

**PASTORAL CARE AND COUNSELLING OF THE PERSON IN
CHRONIC PAIN**

by

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SUMMARY

People experiencing chronic pain encounter increases in needs and endure the consequences of failure to satisfy needs. In much of the management of people with chronic pain, chronic pain is considered an abstract phenomenon with little attention given to the human experience. Numerous literature focus on a mechanistic reductionistic approach in management of chronic pain.

Most literature is written by medical practitioners, nurses and psychologists from a health-care oriented methodology, whereas minimal research literature was contributed from a pastoral care and counselling perspective. This dissertation explores the needs and feelings of people with chronic pain to identify their needs at the various developmental stages of their pain experience, and within their relevant ecosystems, in order to develop a pastoral response.

KEYWORDS IN THE DISSERTATION

Chronic pain; Depersonalisation; Ecostructures; Needs deficiency motivation; Growth motivation; Pastoral care and counselling; Practical-theological ecclesiology of pastoral work care actions.

I dedicate this dissertation to my family:

- To my mother **Alvina Antonia Jacobs** who remains a living example of “discipleship” and commitment to “discipling.” An example that challenged my own commitment in my relationship with God.
- To my father **David Stefanus Jacobs** and my brothers **David, Frank and Clement**.

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CHAPTER 1

INTRODUCTION

1.1. NEW WAYS

This dissertation is not about the difference between acute and chronic pain. Neither is it about the cause and effect of pain. It is about making observations of patterns that interconnect in the chronic pain experience, and in the life cycles of people with chronic pain. By the action of observing interrelationships and interconnections associated with people's experiences with chronic pain, the observer becomes part of these patterns. That is, the researcher cannot stay outside what is being investigated and observed (Van Staden 1989:7-8; Carr 1991:11).

This study's concern is people in chronic pain and what the observations of the interconnections within the life cycles of these people mean to pastoral care and counselling. In other words: how does pastoral care and counselling become part of the experience of people with chronic pain in observing their life cycle patterns? Why must pastoral care and counselling try to find new ways of caring for people in chronic pain when numerous methods have already been produced by medical and psychology professionals? I find four main reasons why it is necessary to find new ways of caring for people in chronic pain. They are the following:

- 1) In much of the management of people with chronic pain, chronic pain is seen as an abstract phenomenon while the human experience is eliminated.
- 2) Numerous items of research literature focus on a mechanistic reductionistic approach to chronic pain management.
- 3) Most research literature was written by medical practitioners, nurses and psychologists, who approached chronic pain management mainly from a health-care oriented methodology.
- 4) Only very limited research literature was written from a pastoral care and counselling perspective.

Pastoral care and counselling is concerned with human beings. Therefore it needs to examine the necessity of an approach to the phenomenon of chronic pain, from the human experience perspective. People who have chronic pain experience ordinary daily living

with the additional burden of constant pain. Their chronic pain experiences are endured within a predominantly Newtonian Western civilisation. Chronic pain, in general, is diagnosed, treated and managed in the health-care environment. Dominant in this health-care environment is the biomedical model that still largely adheres to Cartesian dualism. The model approaches disease as independent of social behavioural relationships. It also explains behaviour in terms of some process of somatic disorder. This model's approach to chronic pain is mainly reductionistic and dualistic. The mind is separated from the body. The patient is on the whole not seen within a social context (Van Staden 1989:3-6). Disease is associated with damage to a part of the body. The cause is treated and the disease is cured. Chronic disorders, such as chronic pain and chronic diseases, defy this kind of thinking or methodology, as a cure is not forthcoming despite treatment. When a cure is not forthcoming chronic pain is often diagnosed as psychogenic. It is because the phenomenon of chronic pain is viewed on an either/or basis and only seen from one perspective. It results in the failure to regard the phenomenon of pain in a systems context, which considers the person within a larger context. In an ecosystems approach pain is considered in relation to the whole living context of the person. Pain runs a course, with onset, duration and various adjustments. However, the experience is interconnected within recursive cycles in the daily living of the person with chronic pain. These people live in a larger context of interrelationships and interconnections, in which reciprocal patterns occur that have an impact upon them and their environments (Rolland 1989:433).

Psychology models have gone a step further in research literature. They argue against dualism and no longer accept a split in body and mind. Chronic pain is discussed in research literature in relation to a biopsychosocial context. However, Dym (1987:36) writes that research into the systems approach is limited, and is still reductionistic in approach. He gives the example of stress-related factors often researched as though stress had caused the disease. For example, stress related to cancer is often portrayed as though stress had caused the cancer. Dym (1987:36) said: "All too often, psychologists who challenge the biomedical reductionism of modern medicine substitute psychological for somatic causes of disease." It seems that the focus on a disorder approached from the point of view of the health-care professional is a strong possibility. Emphasis is placed on the disorder and not on the individual with the disorder in relationship to his/her life cycle environments.

The focus of this dissertation is on the humanness of people with chronic pain. Its interest is to find out what their needs are within their living structures. According to Maslow (1970:38-39), basic needs occur in the individual's ordinary daily living, and if consistently ungratified the basic needs determine the person's behaviour. Meyer, Moore and Viljoen (1989:425) refer to Viktor Frankl's observations in a Nazi concentration camp that all humans are in search of the meaning of life. Frankl believes that ungratified needs may reduce the meaning of life, but that the person has the choice to find meaning in life despite ungratified needs. For him, it is choice that determines behaviour. At this point I do not intend to discuss what determines behaviour, but to note that in ordinary daily living basic needs arise.

Research literature has established that basic needs occur in the condition of chronic pain and that specific needs occur since chronic pain results in limitations and changes in life-style (Oates & Oates 1985:21-25; Hanson & Gerber 1990:15-31; Melzack 1983:2-12; Sternbach 1974:6-9; Tunks, Bellssimo & Roy 1990:60-72; Holzman & Turks 1986:19-20; Nigel 1984:56-57,96-97). The person with chronic pain encounters numerous problems, since chronic pain obstructs satisfactory living, well-being and finding meaning in life. Chronic pain not only hampers satisfactory living for the affected person, but it also affects those in close contact with the person in pain. Frequently it is the family or colleagues and friends. For example, role changes within the family have an impact upon the whole family, and ungratified needs influence the whole family structure. A father experiencing chronic pain may no longer retain his employment, which influences the family's income. It also influences social expectations and emotional elements, that exist in the reversal of roles that take place within the home (Tunks, Bellssimo & Roy 1990:16,60).

1.2. THE PROBLEM STATEMENT

Previous research literature reveals that people with chronic pain encounter numerous problems throughout the various stages of the chronic pain process. Chronic pain brings about limitations and changes in life-style that also give rise to basic and specific needs in association with the particular circumstance of each person with chronic pain (Tunks, Bellssimo and Roy 1990:16-17; Hanson and Gerber 1990:87; Maslow 1970:35).

The needs that occur may prevent social and church inclusion at various stages of the chronic pain process. People with chronic pain and their families often receive minimal help by the church to include them in society and church participation. The church, as a Christian caring unit, understands little of these people's subjective experiences with chronic pain. Pastoral care and counselling do not know enough, nor do enough, to establish what needs exist within the chronic pain experience. Not enough is known about the influence needs have upon people in chronic pain in relation to interconnected recursive patterns within their life cycles. Therefore, what pastoral care and counselling can do to help people in chronic pain within their ecostructures and to assist them to meaningful inclusion into social and church activities is frequently inadequate.

Research literature tends to concentrate on the emotional, psychological elements in the chronic pain experience, with some focus on socio-environmental aspects. Not all that much focuses on what people with chronic pain experience and feel with regard to the limitations of the condition. Neither is it sufficiently understood what these people need to enable them to lead a life that is meaningful despite the condition of chronic pain. It is also important to gain insight into the effects of needs upon people in chronic pain, and their interaction and interrelationships within their eco-structures. Sternbach (1974:2) draws attention to this by noting that: "Pain as described above is an abstract concept associated with tissue damage. Relatively little has been written about pain patients who are real individual persons.we will be referring to those whose pain is chronicfar more has been written to help a patient to die, than has been written to help a patient live with pain."

1.3. THE AIM OF THIS STUDY

The aim of this study is to determine from literature the needs that occur during the experience with chronic pain. It will give some idea of how this affects people with chronic pain within their life cycles. By applying empirical research to a sample of people with chronic pain the kind of limitations and life-style changes that take place in their everyday living experiences may be established. It also requires establishing what problems are encountered at various developmental stages and time-phases of the chronic

pain process and the needs which arise because of this. Establishing what needs occur, and what occurs when the needs are gratified or ungratified, will receive consideration.

In other words, the aim of this study is to come to understand people with chronic pain experiences in living with their pain; what these people need and feel. It is necessary to know and understand their needs and feelings, so that possible ways may be found to help these people to live with their chronic pain. It means that this study of chronic pain is done within the context of the person's interaction within relevant ecosystemic interconnections, interrelations and the recursive patterns that occur (Rolland 1989:433-434; Van Staden 1989:26-30).

It has not been adequately established what pastoral care and counselling can do to assist the person in chronic pain to be included into social and church activity. This needs to be investigated from a pastoral care and counselling perspective. The purpose of the study, after gaining insight into the limitations, changes in life-style and their impact upon the ordinary daily living of people with chronic pain, is to:

- 1) Establish if improved pastoral care and counselling to such people within their experience with chronic pain is necessary. It is only as pastoral theology research gains some understanding into the problems that limit the person with chronic pain from social and church interaction, that some conclusions as to pastoral care response can be decided.
- 2) Develop a theory for the practice of pastoral work caring to people during all the stages of the chronic pain experience. This is care that is given in the context of the person's daily living world and will assist people with chronic pain to find meaning in life despite the condition of pain (Frankl 1978:75-77).

In short, the aim is to identify the needs of people with chronic pain at various developmental stages within their relevant ecosystem in order to develop a pastoral response.

1.4. RESEARCH FORMULATION AND METHOD

This dissertation's format takes the form of an empirical study, from an ecosystemic perspective. People with chronic pain are studied in the context of their living world. People do not live in a vacuum, nor in isolation. People live in a consensual world, and are in constant communication with one another, either verbally, or non-verbally.

Communication by means of language between ecosystemic structures is an intersubjective and recursive activity.

The reason that the above approach is used in this study, is that an ecosystemic understanding of the individual who has chronic pain will contribute to a practice theory of pastoral care and counselling. Guidelines facilitating an appropriate language that addresses chronic pain in the larger context of the person's relevant ecosystemic structures are a priority. This does not mean that a person in chronic pain is discarded as an individual, since ecosystemic thinking is about the individual (Schultz 1984:58). It is, however, the individual in the context of a greater whole in relationships and reciprocal interaction and with interconnecting subsystems in larger systems that is addressed.

Qualitative research using multiple case-studies with a sample of five case-studies, is used. One person is used for the pilot study and four for the empirical study. The sample selection is selected by a simple random selection method. Each person concerned in a case-study is interviewed, and tape-recorded. This recording in turn is transcribed for data analysis purposes (Mouton & Marais 1990:29-34; Dane 1990:113-117; Bogdan & Biklen 1992; Abbey-Livingston & Abbey 1982:23). Data is collected and analysed according to qualitative research structure requirements (Dey 1993; Bogdan & Biklen 1992).

1.4.1. Theoretical structure of this study

The theoretical foundation of this study is ecosystemic epistemology, as a metatheory with communicative action theory, which practical theology embraces. Practical theology uses as a metatheory the communicative action theory of Habermas and the metatheory of systems approach (De Jongh Van Arkel 1991:61). Slowly the idea of embracing the ecosystems approach is being established within pastoral theology. This study attempts to use a binocular metatheory of communicative action and ecosystems. The conceptualisations of people with chronic pain in their ecosystemic structures this dissertation embraces are as follows:

1.4.1.1. Ecosystemic thinking

The starting point in this new thinking is a shift from concentrating on the individual to focusing on a number of people in the treatment unit. Bateson noted that it 'brings with it a new epistemology and ontology, i.e. a new way of thinking' (Van Staden 1989:36).

Epistemology in the above quotation is used to refer to what one knows. In philosophy it is used to describe what knowledge is, and how we know (Van Staden 1989:37).

A shift has taken place, from linear reductionistic thinking of Cartesian/Newtonian epistemology, to a new epistemology of ecosystemic perspective. This perspective places the individual into context. According to Van Staden (1989:7), Keeney views ecosystemic as '...the broadest view for looking at all possible systems, levels of systems, and interrelations among systems'. If the phenomenon of chronic pain is to be understood, it must be studied within the context of the larger whole and all connected recursive patterns relevant to it. The individual is not left out, but is considered in a larger context. The phenomenon is considered from every aspect, in all its interconnections and interactions in the person's living world. In the context of relationships, interactions and the interconnections of subsystems and larger systems, realities are formed. Realities are exposed in these interactions of which language and action form a basis (Carr 1991:10-11).

1.4.1.2. Language

The biomedical model was the main means of chronic pain management, and the language used to describe chronic pain was largely applied from the biomedical model's stance. Then attempts were made by disciplines, such as psychology, to create a variety of models that more adequately addressed the person in chronic pain in a larger context. In practice however, the management of the chronic pain experience still remains in the grip of linear reductionistic thinking of Cartesian/Newtonian influence.

An ecosystemic approach to the chronic pain experience required a new language to accommodate the concept of a chronic disorder, in the daily living world of the person experiencing the pain. Rolland (1989:434) writes: "In the arena of physical illness, particularly chronic disease, the focus of concern is the system created by the interaction of a disease with an individual, family, or other biopsychosocial system (Engel, 1977, 1980)." Rolland conveys the perspective that chronic disease has an unfolding developmental context. It is important that chronic disease be understood within the "intertwining of three evolutionary threads; the illness and the individual and family cycles" (Rolland 1989:434).

In the chronic pain experience the individual experiencing pain needs to be understood in the context of numerous intertwining evolutionary threads; that of chronic pain, individual,

family, social and spiritual life cycles. These life cycles that are interconnected within a societal system. In other words, chronic pain needs to be investigated in a context of subsystems; namely individual and family, social/church, within the context of a larger system of society. This is a context that has recursive patterns in its interconnections and interrelationships.

To enable accommodation of chronic pain in its unfolding developmental process, a common language and concepts needed to be found that may apply to chronic pain. To expand on this concept Rolland (1989:434) is referred to.

1.4.1.3. Needs and meaning of life

Needs occur in the most basic normal ordinary daily living. The meaning of life may be lost if need deficiency overcomes the person. Viktor Frankl (1978:75) maintained that the search for the meaning of life is the most powerful motivation of humankind. In the interconnected recursive patterns of the chronic pain experience there is a greater possibility that needs deficiency will occur at various stages of the chronic pain process. The unfolding developmental phases of the disorder of chronic pain increase needs. Consideration is given to the idea of need deficiency motivation of Maslow (1970), and to Frankl's (1978) suggestion of growth motivation despite severe need deprivation. In addressing the importance of need requirements, theories of Murray, Rogers and Freud (Moore, Meyer & Viljoen 1989; Maddi 1989) are also addressed.

1.4.1.4. Pastoral care and counselling

An appropriate language and concepts to accommodate the person in chronic pain in an ecosystemic perspective, in a practice theory for pastoral care and counselling is developed. Chronic pain affects not only the individual, but has an impact upon the family in various ways. Behavioural outcomes within the subsystem of the family associated with the person experiencing chronic pain has reciprocal outcomes within the family. Pastoral care is frequently directed at the individual. This may be analogous to helping someone who has fallen into a prickly pear bush, by pulling out one thorn. The individual with chronic pain experiences the unfolding process that chronic pain disorders bring, in a world in which various subsystems relevant to the individual interconnect and interact. Pastoral care and counselling need to address these interconnected interrelationships.

In order to attend to this larger context, ideas of Furet (1986); Heitink (1984); Gerkin (1984) and De Jongh Van Arkel (1987) are discussed. Their focus on the kingdom of God is the interest of this study, a focus that this dissertation takes up to present a concept of the inclusiveness of the kingdom of God in pastoral work.

1.4.2. The framework

The aim in the introductory chapter was to give a brief discussion on the way chronic pain was formerly approached, that is, mainly from a linear mechanistic approach. Then, to discuss briefly why pastoral theology needs to find new ways to approach care to people with chronic pain. The problem statement and aim of the study followed, and the argument ended with the theoretical framework considered in the study.

Chapter two enters into a discussion regarding pain and how chronic pain fits into the concept of pain. Instead of viewing chronic pain from the more restrictive view of the pain cycle, I try to paint a picture of the chronic pain experience in the lives of people. The pain cycle tends to be applied in literature in such a way that chronic pain is referred to as an abstract phenomenon, and the tendency is to eliminate the human experience. I use the term chronic pain picture, since I feel that it includes the pain cycle, and relates to the ordinary daily living of individuals with chronic pain. It involves events applicable to people in chronic pain in their living world, and is not centred on behavioural factors only. This is to give some understanding of what chronic pain is, and what living with chronic pain is like.

Chapter three refers to an epistemological shift that takes place. In this chapter a discussion of the various epistemologies, from the Cartesian/Newtonian, family systems therapy, family general systems therapy, to ecosystemic epistemology is applied. A language that applies to the stages of development of the chronic pain process is addressed: a language (metalanguage) which allows for chronic pain to be viewed within an ecological context.

Chapter four discusses the various theories of need. In this dissertation four personality theories are discussed regarding human motivation. Maslow's (1970, 1984) deficiency motivation theory and Frankl's (1978) idea of growth motivation in searching for the meaning of life are frequently referred to.

Chapter five looks into various pastoral care and counselling models and theories. The chapter is a platform for the discussion and conclusions that are drawn up in chapter seven, once the research findings are concluded.

Chapter six discusses the contents of the research methods. The research methodology is described within a qualitative empirical research process.

Chapter seven gives a brief outline of the research analysis and research result findings.

Chapter eight deals with a more detailed evaluation of the research result and the final conclusion of the result findings.

Chapter nine, instead of approaching care to people with chronic pain from only a pastoral care and counselling perspective, gives consideration to the broader approach of a practical-theological ecclesiology of pastoral work actions. It consists of developing a practice theory of pastoral work that applies caring action to people with chronic pain within their relevant ecosystems.

CHAPTER 2

PAIN

The subject of this study is the person experiencing chronic pain. The study is within the field of Practical Theology, and more specifically pastoral care and counselling, with an ecosystemic perspective. Pain is multifaceted, like a diamond cut with numerous surfaces, each with a different reflection. This chapter begins with the phenomenon of pain and its varied perspectives in life. An explanation of the different types of pain follows. The dissertation focuses on chronic pain as one of the facets of pain, that it is discussed more extensively.

2.1. PERSPECTIVES ON PAIN

According to Sternbach (1974:11) the word pain is an abstract phenomenon. He writes: "in this sense the word is like the word beauty, it has no existence of its own, but having an element common to a variety of specific experiences, and ultimately only defined by the experiencer". Pain may occur in physical, social, psychological and emotional situations the human being experiences. Therefore pain can be described in the various forms of the human science languages, e.g. in sociological, psychological, philosophical or medical terms.

