.

Patients may experience various fears when a practitioner has not taken the time to become fully acquainted with their problems, nor tried to understand their character, specific wants and needs. As Susan stated, '...I just feel like they don't even know me, how can they heal me.' Doubt and mistrust about the effectiveness of treatment occurred as a result of poor practitioner-client communication and rapport and associated apprehension and anxiety. Unpleasant treatment experiences may produce feelings of insecurity and physical vulnerability. Sally's experience of practitioner negligence made her fearful of having her body manipulated and insecure about the therapist's competency. '...if you feel that they are unprofessional...you're going to be tense because you're lying there in this vulnerable situation, so it can't work...' '...it can be vulnerable for a lot of people, to give their body up to somebody else.' For Susan, it was important that the practitioner demonstrate a caring attitude for her to feel safe and secure. These reported encounters suggest that the practitioners involved jeopardised the possibility of establishing a therapeutic relationship with their clients. There is widespread acceptance that the relationship between the health professional and their client is of paramount importance in the healing process. For example, Joan preferred a warm therapeutic relationship with highly individualised treatment. 'I like to feel that they are there for you, like you're special...at the time...that they are really concerned about how you are and helping you with your problem...' Very similar views were expressed by all the participants in the study.

After fifteen years seeing one chiropractor, Carol's decision to terminate treatments was made because she felt he was unconcerned for her well-being. '...even though I'd been going to him for years, when it came down to the crunch that I felt that I wasn't getting any better, he wasn't interested. It was as if he just wanted his money, and he didn't really care whether I was okay or not...'

The objective, value-neutral client/therapist relationship exalted by orthodox medicine has socialised health professionals into believing that it is unprofessional to become too involved with patients; as a consequence, the capacity for caring may be compromised (Montgomery, 1994).

'Lack of care' and 'detachment' emerged as issues for all participants in their consultations with certain practitioners; naturally, these interactions influenced their choices of therapist. All participants stated that some health practitioners lacked concern for their well-being and did not treat them as individuals with their own specific concerns. As Anne describes, '...if I'm going to go to someone and I'm going to be in and out and I'm not going to get satisfaction and I'm not going to get questions answered, it means that they haven't basically got the time for me or they are only interested in the money side of things.'

Disputing

In many cases, practitioners failed to validate the women's pain. In fact, the women reported that their experiences of pain were often disputed, which led to a sense of rejection and mistrust of the practitioner.

'Pain patients', as the medical fraternity sometimes refer to patients with chronic back pain, are frequently described as unmanageable, with very low expectations of a cure. Often the only option given patients is to learn to live with the pain (Kotarba & Seidel, 1984). This is exacerbated when no organic basis can be found for the pain. As Carol described, 'My husband said to me a few times, "Well if the doctor can't find anything wrong with you, there can't be anything wrong with you"...I said to him... "I'm not imagining all these pains"...so it was very hard for him to understand why I constantly had a pain somewhere...when you have something wrong with you and nobody seems able to help/believe you...you wonder...if you really have got something wrong.' Carol's experience of not being understood or believed by her doctor, specialists and family caused her feelings of rejection.

The psychological well-being of those individuals who experience difficulties with chronic pain has been found to be positively affected by a high degree of family and friendship support (Revenson, et al. 1991; Jamison & Virts, 1990; Varni, et al. 1988; Kerns & Turk, 1984).

Women need secure relationships to be able to grieve the numerous losses accompanying the experience of chronic pain. This will allow them to recount their experiences of living with chronic pain, and have their pain experiences legitimised (Howell, 1994b).

It was important for the women to have support at home, and receive validation of the pain from health professionals and family members. Three of the women had some positive chiropractic experiences, and expressed some faith in the therapy. For example, one woman announced, 'I went to a chiropractor who helped me a great deal...I liked him because he was prepared to prepare your body...'

Sally experienced strong support from her spouse, who was very understanding when she was in pain. However most of the time, the participants' pain was not acknowledged either in their personal lives or in their contact with practitioners. Like some of the other participants, Carol needed to talk about her pain and associated problems, and when this was denied by her spouse and doctor, she felt that nobody cared. 'It makes me feel as if he really doesn't care, and I know that's not true, but it makes me feel cut off...' Such experiences led to depression and a sense of being invalidated.

This was the condition of the participants at the end of Phase 1, before the BT. (Refer Fig. 1, p. 33).

Axial Coding

Major categories of experience were identified by examining the relationships between concepts that arose during open coding of Phase 1. It became apparent that all the participants had been through specific negative (weakening) experiences, namely, *demoralisation* and *mistrust*.

Demoralisation

The experience of chronic pain for a number of years can have an intensely negative effect, where individuals feel they have little or no control over their lives. This leads to feelings of hopelessness, helplessness and depression (Frank & Frank, 1991; Melzack & Wall, 1982). Everything the person normally takes for granted in terms of a general sense of health and

well-being may become unreliable, resulting in reduced confidence and demoralisation (Kleinman, 1988).

Such was the situation of the women in this study, the recurrence of pain caused a loss of self esteem, loss of control over their lives and feelings of demoralisation. The option they chose to manage their pain was to seek a variety of therapies, which gave only short-term relief. The subsequent feelings of depression were in part attributable to the fact that (in some cases) no organic basis was discovered for the pain (DiMatteo, 1991). The uncertainty about the potential development of their condition caused, as Frank & Frank (1991) found, feelings of fear and despair about ever being able to function normally again.

This demoralisation was exacerbated by experiences these women had with some therapists who were seen as uncaring or failing to validate their client's pain, thus creating mistrust.

Mistrust

People with chronic pain often turn to a range of alternative therapies in their search for a cure. They may include chiropractic, osteopathy, acupuncture, remedial massage, support groups, exercise, stretching, walking, and so on (Howell, 1994b). The women in this study sought such assistance from chiropractors, osteopaths, shiatsu therapists, remedial/relaxation massage therapists. Some encounters resulted in the women feeling mistrustful.

This constituted the mid point of the cycle shared by the seven participants. Despite the fact that their pain had been disputed and the consequent sense of invalidation, each of these women still attempted to find effective treatment, albeit with mixed expectations. Thus they moved into Phase 2.

RESULTS FOR PHASE 2 (WITH THE BOWEN TECHNIQUE AND AFTER)

Open Coding

Stages reported by the participants during their experience of the BT were identified as: testing; doubting; approving; progressing; energising. Experiences with Bowen therapists

included: being treated individually; trusting/respecting; being cocooned; being nurtured; relating; being treated intuitively; being encouraged.

Testing

For six of the participants who had already tried many different therapies, there was initially a degree of ambivalence in experimenting with the new technique. '...I'll try anything once.' 'I've got nothing to lose..' 'Anything is worth a try, so go ahead and see what results we get.' '...I thought well, if it works that's wonderful, if it doesn't, I haven't lost anything...' 'thought I'd give it a go...and hope something happens.' 'Have a go and see if you can fix me.'