Pain has many dimensions. Pain may be very public, but also very private. Throughout history people have attempted to understand what life is about and why situations of deprivation, human struggle and uninvited, unexpected, unfathomable experiences occur. The distresses and insecurities attending tragedies in human experience are potent directives in human lives. Many of these situations of human affliction and misery are unexplicable and remain a mystery (Durand 1994:8).

Modernisation and technological control and progress largely determine the patterns of pain consciousness of today's society, while the modern political world calls for forgetting the past and looking to the future. It removes the experiences of suffering and pain into a frame of mind that tries to obliterate pain from society's midst. Pain and suffering are something not to remember, but rather to ignore, and so they are something not to take

seriously. It is a trend that is readily accepted by contemporary society, since it aids escape from the fact that pain disrupts human existence. The whole trend of modern thinking in society clearly sends a message that awareness of pain and suffering is outside the comfort zone of a progressive society's consciousness (Durand 1994:9; Berger 1977:81-100). Political and social oppression has to do with painful experiences, which contribute strongly to public awareness of pain. The complexities of collective experiences of socio-political suffering reflect the private, personal suffering of the individual. In the process of modernisation and its diverse manipulations of control, society's subtle driving forces promote a view that has no room for pain and suffering. Technological and scientific advances portray success and progress as the essence of life.

Functionality and productivity become the measurement of meaning and success. Pain and suffering are designated a diminutive role of failure and weakness. Technological and scientific advances are rapidly enforcing their control on society, with a sanguine promise of success, and well-being in the general process of living in contemporary society. Advances in medical science convey the promise of new breakthroughs, and convey an expectation of a health-care system that has no limit. Pain and suffering do not fit into such a view of progress and achievement. That which does not fit into the subtle manipulations of technological and scientific engineering of advance and progress is a threat to modern society's utopia of progress and success. From this perspective it would seem normal to attempt to abolish as much awareness of pain and suffering as possible (Berger 1977:100-107; Durand 1994:5-7; Fichter 1981:32-33).

Despite the incredible technological and scientific advances, the world in which the human being exists is filled with suffering, misery and insecurities. Pain has to do with situations of deprivation, situations of need and suffering in general. Pain within human existence in the context of physical, social, psychological and religious environments is difficult to grasp.

Bodily pain is identifiable with a sensation. However, no observer can measure the tolerance of pain as it has no universal measurement. Pain is difficult to describe as it is subjective. The person experiences the pain, but the observer cannot share it at the same time. The pathophysiology of pain and what is experienced as the sensation of pain is not clear. No nerve, nor any stimuli have been found which can produce dependable reports

of pain. The failure to present a sure understanding of the pathophysiology of pain resulted in numerous theories on the perception of pain.

Hanson and Gerber (1990:17) refer to nociceptive stimuli impinging on some specific nerve endings. The interpretation of the perception of the nociceptive input into the brain is what is experienced as pain. The authors point out that this pain cannot be observed directly, but the tissue damage would be observable by diagnostic measurement. Authors share the idea that pain is an unpleasant sensory and emotional experience, associated with tissue damage. Pain is a physical sensory experience that is not separate from the emotional experience (Tunks, Bellssimo & Roy 1990:11-15; Oates & Oates 1985:29; Fichter 1981:32-39; Paterson 1984:17-18; Phillips 1993:14). According to Sternbach (1978:54), Merskey described pain as an unpleasant experience that is primarily associated with tissue damage, or may be described in terms of tissue damage, or both. Sternbach (1974:54) appends an addition to Merskey's definition of pain. He adds the words "and the presence of which is signalled by some form of visible or audible behaviour". Sternbach (1974:11) observed that certain forms of behaviour (such as reflex withdrawal) and physiological changes (such as increased heart rate) are accepted as operational definitions of pain that refer to pain responses. The word pain can be associated with different kinds of stimuli with different experiences and responses. In other words, the observation of various signs that indicate that pain is being experienced, and the knowledge that various stimuli provoke reactions and responses that indicate pain, may provide a limited description of pain. Pain cannot be reified and this therefore limits the description of pain.

A great deal of sociological and psychological engineering is correlated in the phenomenon of pain. Irrespective of what the neural pathway of pain is, a wide range of psychological and sociological responses determine the perception of pain. Pain may indicate various things, such as danger, physical disease, trauma or anxiety. Pain can imply suffering or punishment. The interpretation of pain is dependent on general circumstances, coping mechanisms and the physical state of the person experiencing the pain.

Cultural components in the response to pain may modify or amplify the interpretation of pain. Several studies embrace the view that different cultures and ethnic groups respond differently to pain. A great deal of this is dependent on the learned response to pain, and

how a cultural setting expresses pain. For example, in a cultural upbringing that emphasises stoicism the perception of pain in adulthood may be muted (Bond 1987:31-32).

Bodily pain always includes an associated person. Tolerance of pain is a measure, to some extent, to establish the individual's range of tolerance to a painful stimulus. It is a very subjective and individualistic measurement. An individual's personality is a mark of his or her mental attitude to the experience of pain and it is this that makes each individual unique in experiencing pain. Speaking systemically (the perspective of this study), pain can never be connected to a physical source only, but also holds the implications of emotional, psychological, social and religious essentials. Pain is an experience that envelops the entire person in his/her interconnection with society as a whole. It is not easy to differentiate between bodily pain and mental pain. One could say that they are associates in the pain experience (Bond 1987:31-33; Fichter 1981:32).

The experience of pain has a wide range of manifestations: from temporary to terminal, from the persistent constant to the intermittent, from minor to serious, from the imagined to the genuine. Attitudes towards pain and suffering continue to change throughout the history of human existence. Advances in technological and medical science have changed the perception and expectations of the pain experience. Far greater emphasis has been placed on a cure expectation, from both within the medical profession, and from the general public (Fichter 1981:24-33; Tunks, Bellissimo & Roy 1990:16-22).

Pain, however, remains an experience of the sufferer of the pain. Pain remains a 'thing' and is not tangible, thus making a substantial description or definition of pain difficult. Fichter (1981:26) points out that bodily pain is a puzzle that has three characteristics: "Such pain is perceived by the individual patient as personal, unexpected, and undeserved".

2.2. TYPES OF PAIN

2.2.1. Acute pain

Acute pain seems to be considered as a more direct link between cause and effect. This is why the medical profession is more comfortable with it. The general perception seems to be that acute pain has a meaning to it. Sternbach (1978:243) defines acute pain as: "pain which is of a recent onset, or short duration, is typically associated with changes in autonomic activity, roughly proportional in intensity to the stimulus". Acceptance of acute pain becomes linked to the expectation of a short duration, with cure as its goal. The solution to the puzzle or mystery of pain is medical intervention in acute pain. Hence this kind of pain has a more hopeful outlook for the person experiencing it, and has a higher success record for the medical care team. It becomes a more acceptable type of pain to cope with since there is a more favourable prospect in dealing with acute pain.

Treating acute pain has the added bonus that it brings relief after removing the diseased source of the pain. It gives comfort to the person experiencing the pain. This amplifies the element of achievement. Not only has medical intervention been successful, indicating achievement in the medical sphere, but the person who experienced the pain is grateful and displays this in various ways. Medical intervention in the acute pain symphony is certainly more harmonious to all involved, since it credits the medical care team with congenial acceptance of achievement and success, and fills the person with relief.

Acute pain is described as a warning signal of physical injury or disease (Hanson & Gerber 1990:17). Those who experience the pain can give meaning to the pain as it is an indication to them that something is wrong. The overall pattern of acute pain is that of a crisis (Sternbach 1978:243). Owing to the crisis implication in acute pain, it is usually associated with acute anxiety. However, the anxiety, which may be analogous to a 'panic attack', is usually relieved to some extent by an explanation as to the origin of the pain. The explanation of the origin of the pain gives some reassurance that adequate measures may abolish it. Anti-anxiety manipulations are more effective in acute pain.

As the person experiences relief from the pain, the family life cycle patterns that were exposed to changes during the crisis period return to normal again. The anxieties and discomfort experienced by people with acute pain are of short duration, and therefore more endurable. The duration of the pain is a measurement of the potency of the response to the

pain. Different reactions to the same noxious stimulus are evoked in acute pain (which is short in duration) and chronic pain (which has a prolonged period of duration). The longer the duration of pain, the more problems magnify in coping with the experience (Bond 1987:31-33).

To summarise, acute pain patterns are regarded as:

- of short duration, and more easily controlled
- usually an emergency situation
- a warning signal that something is wrong
- associated with prevalent anxiety, but holding the promise of relief and cure
- giving the satisfaction of achievement, success and well-being

In the conspiracies of social engineering that has constructed a particular view regarding pain and suffering, individuals live in a society where they are constantly in touch with a corporate view of human suffering. Each day they become more prone to share the view of the consensual social persuasions of the society in which they move. To modern society with its sociological finagling exerted to disguise the true realities of pain and suffering, acceptance of the acute pain experience is much more comfortable.

In view of the discussion thus far, acute pain may be defined by combining Merskey's description of bodily pain with part of Sternbach's definition of acute pain. Sternbach (1974:54) writes that acute bodily pain may be defined as follows: "Acute pain is an unpleasant experience which is primarily associated with tissue damage or is described in terms of tissue damage, or both, and of a recent onset, or short duration."

2.2.2. Pain not analysed

There are some people with pain disorders who experience pain, but for whom analysis of nerve activity, causes of disease, and spinal cord changes have revealed no abnormalities (yet they complain of pain). It is apparent from research findings in the complexities of psychological, emotional, sociological and religious conglomerations, pain may develop in certain emotional disorders. This type of pain pattern is not associated with any patterns of

localised tissue or neural pathway damage. It may differ in quality from other patterns of pain that are associated with organic disorder (Bond 1987:31).

2.2.3. Chronic pain

Chronic pain is something which is even more difficult to explain or understand, since chronic pain is complicated by its lengthy duration. It would seem that most literature exploring chronic pain comes to the following conclusions:

- 1) Chronic pain is long-term pain, usually longer than six months.
- 2) Chronic pain consists of complex reactions to a sensory signal, which involves a combination of cognitive, emotional and physical reactions and complex sensory messages. There is greater socio-psychological integration in the chronic pain scenario, owing to the chronic dimension of the pain (Nigel 1984:55-57; Holzman & Turks 1986:4-7).

It may be helpful to classify three types of chronic pain:

- 1) Chronic periodic pain, which occurs with intermittent acute phases (e.g. migraine).
- 2) Chronic intractable pain which is present most of the time in varying intensity (e.g. nerve compression pain).
- 3) Chronic progressive pain which is often associated with certain progressive diseases (e.g. cancer; spinal disease; polyarthritis) (Tunks, Melchenbaum and Genest 1983:75).

I will add to this that chronic pain may be associated with:

- 1) Underlying pathological lesions, which may be actively regressive. In other words, an underlying disease pathology which may slowly or rapidly worsen with time.
- 2) Underlying pathological lesions, or trauma which has healed.
- 3) Conditions where no underlying cause may be found.

The physical perspective of pain, i.e. disease and neurological effects associated with the pain, cannot be separated from the mental perspective of pain, i.e. the mental stress factors. Durand (1994:9) so aptly puts it: "The somatic disharmony thus often leads to mental disharmony". Because chronic pain is a condition which is long-lasting, it robs the person

of physical energy, drains concentration and decreases productivity. Chronic pain exhausts physically, emotionally and mentally. The very fact that it is protracted pain produces mental and emotional pain, and tension accumulated from the mental, emotional pain increases physical pain. Stress is a cardinal factor in chronic pain and makes the endurance of pain more demanding.

In other words, it would be appropriate to say that chronic pain could be thought of as incorporating two kinds of pain: tenacious physical pain (i.e. somatic pain) and "heart pain" (i.e. pain that brings emotional hurt), which develops in response to the consequences of the tedious drawn-out process of chronic pain and its devious intrusions.

It must be remembered that pain cannot be separated from the individual. Pain, suffering and people experiencing the pain are all part of the experience of chronic pain. A concept such as chronic pain is always in jeopardy of being considered a mere phenomenon with the elimination of the human element. Durand (1994:7) illuminates this aspect when he writes: "His/her condition of pain and suffering becomes part of a pain conglomerate challenged by the latest medical invention. The illnesses and the pain that the person has are treated. The fact that it is a very specific person who has these illnesses and pain is incidental."

Usually the chronic dimension of pain is compared with acute pain. An attempt is made to attend to some of these comparisons. All the problems faced in coping with acute pain are magnified in the chronic pain experience. Chronic pain in contrast to acute pain is long-term in duration, usually with no expectations of cure. It may never be relieved, and only the hope remains of controlling the pain to make life more manageable. The outlook for chronic pain is less promising, since it becomes a daily living experience of the person in pain. Instead of providing an incentive for advance and success, chronic pain is a constant reminder that no improvement has been accomplished. The pain becomes meaningless to the person experiencing the pain. Sternbach (1974:6-7) maintains:

The difference between acute and chronic pain experience is that the patient cannot give meaning to the chronic pain. It makes no sense as a warning signal, even when the underlying disease, or pathology can be specified, there may be no effective treatment. In this, pain is meaningless, and does not lead to pain relieving action, as in acute pain.

Chronic pain is a far less comfortable pain to cope with; either by the health-care professionals, by the person experiencing the pain and his/her family, or intimate friends who endure the experience with him/her. It is a pain that persists despite multiple fervent attempts to resolve it. The tenacious nature of chronic pain spurns achievement and progress, and implies failure. Chronic pain implants the idea of the failure of medical progress, in that it has not been able to master it. It conveys failure to the sufferers of the pain in their inability to dispose of it, and to the family and friends in their inability to assist in changing an unpleasant experience. Chronic pain does not bring with it credits of congenial acceptance and praise; neither does it bring consolation and feelings of conquest.

The anxiety associated with chronic pain is not supported by reassurance of the riddance of pain, but instead anxiety takes on a long-term outlook, with all the related pressures and stress of long duration. Instead of a pattern of a short crisis period, and a short disruption of the family cycle, chronic pain ushers in periods of crisis, long periods of adjustments which constantly change and considerable periods of disorganisation of family life.

Hanson and Gerber (1990:18) point out the inter-play that takes place between acute and chronic pain. According to them chronic pain with underlying pathology still holds some assumptions of acute pain for medical personnel. In other words, because there is an underlying disease cause which results in the pain, the sufferer of the pain is treated as though it is acute pain.

I have thus far mainly referred to the medical field and its various perceptions of chronic pain. However, not only medical care is responsible for the view of human suffering that determines attitudes and expectations regarding chronic pain. There is also a great deal of sociological finesse exercised, which has created a view that is not in empathy with the concomitants of suffering linked to the chronic pain pattern. Durand (1994:8) makes a potent point when he said: "Not only did technology provide important tools for social engineering, but it also made it possible to objectivise the process and its concomitant suffering to such a degree that it was robbed of its concreteness." This increases the distress of people with chronic pain as they struggle to come to terms with adjusting to the intrusion of chronic pain into their daily living.

As the focus in this study is chronic pain in the ordinary general daily living of the people experiencing the pain, the emphasis will be on the experiences of these people in their

ecosystemic connections and patterns. The aim of this study is to come to an understanding of the daily needs and struggles of people in chronic pain, and how they feel. Pastoral care and counselling methods that are relevant to the person in chronic pain can be developed once greater insight is gained into the struggles that people with chronic pain experience.

2.3. THE CHRONIC PAIN PICTURE

2.3.1. Introduction

The term “pain cycle” is used in most medical literature. This term generally refers to what takes place when chronic pain occurs and how it affects the behaviour of the person in chronic pain. Some writers broaden the pain cycle to include socio-environmental factors in referring to patterns of chronic pain behaviour. The stress is on the pain and behavioural responses rather than on the person who has the chronic pain.

I prefer to use the term “chronic pain picture” which will include the pain cycle with some of the behavioural patterns associated with it. In the chronic pain picture, the focus will be on the person who has the chronic pain, and a picture will be painted of what people with chronic pain go through in their general daily living. The term chronic pain picture and the chronic pain cycle will be used interchangeably. They are terms that cannot be separated from each other.

While experiencing chronic pain the person must continue to cope with each day’s events, and continue fulfilling a number of obligations of existential living. The longer the duration of the pain, the more the individual is denied the time and opportunity to deal with interpersonal problems, stresses and obligations. Finances, status and perceptions of self are altered by the chronic pain experience. Time management becomes a problem since chronic pain steals physical energy, mental concentration and emotional abilities, with the consequence that time is stolen, since any activity takes longer to accomplish.

2.3.2. The journey of the person in chronic pain through the medical mill

Tunks, Bellssimo and Roy (1990:33) writes:

[when] pain is present the patient feels distressed, lost, increasingly desperate, progressively loses his status as an independent human being, and becomes an object, pushed around from one practitioner to another, subjected to numerous investigations and the discomfort, and distress. Subjected to many painful therapeutic measures, but seldom listened to and understood.

The technological advances of modern medicine have been awesome. Medical science has more to offer in successful cures and relief from disease than ever before. However, it is increasingly realised that medical technology does have limitations. It is also apparent that with the rapid technological progress there is a cost attached that is borne by structures such as:

- 1) The health-care team, who constantly has to consider strategies of mobility in contending with a maze of corridors and huge concrete structures. Coping with higher patient turnover makes a far greater demands on expertise in specialised fields.
- 2) People experiencing chronic pain and their families. As they enter the health-care field, they feel they have landed on a conveyer belt which sweeps them into a world of medical apparatus and coloured lines to follow, where words are used to the minimum. This hurried, emotionally sterile atmosphere is all in the name of professional efficiency. There is a loss of human sensitivity, supportive informative explanation and caring physical contact. The compassionate, empathetic elements of human care are lost or are restricted to the bare essentials. This often brings about a dehumanised emotionally void relationship between the medical profession and the person in chronic pain.

The emotionally devoid, depersonalised atmosphere of the health-care institution and its high technological industry is fearsome to the person in chronic pain, as he/she is swallowed up into a labyrinth of computer data and codes, diagnostic designations and seat allocations. It is disconcerting to the person in chronic pain that while the health-care establishment is concerned with the challenge of the condition of chronic pain, the person is often disregarded. The right to be considered a human being with a specific personality has been lost in the objectification of pain. The person in chronic pain experiences the indignation and hurt of depersonalisation in the experience of living with chronic pain and its consequences (Durand 1994:6-9; Tunks, Bellssimo & Roy 1990:33-34).

The person in chronic pain is often subjected to various diagnostic measures without being given a clear informative explanation. The expectations and complexities of living with chronic pain and the inclusiveness of physical, sociological, psychological, emotional and spiritual elements are not always clearly rationalised and may be misunderstood by the person with chronic pain.

Oates and Oates (1985:22) appropriately state the fact: "...that it is psychologically caused is often interpreted by the patient as an insult to their credibility....their self-esteem is at stake". In the confusion people with chronic pain become more focused on bodily functions, and become convinced that they have a disease which cannot be diagnosed. Pushed from pillar to post, people in chronic pain become increasingly convinced that the medical profession is incompetent. The end result is considerable conflict between the person with chronic pain and the health-care services. Sternbach (1974:9) points out that it is this lack of understanding which brings the person in chronic pain to bitterness, anger and mistrust towards the medical profession.