Doubting

For three women, trying the BT raised initial doubts and some scepticism. As Joan pointed out, 'Some people want to go and really feel that they're being manipulated...' There is a common belief that if it hurts, it is good, that is, no pain without gain.

The women were initially doubtful that the BT could be effective when compared with other therapies, as it was so non-intrusive. Joan still maintains that having faith in the treatment is important. '...it's just this small move...on your body...so non-intrusive...it's hard to believe it actually does the work...I was open to it up to a point...Was I going to get some results...'

The extremely light pressure was a great surprise for Carol, who had been used to years of chiropractic treatments. '...it felt such an insignificant thing, that you wondered how it could really have any effect on anything...there was no pain, doesn't feel uncomfortable...it just felt to me it couldn't work, even though I didn't want to think that...' Moving from strong manipulations and deep massage to the BT caused Sally to feel sceptical initially because of the seeming lack of procedures. '...feel like you've been robbed a bit...it wasn't what I expected...it doesn't seem to do anything...' However, after two treatments she realised it worked.

Approving

This scepticism was not universally experienced. For two participants, the sheer gentleness of the technique was attractive from the first treatment. As Sarah explained, 'One thing I loved about it right from the beginning...it was very gentle.' Perhaps because Mary had experienced

so many invasive techniques, she also was attracted by its lightness. '...the fact that there was no bone manipulation...and it was such a gentle technique...I was quite prepared to keep going and see what came out of it.'

Progressing

For five of the women, a major improvement occurred around the third treatment. Joan's experience is representative of what happened for all of these women: '...by the end of the third treatment, one day, I was sitting here going, "I'm not in pain!"...and the RELIEF, the relief in Y O U R S E L F...'

Six sessions over a few months were needed before Sarah noticed a complete improvement. '...I just found I never had to go back again to have more treatment on my lower back.' Two women find ongoing monthly treatments suit them, while another is still having the BT periodically. Two other participants have approximately three treatments per year, and see the therapist if and when their pain returns.

Sally, however, continues to have weekly Bowen treatments in combination with physiotherapy. In this respect, there are marked differences in terms of her progress and experience of the Bowen technique when compared to the other women. Having reached a plateau after eight months of weekly Bowen treatments, her orthopaedic specialist suggested she try a course of physiotherapy. '...I just couldn't progress without building myself up...' The physiotherapy appears to have helped strengthen her body. 'I don't think either one of them is a cure on their own...I think it's a combination of both.' This combination is unusual, because it is usually recommended that no other tactile therapies are received at the same time as Bowen treatments. Other therapies are believed to detract from the effects of the BT.

Energising

During the course of Bowen treatments, five women experienced some very strong physical, emotional and even spiritual reactions. These reactions have been termed 'energising'. The term 'energy' that some of the women refer to is frequently used by Bowen therapists to describe client's unexplained reactions to treatments. Capra (1983, p. 344) explains that the word energy, or 'Chi' in Chinese medicine, is '...a very subtle way of describing the various

patterns of flow and fluctuation in the human organism'. From a traditional Chinese medicine viewpoint, it is believed that when the Chi is flowing, the organism is in balance and is therefore healthy. The Bowen Technique is considered by some Bowen therapists to be a vibrational energy therapy, working on similar principles to acupuncture, and stimulating energy flows.

Joan discussed how for her the body/mind/spirit are completely intertwined. 'For me, healing...it embraces your emotional, your mental and your...spiritual self...just because I had a physical problem, it's not just that, it comes from an emotional reaction to something as such, which is then coming out in my body...' Joan's responses occurred concurrently with the treatment. '...I always feel a shift straight away, a shift in the sense of how I feel...' In common with four of the women, Sarah describes the energy that she felt flowing through her body. '...one was aware of the energy flowing through your body...I was very emotional at the time...a spiritual awakening for me.'

Anne's reactions during and after the first treatment caused her some concern. 'I felt queer, I felt funny...I just felt as though I wasn't in control of my body...it was a feeling I've never felt before...' Her therapist explained that, among other functions, Bowen therapy shifts energies in the body. This explanation allowed her to understand and accept her experience.

Carol felt a deep sense of relaxation during and after the first session. '...after the first time...I felt at peace with myself.' However, Susan became tearful during a Bowen session. 'It did once bring up some grief I'd been sitting on...I had a bit of a weep...'

Individualising

The practice of the Bowen therapists of treating the client as an individual and explaining what Bowen therapy is, and what would be involved, drew very positive responses from all the women. Susan encapsulates five of the women's experiences: '..she's not interested in treating people as numbers...each person is an individual with an individual set of problems, needs, wants...that's really important for me...She discussed with you what she's about to do...or advises me on what she thought was best, but it was always up to me to make the decision...it becomes a team effort.'

Trusting/Respecting

Experiences of mutual trust and respect were developed in different ways by each therapist. For example, Carol had already established a very good relationship with her massage therapist prior to having the Bowen Technique. ‘...because I’d known her for some time, I felt really comfortable and I trusted her...right from the beginning I really liked her...I said to her right from the beginning, “you know I trust you and I know it’s not going to do me any harm”...’

Some therapists use what is generally termed a ‘metaphysical’ approach. This style used by Sarah’s and Mary’s therapists may have had an impact on trust being established. Sarah felt immediately reassured when she discovered the therapist used a metaphysical style with clients, ‘...she works with spirit...I found that quite calming...I just felt completely comfortable with her from the first moment...I really liked her honesty...’ Despite the fact that Mary did not share her therapist’s metaphysical views, she felt this difference in philosophical beliefs was well respected by the therapist. ‘...I felt very comfortable with her...I didn’t feel that she was...saying to me, because you’ve come for a Bowen...you must come along with everything else that I am believing and into...’

Susan’s therapist was able to demonstrate that she believed the client should have as much input and autonomy in the therapeutic relationship as she wished. ‘...honouring the client as a participant rather than someone who’s come there to put themselves in your hands.’

Cocooning

The environment the therapist created in which to work with clients provided a protective feeling for most of the women. Joan’s and Susan’s descriptions reflect all the women’s experiences in this respect. ‘...her room was lovely, inviting...you felt very relaxed there...even the way that she covers you and...makes you feel very attended to...that aspect of it is very important for the healing process too...’ ‘...her towels are always warm...you don’t have the shock of being cold...this warm cocooning feeling...created a really good environment in which to be working on somebody’s body...’

Once her therapist had established a proper room in which to treat clients, Sally was better able to relax and felt this contributed strongly to the overall treatment. ‘...it seems to me that

Bowen depends quite a bit on the environment and conditions, everything has to be just sort of relaxed and calm.'

Nurturing

Four of the women commented on how they interpreted the gestures of caring and nurturing provided by the Bowen therapists. Anne's experience is indicative of four of the women's experiences of feeling nurtured. '...he cared...just his whole approach...he's such a gentle guy...'

The cocooning and nurturing provided by the therapists enabled the women to relax, an important factor when receiving the technique.

Relating

Relating well to the therapist, and being able to communicate easily about everyday topics, were significant factors for four of the women. Mary's experiences with her therapist were shared by all of the women. 'We shared everyday experiences...she'd say something about one of her children, I'd say something about something at school, so it was this ease of communication that was there from the start.'

For a helping-trusting relationship to develop, Watson (1985) states therapists' interactions with clients must include a strong degree of congruence (that is, being genuine), empathy (that is, showing a degree of understanding of others' feelings), and non-possessive warmth (that is, valuing others in a total, instead of a conditional way).

Intuiting

Intuition is defined as having a sense of the whole even though you are attending to the parts and is based on listening to the instincts or 'gut feelings' that emanate from within ourselves (Page, 1992). An intuitive approach plays an integral role for some Bowen therapists when treating clients.

The women developed a strong faith in their therapist's intuition. 'She's very intuitive...to meeting your needs...when you are in the process of the Bowen, whether we're talking or just

being quiet...she has a wonderful sense of knowing...what you need as far as the Bowen moves...and anything else...’, said Joan.

Encouraging

Carol talked about the importance of being given a sense of positive expectation. ‘...she made me feel that there was hope, that I wasn’t going to just get worse, that there was a way for me to maintain my health.’ The therapist gave Carol some literature from the Arthritis Foundation, and discovered a support group that she could join for sufferers of Fibromyalgia.

Axial Coding

This is the second stage of analysis; these categories were generated from the open codes during Phase 2 ‘with the BT and after’. The major categories identified as a result of axial coding of Phase 2 were: venturing, affirming and reclaiming.

Venturing

In their continued search for a therapy that would give them long-term relief, all the women eventually sought the Bowen Technique. The major theme of the experience of embarking on and receiving the Bowen Technique has been termed ‘venturing’ because it explains the unfolding process all the women experienced in their journey to find a ‘cure’ for their pain.

The women located their Bowen therapists in different ways. For four women, their remedial or relaxation massage therapists (who were also Bowen therapists) introduced them to the technique. Three of the women’s friends (who had suffered similar complaints), all highly recommended a particular Bowen therapist for help with their problem. People suffering from a particular problem long term who wish to locate the most appropriate therapist will frequently seek help from those who have had personal experience of a similar nature (Helman, 1984). For example, Sally’s therapist had back pain for a number of years and had experienced considerable relief with the Bowen Technique.

Affirming

There is widespread acceptance that the relationship between the health professional and their client is of paramount importance in terms of the overall healing process, especially in the

establishment of rapport with the patient and legitimisation of their problems. 'Rapport' means that mutual trust and respect exist between practitioner and client, with the shared goal of procuring the patient's health (DiMatteo, 1991). Borkan et al. (1995) suggest this relationship plays an essential part in the overall healing process and may have positive results with low back pain patients. Watson (1985) extends this by suggesting that trust, hope and faith can be promoted by the practitioner demonstrating genuine care and concern for the individual's needs.

Howell (1994b, p. 104) states that:

The most essential element in a therapeutic relationship with a woman who has chronic pain is a primary health care provider who believes in (validates) the woman's body pain, helps her relieve it, and respects her unique response to the pain.

The women in this study felt they were being listened to and were treated as an individual by their Bowen therapists; thus the term 'affirming'. The women valued these practices highly in their relationship with their therapist.

Reclaiming

Carol's and Joan's feelings and experiences after the BT are representative of those of the other participants. After treatment, Carol was better able to handle herself and her problem. '...it's made me cope better with myself...as though I could accept my problems...I feel at peace with myself and my family...therefore, I can cope better with other people...I cope much better with emotional things...it just makes it easier to get through each day...I sleep so much better...I don't have constant pain like I used to have...I really think I am a different person...I just feel so much better.'

Joan felt the Bowen therapy had very positive effects on her ability to cope and be in control of her life. This gave rise to a sense of self-determination. '...it gives you a confidence in yourself that you're getting on with other areas of your life...it just gives me so much a sense of being able to be there...you sort of feel in control of yourself again...because Bowen initially healed

that physical level, which gave me back my sense of emotional well-being, in a way it sort of gives you back your life!

END OF CYCLE

Transforming

The outcome of having the course of Bowen treatments had far-reaching effects on all of the women's lives in terms of pain reduction. The final part of their journey is termed 'transforming'; this transformation, experienced by all the women, led them to reclaim themselves.

PHASES 1 AND 2

Selective Coding

Two core sub-categories 'Loss' (Phase 1) and 'Revitalisation' (Phase 2) were identified as a result of selectively coding within axial coding all the major categories that related to each other. This subsequently allowed for the creation of the core category 'Sense of well-being' that related to all the other major and minor categories in the analysis (See Fig. 1, p. 33)

Summary

All the women had CLBP, had suffered from four to over forty years and had sought help across a range of therapies. They had all gone through a series of similar stages in their experience of chronic pain and the therapies they tried in their search for long-term relief.

The debilitating experience of unresolved pain meant the women suffered loss of self esteem and loss of control of their lives. The dual reactions to this experience of either enduring and/or resenting their predicament resulted in the women feeling demoralised, that is, frustrated, hopeless, helpless and depressed.

During their experience of different therapies, they all began to develop a sense of mistrust. This occurred as a result of their belief that some therapies had caused them physical harm and was compounded by a sense that some practitioners showed a lack of genuine care and concern for their problem. Further, they felt their individual needs were disregarded. This lack of trust was aggravated by some practitioners not legitimating their pain. Furthermore, despite

many years of seeing the same therapist, some of the women felt there was no improvement in their condition.

The women then 'ventured' into Bowen therapy which they found completely different to previous therapies they had experienced. The gentleness of the technique was a positive experience for all the women.

Through the course of their treatment, the women felt 'affirmed' in their relationship with their therapist. This occurred as a result of the high value the participants placed on the interaction with the Bowen therapist. These were experienced as: being treated as an individual; having a sense of mutual trust and respect; feeling protected and nurtured; able to relax and to relate well; and the therapist being intuitive and encouraging. The Bowen therapists in this study provided a safe and trusting atmosphere in which the women felt they could air their feelings.

Most of the women were able to revert to a position of non-pain and reclaim their original selves. They felt this as a transformation, enhanced by the Bowen therapist acknowledging their pain and treating them as an individual.

All found the Bowen Technique gave them either total or considerably longer lasting relief from pain. One woman experienced permanent relief, two women continue to have monthly treatments, one woman has the BT periodically and two others return perhaps three times per year if the pain returns. One is continuing to see her therapist weekly.