There are numerous disrupting intruders which invade the lives of people with chronic pain and produce confusion and disappointment. The individual has not asked for the health-care giant and its industrious manipulations of control into his or her life. Anger becomes the natural response to the disappointment of loss and impending loss of control in various areas of the person's life. Frequently anger is displaced towards the more concrete aspects of the chronic pain person's living environment (on more secure grounds of living) such as the home. However, it is anger that feeds conflict and scepticism between the person in chronic pain and health-care personnel.

The consequences of technological control and consciousness of success often fashion an attitude where mutual responsibility is discarded. In this atmosphere pain is objectified and loses its concreteness, leaving the individual experiencing the pain with the sole responsibility for his or her pain. This abandonment serves to insulate the individual within the health-care intricacies, as the person in chronic pain feels inequitably managed as a human personality (Durand 1994:8,9).

2.3.3. Role changes and expectations

Socio-psychological and emotional dynamics are evident in the consensual social domain of the family life cycles. Role changes and expectations have an intrusive effect upon the family's interrelations. The individual with chronic pain is born into a family that in turn lives in a society. Every society forms its own code of values, rules and norms. Conformity to the expectations of these norms is part of identifying with the society lived in. The family is confronted with specific expectations and expected responses associated with specific values, roles and norms of society. Deviance from these norms increases pressure on the family as the society's expectation is that norms must be observed, although these role expectations are not so constrictive that they do not allow for some leeway. The individual or groups are, however, expected to remain within the parameters of the norms of specific roles. For example, two students may differ in their motives for studying, but as long as they remain within the parameters of the role expectations of a student they will have complied with society's norms (Berger 1977:111-112).

In the family structure occupation is usually linked to the role of the provider. Usually the provider of the family is the father. Society has been undergoing rapid change of late, but it has not changed radically enough. The reversal of roles within the family still implies a deviance from society's expectations regarding correlation between the roles of head of the home and provider. Change of work or loss of work is a frequent occurrence in the experience of chronic pain. If the provider of the family is disabled and pensioned with chronic pain, the emotional and psychological pressures of the role reversal in the family may be burdensome and relationships within the home may be severely tested.

It is to be remembered that roles involve specific actions to which emotions and attitudes belong. The actions of the provider of the family assume recognition of his or her authority and status as head of the home. Role acceptance in society is a learned process. The role shapes the individual and patterns actions to the expectations of the rules and norms of the society within which he or she moves. An identity is attached to the learned process of role expectation, and society gives recognition to the individual identified with the role. Usually the father provides for the family and is looked up to by his family, and his friends and associates in society acknowledge his status, since he fulfils his responsibility of the role's expectations. The intrusion of chronic pain upon the family is disruptive as the family is plunged into the uncertainties of coping, not only with loss of

work and consequent financial straits, but also the insecurity of the loss of role identity. Changed values and beliefs associated with identification with the role become a difficult process to adjust to within the family (Berger 1977:113-116).

Tunks, Bellssimo and Roy (1990:60) note that: "...with the inability to return to the premorbid state the patient now has a new set of obligations, but society at large, which includes the family, may have different expectations which may give rise to various tensions and hostilities". An attempt has been made to give some idea of the power of chronic pain to disturb the family's life patterns.

2.3.4. Stigmas and labels

Stigmatisation and labelling usually occur at some stage of the chronic pain process. Physical disability is closely associated with chronic pain and carries its own stigmas and labels. Disability will be discussed under the heading of stigmas and labels.

Oates and Oates (1985:25-26) point out :

Of intense pastoral concern is the degree to which the pain suffered renders the person incapable of doing regular work or causes the person to lose confidence in the ability to do regular work. Lurking in this issue is the persistent question whether dislike for, disenchantment with, or positive desire to malingering preceded and contributed to the pain syndrome or whether the pain itself eroded the person's ability and confidence as a working member of society.

It is an interesting point made by these authors, that this issue always holds the constant lurking suspicion as to the genuineness of the pain. Attitudes are intricate determinants in applying labels and stigmas. Oates and Oates (1985:22) noted that: "the fallacy underlying this bad miscommunication is the old mind-body dualism in the heads of both scientists and lay people."

Fichter (1981:36) in his research investigating the attitudes of hospital staff to persons in chronic pain, found that there was considerable lack of compassion, empathy and tolerance towards the person in chronic pain. He writes that medical doctors become frustrated with some patients in chronic pain. He recalls one physician who referred to these people as a subgroup whom he maintained were psychologically sick and needed a psychiatrist. Many

attitudes are due to generalisation and objectification of the chronic pain phenomenon. Parmenter (1988:10) suggests that society uses various processes in making social definitions, and included in this process is collective rule-making, interpersonal reactions and the organisational process.

1) Collective-rule making.

Collective-rule making implies that social order is obtained and maintained by “construction of a system classifying human existence” (Parmenter 1988:10). The aim of categorisation, according to Parmenter, is simply to “discriminate among classes of things”. However, the writer points out that the result is conformity to the categorisation, and the individual is put under pressure to conform to the expectations of the classification.

2) The context of interpersonal relations.

In developing a social identity or stereotyping, the intention is to assign meaning to specific categories identified, to know how to behave towards the person. For able-bodied persons, this categorisation “simplifies their interaction with people who are handicapped” (Parmenter 1988:11).

3) The organisational context.

Bureaucracies are employed in society specifically to provide services to specific groups. The anomalous position of those with disabilities results in deviant behavioural properties assigned to such persons. Disability is usually associated with the chronic pain disorder and the stigmas and labels attached to the disabled are also carried over in attitudes towards the person in chronic pain. Literature on chronic pain deals rather scantily with the dimensions of disability experienced by the person in chronic pain. A considerable amount of literature addresses disability associated with chronic pain, as caused by the chronic pain. In other words, increase in the pain increases the disability, decrease in the pain relieves the disability. Little is said regarding disability which is due to underlying disease, or trauma, which increases pain. Decreasing the pain will not relieve the disability.

Parmenter (1988:14) refers to the process of labels and categorisation: “...labelling and categorizing people is a normal process of apprehending and organizing our world. Of

more importance is how we label (people) and with what consequences". The writer points out that disabled people have two issues confronting them, one from outside, which comes from the social order, and the other from inside. The suggestion is made that disabled people have to cope not only with their personal physical condition, but also with the negative effects of stigmatisation, and stereotyping. The conflict between these two aspects frequently causes unconquerable problems for the individual. It needs to be recognised that chronic pain associated with an underlying progressive disease brings with it a threefold problem for the person in chronic pain, namely:

- 1) A chronic disease which may be the cause of the chronic pain and disability.
- 2) A disability.
- 3) Chronic pain.

The individual with chronic pain associated with disease has major adjustments to contend with in coping with stigmas and labels associated with the three above-mentioned elements. Interpretations based on generalisations in the process of categorisation are made by people who themselves are from different socio-environmental backgrounds, therefore categorisation will seldom be totally free from attitudes of bias and prejudice (Fichter 1981:36; Hanson & Gerber 1990:17-19; Tunks, Bellssimo & Roy 1990:98). The person in chronic pain has to cope not only with living with persistent aggravating pain, but also with aggravating circumstances, such as being labelled and stigmatised in various ways.

2.3.5. Homebound

Literature on chronic pain discusses factors such as isolation and loneliness, but hardly any literature analyses the implications of the person in chronic pain becoming homebound at different stages of the chronic pain process. The person in chronic pain may be homebound for a number of reasons. Some with disabilities may become partially homebound owing to environmental circumstances, such as inaccessibility of a place, or facilities that are unavailable. For example, a convention campsite that has steps makes accessibility by wheelchair, or walking aids, difficult. Toilet facilities that are confined, or steps that have to be breached to gain entry, or a church that has an entrance that does not

allow the use of wheelchairs, are all examples of lack of consideration in architectural design.

Frequently the actual underlying disease may regress and confine the person in chronic pain to his/her home. Certain chronic diseases, such as polyarthritis, have periods of acute 'flare up' that require bedrest for the acute period. Some degenerative diseases of the spine or bone regress, and intervention surgery is required with long periods of recovery, limiting the mobility of the person during this time. Literature supports the fact that many persons in chronic pain enter into the 'sick role' and are homebound. Withdrawal and isolation of self may occur (Hanson & Gerber 1990:22-23).

Ellor and Tobin (1985:12-21) say, in the article titled *Beyond Visitation: Ministries with the Homebound Elderly*: "Visitation ministries to the sick and the shut-in reflect on the old approaches used by clergy and laity to address the needs of the elderly." The writers point out that there are numerous needs to be met that go beyond visitation. The homebound person's world tends to shrink, especially if he or she is confined for prolonged periods. As the person loses more and more contact with the outside world (i.e., the world outside the home) there is the frightening prospect, or fear, that mental decay will set in.

With regard to periods of homeboundness in the chronic pain process, much needs to be discovered as to what takes place within this realm, for example, how the person in chronic pain feels about the limitation of being homebound, and what needs occur during this time. This aspect will be included in the empirical research phase of this study, to gain insight into needs within this area of the life of the person in chronic pain. Homeboundness must affect the person in chronic pain, as it is closely connected with self-concept factors.

2.3.6. Losses occurring in the chronic pain process

Manzuik (1993:50) points out that people living with chronic pain deal with numerous losses, namely the confusion of the chronic pain process, the labels and stigmas attached, the related disabilities and the possibility of stages of being homebound. It is obvious that within the chronic pain experience there are losses which the person with chronic pain has

to cope with. In this study only a few main problematic losses will be addressed regarding the chronic pain experience.

2.3.6.1. Losses which occur in association with stress

Stress is a common factor in the life of the person in chronic pain. There is no chronic pain experience that is stress-free. According to authors writing about chronic pain it is clear that where there is pain, there is stress, and where the pain takes on a long-term chronic nature, stress factors increase and accumulate (Turks, Flor & Rudy 1987:4-5,16).

Work loss, or change in work, and its economic influence upon the family has already been mentioned. Fichter (1981:36) writes that “in its chronic pathologic form, pain is a malefic force which often imposes severe emotional, physical and economic stress on the patient, on his family, and on society.”

Losses that occur within the process of stress may give rise to conflict and strained relationships. Conflicts that are not resolved strain relationships and make family dysfunction probable. Emotional distress, if not dealt with, increasingly results in anger, bitterness and hate, with an outcome that may be detrimental to people in chronic pain, and to those in close interaction with them. The losses occurring in these events rob the person of peace, joy, reciprocal relationships and meaning to life.

Manzuik (1993:50) says that “most feel a deep isolation, if not abandonment, by friends and family, and often by the church as well”. Fichter (1981:62-63) refers to the struggle of people in chronic pain in their relationship with God, because they feel cheated, and their suffering lacks any meaning. They rebel, their relationship with others suffer and they feel lonely.

The family and friends may also endure similar stresses due to the changes in life-style and in their interaction with the person in chronic pain. Changes may occur in family and friendship situations which stress relationship values, that may anger, cause bitterness and withdrawal. The result of this may be the isolation of person in chronic pain and the loss of valuable relationships. It will suffice to quote Turks Flor and Rudy (1987:4,16-17): “Despite the wealth of literature on the importance of families in considering health and

illness in general, when chronic pain problems are considered, the role of the family has largely been ignored.”

2.3.6.2. The self-concept

Hanson and Gerber (1990:99) suggest that often the concentration is on the pre-morbid state, which makes the post-morbid state more difficult to accept, and they say that because of the difficulty due to physical limitation chronic frustration and irritability occur. The writers refer to the cycle of alternating between under-activity and over-activity, that frequently occurs when persons in chronic pain attempt to deny their physical limitations. Under-activity leaves a feeling of lack of accomplishment, or purpose in life, and this is compensated for by increasing activities to extremes, which increases the pain (Hanson & Gerber 1990:101-102)

These factors challenge the self-image of the person experiencing chronic pain. Limitation of activities, restriction of the physical body and the outcome of these problems often result in loss of status and dignity. The person in chronic pain may eventually experience loss of authority and status within the family. Changes in position at work or loss of employment may be devastating in that dignity is lost, so that trust and confidence in the self may be destroyed.

Another label may be given to the person. Instead of Managing Director, Headmistress, Sister, the person may be referred to as a disability pensioner. For many people this may be a considerable blow to the self-image. The person in chronic pain frequently has to develop new goals regarding work, or work-like activities (Hanson & Gerber 1990:109). Some people may resort to the sick role in an attempt to cope with the inability to return to the pre-pain status. Attempting to make the sick role a substitute for the loss of status, however, complicates the situation, since its outcome is that of further loss, the loss of independence (Hanson & Gerber 1990:22-25).

People in chronic pain enter a health-care environment that is foreign to them; an environment that may be very frightening and full of insecurities. Suddenly there are rules to obey, and the right to make a choice is taken away from the person. The significant others (health-care team) have control, and the people experiencing chronic pain feel that they have lost mastery over their lives (Tunks, Bellssimo & Roy 1990:60; Brown

1988:269). The health-care environment is frequently experienced as intimidating by people in chronic pain and their families, often because the hospital environment with all its hustle and bustle is an unknown field for these people.

The response to this loss of mastery and the consequences of the loss of the right of choice are illustrated in the following quotation from Felske (1988:269):

A young quadriplegic man, recently disabled, attended a planning conference at the auxiliary hospital in which he was residing, hoping to plan to move to independent living. Seven professionals from different medical specialities attended and discussed his condition for two hours. He was never asked for an opinion or his concerns during the conference. At its conclusion the man stated loudly to his nursing aid that he would never again attend a case conference.

Felske (1988:269-271) points out that the person and the family enter the rehabilitation process with their interest oriented towards their needs as family members, while the professional services involved work within a "universal framework as a diagnostic guide." However, the individual and the family read this generalisation as a lack of interest, and the feeling of being depersonalised results. In this area of different frames of reference, many conflicts may arise, conflicts that remain unresolved and may cause hurts, damage the self-concept, and interrupt the adjustment to independent living. The person in chronic pain and the family may be left with the feeling that they have been stripped of their dignity and have lost control of making choices of their own.

The unpleasant stress of unresolved conflict and distressing relational interactions make the maintenance of a healthy self-image very difficult for the person in chronic pain. This study is from a systemic perspective, and the elements of relationship conflict illustrate the necessity of considering people in chronic pain within their ecostructures. The person in chronic pain does not live in a vacuum, but exists within relevant relational interacting, connected structures which are interdependent and from which recursive patterns occur. The inter-activities within and between the relevant ecostructures make up the chronic pain picture in the chronic pain experience.

2.3.6.3. Depression, anxiety and fear

Depression is a common factor in the life of the person in chronic pain. Owing to the emotional turmoil and mental distress involved in trying to cope with all the changes, losses and adjustments, a reactionary depression often occurs. Changes and adjustments may be physically exhausting to the person in chronic pain when trying to cope with living with persistent pain. Physical exhaustion can never be separated from the psychological and emotional elements, since a tired body influences mental and emotional competence, and vice versa. Mental judgement becomes affected and emotional control impaired, which may mean considerable mental fatigue and emotional hurts for the person experiencing chronic pain. The family to whom the person in chronic pain belongs, and those in close relational contact with the person in chronic pain, are not free from mental and emotional turmoil. They are in close association with the person who is suddenly experiencing periodic loss of coping abilities, and it is stressful. It must have its repercussions on the family. The family members and close friends, in their interaction with the person in chronic pain, may at times project their own mental emotional instabilities upon the person experiencing chronic pain.

Oates and Oates (1989:97,98), in discussing the elements of anxiety and fear of meaninglessness that is part of the daily living experience of the person in chronic pain, ask:

Does pain destroy usefulness, disable, and impair the person? Much of the meaning of life comes from work, and a large number of chronic pain patients are on disability. Does the pain itself become the central meaning of the person's life? Or, if the person continues to work, does the pain take the joy, zest, and creativity out of the work and produce so much fatigue that little or no energy is left for play? How does the pain syndrome prejudice major decisions and skew the meanings of relationships with family, co-workers, and friends?

Associated with anxiety and fear are the elements of guilt and condemnation. Constant misunderstandings occur in the chronic pain experience, which leave the person with a constant struggle with feelings of guilt. Added to this is the perception associated with suffering, that of punishment and sin, which leaves the person in chronic pain feeling judged and condemned. The fears and feeling of being unloved, alone, forgotten, losing

personal identity in the throes of the struggle to adjust, are part of the life of the person in chronic pain.

Fear and anxiety are existential. Oates and Oates (1989:98) point out that the various forms of anxiety are essential in that they belong to existence as such, and not to an abnormal state of mind as in neurotic (and psychotic) anxiety. Intertwined with this anxiety are the elements of anger, bitterness, loss of dignity, right of choice being taken away, and a general feeling of being belittled. These are living existential experiences in the daily living of people in chronic pain as they interact with relevant ecosystemic structures. It is these elements of emotional hurt that shatter trust in self and others, and have an impact upon relationships. Disturbed mental and spiritual peace may result in sleeplessness.

Oates and Oates (1989:98,99) refer to Sternbach who says that 'depression is associated with the consequence of these, in the form of intropunitive anger, or mourning.' Oates and Oates (1989:99) write that besides anger at oneself, and mourning losses, depression also presents as feelings of helplessness and loss of control. It may not stop at a reactionary depression, and if left unchecked, it may slide into a clinical depression, or into suicidal tendencies. The coping mechanisms of the person in chronic pain become drained, his or her perceived world is distorted by despair and despondency, and poor judgement in perception and action takes place. Decision-making at such times may become a nightmare experience. Yet it is frequently at such stages that the person with chronic pain must make decisions with important consequences.

These frightening experiences of mental and emotional turmoil and despair have an effect upon the perception of the physical pain, and increase the experience of pain. The physical body is affected since sleeplessness, stress, increased muscle tension and increased muscle spasm increase the pain. This may start a pain cycle: muscle spasm increases pain, pain increases muscle spasm, causing a higher level of pain.

2.3.7. Understanding God

As there are many theories regarding the chronic pain experience, so there are abundant theories of suffering in the context of a relationship with God. They vary from one theological tradition to another. The Pentecostal attitude is one of rejoicing in that God

can heal anyone who is suffering, because he wants all to be well. Judeo-Christian history expresses that suffering is accepted joyfully (Fichter 1981:17).

Fichter (1981:20-21) in his discussion of the meaning of suffering as a religious reality suggests that there is a slowness to admit that suffering goes beyond human comprehension, that it remains in the realm of mystery. However, because this is a mystery which becomes related to God, the religious believer has to find a way to defend God's goodness and omnipotence in the face of universal suffering and inexplicable pain (Fichter 1981:43).

The person experiencing chronic pain faces the paradox of a good and provident God, and pain experienced in a world God created (Fichter 1981:44). All sorts of questions surface : why? How can God allow this? God's sovereignty is questioned. On the other hand, there is the teaching that God is disciplining, or punishing sin in the life of the culprit (Ohsberg 1982:27-29).