The key finding is that the relationship the women had with their therapists is seen by them to be central to their regaining a feeling of well-being and the consequent 'reclamation of a sense of self' (well-being).

CONCLUSION

Introduction

In this chapter, the findings of the study are discussed in the light of the cited literature. Throughout the discussion, reference will be made to the Bowen Technique (BT), chronic low back pain (CLBP), orthodox medicine and complementary therapies. A conditional matrix, based on Corbin & Strauss (1990), is used to clarify this discussion. (See Appendix C). Suggestions will be made for further research.

Bowen Therapy

BT is a gentle, remedial technique that works by stimulating energy flows involving a system of muscle and connective tissue movements; the locations correspond closely with acupuncture and trigger points. Therapists use their hands to 'roll over' certain muscles, tendons and ligaments, thus promoting healing. Conditions treated include asthma, arthritis and problems such as tension headaches and menstrual difficulties, in addition to back, neck and shoulder problems.

The survey of Bowen Therapists was the first to be conducted in this country. There are now over 500 Bowen therapists in Australia, many of whom are treating serious conditions. Clearly, this involves a large number of clients and Bowen therapists constitute an important part of the health work-force. Hence, this study provides important insights into a therapy of increasing significance.

It is clear from the findings of this study that the sense of well-being of all the participants was positively affected after they received the BT. Dramatic alleviation of their CLBP led them to report a transformation of their quality of life.

The women's experience has already been graphically represented as a cyclical journey. (See Fig. 1, p. 33). A more sophisticated aid to analysis is a conditional matrix which allows links to be made between the individual participants' experiences with CLBP and the international

profile of back pain sufferers. The matrix links the central phenomenon at all levels - from the global experience of pain to the individual's search for and final discovery of relief from pain through Bowen therapy. Central to this experience is the interaction between the patient and the Bowen therapist. This global view allows clarification of the 'conditional path' that occurred as a result of the participants' attempts to access treatment which would be successful in alleviating their CLBP. (See Appendix C).

Phenomenon of CLBP - worldwide

On the global level, Borkan et al. (1995) found that CLBP is one of the most prevalent conditions worldwide. Further, this condition causes numerous negative emotions for the sufferers, their families and colleagues (Frank & Frank, 1991; Hanson & Gerber, 1990; McCaffery & Beebe, 1989; Melzack & Wall, 1982).

The negative impact of CLBP on its sufferers, well beyond the actual experience of pain, was a significant finding of this study. All the women reported reaching an extremely low point in their sense of well-being, in fact in their sense of self. This occurred despite differences in participants' ages and the range of time suffering CLBP.

It is also evident that, as well as a depleted sense of well-being, the participants suffered ongoing depression about the condition and their subsequent situation. The women's despair about the possibility of ever feeling well again particularly illustrates this point and is reflected in the literature by Kleinman (1988), Frank & Frank (1991), Melzack & Wall, (1982) and DiMatteo (1991).

In addition, Svebak et al.'s (1991) study of back pain sufferers' resentment about their pain is mirrored in the experiences communicated by three participants. For example, the inability to undertake and enjoy any activities with the family led to a sense of hopelessness, alienation and resentment.

CLBP sufferers' experiences and feelings are affected by the attitudes of those about them.

Revenson et al. (1991), Jamison & Virts (1990), Varni et al. (1988) and Kerns & Turk (1984) all highlight the positive effects of strong support and understanding from family members for

individuals with chronic pain. The findings of these studies match the experience of some of the current study's participants, where a significant part of the cycle of suffering was the perceived absence of support from family and significant others.

CLBP can cause a sense of profound loss, for example, loss of work and career, financial loss, loss of relationships, loss of everyday activities with family, friends and work colleagues. In addition, loss of mobility and basic movements like walking, can culminate in the sense of loss of any control and subsequent loss of a sense of self (Charmaz, 1983; Watson, 1985; Leder, 1984-85; Linton, 1994; Bendelow & Williams, 1995). Plainly, all the participants in this study experienced a sense of loss, albeit in varying degrees.

Some people suffering chronic pain take steps to control, or at least contain its effects. Borkan et al.'s (1995) description of 'living around the pain' is precisely reflected in the reported experience of some participants; seeking solitude when in pain at work exemplifies this strategy.

Finding a meaning for the pain is considered important as it is suggested this may provide the individual with an understanding of their affliction and a sense of hope for the future (Dubree & Vogelpohl, 1988). Possessing this sense of hope may also be dependent on how individuals view the level of control they have in their lives, that is, whether they have an internal or external locus of control (Rotter, 1966, in Harkapaa et al., 1996). Strong et al. (1990) found that having a sense of personal control was helpful when dealing with the restrictions of CLBP. All of the women in this study reported a sense of helplessness and a loss of control in various areas of their lives.

Consideration of the findings makes it clear that the responses to CLBP of the participants in this study were typical of those reported in the international literature.

The search for effective treatment

All of the CLBP sufferers who participated in this study sought alleviation of their condition with a range of therapists, both orthodox (biomedical) and others. A factor central to the attitudes and even the potential recovery of chronic pain sufferers is their experience with

health professionals. For the purposes of this discussion, 'health professionals' includes biomedical practitioners (orthodox) and complementary therapists.

Orthodox (biomedical) approaches to health care

The mainstream medical model used throughout Australia is in the tradition of western medicine. Orthodox medicine has not been successful in treating CLBP, which is an extremely complex phenomenon affecting the whole person in every facet of life. The focus of orthodox medicine on symptomatology, the measurement of pain sensation and its alleviation through drugs, may overlook the common experiences of people's pain and the association they have between their pain and its meaning (Bendelow & Williams, 1995; Morris, 1991). The difficulty with providing alleviation for physical symptoms associated with indefinable problems of the psyche, emotions and human spirit places these factors beyond the realm of orthodox medicine (Watkins, 1996).

The approach adopted by some orthodox health professionals may result in individuals being advised to live with their CLBP if no organic cause can be found (Hafferty, 1991; Chibnall et al., 1995; Goldman, 1991a; Weber, 1979, in Lindsey, 1995). Subsequently, Kotarba & Seidel's (1984) description of 'low back loser' exactly reflects the experiences of the participants; the women reported feelings of being rejected by their doctors. This negative relationship with some doctors was also related to the lack of validation of the women's chronic pain reported by most participants (Schlesinger, 1993; Howell, 1994b).

The results of Chibnall et al.'s (1995) study on physician frustration with patients suffering from chronic headaches is pertinent to this study in terms of the absence of legitimization of pain, (although the cause of pain is different). The negative relationships with orthodox practitioners was often the deciding factor for the women to cease particular treatment.

The finding that most of the participants in this study reported these negative experiences with orthodox practitioners is of crucial importance. The emphasis in training in orthodox medicine is on illness, technology and medication, with little attention paid to the client-therapist relationship. Montgomery (1994) highlights that a detached, objective position may compromise the potential for caring.