The person often feels judged and guilty, because preconceived ideas surface (for example, God must not be questioned, and we, his creation, may not be angry with God). These preconceived views with regard to the subject of pain and suffering, and the relationship values between the believer and God, may cause considerable conflict for the person. Viktor Frankl (1978:67) writing on the suffering of Jews in the Nazi concentration camp centres on the point that despite incredible human suffering and degradation, some found the means to endure such suffering. He maintains that humankind is in search of meaning in life, and if they can find meaning in a situation this will carry them through it, despite the great odds against them. How humankind accepts suffering will direct their attitude towards life.

The way in which a man accepts his fate and all the suffering it entails, the way in which he takes up his cross, gives him ample opportunity - even under the most difficult circumstances - to add a deeper meaning to his life. It may remain brave, dignified and unselfish. Or in the bitter fight for self-preservation he may forget his human dignity and become no more than an animal.

(Frankl 1978:67)

Pain and suffering should not, however, be idealised. To consider sufferings to be mechanisms of healing growth, and to laud them is misleading. Durand (1994:9) writes:

“The concept that suffering is always ennobling, and talks about the healing power of pain and the enhancement of the moral elements in life through redemptive pain can be misleading.” The capacity to be human is also the capacity to endure suffering, and it is this which gives the capacity to identify with the grieving of others, and the ability to empathise with fellow humanity. Frankl (1978:120) asks the question:

Are you sure that the human world is a terminal point in the evolution of the cosmos? Is it not conceivable that there is still another dimension possible, a world beyond man's world in which the question of an ultimate meaning of human suffering would find an answer?

The obvious trend to these questions is that ultimate meaning is found in a future life, in which the mystery of suffering will be made clear and understandable. In this, a goal for suffering may be found (Fichter 1981:21). Life and hope is not based on the here and now experience, but on a far wider experience. Frankl (1978:72) refers to the challenge that real opportunities in life never stop but each situation is an opportunity of challenge:

Varying this, we could say that most men in a concentration camp believed that the real opportunities of life had passed. Yet, in reality, there was an opportunity and a challenge. One could make a victory of those experiences, turning life into an inner triumph, or one could ignore the challenge and simply vegetate, as did a majority of the prisoners.

In journeying through life, evidence of suffering is encountered. Fichter (1981:25-27) refers to suffering that may be self-inflicted, such as a hangover after a drinking binge. However, chronic pain, like so much other suffering in life, is something that people in chronic pain have not wished upon themselves. Fichter (1981:26) refers to it as a puzzle, that may be perceived by the person suffering from chronic pain as personal, unexpected and undeserved. The fact that the very element of pain is inexplicable and a mystery in relation to God gives rise to questions and conflicts for the person with the condition of chronic pain. Persistent pain also has the effect of wearing the person down. Wear and tear on the mind, emotions and body may often result in faith in God being severely tested. These people look for answers to try to find some meaning in what is happening to them. Perhaps the element of questioning and seeking an explanation is a necessity, for often it may result in the person seeking the ultimate meaning to life.

However, this search for the meaning of life may not be without great conflict of emotions analogous to a roller coaster ride. In trying to find an explanation for the experiences encountered in dealing with chronic pain, the person frequently experiences emotions of guilt, anger, sadness and aggression. At times the very experience of trying to gain some understanding of the chronic pain experience may result in the person turning away from the ultimate meaning of life. The person may try to find some other meaning, or disregard any meaning at all to the pain experience, and see no goal for the future.

The Christian faith's focus is hope, which is life itself in that Jesus Christ gave his life for humankind. In Christ, humankind may have life that continues to give hope that extends into eternity and is fulfilled in eternity. There is every possibility that the chronic pain experience may become one that is made more endurable in view of the eschatological nature of ultimate meaning.

Oates and Oates (1985:120-121) point out that "the integrity of people in pain is tested mightily by the persistent pain they suffer." Oates and Oates furthermore write that temptation becomes a struggle in the experience of the life of the person in chronic pain. They quote Dietrich Bonhoeffer: 'This is the decisive factor in the temptation of the Christian, that he is abandoned, abandoned by all his powers - indeed, attacked by them - abandoned by all men, abandoned by God himself... The man is not alone in his temptation.'

Oates and Oates (1985:122-123) refers to temptations that may occur, such as:

- the temptation to give up, and to give in during the experience of intractable pain, those giving in to the pain cease to believe that they can direct their own destiny
- the temptation to play god not only in their demands of others, but also the temptation to expect others to be perfect
- the temptation to make pain one's God, to allow the pain to control one in every aspect of living, and become the centre of life

In the process of trying to gain some understanding in relation to God in the chronic pain experience, there is much mental and emotional conflict. From situations of conflict, needs increase, and it becomes more urgent for the needs to be relieved in some way, or

meaning to be brought into the situation, where the need cannot be relieved (Paterson 1984:26-29).

2.3.8. Conclusion

It should be obvious by now that this study concentrates on the “normal picture” of the chronic pain experience, with less emphasis on the person with psychiatric disorders with chronic pain. *The focus is the normal general pathway of the chronic pain experience*, and its impact upon people experiencing chronic pain and their interacting, interrelating ecostructures. *My focus is primarily on the person in chronic pain as an individual* who is experiencing the condition of chronic pain, and on *how pastoral care may be applied effectively* to these people, within their experiential living.

In the empirical research I will try to ascertain the feelings and the needs of the person in chronic pain. The sociological, psychological, emotional, spiritual and physical elements cannot be separated from one another, or be exclusively responsible for needs arising out of the chronic pain condition. The emphasis of this study is intended to relate to chronic pain with underlying pathology, that is, an underlying progressive disease, or post-trauma. There will be needs which will apply more specifically to persons in chronic pain who have an ongoing disease, that will not be explicit in the person without an underlying disease. The individual who has nerve compression due to degenerative spine disease; the polyarthritic may at times move into a more acute phase. In these cases considerable pain management is specifically related to the underlying disease process. It is the changes in the chronic and acute phases that change the pattern of the chronic pain process and will present more specific needs. A later chapter will follow with a discussion of language use in an ecosystemic perspective of chronic pain.

This study will focus on the types of chronic pain that are associated with:

- 1) An underlying disease source which is regressive in nature and expectations, and where intervention treatment is required to address the disease in its regressive stages, but where cure is not the outlook.
- 2) Lesions that have healed, but owing to damage caused by the trauma, chronic pain develops.

I would like to make it clear that I am not disputing the reasoning that pain, where no lesion may be found, is genuine pain. These individuals must be included in any pastoral care given to people in chronic pain.

CHAPTER 3

AN ECOSYSTEMIC PERSPECTIVE AND THE PERSON IN CHRONIC PAIN

Chronic pain is usually viewed from the perspective of the medical paradigm that is traditionally reductionistic and individualistic in approach. This is, however, a study from an ecosystemic perspective, because I believe a broader scope is needed to understand the condition of chronic pain. It is more than an approach. It has to do with an epistemological stance. The shift in epistemology that has taken place over the last few centuries is briefly referred to in this chapter. Some ideas of language use are considered to accommodate the chronic pain experience, since the adaptation of language is an important consideration in the ecosystemic perspective. However, it is appropriate to first define epistemology.

3.1. DEFINITIONS OF EPISTEMOLOGY

Auerswald (1987:1-2) refers to a dictionary definition of epistemology, “....the study, or a theory of the nature and grounds of knowledge.” Auerswald reasons that, “....knowledge consists of information based on prior thought”. He concludes that another way to define epistemology could be, “....thinking about thinking”. Auerswald considers epistemology preceded by ‘an’ or ‘the’ as Bateson used it. Used in this way epistemology is defined as “....a set of immanent rules used in thought by large groups of people to define reality”. Van Staden (1989:36) refers to epistemology used in philosophy as: what knowledge is and how we know.

3.2. HISTORY OF THE EPISTEMOLOGICAL SHIFT

The shift in epistemology that has taken place throughout history, from the 16th century, is briefly as follows: The 16th and 17th century ushered in the idea of an absolute point of view of mathematical calculation and scientific observation. Heaven and earth joined forces in following universal and regular law. Galileo provided evidence, increasing the

conviction that there is no distinction between the heavens and the earth. These findings threatened the beliefs of the church, as they challenged the then current concept of heaven as a superior and ideal force.

The Cartesian revolution commenced with Descartes (1596-1650), who maintained that only knowledge that cannot be doubted can be believed. Descartes introduced the idea of natural laws of mechanics, and that the human, distinct from the animal kingdom, has a mind that is separate from the body.

Newtonian/Cartesian thinking dominated the 19th century, and still influences the 20th century. Newton (1642 - 1727) described mechanical motion mathematically and asserted that it applied universally. The principles and methods used to explain and study physics were also used to study human behaviour. The individual is the subject matter in such thinking. The individual is considered a whole consisting of parts. This kind of thinking is very mechanistically oriented, and it so dominated Western scientific explanation that to think in any other way was difficult. Such thinking contained a rule of monism, and a rule of dualism. This demanded that a theory be either true or false (De Jongh Van Arkel 1987:60-65; Keeney 1979:118-120; Auerswald 1987:322).

Darwin's theory of evolution was introduced into the mechanistic reductionist paradigm of Newtonian thought. Evolutionary theory fitted into Newtonian methodology and did not revitalise scientific thought as such. Planck and Einstein laid the groundwork that brought a new view into the Cartesian/Newtonian view of physical reality. In 1900, Planck proposed the theory of the quantum as a unit of energy. Einstein presented his theory of special relativity and followed this with the general theory of relativity. These theories later evolved into a new paradigm in physics (Auerswald 1987:322-323).

The new physics became a basis for other science disciplines. The outcome of this new science was that a new set of rules were developed to define a universal reality. Auerswald (1987:323) says, "...they could serve as the basis for a new epistemology". The Newtonian reality system lost its predominance when the new science rules appeared. The latter contained both new science and Newtonian epistemologies, which means that Newtonian science was not discarded, but rather included into the new epistemology, as a paradigm. Auerswald (1987:323) writes: "...the new science epistemology contained a rule of monism and a rule that truth be defined as heuristic. The rules demanded a both-

and, rather than an either-or perspective, and they endowed both the Western/Newtonian and the new science epistemologies with the status of heuristic truth”.

According to quantum theory it is not possible to observe reality without altering what is observed. The observer becomes incorporated within the world observed. This new science or new epistemology served to form the basis of systems thinking. To think systemically meant moving away from the usual mechanistic application to human behaviour. Systems thinking sees the individual, according to Schultz (1984:56) as “...a part of a larger whole rather than as a whole in itself”.

Ecosystemic epistemology evolved from systemic perspectives. According to Van Staden (1989:36), Dell refers to the systems approach: “...as an epistemology of organized pattern, such that one cannot talk of discrete elements exerting force on another in a Newtonian fashion. It is a systemic epistemology that subordinates elements to organization of the whole pattern.”

3.3. ECOLOGICAL SYSTEMS PARADIGM

Auerswald (1987:329) states: “The ecological systems paradigm is more than a paradigm. It is an epistemology, a new system of thought rules used to define universal reality.” Keeney (1979:118) discusses Auerswald’s view that any therapist has an epistemological base from which he/she works. He refers to three categories of epistemological viewpoints : 1) traditional linear epistemology, 2) ecological epistemology, and 3) those who are in transition from the former to the latter.

Dym (1987:36) points out the lack of ecosystemic models in the treatment of physical illness. He says that “the global generalisations of the holistic health movement often focus on individuals and the general ecology, but omit family and community.” In view of what has been discussed this far, it is clear that ecosystemic thinking is an altogether new way of thinking. Ecosystemic epistemology moves away from an atomistic and reductionistic approach, which is anticontextual; where the whole consists of constituent parts. Keeney (1979:118) says about ecosystemic epistemology, that it: “...emphasizes ecology, relationships and whole systems....it attunes itself to interrelation, complexity, and context”.

Van Staden (1989:50) quotes from Keeney and Auerswald, and defines the ecosystemic paradigm as follows: "Ecology is the study of the complex interrelatedness of things in nature, including humans (Keeney, 1984). The ecosystemic paradigm evolved from the study of a segment of this interrelated living universe, namely, from the study of human interactions systems in the wider socio-cultural context (Auerswald 1989)."

These movements in science started a general trend towards a systemic viewpoint and slowly evolved into an ecosystemic perspective. Each scientific discipline is at a different stage in developing ecosystemic thinking. Practical theology has used systems theory and is in the throes of developing ecosystemic perspectives into pastoral care and counselling.

3.3.1. A relational network

As previously stated the proposed pastoral care and counselling in this study are ecosystemic in perspective. This means that the individual is seen as part of a larger context. This larger context embraces the idea of a number of elements that are connected to form a whole. These connected elements are properties of the whole. The integrated whole is not that of smaller units, or constituent parts, but rather that of interrelating, interdependent dynamic teleological elements incorporated as a whole (De Jongh Van Arkel 1987:206-207).

In the systems approach, the functioning of people is understood in terms of their own interactions, and interactions within a larger context, or system. These interrelations and interconnected interactions are circular in action. It is these elements that make pastoral care and counselling systemic in approach, and not the multi-persons factor. It is the interrelations between the interdependent actions of connected parts and the recursive patterns of the whole that place the problems addressed by pastoral care into a different light. They change the perception of the phenomenon observed as well as provide ways of observation (De Jongh Van Arkel 1987:208-213).

Keeney (1979:119-120) defines a system as a cybernetic framework that processes relevant information. Incorporated into the idea of a relation network is a feedback structure of information. Usually two types of system are encountered, namely:

- the closed system, which usually applies to a laboratory setting that is isolated and independent of its environment

- the open system; human and social systems are usually open systems, and enable growth due to their interaction and connected interrelations, and interaction with their environment

3.4. AN ECOSYSTEMIC PERSPECTIVE APPLIED TO CHRONIC PAIN

The socio-cultural system that is relevant to the person in chronic pain is an open system of human relationships. Ecosystemic thinking evolved from the general systems paradigm developed in family systems therapy. A simplistic explanation of systems theory is that the system is the whole, the parts within the system are called subsystems, and everything outside the system is referred to as the environment (Schultz 1984:59). An ecosystemic perspective addresses the system (e.g. the family) in a larger context (i.e. society). The person in chronic pain lives within a family context that may be called a subsystem. Relevant subsystem structures in the experience of the person in chronic pain may be considered to be, 1) the health-care institution and its relevant helping services, 2) the church and its pastoral work disciplines, and 3) social groups that include friendship circles, colleagues and related personal supportive social activities. Interaction takes place within the whole. The system exchanges information with its environment. Relevant to the person in chronic pain, the environment may be considered to be the political and economic structures of society.

3.4.1. Cybernetics

Cybernetics is often used interchangeably with general systems theory. Cybernetics form a relational network between subsystems and subsystems. Recursive patterns of interaction take place between the subsystems and the system, and with the environment. Cybernetics has to do with how systems are regulated, i.e. changes that occur, and that which remains static within the system. A flow, of information, back-and-forth occurs in the system in circular motion (Schultz 1984:60).

The person in chronic pain interrelates and interacts within a family. The individual and his/her family interact with the health-care services, the church and social circles. These interactions with the relevant connected subsystems occur within a relationship of interdependence. Behavioural actions and reactions have an impact upon the whole socio-

cultural system. The interactions within the system between the relevant subsystems influence the whole, which in turn, results in feedback and influences the subsystems. In other words, behavioural interaction takes place between the individual with chronic pain, the family members, the health-care services, church contact and the relevant social influences. The socio-cultural system and all involved are influenced by reactions in the relational interactions. The reactions constitute negative or positive feedback. Negative feedback maintains a status quo within the systems network, and positive feedback (unbalance) leads to continuous change in the system, which may reorganise (correct) or threaten the system (Schultz 1984:61-63).

3.4.2. Complementary

A phenomenon may be observed and described from a number of perspectives. The plurality of perspectives make a single description of observation of reality impossible. It challenges the Newtonian view of either/or, of linear causality of mechanistic thinking. Duality is discarded in the new systems thinking. Approaching chronic pain from the ecosystemic perspective calls for a move from the linear causality of Newtonian thinking of A leads to B. Cybernetics introduce a circular causal process, where A leads to B and B leads back to A (De Jongh Van Arkel 1987:75-78).

Chronic pain has more frequently been diagnosed and managed in a linear causal manner. Chronic pain requires management in a circular manner to understand it in the wider context of the chronic pain experience. This calls for a look into ways that chronic pain may be communicated in an ecosystemic language, since it has formerly been communicated in the language of cause and effect in past centuries, by the medical profession. Pastoral care and counselling have gone through a period of individual oriented care, with the illness the focus of care. To a large extent, pastoral care to the sick has taken a rather limited role, that of ministry in visitation, prayer and encouraging from scripture. Approaching the person in chronic pain a larger relational context will mean a far larger field of involvement of pastoral work.

3.4.3. Language

Physical disease, particularly chronic disease that is of long duration, must focus on the system of interaction between the disease, the individual and relevant ecostructures. In

other words, chronic disease is not merely an outcome of the effects of disease on the individual. It is also the outcome of the effects of disease on related relevant ecostructures, that are interconnected to the individual with the disease (Rolland 1989:433). Chronic pain may be associated with the same patterns of the life cycles of chronic disease, i.e. it is also an everyday living occurrence, and of long duration. Chronic pain as approached in this study, associated with underlying disease, or trauma, may be even more closely linked with the patterns of chronic disease.

Rolland (1989:433) points out that in chronic disease, the illness system must be included so as to manage the chronic illness adequately. In his consideration of chronic disease in a systemic perspective, Rolland maintains that language used must include the triad of 1) illness, 2) family, and 3) the individual. To approach chronic pain from an ecosystemic perspective, a common language and a set of concepts need to be devised to accommodate chronic pain from this point of view.

From the perspective of this study, concepts and a language must address the chronic pain experience in the context of the person in chronic pain, the family structure and relevant ecostructures. The ecostructures that will be considered relevant are the health-care institute and social and religious structures. Concepts and language must not be applied to each individual structure, but rather to the evolutionary thread that run throughout the chronic pain experience and the relevant applicable structures.

In attempting to lay some foundation in the formulation of concepts and language applicable to chronic disease, Rolland (1989:433) says that each illness has its own "...particular personality and expected developmental life course". The developmental and personality concepts may be analogous to language descriptive of human relationships. Chronic pain needs to be conceptualised relevant to the interaction of psychosocial and biological perspectives. A common metalanguage is required to reclassify and consider chronic pain in its broader context, removing it from the dominance of biological language. Some consideration was given to view chronic pain in the light of some psychosocial factors, but the language used to describe chronic pain still mainly complies with Newtonian thinking.

Chronic pain is a condition that differs from acute pain, in that it is of long duration. The protracted nature of chronic pain places it into lengthy complexities of relationship interactions. The lengthy duration of chronic pain, the developmental characteristics and

time-phase changes dictate significantly more demanding psychosocial implications for the person in chronic pain. According to Rolland (1989:434) chronic disease may be categorised differently from acute disease, and in the same way chronic pain may be classified differently from acute pain. As chronic disease may be seen as developmental and time-phased, so chronic pain associated with underlying disease or trauma may be considered to have developmental phases which are constantly changing. The psychosocial context of chronic pain is far more diverse and complex with far greater interaction and interrelated connections than acute pain.