For these seven women at least, the experience of orthodox medicine was reported as at best useless and at worst frustrating.

Complementary therapies

The practice of holism, where the individual's physical, psychosocial and spiritual health are considered, may provide a less reductionist approach to healing (Bendelow & Williams, 1995; Morris, 1991; Watkins, 1996; Micozzi, 1996; Penrose & Barret, 1982; Quinn, 1989; Drew & Dahlberg, 1995). At an individual level, the participants in this study initially chose orthodox treatment and moved through fairly mainstream complementary therapies (for example, chiropractic and osteopathy) to the less well known BT. This move to complementary therapies reflects to an extent a larger social pattern in health provision (Simon, 1989; Litt, 1986; Wasner, 1991; Eidinger & Schapira, 1984; McGuire & Kantor, 1987)

Complementary therapies take a more holistic approach and may therefore be more appropriate for CLBP. By definition, holistic practice should include the qualities of care and compassion (Watson, 1985; Drew & Dahlberg, 1995; Baume, 1996). However, not all complementary therapists are holistic in their approach or demonstrate caring qualities. A sense of feeling neglected and discarded by some complementary practitioners as well as by their doctors were experiences common to the majority of women in this study.

All the women had developed a deep sense of mistrust of some therapists and therapies (both orthodox and complementary) because of a perceived lack of genuine care and concern on the part of the practitioner. Six participants reported experiences of a complementary therapy being actually harmful; in particular, chiropractic produced strong feelings of aversion in this regard.

There is a belief that chiropractic is gradually embracing the medical model, where some individuals fear the loss of the philosophy, art and science upon which chiropractic is based (Kats, 1995). If it is the case that chiropractic is gravitating toward the medical model, this might account for the negative encounters and feelings of aversion experienced by some of the women, which acted as a catalyst for them to leave treatment. Such feelings are apparently not

uncommon, as O'Neil (1994) discovered in his study of 'Danger and Safety in Medicine'. It is likely that this mistrust did nothing to promote recovery, and probably impeded it.

BT intervention

The findings clearly indicate that a powerful positive relationship existed between each woman and her Bowen therapist. The positive effect such a relationship has on the entire healing process, (where rapport, mutual trust, respect, and genuine care and concern are present), is well reported in the literature (DiMatteo, 1991; Watson, 1985; Drew & Dahlberg, 1995). This kind of relationship has been found to be helpful with patients suffering low back pain (Borkan et al., 1995). It is suggested that the therapeutic relationship may be compromised when the practitioner does not demonstrate care, warmth and understanding toward their patient (DiMatteo, 1991; Stewart, 1987; Finn, 1986; Kotarba & Seidel, 1984). In particular, it may be this could be deleterious to the self-worth of the patient (Lloyd & Maas, 1991).

The Bowen therapists in this study adopted a holistic approach in their work by offering a highly personalised treatment involving time, empathy, effective listening and affirmation of the participants' CLBP. Thus, an effective environment within which to understand and treat the women's problems was provided. This was evident in the findings and reported by all of the women when they described the individualising, cocooning, trusting and nurturing experiences they had with their Bowen therapist.

It is widely accepted that if a treatment offers reassurance and the prospect of help, it may result in a noticeable improvement in the presenting condition (Rosenthal & Frank, 1956, in Sundblom et al., 1994; Frank & Frank 1991; White et al. 1985; Davies 1980; Peck, 1981). Therefore, it is likely (as the literature cited suggests) that the relationship that developed between the women and their Bowen practitioners was so powerful and therapeutic that it promoted their recuperation.

However, it is worth noting that Tom Bowen, the founder of the technique, apparently spent very little time interacting with his clients and employed a nurse to fulfil this task. It could be that in the case of the founder of the BT, some placebo effect was at work. Bowen's

reputation as a great healer was such that it would have created a strong degree of positive expectation of a beneficial treatment outcome in his clients.

In the literature, expectant trust is an important part of successful therapy. 'Expectant trust' as described by Weatherhead (1951, in Frank & Frank, 1991), is precisely reflected in reports by several participants, who described the development of positive expectations of the Bowen therapy after their initial treatment.

While the therapeutic relationship with the Bowen practitioner was clearly reported by the women as crucial to their recovery, the effectiveness of the technique itself cannot be overlooked. The seven participants all believed that the technique itself is effective, non-threatening, non-damaging, and relaxing. It is certainly apparent that the gentleness of the technique was experienced by the women as a very positive aspect of the therapy.

Whatever the explanation, a major finding is that all of the participants used superlatives to describe the effects of the BT on their lives. We could, of course, assume alleviation of long term CLBP would automatically have this effect. However, it is clear they all re-engaged in activities after the BT, and all described the results of their treatments as having a profound effect on their lives. This included feeling at peace with themselves and their families, coping better with emotional concerns and with other people and sleeping better. They had more confidence in themselves and felt that at last they were able to get on with their lives. With feelings of being in control again, reclaiming their emotional well-being, and being given back their life, they regained a sense of self.

It is clear that these findings are significant for this particular group of people. All the participants reported experiences that placed them firmly in the typical profile of sufferers of chronic pain as reported in the literature, yet they all atypically experienced significant relief, and some recovered from what is recognised as a particularly recalcitrant condition (CLBP) after undergoing the BT.

Further research

Given the findings of the national survey, it would seem desirable in the first instance to develop a data-base of BT practitioners, to establish both the national scope of the practice of the BT and the training profile of BT therapists. Such a data-base would provide the basis for more detailed research.

This exploratory study of the well-being of people suffering with CLBP and receiving the BT sets the scene for further research. A clinical trial of a larger population specifically related to the treatment of CLBP using the BT would also be of value. Future research may include a larger number of participants, with a study carried out over a longer term. In the light of the findings regarding the holistic approach of the BT therapists, it could be useful to study the relationship between differences in Bowen therapists. Variables such as gender, training and practices and the kind of results they achieve with the technique should all be investigated.

Summary

This study is important since no other research has been conducted in this area on the Bowen Technique. The complexities of suffering with chronic low back pain (a global problem) and the myriad accompanying effects, including loss of control and of the sense of self, was investigated. The study traced the women's journey as they sought treatment. In the process, they moved away from orthodox medicine which they found at best unhelpful and sought a more caring and effective approach in various complementary therapies. Since complementary therapies are understood to embrace a holistic philosophy, the participants' expectations were not unreasonable. However, when they tried complementary therapies, they were distressed to find in many instances that these expectations were thwarted. Recurring pain led them to a less well known complementary therapy, the Bowen Technique. Finally, the study arrived at the finding that they all had significant relief from pain after receiving the Bowen Technique. In every case, the participants made reference to the holistic approach adopted by their particular Bowen therapist. The effectiveness of the technique for these women and the acknowledged importance of the therapeutic relationship could have considerable implications for the treatment and alleviation of chronic low back pain, should the findings of the study be supported in future research.