3.4.4. Language expectations

Chronic disease and chronic pain classifications, and expectations, were accommodated within biological criteria that meet the demands of medical care. The focus of medical care is the individual and the family, from the disease process orientation. Interaction takes place at various stages of the pain or illness life cycle. Seldom is interaction sequentially followed throughout the course of the history of the person in chronic pain. Care is frequently given in relation to investigations, laboratory results, diagnosis and management of the symptoms (Rolland 1989:435-438).

To place the person in chronic pain into a larger context of interactions and relationships, within the chronic pain process in relation to ecostructures, necessitates a view of the person in chronic pain in the experience of relational interactions; that is, to address people in chronic pain in relation to their world, the significant others, as well as the interaction between the individual, and the chronic pain process. The intention of this study is to follow Rolland's idea of development and the time-phase of chronic disease.

Rolland (1989:434) uses the concept of typology, i.e. to facilitate the creation of categories for chronic illness. He refers to the psychosocial typology of illness that is designed to examine the relationship between family or individual dynamics and chronic disease. This helps to place chronic disease into a psychosocial language. Rolland's (1989:439-444) conceptualisation of the psychosocial typology of chronic disease is onset, course, outcome and degree of incapacitation.

A language and a conceptualisation of chronic pain are required that examine and manage the relationship between the individual, the family and other relevant structures, as well as the somatic influences associated with chronic pain. Chronic pain may be likened to

chronic disease, in that 1) it has an onset which is variable, 2) a course, 3) an outcome that is constantly changing, and 4) various stages and degrees of incapacitation, owing to the interaction of chronic pain and the underlying disease. This conceptualisation of chronic pain places it into a continuous series. Because of its continuous and long duration, and its developmental time-phase implications, chronic pain affects and determines to a large extent the living world context of the individual. In the chronic pain process, a process evolves and influences every aspect of living for the person in chronic pain (Rolland 1989:434).

Each phase of the evolving process of chronic pain has an impact upon the whole. Chronic pain must be seen in the perspective of the whole, i.e. the ordinary daily living context of the person in chronic pain. Considering chronic pain in terms of onset, course, outcome and incapacitation may provide the key to observe chronic pain from the larger perspective of an ecosystemic context.

An attempt to restructure criteria for chronic pain in the larger context of the individual, family and socio-cultural context is made by using the idea of a developmental process as implied by Rolland (1989:434).

3.4.4.1. Rolland

a) Onset

The approach of this study is chronic pain associated with underlying progressive disease, or post-trauma outcome. Chronic pain may start as a sudden crisis situation. It may begin as acute pain and gradually become chronic in nature. The crisis situation of chronic pain brings changes in the family and work structures, and compresses these changes into a short time. Crisis management skills are required to cope with the changes, that are generally more easily coped with, owing to the shortness of the acute onset period. However, as the pain develops into a gradual and continuous process, it is termed chronic pain with a long-term expectancy, and a different pressure of stressors are applied to the individual and the family.

Some families are better equipped to cope with short term crises than with the long term affective implications of role flexibility and problem-solving requirements of persistent pain. As the pain becomes more persistent and is established as chronic in character, family and social ecostructures associated with chronic pain must allow for prolonged and

ever-changing stages of adjustments. Chronic pain that has a gradual onset will have the same implications as pain that moves into a chronic situation from a crisis situation. The individual and the family will, however, have been spared the upheaval of an acute crisis situation, but on the other hand, will face the implication of managing a slow process of structural changes in living circumstances (Rolland 1989:436-444).

b) Course

The chronic disease course may follow three general forms, referred to by Rolland (1989:435) as progressive, constant and relapsing / episodic. The course of chronic pain may also be considered to be progressive / regressive, constant / stable and relapsing / episodic.

i) Progressive / regressive

Chronic pain associated with progressive disease (e.g. rheumatoid arthritis, degenerating spinal disease, cancer) is usually one of gradual progression in the disease, with changes that may either increase the level of chronic pain, or result in periods of more acute pain. Pain management and control may be more difficult to maintain because of the disease process or injury deficits. Constant adjustments are needed for the person experiencing the pain. The pain experienced in combination with the disease process may increase exhaustion, and so increase the involvement of the health-care institution and pastoral care and counselling at various stages (Oates & Oates 1985:104-107).

The rate of regression due to the disease, and destruction to underlying physical structures may have a direct outcome upon the pain. A crisis situation may occur that requires methods of surgical intervention to prevent further physical destruction. However, the pattern of the usual chronic pain experience will not change in the long term. Hence in the progression of the underlying disease, the person in chronic pain may encounter crisis situations from time to time. Help from outside the family is usually essential during these phases, as care is usually more strenuous to bear. Family roles undergo reorganisation during such periods, and readjustments occur once the crisis situation settles into a more stable course (Oates & Oates 1985:27,74,111-116).

ii) Stable / constant

Stabilisation of the pain may occur as control of pain is established by pain management methods, and the associated disease or trauma course becomes stable, which enables maintenance of pain control. If surgical intervention is called for, certain post-surgery deficits may be experienced, e.g. sufferers of Berger's disease experience pain from circulatory insufficiency and may enter a regressive disease phase that may require amputation of the affected limb as a measure to save life. However, a more stable and more predictable period of pain control will once again be experienced, as pain control measures take effect.

The stable phase of chronic pain is a semi-permanent one, since the reoccurrence of disease activity and the change it brings into the chronic pain experience is a persistent threat. The movement between periodic predictability and unpredictability in the chronic pain process is demanding upon the family's roles, with the potential for family disharmony (Rolland 1989:434-435).

iii) Relapse / episodic

Episodic relapses may occur in various ways. Pain control may be lost, unrelated to accompanying disease disorder. Overactivity may result in loss of pain control. In relation to the progressive concurrent disease course, chronic pain may increase as the disease relapses, e.g. the polyarthritic experiences acute phases of the disease, with increase in pain levels, since various joints are inflamed. Cancer patients in remission come out of remission and chronic pain is once again their uninvited companion.

Irrespective of the cause of the relapse, the individual frequently enters a sick-role period during this phase, until disease and pain control are obtained through various medical and environmental measures. The relapsing episodic perspective of chronic pain management requires a flexibility within the family and social life cycles, that allows for a back-and-forth movement of changing family and social reorganisation. There may be a constant reorganisation of family and social life-styles, which may be very trying to the individual, his/her family and social structures (Sternbach 1974:9; Rolland 1989:437-439).

Chronic pain calls for constant transition between crisis and non-crisis situations, also transition between periods of stability with reasonable normality, and periods of the sick role, where the individual may be at bedrest, or more restricted in normal activities. The

wear and tear of such circumstances may have broad psychological, sociological and religious implications for the individual and family structures. These are circumstances that are unique to the relapse/episodic phase of chronic pain (Fichter 1981:59-63; Rolland 1989:450-454).

c) Outcome and degree of incapacitation

Rolland (1989:436) points out that chronic disease may shorten a life span, or it may be a gradual life-time process. Chronic pain may fit into the same pattern, since it may be associated with a disease such as cancer, which may shorten life. It may also follow a gradual course with various outcomes of life-style limitations, or disability, e.g. spinal cord injury, vertebral disc disease, polyarthritis. Incapacitation may take a variety of forms. There may be motor or sensory deficits or a combination of both. There may be cognitive loss and the possibility of performance deficits are a reality. Loss in self-confidence is common in the chronic pain experience. In life-threatening and life-style limitation situations the experience and expectations of loss increasingly strain family relationships, in the attempt to keep an organised balance within the structure of the family, and its interactions with society.

Rolland (1989:438), in his attempt to apply chronic disease within a psychosocial schema, considers chronic disease as developmental and time-phased. In this study an attempt is made to apply chronic pain within a developmental framework. Like chronic disease, chronic pain may be considered to be time-phased in character. Each time-phase has its own psychosocial and physical interactions within the relevant ecostructures of the individual experiencing chronic pain. Interaction and changes occur within these relevant ecostructures during each time-phase of the chronic pain process. The time-phase (or periods, or stages) in the chronic pain process will be referred to as follows: crisis phase, interim phase and complexities phase.

i) Crisis phase

Numerous readjustments occur during this phase. Rolland (1989:439) refers to Moos 1984, who describes a certain universal and practical involvement of the individual and family influenced by chronic disease. I will modify the writers' points, and relate them to adjustments that must occur in the chronic pain experience; namely to:

- learn to deal with pain and physical limitations
- learn to cope with a hospital environment and its procedures
- establish a relationship with the various health-care team workers
- consider family needs : mourn losses; maximise control and mastery; come to an acceptance, and move to change and reorganise family and social structures; face uncertainties and develop flexible goals for the future

ii) Interim phase

Rolland (1989:439-440) uses the term 'chronic phase'. He refers to it as the time span between initial diagnosis and the last phase. During the interim phase the individual and family come to terms with permanent changes and the reorganisation that must take place (adjustment phase). The family attempts to live a reasonably normal life within the abnormal limits of the chronic pain process.

iii) Losses and complexities phase

Losses may be in the terminality of the disease process, such as in cancer with metastases. Loss may be experienced as increasing limitations due to disability or loss in family organisation. Mourning of losses is a common occurrence during the chronic pain process. More often the loss is experienced as having to live with the loss, e.g. amputees have to live with the loss of the limb every day of their lives. Complexities occur in the transition of phases, and in the developmental perspective of chronic pain. Rolland (1989:440) says that: "...unfinished business from the previous phase may complicate, or block movement through the transitions". The end result may be maladaptive behaviour. Rolland (1989:440) writes: "The interaction of the time-phase and typology of illness provides a framework for a chronic-disease, psychosocial-development model."

Chronic pain may be considered in the same light as a type of pain with a developmental course, with specific time-phases. The phases may be considered specific periods with different tasks, or events that have to be coped with. The relational interaction during the time-phase transitions may be associated with the unfolding of human relationship interactions and developments within the relevant ecostructures.

It should be obvious from the discussion of the above perspective of the chronic pain process, that chronic pain cannot be viewed as biological behaviour alone. It is necessary

to speak of chronic pain in relation to its psychosocial and religious constructs in general ordinary daily living circumstances. This gives a different perspective to any care given to the person in chronic pain. Chronic pain can no longer be considered exclusively a medical problem; nor an individualised problem. Care must be addressed in its socio-cultural context. Chronic pain can no longer be considered in the biological language of the medical profession alone. As chronic pain takes on the language of psychosocial and religious realities, it becomes a problem in the context of the physical, psychological, social and religious environments. Pastoral care and counselling are challenged to apply care to a much broader spectrum than the individual with physical protracted pain symptoms.

CHAPTER 4

THEORIES OF NEEDS

4.1. INTRODUCTION

If pastoral care and counselling is to succeed in effectively helping people with chronic pain, it must gain some insight into the circumstances and needs of people in chronic pain. Since pastoral care is caring Christian communicative action, it needs to gain insight into the influence that chronic pain has upon the lives of people who experience chronic pain. Pastoral care and the human science disciplines are about caring for people from different perspectives, neither has dominance over the other in addressing human care needs. Practical theology may benefit from human science theories and methodology, just as the various human science disciplines may benefit from practical theology theories and methodology. This does not mean that practical theology accepts human science theories gullibly, but rather that it critically reflects on the theories and their applicability and validity to theology. It is only once this is done thoroughly that the use of the theories may be considered for pastoral care structures (De Jongh Van Arkel 1987:85,86).

In this dissertation theories of needs as proposed by various psychologists are discussed and considered in relation to people in chronic pain, and pastoral care and counselling. Strategies may then be considered in the development of a pastoral care theory to address the needs of people in chronic pain in relation to their relevant ecostructures. In this chapter current literature is used to try to establish what importance is attached to the gratification of basic needs.

To give some idea of the implications and influences of needs that are an existential experience in peoples lives, this chapter focuses on some personologists' viewpoints. Personology is the branch of psychology which studies the similarities and differences of characteristics between people. The aim is to gain a general insight into human functioning, and general models of human functioning which were constructed from such studies (Meyer, Moore & Viljoen 1989:4).

Meyer, Moore and Viljoen (1989:5) describe a personality theory as follows: "*A personality theory is the result of a purposeful and sustained effort to develop a logically*

consistent conceptual system for the description, explanation and/or prediction of human behaviour."

There are numerous personality theories that have been developed from investigating the complexity of a person and associated behaviour. Psychologists may agree that the person's personality and circumstances may influence behaviour, but there are diverse opinions as to how these influences operate.

Maddi (1989:40) addresses three categories of personologists' views, namely: the conflict model, the fulfilment model and the consistency model. According to Maddi each of these models have two different versions applied to them. It is important to come to some conclusion in this study as to what motivates and determines the person's behaviour. In studying the person in chronic pain it is important to gain some insight into the influences of needs in the daily living of the individual. In an earlier chapter, it was established that according to current literature, chronic pain has a destabilising effect upon a person an effect which not only makes the rehabilitative process towards independent living difficult, and often a long-term one, but in general makes life difficult. Needs may increase in ordinary daily living in the process of chronic pain.

According to Maslow (1970:37) all people in general have basic needs which must be met for satisfactory living and well-being. Circumstances in general living will decide whether these needs will be met or not, and the degree to which they will be met. With such a viewpoint we must look more deeply into the various theories of needs. If Maslow's view is valid, then for the person in chronic pain who is plunged into circumstances which may increase basic and specific needs, it is important to establish a theory with regard to needs gratification requirements. Viktor Frankl (1978:113), on the other hand, sees humankind as searching for the meaning of life, and the will to meaning as the most powerful motivation of humankind. His view implies, that basic needs that are not satisfied may increasingly hinder the accomplishment of meaning to life. However, for Frankl it does not mean that meaning to life cannot be achieved if basic needs are not satisfied.

One may ask what the above mentioned views have to do with the person in chronic pain. In taking note of these two views it is apparent that there is some threat to the well-being of people in chronic pain and to the meaning of their existence, due to the circumstances of the chronic pain process. Pastoral care and counselling is a Christian-faith oriented helping profession, one that is concerned about caring for people and helping them in their

search for meaning to life. Pastoral care and counselling from a Christian faith perspective is concerned with assisting people to obtain the highest level of well-being that is possible in the individual's situation.

This study will take the approach of looking into the viewpoint of personologists such as Freud, Murray, Maslow, Frankl, and Rogers within the three categories selected by Maddi (1989:41). The purpose of the personologists' studies is to determine similarities and differences in the characteristics of individuals. According to Maddi (1989) the differences between the characteristics are considered to be the basis for the theory of the periphery of personality, with emphasis placed on personality types. On the other hand, the similarities identified are the basis for constructing the core of personality theory. The emphasis is on characteristics and tendencies that define human nature and that are regularly expressed in living. Core personality is considered to be related to the basic attributes and the long term direction of the human being. Core tendencies and characteristic are usually very general, and their influence on human behaviour is in the overall pattern of functioning (Maddi 1989:41-42).

I will commence with the theorising of Freud as his influence carries through into the theories of some of the other personologists. I will deal with most of the models in Maddi's (1989) categories, but not necessarily with all the versions of each category. This chapter will discuss each personologist's view, and then refer to similarities in their various theories. Finally, the need theories applicable to people in chronic pain will be considered.

4.2. PERSONOLOGISTS MODELS

4.2.1. Conflict model

There are two versions to this model according to Maddi (1989:43). Firstly, there is the psychosocial version which holds to two forces which appose each other, one being internal to the individual while the other is external, such as society. This version is upheld mainly by Freudian thought. The second version is very similar to the above but differs from the view that conflict is continual and that there is a constant state of tension. Murray supports this differing view in that he believes that a part of life remains free from a state of tension.

4.2.1.1. Freud's view

Maddi (1989:44) writes: "Freud used the core tendency of living as the tendency to maximize instinctual gratification while minimizing punishment and guilt." Freud's basic tendency of living included three main ideas: the instincts, the sources of punishment and guilt and the mechanisms of defence. It is the defence mechanisms that satisfy the instincts, and punishment and guilt are avoided. For Freud the instincts (drives) are the core characteristics of personality, and he discusses three types of instincts. All instincts have the same form, but differ only in content. All instincts have a source, a type of energy or driving force, and an aim and an object.

According to Freud the component of an instinct is physical (biological) in nature. Human behaviour is explained on the basis of two types of drives. Freud believed that the person requires psyche energy to function, and this psyche energy is obtained from the release of the body's energy. In other words a drive has a bodily and psychic element. Unless gratified the desire (need) remains operative. Needs which are not satisfied cause conflict between the types of drives, resulting in psychological problems (Meyer, Moore & Viljoen 1989:47-49; Maddi 1989:41-46).

According to Freud the source of energy is within the organism, that is, it is an internal source. Bodily deprivation results in instinctual energy that releases somatic manifestations, which in turn are represented mentally. In other words the instinct is not the somatic presentation but rather the stimulus of mental representation thereof. Mental activity is dependent on bodily processes. Maddi (1989:45) says regarding Freud's view: "An instinct is a sign that the organism lacks something it needs, that it is a state of deprivation. Such deprivation states are experienced as tension, or pressure."

It seems that Freud regarded a need as a bodily requirement that has arisen owing to deprivation, and an instinct presents this by means of a somatic manifestation that stimulates a mind (mental) response. Hence, for Freud the psychic manifestations (such as thoughts, wishes, emotions) are all expressions that are dependent on biological factors (Maddi 1989:44). Therefore the reactions between bodily processes and mind are not only internal (originates within the organism) but also expresses the organism's biological requirements (needs). A need is forced into action by an instinct (drive).

Freud distinguishes between internal instinctual stimulus and external stimulus, the former being constant in impact in contrast to the latter. To him, satisfaction is what removes a

need by altering the source of the stimulation, e.g. food intake when the hunger drive presents. Freud believed that the aim of the instinct is at all times gratification, which is obtained by removing the state of stimulation at the source of the instinct, thus reducing biological deprivation.

To understand the biological and mental relationship with regard to instincts requires a discussion on the content of an instinct. There are three kinds of instincts in a person, namely: the life instinct, the sexual instinct and the death instinct. These exist within the concept of the id, which is the component of the psyche from which all energy is obtained for all behaviour. It has direct biological contact. The id may be seen as a core characteristic of personality as it is common to all humankind (Maddi 1989:46-47).

The id functions according to primary processes and pleasure principles. The id's energy drives (instinctual forces) want immediate satisfaction. However, the id is incapable of realistic planned drive satisfaction; instead it uses fantasising to appease a drive. In satisfying drive stimulus and need requirements it is selfish and unrealistic. The id needs the ego subsystem of the personality to give reality to the planned measures required to obtain satisfaction (Meyer, Moore & Viljoen 1989:43 -45; Maddi 1989:48).

The ego is the component of the psyche that applies reality testing, object choice and object cathexis. It is the ego that applies a concentration of psyche energy to appropriate objects that it chooses from the external environment for drive satisfaction. The ego is the component of the psyche that learns to adapt to internal and external circumstances, that is, to change the drives (instincts) and circumstances in the physical and social reality. The id places pressure on the ego to satisfy the drives that constitute the physical reality. On the other hand the superego (which represents society's moral codes) puts pressure on the ego by means of punishment and feelings of guilt.

The conflict created by the constant demands of these two components place great pressure on the ego to satisfy these demands. The ego is necessary to ensure the individual's survival in the person's contact with the external environment. While the id merely considers biological reality, the ego applies secondary process thoughts, that are perceptual processes that use recognition and rational thinking to judge a situation. It is the component of the mind that is able to consider from a learned process the action that should be carried out to satisfy a drive, or not. Hence the ego in its endeavour to come to

conclusions regarding drive satisfaction, considers social reality as well (Meyer, Moore & Viljoen 1989:43-45).

For Freud, if behaviour were to function out of instinctual demand only (which is functioning on the pleasure principle alone), the world would be an unliveable place. However, there is an equalising dimension, that of society's moral codes, that places demands upon the individual. The individual's aim to gratify instinct stimulus (need) is selfish, while the aim of society is for the common good. The concept of conflict between the self and the communal good is what classifies Freud's theory into the psychosocial conflict model (Maddi 1989:50-53). The theory of defence mechanisms is brought into the process. These are the mechanisms that maximise instinct gratification and minimise the punishment and guilt aspects. Basically the instincts are the forces that try to gain expression and that create conflict. The defence mechanism is stimulated when the conflict force from the instinctual stimulus becomes forceful enough to cause an alarm reaction, in the form of anxiety. The defences function by avoiding repressed desires from entering consciousness (which means that truth about oneself is possibly permanently hidden), a process used to ease conflict (Maddi 1989:55). Hence to Freud, behaviour is not only motivational but also defensive, which means that humans are controlled by forces internally, and pressures externally without knowing this.

4.2.1.2. Murray's view

Murray follows a similar trend of psychoanalytic thinking, and uses the concept of id, ego and superego as three dimensions of personality that exists in all people. Hence for him they are considered to be the core of personality. However, Murray sees in the ego and superego differentiation from person to person. For Freud the contents of the id are the three drive forces that remain constant, but Murray believes that the id acts more as a container of all motivations, which probably includes all needs. Hence he sees all these dimensions as on the periphery of personality. According to Maddi (1989:286), Murray's major peripheral characteristics are needs, and they are motivational in nature, which means they are goal-directed.

Murray does not believe that human motivation is primarily based on drives. He has a much broader view that regards needs as the motivational factor of human behaviour. He holds that the human is motivated to strive for satisfaction and happiness. He does

acknowledge the importance of physical needs, but does not agree with Freud that the psychological needs are dependent on the physical needs.

Needs present differently in people, according to Murray, and needs analysis is important in pinpointing individuality (Maddi 1989:285-287). If consideration is given to the fact that Murray considers the content characteristics of the id, ego and superego to be peripheral, the core characteristic of personality seems to be contentless. He sees core characteristics to be the constant motivatedness of people, and their constant attempt to reach their goals, within the restrictions of the environment and in accordance with their own values and principles. Maddi (1989:286) feels that it is unclear what Murray considers as the content characteristics of the id, ego and superego. Murray attempts to fit needs as the content, but he does not quite achieve this. Concerning the superego, needs are considered to be too motivational to be the content. Then again there is the possibility that needs may be considered to be the content characteristics of the id, but according to Murray needs are not innate. They cannot fit neatly into the meaning of the id. The ego, to him, seems to constitute a set of functions which are really abilities in the perceptual, apperceptual, intellectual and affective realms of experience. Maddi's (1989) criticism of this is that it is not clear what Murray sees as the content characteristics of the id, ego and superego. It does cause a problem as to the nature of the relationship between core and peripheral characteristics of personality, which is the basis for understanding a theory of personology. Maddi (1989:286) does say: "Actually Murray's major contribution to personology has been his taxonomy of needs and his extensive and continuing attempts to collect systematic empirical evidence bearing on it."

Murray (1938) describes a need as:

a construct (a convenient fiction or hypothetical concept) which stands for a force ... in the brain region, a force which organizes perception, apperception, intellection, conation and action in such a way as to transform in a certain direction an existing, unsatisfying situation. A need is sometimes provoked by internal processes of a kind but, more frequently (when in a state of readiness) by the occurrence of one of a few commonly effective press.

(Maddi 1989:287)

The behaviourists and other psychoanalysts regard satisfaction and happiness as the result of drive satisfaction. Satisfaction is achieved by the choice and implementation of

appropriate objects to consume the energy of the drive and bring about a tension-free state. Murray differs from this, since he does not regard happiness achieved as a tension-free state, but rather as a tension-reduction process (Meyer, Moore & Viljoen 1989:268-269). He distinguishes between behaviour that is due to pleasure activity (modal activity) and behaviour that occurs to meet a specific need (directed behaviour).

For Murray, the individual uses different ways to satisfy needs. More than one need operate simultaneously; in the same way one action can satisfy a number of needs simultaneously. For example, when hunger is satisfied, at the same time the need for nurturing is satisfied (e.g. the baby who is breast-fed). Murray calls this the fusion of needs. Whereas a specific motive, such as a social dinner may serve the purpose of the need for achievement, the need for food, social interaction and gaining information are all satisfied simultaneously, while fulfilling the purpose of the achievement need. He calls this subsidiation of needs.

At the same time needs which are activated may conflict with one another. For example, conflict between the need for achievement and the need to avoid harm is experienced when a person with chronic pain may want to drive a car to go to the shops, but fears the dangers involved (such as diminished reflex responses of limbs which result in inadequate control of the car). The person experiences conflict between the need for achievement and the need to avoid harm.

For Murray, needs are not hierarchical. His view is that humans have a variety of needs, which include the higher needs, such as achievement. To him the self-actualising process is the striving of the person for happiness in the development process of the human in achieving the goal of happiness (Meyer, Moore & Viljoen 1989:273-284). Over a period of time a person may go through a number of activities and procedures to meet a need. Hence Murray understands the meeting of needs as goal-directed. For example, a person who studies to become a doctor goes through all the activities of study to gain the status of doctor to satisfy the need to help people. This long-term process of achievement of an objective he calls a serial program. Not only are there immediate short term needs which necessitate satisfaction, but also long term achievement goals which are considered as needs (Meyer, Moore & Viljoen 1989:272).

For Murray, the functioning of the human is determined by the interaction between the environment and the needs of the individual (he refers to it as a thema). He refers to the

environmental influences as presses, which are the external determinants of behaviour. For example, the person eats food (press) to satisfy his hunger (need). Either the external or internal determinants may influence human functioning and result in behaviour (Meyer, Moore & Viljoen 1989:270-273).

Regarding the classification, types and quality of needs, Murray seems to have a rather loose classification scheme. He attempts to classify numerous needs with a great deal of overlap. Maddi's (1989:291) criticism is that Murray has not adequately addressed the relationships between the available needs to state his thinking clearly. The extreme heterogeneity of his needs concept makes it difficult to find a basis for a distinct clarification of needs in theory and practice.

According to Murray needs wax and wane. The need is strong during deprivation, and it is less evident under saturating conditions. This would mean that human behaviour will not remain steady. Maddi (1989:291-292) feels that on the whole human behaviour is consistent, and that Murray does not give an adequate explanation to tie up all the loose ends of his theory. Maddi does, however, feel that Murray's needs concept is a workable concept in psychology, until more theorising has been accomplished to explain the needs concept more fully. In other words there is still work to be accomplished in the dimension of the theory of needs.

Murray's personality theory of needs is unfortunately a rather complex one. It has been criticised by modern psychology, in that it is too comprehensive. However, it seems his intention is to cover needs in a variety of perspectives, such as individual needs, physiological needs, psychological needs, and social needs. His comprehensive scope should be suitable to an ecosystemic approach theory.

4.2.2. Fulfilment model

Personologists of this model believe that life is a process of the unfolding of one force.

There are two versions to this model, namely:

- the actualisation version which holds that the force is the tendency to place more emphasis on potentials and capabilities, based on the genetic constitution of a human
- the perfection version which considers the force as the tendency to strive for the ideal in life, the essential difference between the two versions is that which each considers the force to be

I will consider Rogers' and Maslow's position; both are the actualisation version of the fulfilment model, but with some differences (Maddi 1989:97).

4.2.2.1. Rogers' view

Carl Rogers regards the motivation of human functioning as the actualising tendency. For him the core tendency of humans is to actualise their potentialities. There is a force in people that helps them develop inborn potentials. Rogers considers the inherent potentialities in a person as relevant in the developmental process of life. In relation to Freud's theory, the inherent potentialities would be regarded as instincts. However, for Freud, a person's relationship to society is one which is selfish and competitive in the process of life, whereas for Rogers, the human's true nature is basically good, and such behaviour is consistent with maintaining and enhancing life and social living (Maddi 1989:99-100).

Humans, according to Rogers, have the capacity to accept all experiences in life, and with all the psyche and physical abilities they possess, to actualise themselves. In other words, it would seem that he believes that each person is born with potentialities, which can be actualised as the person strives to unfold and develop this potential in relation to life's experiences. This potential actualisation seems to be directly related to the self-concept; i.e. how people see themselves in relationship with their experiential world (Meyer, Moore & Viljoen 1989:381-382).

The actualising tendencies may be seen as a biological pressure to fulfil the genetic blueprint in an effort to counteract the difficulties encountered in the environment. Hence the actualising tendency does not aim to reduce tension, but rather indicates increased tension (Maddi 1989:104). Rogers contended that the human has psychological forms of actualising tendency. The most important is the tendency toward self-actualisation. According to Maddi (1989:109) Rogers' view of self is:

the organized, consistent conceptual gestalt composed of perceptions of the characteristics of the "I" or "me" and the perceptions of the relationships of the "I" or "me" to others and to various aspects of life, together with the values attached to these perceptions. It is a gestalt which is available to awareness though not necessarily in awareness.

Maddi (1989:105) says: "Thus, the self-actualization tendency is the pressure to behave and develop - experience oneself - consistently with one's conscious view of what one is." Besides the need for actualisation there are the need for positive regard by others and the need for positive self regard. Rogers regards both these needs as determinants of behaviour and considers both learned needs. The need for positive regard by others is the need for approval by others, and frustration at receiving disapproval. The need for positive self-regard is the internal satisfaction of approving, or dissatisfaction at disapproving of oneself. The process of gaining others' approval, or disapproval, is necessary for a conscious development of self-concept. Humans also develop the need for positive self-regard, that ensures development of the tendency towards self-actualisation in relationship to the self-concept (Maddi 1989:105; Meyer, Moore & Viljoen 1989:380). However, the need for positive regard may be a hindrance to actualisation, since the need for approval may prove stronger than the desire to fulfil potential, for example, the son who enters the family business to gain approval from his father, when his potentiality and desire is to become an artist (Meyer, Moore & Viljoen 1989:383).

It may be considered that for Rogers, the core tendencies of personality are 1) the inborn potentialities which are developed by the person in an attempt to actualise ways to maintain and enhance life, and 2) the psychological manifestation occurring in the attempt to actualise the self-concept. The needs for positive regard and positive self-regard are learned offshoots of the core tendencies. The characteristics of the core of personality are, the direction in the ways in which the actualising tendency will be expressed by means of the inherent potentials and the ways the self-actualising tendency will be expressed in relation to the self-concept (Maddi 1989:106).

For Rogers, problems occur when the person denies needs and experiences, and these conflict with the self-concept. Rogers maintained that the conflict with the self-concept is usually associated with distortion of the self-concept, which is based on the values of others and not on the person's own needs. It seems that Rogers considers that interaction with the social environment influences the way the person internalises needs, and experiences in life. The outcome of the self-concept will determine the person's functioning.

How the person views and responds to experiences, needs and self-concept will determine how actualisation does or does not take place. In the development of potentials the

relationship between unconditional positive regard and conditional positive regard must be considered (Meyer, Moore & Viljoen 1989:384-386). Unconditional positive regard is essential to complete actualisation of potentialities, since acceptance of the person releases the ability to develop potentials. The person is accepted as a unique being with specific needs and expression of feelings. This allows for functioning within the individual's own self-concept values, and not according to values of others. Rogers feels this allows the person freedom of choice which results in the realisation of abilities and potentiality development (Meyer, Moore & Viljoen 1989:385).

Conditional positive regard on the other hand, as considered by Rogers, is when the actions, feelings, and thoughts of the person are not accepted and supported by others significant in the person's life. The self-concept is developed, based on the positive responses of others. The person will take the direction in which the self is viewed in relation to actions, thoughts, and feelings that are approved by others.

Feelings of approval, or disapproval, are based on interpretation (by the individual) of others' assessment of the individual's performance within the conditions of others. These conditions become incorporated into the person's values of the self-concept and influence functioning of the person. Rogers calls the measurement of what is valuable and what is not valuable about the self conditions of worth.

The condition of worth functions very similarly to Freud's theory of the superego. Society functions as a moral, ethical determinant of moral human behaviour (Maddi 1989:106). Once the condition of worth is in action in the self-concept, guilt or feelings of unworthiness are operational. In circumstances of feeling guilt, or unworthiness, defences are put into action. Rogers refers to two types of general defences, namely denial and distortion. The aim of the defences is to protect the person from feeling unworthy or guilty, and to assist behaviour to attain to the moral standards of society.

Rogers differs from Freud's theory of defences. For Freud, defences aid in giving success to life, whereas Rogers believes that defences are crippling because they lead to rejection of thoughts, feelings and actions that are the true expression of inborn potentialities of the person. He refers to this as the state of congruence (Maddi 1989:107).

It must be noted that Rogers does make a difference between acceptance of the person, needs and feelings, and behaviour which cannot be accepted. For Rogers it is possible to accept the person, but reject unacceptable behaviour. It is, however, one thing to achieve

this in the therapeutic setting, but more difficult to do so in ordinary daily living. It is an infrequent occurrence in the ordinary daily living experience, and would probably only be possible in an ideal living situation, which is unfortunately very rare.

According to Maddi (1989), there is only one broad distinction in ways of living made by Rogers' theory, which results in the separation of people into two general types. At core tendency level, he classifies people into those actualising tendencies which enhance living, and those in whom actualising tendencies are protective and defensive. The former refers to a fully functioning person, and the latter to a malfunctioning person (Maddi 1989:315).

Rogers, however, has formulated a set of peripheral characteristics. He refers to such characteristics as:

- 1) Openness to experience, which is the opposite to the defence mechanisms. The process of openness to experience incorporates a number of characteristics, such as emotional effects and reflectiveness.
- 2) The existential living characteristics are those which give the person freedom of choice and realisation of the person's capabilities. Characteristics of flexibility, adaptability, spontaneity and inductive thinking are found in the concept of existential living.
- 3) Organism trusting, which consists of weighing up all available data for a situation to discover a course of action to satisfy all needs in the situation to the fullest.
- 4) Experiential freedom, which is basically considered to be the freedom of choice of alternative courses of action.
- 5) Creativity in producing new thoughts, actions and things.

In maladjusted people the emphasis is on characteristics which are the opposite of fully functional people (Maddi 1989:316-318).

The difficulty with Rogers' theory is that individuals are limited by their own ability in developing potentiality. The actualisation of potentiality is largely dependent on conditions met by obtaining positive regard. In this process the individual's behavioural decisions are largely influenced by the values of others. Hence, self-concept is dependent on others and freedom is governed by circumstances and the values of others. Rogers does, however, leave space for actualisation as an internal response, by individuals following their own desires and best potentials in self-honesty. However, on the whole he portrays the development process in the experiential world as possible only in an ideal environmental situation.

4.2.2.2. Maslow's view

Maslow differs from Rogers, since he believes that there are two forces within the person. These two forces are, however, not necessarily opposed to each other. One force is always less than the other. He uses a more eclectic approach in his motivational theory of needs, as well as holding a variant position on the fulfilment personology model.

For Maslow, the core tendency of a person is to push towards actualisation of inherent potentialities. In this view he is in agreement with Rogers. The realisation of the push towards actualisation of potentialities is considered the self-actualising tendency, according to Maslow. He differs from other fulfilment theorist's views in that he believes that another core personality is the tendency to strive for need gratification to ensure physiological and psychological survival of the individual (Maddi 1989:111).

As a humanist, Maslow believes that the human is essentially good with good potential. The human needs a good society to grow in and develop potentiality. The environment is considered an important influence in the development of human potential. However, he does acknowledge that people's basic needs, values, goals and plans are important elements in the self-actualisation process. This view does differ from that of the psychoanalysts who emphasise that unconscious drives determine behaviour, and that of the behaviourists who believe that the environmental influences are dominant. According to Maslow the greatest motivation of the human is self-actualisation. Humans need to discover their potential and are capable of doing so. However, since society is not ideally good, few individuals succeed in this self-actualisation process (Meyer, Moore & Viljoen 1989:357-358).

Maslow refers to physiological sources and their psychological concomitants of the actualising tendency. The physiological source is considered the somatic component of people that function according to their biological role. The psychological concomitant is the tendency used by the person to make satisfying choices. Hence, choices are made to give satisfaction to the somatic components in appropriation to their physiological demands. According to Maslow, the person merely actualises potentialities for the purpose of well-being (Maddi 1989:111).

Maslow considers that in life in general each individual has basic needs, which need to be gratified. The gratification of the basic needs determines human behaviour. The organism is dominated and its behaviour is organised only by ungratified needs. The human

constantly has needs, which must be gratified to release tension and frustration; this process also provides for development and growth in the individual's life. Gratification is essential for people to fulfil their highest potentiality of self-actualisation, according to Maslow (1970:37,38).

Maslow believes that needs are seldom satisfied, since gratification of needs results in the surfacing of another need to be gratified. Basic needs are hierarchically arranged, and begin with physiological needs, moving to what he refers to as higher needs. This means that the survival needs must be satisfied before the actualising tendency can be expressed, and self-actualisation achieved in any way. Maslow considers the actualisation tendency growth motivational, whereas the survival tendency is deprivation-motivated. The aim of deprivation motivation is to bring about a relief in tension. It is the state that motivates the person to strive for goal states, which will result in a homeostatic state. For example, food intake not experienced for a while increases gastric activity, which builds up tension that is experienced psychologically as hunger. In such activities, the homeostatic balance of the body is upset. Action is taken (food intake) to achieve the required goal state, and homeostasis is achieved again by need gratification (hunger relieved) (Maddi 1989:113-114).

The growth motivation is what motivates the person to enrich living and well-being. Maslow seems to consider the higher need of self-actualisation and the need for cognitive understanding as two different perspectives of the unfolding of inherent potentialities. The process of psychological reflection is the inherent function of the nervous system in processing information, and may be seen as the need for cognitive understanding (Maddi 1989:115).