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APPENDIX A

COVERING LETTER TO BOWEN THERAPISTS

QUESTIONNAIRE

RESULTS OF NATION-WIDE SURVEY

Dear

re: **RESEARCH ON THE BOWEN TECHNIQUE**

I am writing to request your involvement in research I am conducting on the Bowen Technique.

I am enclosing with this letter a questionnaire for your completion. The purpose of this questionnaire is to gain greater understanding about how the Bowen Technique is being utilised by practitioners nation-wide, and the results that are being achieved. It is hoped this research will provide greater insight into the effects of this particular complementary therapy, thus adding to the general body of knowledge.

I should be most grateful if you would kindly complete the enclosed questionnaire and return to me by no later than the 8th March, 1996. I have enclosed a stamped addressed envelope for the return of the questionnaire.

The questionnaire will be entirely confidential and your name will not be used either during or following this survey at any time.

Continued/2...

For your information, I am conducting this research as part of my Masters of Health Science, at Victoria University of Technology, St. Albans, Victoria.

In anticipation, may I take this opportunity of thanking you very much for participating in this study.

With best wishes,

Yours sincerely,

Judith Rayment

Encls. Questionnaire

Stamped addressed envelope

Code:

PLEASE READ QUESTIONNAIRE IN FULL
BEFORE YOU ANSWER ANY QUESTIONS
QUESTIONNAIRE

(SOME QUESTIONS REQUIRE YOU TO TICK OR CIRCLE THE APPROPRIATE ANSWER, WHILE OTHERS REQUIRE YOU TO MAKE SPECIFIC STATEMENTS. THEREFORE, PLEASE READ VERY CAREFULLY AND ANSWER ALL QUESTIONS CLEARLY)

(1) How long have you been practising as a Bowen Therapist?

(Please tick the appropriate box)

- | | | | |
|-------------|--------------------------|------------|--------------------------|
| 0-6 months | <input type="checkbox"/> | 3-5 years | <input type="checkbox"/> |
| 6-12 months | <input type="checkbox"/> | 5-7 years | <input type="checkbox"/> |
| 1-2 years | <input type="checkbox"/> | 7-10 years | <input type="checkbox"/> |
| 2-3 years | <input type="checkbox"/> | | |

(2) Do you have recognised qualifications in other therapies, in addition to those of the Bowen Technique? Yes / No

If Yes, please tick the appropriate box(es):

- | | | | |
|------------------|--------------------------|--------------------|--------------------------|
| Aromatherapy | <input type="checkbox"/> | Reflexology | <input type="checkbox"/> |
| Acupuncture | <input type="checkbox"/> | Reiki | <input type="checkbox"/> |
| Acupressure | <input type="checkbox"/> | Counselling | <input type="checkbox"/> |
| Shiatsu | <input type="checkbox"/> | Naturopathy | <input type="checkbox"/> |
| Remedial Massage | <input type="checkbox"/> | Relaxation Massage | <input type="checkbox"/> |
| Medicine | <input type="checkbox"/> | Chiropractic | <input type="checkbox"/> |
| Osteopathy | <input type="checkbox"/> | Nursing | <input type="checkbox"/> |
| Psychology | <input type="checkbox"/> | Kinesiology | <input type="checkbox"/> |
| Flower Essences | <input type="checkbox"/> | | |

Other (please specify): _____

- (3) Are you currently studying towards any other therapies? Yes / No

If yes, state which therapies:

- (4) Do you have any formal training/qualifications in anatomy and physiology?
Yes / No

If Yes, please tick the appropriate box(es):

- a) Short course
- b) Certificate
- Diploma (Private College)
- Under.Grad. Diploma
- Under.Grad. Degree
- Post. Grad. Diploma
- Post. Grad. Degree
- c) Other (please specify): _____

- (5) OF ALL THE CLIENTS you have treated with the Bowen Technique IN THE LAST 12 MONTHS, what percentage (%) of clients have reported:

- a) 100% resolution of condition _____
- b) 76%-99% resolution of condition _____
- c) 51%-75% resolution of condition _____
- d) 26%-50% resolution of condition _____
- e) 1%-25% resolution of condition _____
- f) No resolution of condition _____
- g) Don't know _____

(PLEASE BE AS ACCURATE AS POSSIBLE)

(6) OF ALL THE CLIENTS YOU HAVE TREATED WITH THE BOWEN TECHNIQUE IN THE LAST 12 MONTHS, what is the MOST COMMON PRESENTING PROBLEM: (please tick ONE BOX ONLY)

- | | | | |
|------------------------|--------------------------|----------------------|--------------------------|
| a) Back | <input type="checkbox"/> | b) Neck/Shoulder | <input type="checkbox"/> |
| c) Arm/Hand | <input type="checkbox"/> | d) Chest/Respiratory | <input type="checkbox"/> |
| e) Hip | <input type="checkbox"/> | f) Leg/Knee | <input type="checkbox"/> |
| g) Ankle/Foot | <input type="checkbox"/> | h) Jaw | <input type="checkbox"/> |
| i) Headaches/Migraines | <input type="checkbox"/> | j) Digestive | <input type="checkbox"/> |
| k) Arthritis | <input type="checkbox"/> | l) Menstrual | <input type="checkbox"/> |
| m) Urinary | <input type="checkbox"/> | n) Hayfever | <input type="checkbox"/> |
| o) Menopausal | <input type="checkbox"/> | | |

Other (please specify ONE PROBLEM ONLY, if not listed in any of the above):

(7) Please indicate (by ticking one box only) how many times on average you would see clients for the problem (above):

- | | |
|------------------------|--------------------------|
| a) 1-2 visits | <input type="checkbox"/> |
| b) 3-4 visits | <input type="checkbox"/> |
| c) 5-10 visits | <input type="checkbox"/> |
| d) More than 10 visits | <input type="checkbox"/> |

(8) IN ADDITION TO PAGES 1, 2 & 3 of the Bowen Technique Manual, state THE MAIN Bowen procedure you would use to alleviate the problem (above):

(9) Are there ADDITIONAL BOWEN PROCEDURES that you use to treat the problem (above):

Yes / No

If Yes, please state up to 3 other Bowen procedures that you use to treat the problem (above):

- i) _____
- ii) _____
- iii) _____

(10) Are there modalities IN ADDITION TO BOWEN that you would use to treat the problem (above):