The deprivation motivation (or deficiency motives) is regarded by Maslow (1970) as:

- physiological needs: which are needs required for survival, a person who is constantly hungry (deprived of food), will be uninterested in gratifying higher needs. The individual's aim in life will be to obtain food. It may obscure all future vision, and even result in low values, i.e. needs like love, respect and freedom may be considered of minimal value (Maslow 1970:35-38).
- needs for security and safety: once physiological needs of survival are regularly satisfied, the safety needs will surface and become important in the functioning of the

individual. The aim of the individual is directed towards achieving security, safety, law and order, freedom from fear, ecetera (Maslow 1970:39-42).

- needs for belonging and love: once the safety needs are satisfied regularly, people become aware of their need to belong and be loved. The love need has to do with giving and receiving love. Needs to belong include identification with family and society. The thwarting of these needs increases problems (Maslow 1970:44).
- need for self-esteem: again the cycle occurs once the need for love and belonging is satisfied. Maslow divides the self-esteem needs into two categories, namely the self-esteem needs which are related to the individual's achievements, efficiency, capability, confidence and independence and needs related to the esteem of others, honour, importance, dignity, appreciation, social status (Maslow 1970:45-46).

Growth motivation needs are considered by Maslow as the need for self-actualisation. The growth motivation of the self-actualisation process is reached as basic needs are satisfied on a regular basis. Self-actualisation is the process of becoming all that the individual is capable of becoming. Closely associated with basic needs are preconditions of freedom: freedom to express oneself, defend oneself, ecetera. According to Maslow (1970:47) the preconditions are a prerequisite to satisfy needs.

Maslow holds to a theory similar to that of Rogers regarding the conditions of fulfilment. However, for Maslow, gratification of the survival tendency gives the requirements necessary for self-actualisation, in that goal states will be sought after by the person. The success of seeking the goal states will depend upon the person's physical and social environment. Maslow differs from Rogers: for Rogers, the actualising tendency includes maintaining and enhancing life. For Maslow, only enhancement of life is included in the actualising tendency. The function of the survival tendency is to maintain life enrichment. Both of the above mentioned theorists agree on what achievement of self-actualisation is, they merely use different descriptive words (Maddi 1989:117).

Regarding Maslow's theory on the hierarchy of needs: the fact that survival needs must be met before actualisation of potentialities may take place means that the person must be fed, nurtured and respected before any potential is activated, or developed. Life's situations frequently disprove this, e.g. despite gross deprivation, thousands of World War Two Nazi concentration camp victims survived and went on to live creative and productive lives. It

does cast doubt on the idea that ungratified survival needs will stunt self-actualisation. Maslow does allow for exceptions, as he says that exceptional people may advance to self-actualisation despite gross ungratified lower-ranked needs. However, it seems he considers the exceptions to the rule to be very few.

Maslow places importance on environmental factors for self-actualisation. He believes in a good society, but much of society is not good. This reliance on the goodness of society would imply that an ideal environment is necessary for self-actualisation (Maddi 1989:116; Meyer, Moore & Viljoen 1989:358-359; Maslow 1970:46-51).

4.2.2.3. Existentialists' view

The existential view is considered a fulfilment model, the perfection version, according to Maddi (1989:137). Existentialism has taken an influential position amongst a variety of theorists and therapists. Theorists of the existential view take a phenomenological approach that considers one person's reality different from another, as each person is likely to perceive things differently. Existentialism has varied theories and emphasis from theorist to theorist (Maddi 1989:137-138). Fulfilment is determined by ideals and values in the good life. It is an expression of idealism according to Maddi (1989:118). I will move away from following Maddi's (1989) discussion of the existentialist view, since I would like to specifically discuss Viktor Frankl's existential theory for this study.

a) Viktor Frankl's view

Frankl developed what he called logotherapy, from observations made during his experience in a Nazi concentration camp. He observed that although the inmates of the concentration camp were living in constant degradation and constantly experiencing the deprivation of the most basic needs in life; some managed to survive the worst of conditions.

Frankl concluded that the primary motivational force in humankind is the search for the meaning of life. The fundamental premises that he related to humankind are:

- 1) The human has a free will.
- 2) The individual's primary force in life is a will to meaning.
- 3) There is actual meaning in life (Frankl 1978:98-102).

i) The will to meaning

The will to meaning is a primary force in humans' lives, and is not an instinctual drive. The meaning to life can be attained to by the person alone. Frankl believes that values and meanings are something which the human will live and die for, and that values and meanings are not mere defence mechanisms. It means that human behaviour is goal-and-value-oriented. Human actions are directed, and achieved by the human being's own goals and values. Achievement is possible because of the person's spiritual level. The spiritual level enables people to reflect on themselves and their world, and to take the responsibility to make decisions. Humans are therefore teleological beings, according to Frankl (1978:99)

For Frankl (1978:100) meaning is not a mere self-expression of the individual, he writes:

For logos, or 'meaning,' is not only an emerging from existence itself but rather something confronting existence. If the meaning which is waiting to be fulfilled by man were really but a mere expression of self, or no more than a projection of his wishful thinking, it would immediately lose its demanding and challenging character, it could no longer call man forth or summon him....This holds true as well for the contention of some existentialist thinkers who see in man's ideals nothing but his own inventions.

Frankl (1978:101) maintains that values are not the driving force of humans, since they do not push them, but rather pull them. The concept of being pulled by values implies that freedom of choice is involved. The freedom of choice means that the individual decides to behave in a specific way, e.g. to behave morally. To behave morally is not directed by a drive.

Man is never driven to moral behaviour, in each instance, he decides to behave morally. Man does not do so in order to satisfy a moral drive and to have a good conscience. Man does not behave morally for the sake of having a good conscience but for the sake of a cause to which he commits himself, or for a person whom he loves, or for the sake of his God.

(Frankl 1978:101-102)

Frankl believes in three levels of human existence, namely: physical, psychological and spiritual. On the physical level, the human is a complex biochemical mechanism. On the psychological level humans have needs, drives, intelligence, ecetera. It is, however, the

spiritual level which distinguishes the human from animals. These three levels are not seen as separate entities, but rather one. He contends that it is not the satisfaction of physical and psychological needs that are the priorities of human strivings, but rather that humankind is free to persevere for spiritual goals. Frankl does not agree with Maslow's theory of a hierarchy of needs. He believes that the importance lies in ungratified needs presenting a hindrance to the person in search for meaning. For him, ungratified lower needs do not block the higher needs from surfacing. He is convinced that people's basic need is the need for meaning in their lives. Frankl (1978:36) writes:

Maslow's distinction between higher and lower needs does not take into account that when lower needs are not satisfied, a higher need, such as the will to meaning may become more urgent. Just consider such situations as are met in death camps, or simply on deathbeds: who would deny that in such circumstance the thirst for meaning, even ultimate meaning, breaks through irresistibly?

The human's aim is not the priority of satisfaction of physical and psychological needs but to strive to be free to attain to spiritual goals. In other words, Frankl seems to believe that motivation to find the meaning of life is the means to achieve, even in situations of great physical and psychological needs deprivation. It is this dominant need to find the meaning of life that helps to cope with situations, where basic physical and psychological needs cannot be satisfied. The search for meaning may, however, be frustrated by ungratified physical and psychological needs (Meyer, Moore & Viljoen 1989:429).

Frankl considered frustrations as the outcome of neuroses, which he refers to as "noogenic neuroses", that relate to the human existence element. The spiritual level of humans does not have a primarily religious connotation. Noogenic neuroses are associated with conflict between drives and instincts. They are conflicts between values. For Frankl (1978:104) conflicts can be considered to be normal, he writes: "suffering is not always a pathological phenomenon; rather than being a symptom of neurosis, suffering may well be a human achievement, especially if the suffering grows out of existential frustration ... A man's concern, even in his despair, over the worthwhileness of life is a *spiritual distress* but by no means a mental disease."

Frankl disagrees with Maslow's theory of homeostasis. He is convinced that the search for meaning and values may cause inner tension instead of creating inner equilibrium. He maintains that this is an essential requirement for mental health and well-being (Frankl

1978:105). He is of the conviction that there is more to life than gratification of needs and drives. People's adjustment to life can be found in actualising values and goals in their life's cycles. It means that the meaning of life may be fulfilled in any circumstances. Conflicts and tensions are a normal requisition for development. He says regarding homeostasis (1978:107): "I considered it a dangerous misconception of mental hygiene to assume that what man needs in the first place is equilibrium or, as it is called in biology, 'homeostasis,' i.e., a tension-free state."

ii) Responsibility in freedom of will

An essential vacuum has occurred as humans lost some of the basic animal instincts, and in the loss of traditional direction, which is diminishing in contemporary changes taking place. People are subjected to making choices regarding their own behaviour. No traditions or instincts tell them what to do. In facing dilemmas humans sometimes wish to do what others do, which results in conformism. On the other hand, when they do what others think they should do, the result is totalitarianism. Submitting to such manipulation results in loss of meaning of life, which Frankl refers to as an existential vacuum (Frankl 1978:108-109). For Frankl, responsibility-taking is absolutely essential for human existence. He says (1978:111): "In a word, each man is questioned by life; and he can only answer to life by *answering for* his own life; to life he can only respond by being responsible."

iii) Meaning of life

The meaning of life is something which cannot be fixed, and cannot be predicted. Ways of finding the meaning of life must be associated with the specific meanings of a person's life at specific moments in time. Meanings of life cannot be generalised, since they differ from person to person, as well as on a daily basis. As a responsible person with freedom of choice within environmental limitations, each individual has the ability to actualise the potential meaning of his/her life. Frankl, however, rejects self-actualisation. He maintains that:

....true meaning of life is to be found in the world rather than within man or his own *psyche*, as though it were a closed system ... the real aim of human existence cannot be found in what is called self-actualization. Human existence is essentially self-

transcendence rather than self-actualization. Self-actualization is not a possible aim at all, for the simple reason that the more a man would strive for it, the more he would miss it.

(Frankl 1978:113)

Frankl pointed out that meaning of life is found in three types of experiences; namely :

- experience of achievement in contributing to life
- experiential values, values that we receive from life, the greatest is life
- experiencing suffering, that is concerned with the attitudinal value of life's experiences

4.3. AGREEMENTS IN THEORIES

Although the theorists discussed vary in numerous points of view concerning needs presentation and needs gratification requirements, they do agree on a number of points.

All agree to some degree or other, that:

- 1) Needs occur in human daily living. Although there may be a degree of differing amongst the theorist on whether needs are basic or specific by nature, or whether psychological needs are dependent on physiological needs; on the whole all are convinced, needs do occur.
- 2) Ungratified needs prevent or stunt the development of potentialities in the person. Maslow believes that ungratified lower needs prevent potential from being actualised. Rogers connects development to gratified needs and a self-concept, which may increase or stunt growth. Murray and Frankl make room for the actualisation process (growth) by means of goal directiveness and striving towards achievement.
- 3) The human either strives, pushes or pulls for happiness and well-being, or the meaning of life.
- 4) Goal directiveness plays an important role in meeting human needs.
- 5) Life is a continual state of tension and happiness is achieved in a tension-free state Freud maintains, while Murray holds that part of life is tension-free, and that a tension-reduction process achieves happiness. Rogers, and Frankl consider that a tension-increasing state may occur. Maslow refers to relief in tension and a homeostatic state. All the theorists agree that the state of tension, whether relief, reduction, or tension-free, is the motivation for goal directiveness.

6) All agree that internal and external factors have a role to play in human behaviour.

4.4. NEED THEORY APPLIED TO THE PERSON IN CHRONIC PAIN

In considering what has been discussed thus far concerning the person in chronic pain, it will be helpful to look at other versions of what a need is considered to be. Murray's definition of a need has already been referred to. In the A.F.B. Research Report Delaney and Nuttall (1978:4) refer to Kahn, who defines needs as: "Needs are social definitions, representing a view of what an individual or group requires in order to play a role, meet a commitment, participate adequately in a social process, retain an adequate level of energy and productivity at a given moment in history."

Abbey-Livingston and Abbey (1982:15) point out that the term needs can have different meanings. Used in the sense of what people need, needs to them mean the gap between what experts say is necessary and what people actually have available. The need is the difference between what people currently have and the standard for survival. They consider that needs assessment is often about finding out what people require to meet some standard established by some experts.

The view that will be used for the purpose of this study is as follows: needs are requirements in human living, and ungratified needs may present a hindrance to the person, and the meaning of life may be lost. Basically this is in agreement with Frankl's approach. However, needs are goal-directive and motivational. The human has all the potentialities to strive for goal achievement, using internal and external potentials to find meaning in life despite need deprivation circumstances. This statement is in line with the growth motivation needs version of Maslow (and the developmental versions of Rogers, Murray and Frankl).

I do not agree with Maslow that needs are hierarchical in gratification requirements, and that the actualisation process is stopped by ungratified lower needs. This study will not follow any claims to a hierarchy of needs. For this study, the assessment of needs of people in chronic pain is about finding out what they require to meet some standard established by some experts. For care of a pastoral work nature, it is important to determine the need gap between what is required and what is lacking concerning people in

chronic pain. This will assist in developing more effective help from a pastoral work perspective.

There are a few points that I would like to draw attention to with regard to the various personologists' theories discussed, that are relevant to the chronic pain process.

1) Rogers' belief is that each individual has a need for actualisation, and that associated with the process of actualisation of inborn potentialities is the need for positive regard by others and positive self-regard. Needs not satisfied in these areas have consequences against actualisation of potentials, and therefore upon the self-concept of the individual. The effect may be positive or negative to the person's concept of self and to behavioural consequences. This concept of self is relevant to people in chronic pain, since throughout the chronic pain process they encounter onslaughts against their self-concept, in various ways. Physical changes and limitations, and the consequences of these, change the way the individual sees him/herself. At some stage of the chronic pain process, people in chronic pain struggle with their self-image.

2) All the theorists agree that the external environment has some influence in the development of the individual. Freud, Murray and Rogers see the moral codes and values of society as an external pressure upon people, in the form of guilt (conflict between the ego and superego) or as disapproval or approval. People in chronic pain may experience moral codes and values in society which cause conflict situations for them, and it may result in them taking action to relieve the conflicting tense situation. For example, in a church where the norm is to sit still, and to listen quietly, a person in pain may not be able to sit still and may disturb others. They may fear that they are disturbing the normative expected behaviour of the congregation. To ease the discomfort of the situation the person may decide it is better to stay away from church.

3) Murray refers to what he calls the fusion of needs, and states that needs activated simultaneously may conflict with each other. It has already been explained what sort of an incident may occur in such a situation, relevant to people in chronic pain. All the theorists place some importance upon values and goal-directed action towards actualisation. Relevant to the chronic pain process is the difficulty to maintain goal directiveness in a process which is constantly changing. Adjustments must continually be made. For people in chronic pain short term and long term goals must frequently be discarded or re-directed.

For example, a student may have to interrupt his or her studies permanently or temporarily, owing to the developmental phases of the chronic pain and associated disease process.

4) Human motivation is about striving for satisfaction and happiness in various ways. Goal-directiveness and achievement needs are important factors in striving for well-being and growth. The person in chronic pain may have difficulty in achieving satisfaction of the most basic needs. At some stages of the chronic pain process, e.g. owing to physical limitations at particular phases of the pain process, simple tasks may be impossible to accomplish, such as ablution needs. Achievement needs for the person in chronic pain may be constantly frustrated.

5) People in chronic pain frequently experience difficulty in finding meaning in life, owing to frustration of goals and achievement needs. Hope becomes something which fluctuates continually, and becomes an abstract concept instead of something concrete. Frankl is convinced that the human, as a teleological being, has the will to find meaning in life, as the primary force in the human's life. Associated with the will to find meaning in life is the freedom to exercise choice and assume responsibility for this choice. This means that the person has the potential, despite adverse circumstances, to rise above any need deprivation situation.

What have the above points to do with pastoral care and counselling? Pastoral work includes the actions of help by which the various levels of pastoral-oriented care may be exercised, to people in chronic pain. It is the area of care, which helps by alleviating needs and problem areas that occur in the daily living of people in chronic pain. Pastoral work embraces the disciplines that should assess the situation, and give direction to the faith community regarding care to be exercised. It is also the area of care that tries to help people in chronic pain find ways to exercise the right choices and to take their own responsibility for the choices made. People in chronic pain require help to correctly manage decisions that will enhance life and well-being for themselves. Hence it is imperative for pastoral care and counselling that a deeper understanding of the circumstances, feelings and need requirements of the person in chronic pain is reached.

CHAPTER 5

PASTORAL CARE AND COUNSELLING

5.1. INTRODUCTION

There are numerous theories describing practical theology. There are also numerous versions of understanding concerning each approach (theory). Theories and versions of each approach vary from the confessional to the more liberal approaches to practical theology. Each approach with its varied versions as they come under the searchlight of constructive critical reflection is found to have some advantages and disadvantages in some way or other. The theory (object of study, source and norm) favoured as to what practical theology is influences the kind of pastoral care and counselling given to others (Heyns & Pieterse 1990:3-10). The stance that this study takes is more of a constructive critical correlative approach. Pastoral care given to people in chronic pain will include a pastoral praxis that is integrated and interconnected. It also includes a Christian social praxis (Cochrane, de Gruchy & Petersen 1991:2,17).

This chapter will discuss the various perspectives of pastoral work, how and where each is applicable to the Christian caring establishment. A brief account of the history of pastoral care and counselling and a discussion of the language distinction between theology and psychology will follow. Finally some pastoral care and counselling theories will be considered. Using the term "pastoral work" and "Christian caring establishment" or "faith community" indicates that I base this care on faith in God, and it is Christ-centred motivated. However, care is aimed not only at the community of faith, but also at those who do not go to church. To avoid confusion the term pastoral work is used to indicate the incorporation of the three levels of Christian caring action.

Care occurs when one person responds to another by an act that indicates helpfulness. Situations of caring are found in numerous daily activities and cover a vast field. This study is concerned with a perspective of caring which may be considered specifically Christian, or pastoral in character. Caring in the context of pastoral work is motivated by the compassionate love of God, and conveys actions of God's caring from one person to another in dialogue. It is to enter into the other person's story, and in reciprocal dialogue to bring the Christian faith story of hope to the person in need (Gerkin 1984:25-28).

Pastoral work and people go together. Pastoral care cannot be given without becoming involved with people. It means becoming involved with people's lives, bringing the redeeming, transforming presence of Jesus Christ to them, in a manner that encourages and builds up.

5.2. CHRISTIAN FAITH COMMUNITY

Traditionally practical theology largely focused on the action of the pastor (clergy) within a congregation. The image of the Shepherd and his flock indicated an authoritarian pastoral role where the flock consisted of merely passive members of the church. Contemporary Christian society perceives the faith community more in line with the Pauline image of the church in comparison to the human body (1 Cor 12) (Heyns & Pieterse 1990:16-17). It allows for the idea of interdependency and interaction between the members in the body of Christ. This focuses the attention of practical theology on the laity as well as the clergy's role. Heyns and Pieterse (1990:17) point out that "Faith is no longer confined to Sundays and Church: it has become a way of everyday life." (Eph 4:13-16).