Yes / No

If Yes, please state what these are: _____

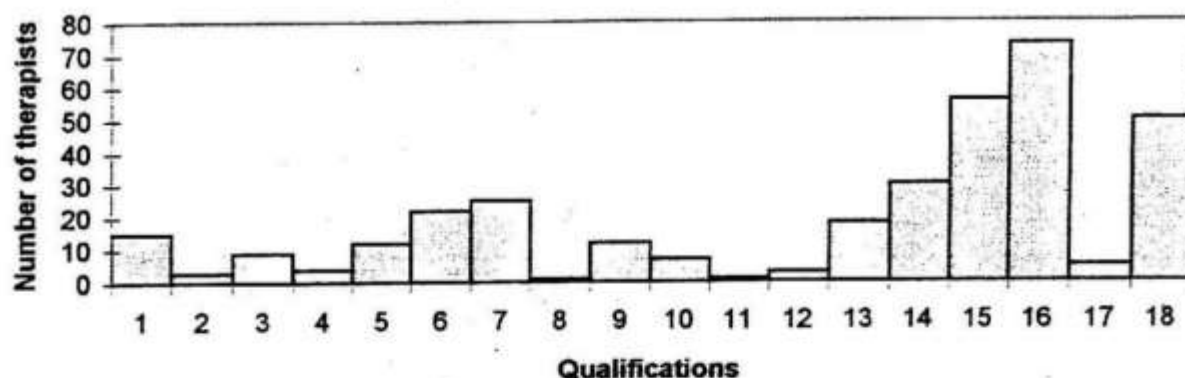
IMPORTANT NOTICE: PLEASE RETURN THIS QUESTIONNAIRE TO MYSELF, IN THE ENCLOSED STAMPED ADDRESSED ENVELOPE, TO REACH ME NO LATER THAN FRIDAY, 8TH MARCH, 1996.

THANK YOU SO MUCH FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE.

JUDY RAYMENT, 36 The Esplanade, Clifton Hill, Victoria 3068.

Question (2) - (n = 123) 91.9% had recognised qualifications in other therapies.

QUALIFICATIONS IN OTHER THERAPIES



Key for chart

1	Acupressure	7	Kinesiology	13	Reflexology
2	Acupuncture	8	Medicine	14	Reiki
3	Aromatherapy	9	Naturopathy	15	Relaxation Massage
4	Chiropractic	10	Nursing	16	Remedial Massage
5	Counselling	11	Osteopathy	17	Shiatsu
6	Flower Essences	12	Psychology	18	Other

DETAILS OF 'OTHER' QUALIFICATIONS

Aged care	1	Infant massage	2	Onsen technique	1
Beauty therapy	1	Iridology	6	Ortho-bionomy	2
Cranio-sacral therapy	3	Lymph drainage	2	Seichim	1
Deep muscle therapy	2	Midwifery	1	Spiritual healing	1
Dentistry	1	Myofascial release	1	Sports massage	2
Feldenkrais	1	Neuro-emotional technique	1	Sports medicine	3
Herbalism	12	Nutrition	7	Total Body method	1
Homeopathy	4	Occupational therapy	1	Touch for Health	3

The Bowen therapists are qualified in a diverse range of therapies.

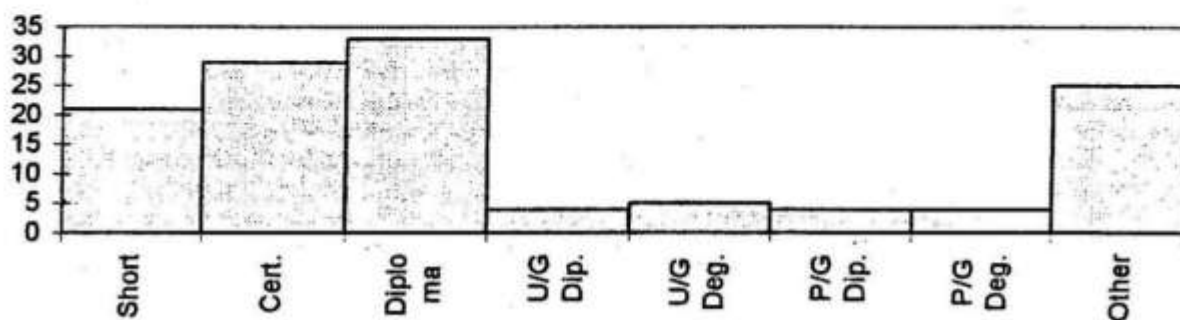
Question (3) - (n = 123) 20.3% of respondents were studying toward other therapies.

CURRENT STUDIES

Therapy	No. studying	Therapy	No. studying
Certificate body massage	1	Massage certificate	1
Clinical nutrition	1	Master of Applied Science (Acupuncture)	1
Cranio-sacral therapy	1	Myofascial release	1
Healing Touch	1	Naturopathy	2
Herbal Medicine	1	Process oriented psychology	1
Homeopathy	5	Professional counselling (AIPC)	1
Infant Massage	1	Remedial massage	2
Iridology	1	Therapeutic Touch	1
Kinesiology	1		

Question (4) - (n = 123) 82.9% of respondents had Anatomy & Physiology qualifications.

Anatomy & Physiology Qualifications



A high percentage of respondents possessed qualifications in Anatomy and Physiology

'OTHER' QUALIFICATIONS ASSOCIATED WITH ANATOMY & PHYSIOLOGY

Assoc. Dip. Applied Science (Beauty Therapy)	1	B.A. Physical Education	2
Assoc. Dip. Clinical Lab. Tech.	1	Herbal Medicine	2
Assoc. Dip. Health Science	1	Iris Diagnosis	1
Assoc. Dip. Myotherapy	1	Nursing	6
Aust. School of Natural Medicine	1	Private home study	1
Bachelor. of Science	1	Remedial Massage	6

Question (6) - (n = 112) Clients' most common presenting problem.

CLIENTS' MOST COMMON PRESENTING PROBLEM

CONDITION	FREQUENCY	VALID PERCENT
Back	63	56.3
Neck/shoulders	34	30.4
Headaches/migraines	4	0.9
Leg/knee	3	1.8
Jaw	2	3.6
Arm/hand	1	1.8
Hip	1	3.6
TOTAL	123	100

Other: Stress affecting all areas of the body: 2

Asthma : 1

Back pain is the most common complaint and constitutes the basis of the major study.

Question (7) - (n = 118) Number of visits for the most common presenting problem.

Number of visits

NO. OF VISITS	FREQUENCY	PERCENT
1-2	49	41.5
3-4	61	51.7
5-10	7	5.9
>10	1	0.8
Missing	5	Missing
TOTAL	123	100

110 practitioners saw their clients 4 times or less to treat the most common presenting condition.

APPENDIX B

INFORMED CONSENT FORM

INTERVIEW SCHEDULE

INFORMED CONSENT

I, _____ agree to be interviewed by Judith Rayment, a Master of Health Science student at Victoria University of Technology.

I understand that the interview will take approximately one hour, and that it will be recorded on a cassette tape.

I understand also that my name will not be mentioned in the transcription and that a code will be used in place of my name for analysis purposes.

I understand I am eligible to receive a copy of the transcript of the interview prior to analysis, to ensure everything I have said has been correctly transcribed. I understand also that I can view a copy of the analysis for verification purposes.

I understand a follow-up interview(s) may be necessary to re-clarify certain points, and that I am entitled to view transcription and analyses thereof.

I understand the tape will be kept locked in a filing cabinet and will not have mention of my name and address on the outside of the tape, and that any other information concerning this or these interviews will be locked in same filing cabinet, to protect my confidentiality, and will be destroyed after five years.

I understand that I can withdraw as a participant from this research at any time and that this will not jeopardise me in any way.

Signed

Dated

INTERVIEW SCHEDULE

MAIN THEME: WHAT WERE YOUR REASONS FOR VISITING THE BOWEN THERAPIST?

(EXPLORE)

- WHAT WAS THE PROBLEM?
- HOW DID YOU HEAR ABOUT IT?

MAIN THEME: TELL ME ABOUT THE ROLE OF THE BOWEN THERAPIST DURING THIS PROCESS OF RECEIVING THE BOWEN TREATMENTS.

(EXPLORE)

- CONFIDENCE IN THERAPIST
- THERAPIST'S PARTICULAR QUALITIES
- THERAPIST'S PROFESSIONAL APPROACH

MAIN THEME: TELL ME ABOUT HOW THE TECHNIQUE WAS APPLIED

(EXPLORE)

- LEVELS OF COMFORT
- DURING TREATMENT, OTHER MODALITIES USED
- NUMBER OF VISITS/INTERVALS OF VISITS

MAIN THEME: DESCRIBE WHAT KIND OF REACTIONS YOU EXPERIENCED

(EXPLORE)

- PHYSICAL - BEFORE/DURING/AFTER TREATMENT
- EMOTIONAL - " " " "
- SPIRITUAL - " " " "
- WHEN AWARENESS OF ABOVE WAS NOTED
- SKEPTICAL/CYNICAL
- REACTIONS - HOW THEY FIT WITH PERCEPTIONS OF WELLBEING

MAIN THEME: DESCRIBE WHAT HEALTH AND WELLBEING MEAN TO YOU

(EXPLORE)

- WHAT DOES IT INCLUDE: PHYSICAL/EMOTIONAL/MENTAL/SPIRITUAL
- IN WHAT WAY MIGHT THE BOWEN TREATMENT HAVE AFFECTED THESE AREAS?

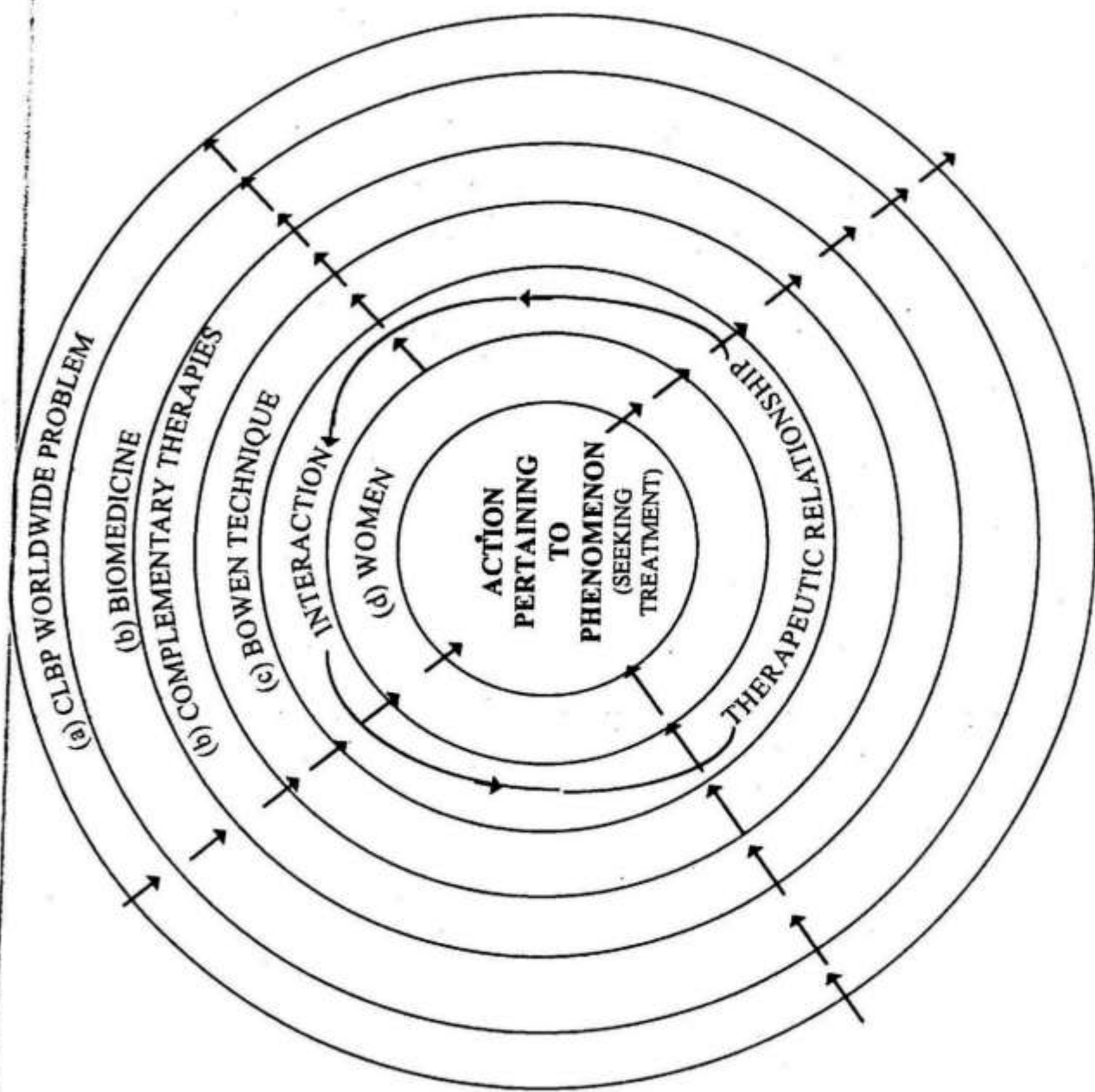
MAIN THEME: DESCRIBE WHAT CHANGES OCCURRED FOLLOWING THE BOWEN TREATMENT

(EXPLORE)

- IF A CHANGE WAS NOTICED
- WHAT CHANGED (PAIN LESS, ETC. - SPECIFIC TO CONDITION)
- DESCRIBE FEELINGS SINCE CHANGE(S)
- HOW MUCH CHANGED
- EFFECTS ON YOUR LIFE
- OTHER AREAS OF LIFE - E.G. RELATIONSHIPS

APPENDIX C

CONDITIONAL MATRIX



KEY

- (a) Global
- (b) Organisational
- (c) Sub-organisational
- (d) Group/Individual