The church remains important, that is its inward function, but also the (outward function) faith activities of all believers in their interrelations and interactions in the world. The body of Christ image may be described in ecosystemic structures in relation to Christ's redemptive action. According to this study, the Christian faith is firmly established and embodied in the redemptive action of Christ as the "new (second) Adam" enabling the "old Adam" (renewed in Christ) to function in the body of Christ (Eph 4:13 -16). De Jongh Van Arkel (1987:214-215) appropriately points out that Scripture is systemic in its perspective on the individual. He says: "The individual can only be understood when the 'systemic' corporeality of 'in Adam' and 'in Christ' is taken into account as the metasytem of his or her life."

5.3. DIMENSIONS OF PASTORAL WORK

Pastoral work is multi-dimensional, or have numerous perspectives, each with a different level of care, that interconnects, interrelates, and interacts with others. Each dimension may provide a level of care that may be specific to that perspective, yet there may be an

overlapping of the levels of care. The basic dimensions of pastoral work considered for the purpose of this study are mutual care, pastoral care and pastoral counselling (De Jongh Van Arkel 1991:102-104).

This study approaches care given to people with chronic pain as perspectives of pastoral work that integrate and do not form compartments. In other words, this approach will not centre on any one perspective of pastoral care, but will rather demonstrate the integration of all the above-mentioned perspectives of pastoral work in caring for people in chronic pain.

5.3.1. Mutual care

Mutual care is given by the lay people of the faith community. The laity exercises the level of care that gives support and encouragement to one another in interaction, within the body of Christ. Sustaining describes this type of care exercised towards one another. Galations 6:1-10 and Ephesians 3:12-16 describe the action of sustaining since it urges believers to bear one another's burdens, and to admonish one another. These scriptures refer to the attitude within the body of Christ. James 2:14-26 considers the relationship between faith and caring actions. Faith and actions of caring are inseparable to James, since he specifically refers to practical help in caring for the faith community. Sustaining care brings encouragement, comfort and the presence of caring persons who give reassurance to someone in need or distress (De Jongh Van Arkel 1991:103; Pattison 1988:5-8).

Mutual care should be an everyday participation by each member of the body of faith. Every member should exercise, and experience such care: friendship, visitation, prayer in times of need, practical help in times of a crisis. Availability in times when help is needed, a telephone call to give encouragement, are all daily exercises of mutual care (Pattison 1988:11-12; De Jong Van Arkel 1991:103).

5.3.2. Pastoral care

Pastoral care is the next type of care in pastoral work. Again it is usually care exercised within the church. It requires greater expertise than that given in mutual care. However, often selectivity is exercised, and the laity is included in participating in pastoral care. Frequently the deacons and elders are included in this kind of care. Since greater expertise

is required as the needs are more complex, some training is required to cope with the complexity of needs and problems. The training expectations are theological qualifications or specific programmed courses with specific requirements attached to the courses. In a caring situation there is the danger of causing harm no matter how well-meaning the intentions might be. This is the reason for expertise as a prerequisite in giving care in more complex circumstances (Pattison 1988:9-10,13-14; Patton 1983:11-16).

5.3.3. Pastoral counselling

Pastoral counselling is the third type of care. It is caring that is on the same level as other helping professions, that is, clinical or counselling psychology and social work. This level requires qualifications in theology and counselling that include enhancement of counselling skills that introduce psychotherapeutic models. It must consider the psychology active in every human situation, since effective and perceptive actions have a strong influence on sustaining care activity. Hence, when problems arise from difficult unchanging, painful situations, hurts and needs occur that inflict distress. It means that bearing one another's burden, giving encouragement, and exercising caring actions may have both theological and psychological therapeutic claims. The human being has physical needs, psychological needs, social needs and spiritual needs. None of these needs can be compartmentalised since human needs overlap, interconnect and interrelate in interaction with one another. This form of pastoral work deals with people (individuals, couples, families and groups) with deep relationship problems (Heitink 1984:77-78; Patton 1983:17; Gerkin 1984:11, De Jongh Van Arkel 1991:105).

Each type of care is a priority in the caring actions of pastoral work. Although the last two types mentioned require more expertise, each level of care has an important role to play. There is no hierarchy, or inferiority or superiority, since each care level overlaps with others at times, and each has a specific role to play in giving Christian care. The various levels of care are not separate, yet separate from one another. They are interconnecting and interdependent in action. One could say that each level of care needs the others to exercise Christian care to the needs of the whole person.

The situation is not perhaps as clear-cut an impression as the above discussion has given. There has been tension throughout the history of pastoral care and counselling. At this

stage it will be appropriate to deal with the various tensions that occurred (Patton 1983:21-22;).

5.4. PERSPECTIVES ON TENSIONS IN PASTORAL CARE AND COUNSELLING

Throughout the history of pastoral care and pastoral counselling numerous definitions developed. Steven Pattison (1986:6) draws attention to the lack of a clear definition of pastoral care. He suggests that pastoral care was perceived as a practical activity that covered an extensive variety of activities. Clebsch and Jaekle (1964:44-56) conclude that the effects of pastoral care are healing, sustaining, reconciling and guiding. Thurneysen considers pastoral care as the task of the church in preaching the gospel.

Various arguments ranged from one extreme to another. One argument was that pastoral care was restricted to the role of the church. Another considered it as care given in the name of the Church with no necessity of any training (Pattison 1988:9-11).

Specialisation occurred and private practice developed, and pastoral counselling became individualistic and problem-oriented. It did not address the individual in the context of a larger community (Pattison 1988:12; Patton 1983:10). Pattison (1988:13) defines pastoral care as *“the activity, undertaken especially by representative Christian persons, directed towards the elimination and relief of sin and sorrow and the presentation of all people perfect in Christ to God.”* Pattison also does not consider pastoral care as solely directed towards Christians.

John Patton believes that pastoral counselling in all its forms needs to address the need for dialogue between theology and psychology to accomplish full pastoral care to a broken humanity. For Patton (1983:14), humanness offered in a relationship patterned after the humanness of Christ to us is what pastoral counselling is about. Patton (1983:16) defines pastoral care as: *“Pastoral care is one of those distinctive forms, and it is understood here as the broad response of the Christian community through her ministers to persons who are some way alienated from their faith, or from other persons.”* The problem with Patton’s definition is that pastoral care includes only ordained ministers and it excludes the laity from this function. It does not address the mutual care function of the church. Patton maintains that pastoral counselling is a type of pastoral care performed by an ordained

minister, and includes support, guidance and various means by which care is expressed (Patton 1983:17). It becomes apparent from the above discussion that the idea of pastoral work is a rather complex and variegated one.

Gerkin (1984:11), while discussing the need for a balance between pastoral theology and psychology asks: "How can pastoral counseling be at the same time both an authentically theological and a scientifically psychological discipline?" He points out that it was necessary for pastoral counsellors to consider the language and theories of psychology in their confrontation of human problems. Pattison (1988:26) upholds the same reasoning as he acknowledges that too many pastors are still ignorant and unskilled in counselling methods. However, Pattison (1988:27) refers to Thomas Oden, who was a major leader in incorporating concepts and methodology from psychology into pastoral counselling. Oden advocated critical scrutiny of any psychological theories before acceptance into pastoral counselling. Oden himself rejected views such as:

- autonomous individualism (ie. the focus entirely on the individual)
- naturalistic reductionism (i.e. only the concrete can be studied)
- narcissistic hedonism (i.e. the idea that the individual seeks the best in her/himself)

Clinebell's pastoral care and counselling has moved towards a more holistic focus on the individual in the context of social and biological systems (Pattison 1988:28-29). It is obvious from the previous discussion that there are numerous tensions that developed throughout the years. Sorting out the distinction between pastoral care and pastoral counselling became complex.

At the beginning of this chapter, I attempted to place the types of care into levels of care and placed these caring actions under the category of pastoral work. The purpose was to convey the separateness, yet the integrated nature of mutual care, pastoral care and pastoral counselling, also to convey that there is no hierarchy of these three types of pastoral caring action, that each is relevant in applying Christian caring to people, and that there is an interdependency between the types of care. However, in practice it is not so apparent.

I understand pastoral work (in the context of Christian faith care) to be the process of communicative action by reciprocal dialogue (between the giver and the receiver, or receivers of care) to come to an understanding and interpretation of the care needs. Action is taken to assist the person (people) to find goals that will bring hope and growth into the situation, within the context of the hope in the Christ story. Pastoral care, pastoral

counselling and mutual care are integrated in this process by spontaneous or planned action.

In terms of an ecosystemic perspective in defining pastoral care and counselling, Keeney's (1979:111) view on diagnosis will be appropriate to apply to pastoral care and counselling. I consider pastoral care and counselling as a way of coming to know, to understand and interpret a need situation (within the person's story) through an epistemological framework that contains cybernetics, ecology, and systems theory, in reciprocal communicative action. Retracing the historical steps of pastoral care reveal a tension between pastoral counselling and psychology. It appears that the problem is to line up theological language and psychological language when dealing with human lives and ultimate meaning. This study has already discussed some human development concepts, however, the question remains as to the acceptability of these concepts to theology.

5.5. LANGUAGE OF FAITH AND PSYCHOLOGY

This study is concerned with pastoral care and counselling to people with chronic pain. It has taken the direction of exploring avenues associated with human behaviour and development. Many of the concepts are formulated from psychology. Terms such as self-actualisation, innate potentialities, needs, happiness, well-being and relationships have been used. Questions arise, namely:

- 1) Is it possible and acceptable to mix the ideas and language of psychology and theology?
- 2) Can psychological language be used to talk about man's relationship to God?
- 3) Is there a distinction between the Word of God and the word of man's wisdom?
- 4) How can one avoid the danger of psychological reductionism, that is, reducing the truths of the Word of God to psychological terms (e.g. forgiveness to acceptance, faith to self-actualisation)?

Droege (1978:35) suggests that it is necessary to consider the relation between God's and man's word, but also to respect the distinction. According to him the Christian community's language is grounded in terms such as confession, repentance, reconciliation, witness and praise. Psychology cannot be used to understand the structures of faith. Scripture is the primary source of faith understanding and faith language. The language of faith stems from the salvation history contained in the Word of God, and is the norm for

understanding faith. It is carried forward into history by the Christian church. The same language used to describe faith history (past, present, future) is used to describe relationships. Faith is the experience of knowing a relationship with God, however, knowing God also brings the person to know a relationship with others (humans).

Thomas Droege (1978:36) says: "This raises the sticky question of the relationship between the language used to describe man's relation to God (theology) and the language used to describe man's relation to others (psychology)." For example, this study discusses self-actualisation theory among psychology theories. Is it possible to have a self of theology and a self of psychology? It is feasible if self is considered as one concept, but approached from two different perspective. Actualisation of self (actualisation of innate potentialities, development and growth) is considered from two different points of view. It is not two selves (one person with two selves), but rather two ways of looking at one self. In other words, the person who relates to God is the same as the person relating to people. To trust in God (relationship with God) is an act of faith (theological language), yet trusting others (relationship with people) is usually described as a psychological function (psychological language). However, it is the same person in relationship in both situations. Theology may have its own theory regarding actualisation and does not necessarily accept the theory of psychology concerning self if it goes against faith beliefs (Droege 1978:37).

Regarding different perspectives and languages concerning humans, the psychological functions of personality and functioning arising out of the person's relationship with God are not separate from one another. Theology and psychology address the same individual. The individual is not a spiritual being addressed only in the language of theology, nor a psychological being addressed only in the language of psychology (Droege 1978:38-39). The human is a relational personality (with God and man). The understanding of the person in terms of behaviour, development and growth (within ecostructures) is what is different, and the language used to express this is different. However, this distinction does not necessarily mean that the baby gets thrown out with the bath water. Theology is justified in addressing the person in terms of his or her relationship with God and in terms of relationship with others. Faith in God results in relationships with others (humans) (Patton 1983:14-16). Humans are created beings of God, hence the wholeness of man

originated from God. The following quotation may express the faith concept more adequately:

In terms of faith, holism points to the fact that faith encompasses the whole person (it does not involve only cognitive or affective or conative aspects) and integrates emotional and physical elements, bridging the old divisions of body and soul. Faith does not only relate to redemption but is also relational: God and neighbour, creation and the world are connected through faith.

(De Jongh Van Arkel 1987:218).

Both disciplines' (psychology, theology) involvement in caring activities are justified, but neither have dominance in describing humans in terms of relationships or methodology in care actions.

The history of pastoral care and counselling reveals the tensions incurred during particular phases. Pattison (1988:23) describes it as a syndrome of jumping on the bandwagon on the one hand, and on the other hand, specialisation became a reason for suspicion. A better balance between concepts from psychology and theology, language usage, and the distinction and relationship between the two disciplines, has to a large extent been accomplished. The possibility of interchanging concepts, terminology and methodology in addressing the human being became more feasible. It is however, imperative for theology to weigh each concept against principles of faith before accepting psychological theories.

De Jongh Van Arkel (1987:186), in referring to pastoral counselling, says that it:

....is a specific form of helping which takes place on the same level as other helping professions. The theory of pastoral counselling uses theological and psychological insights. Its uniqueness has to do with the perspective and heritage which it presents. Because the basic perspective is theological, all (psychological and other) theories need to be evaluated and 'transformed' for use, and then used only in so far as they are acceptable to the basic theology.

This study gives priority to theological language. However, psychological language makes an important contribution to the dissertation, but maintaining a balance acceptable to a theological approach receives priority. Practical theology's focus is often described in many ways. The history of Jesus and the relevance of his life in the history of the world, the incarnation and the kingdom of God are some ideas that are the norm for pastoral

theology. A discussion follows of the study of some theories and models of pastoral care and counselling to explore various focuses of pastoral theology.

5.6. PASTORAL WORK THEORIES

5.6.1. Heitink

Heitink's (1984) aim was to form a model of pastoral counselling. The core principle of his model is bipolarity. The two poles are interdependent yet balanced. They operate in a balanced relationship with one another. In the model of bipolarity, relationship interactions are constantly present. For example, God is known only in relationship with himself, since God created humankind to relate to. Humans in turn are understood in their relationship with God. God and humankind are the two focal poles. Heitink is convinced that a relationship with God (one pole), must result in a relationship with God's creation (humankind, the other pole). This does not mean that humans are equal to God, but rather, that the pastoral counsellor in relationship with God will relate on the horizontal level to humans. All human beings are God's creation. The pastoral counsellor in relating to God (knowing God) brings the message of God (caring action) to God's creation (people) (Heitink 1984: 20-23).

Heitink looked at some perspectives of pastoral counselling, and applied his principles of bipolarity to them. For example:

- 1) Pastoral care and counselling: Pastoral counselling with a theologically oriented foundation (one pole) and counselling which uses psychological theory and methodology (the other pole).
- 2) The pastor (one pole) and the counsellee (the other pole). The pastor in his relationship with God can only fulfil his calling in an encounter with another human.
- 3) A relationship with God by salvation through Jesus is a must, but humans also have their everyday lives to live in their humanness. God is not known without a relationship (through Christ), but this does not mean guaranteed successful social living. Abiding by Christian principles is a necessity to maintain a Christ-likeness, as members of society. On the other hand, good social living does not guarantee knowing God (Heitink 1984:84-89,125-129,131). There is this constant relational balance of God in relation to man (and man to God). In his book *Pastoraat als hulpverlening: Inleiding in de pastorale theologie*

en psychologie (1984), Heitink (1984:23), draws attention to the pastoral theology and psychology dilemma. He writes: “Wanneer we spreken van ‘pastoraat als hulpverlening’ is dit het resultaat van een ontwikkeling, die zich de laatste tientallen jaren op het gebied van de pastorale theologie en psychologie voltrokken heeft.”

Heitink criticises the one-sided polarity that pastoral theology has taken over the years. Into this he brings his concept of bipolarity (Heitink 1984:75-81). For Heitink, the helping professions are concerned with people. It is to people that helping actions are directed. Heitink (1984:76) distinguishes three forms of pastoral work, namely:

- “.... onderling pastoraat, pastoraat als gemeenteopbouw en pastoraat als hulpverlening”
- “onderling pastoraat” he describes as mutual care, biblically described as the priesthood of all believers (1 Pet 2:9) and the body of Christ (Rom 12 and 1 Cor 12) (Heitink 1984:76)
- “pastoraat als gemeenteopbouw” he describes specifically related to building up the body of Christ, by house visitation (Eph 4:12). This includes pastoral helpers, volunteer workers and contact people (Heitink 1984:77)
- “pastoraat als hulpverlening” refers to the professional pastor: what we call pastoral counselling

Heitink believes that pastoral work has common grounds with all caring disciplines, in that all caring actions are in relationship to people. He claims that various helping disciplines have gained consensus on what human nature is. Heitink (1984:82), when considering whether pastoral counselling, in its pastoral-theological anthropology, can agree with human science anthropology, writes: “Alle vormen van hulpverlening hebben gemeen, dat ze gericht zijn op de mens. Daarom kiezen wij voor een inzet op het vlak van de anthropologie.”

In his attempts to find grounds for agreement between the disciplines, he points out that all helping disciplines agree that:

- a) Humans must be regarded in their totality. I believe that the idea of the human as a holistic being disagrees with Newtonian thinking which breaks the human into parts that are constituents of the whole. However, the new science epistemology approaches humans in their totality within a system, and Heitink’s thinking can include an ecosystemic perspective of pastoral work actions. Heitink (1984:84) says: “....dat iedere helper vanuit

zijn eigen invalshoek te maken, heeft het lichaam, de ziel of de geest van die mens. Allen bewegen zich in het een veld van de menselijke ervaring”.

b) Heitink (1984:89) quotes Paul Tillich, ‘Man experiences himself as having a world to which he belongs.’ Neither the self (one pole), nor the world (other pole), can exist alone, since they need one another.

De mens als persoon is de mens in verbondenheid met de wereld, waarin hij leeft. De ontwikkeling van de persoon kan eveneens gezien worden, als een proces van socialisatie, waarmee we op het terrein van sociale psychologie komen. We kunnen daarom de mens verstaan als een communicatief systeem, van jongsaf opgenomen in relaties....

(Heitink 1984:90-91).

c) Every human not only has a conscious element but also an unconscious element of being. Heitink discusses the psychoanalysts’ view that the unconscious being cannot be left out, since doing so deals only with one level of the personality (Heitink 1984:93).

d) Humans are homo religiosus. Heitink (1984:102) points out that all human science disciplines recognise that human beings are by nature religious.

e) Helping professions accept the idea of development and growth. Secular caring professions talk about actualisation, or self-actualisation. From a theological viewpoint self-actualisation that refers to the human’s own efforts to actualise self is problematic.

Theology has, however, always considered two avenues of thought regarding human nature, namely:

i) The fallen state of man and the relationship between sin and grace. God’s grace (Jesus in salvation event) reconciles humankind to God in dealing with the sin element (Heitink 1984:110-111). This is referred to as special revelation.

ii) Before the fallen state of humankind and the relationship between God and his creation (referred to as general revelation). The human is made in the image of God, and general revelation considers that, despite the fall into sin, some knowledge of God remains. Despite sin, God’s relationship with his creation continues. This suggests that even in the fallen state of sin some element of goodness remains in the human. God created humankind in his own image, but an image that was marred by sin. However, this image may be restored in Christ.

It is in the broader view of creation and recreation (renewal) that Heitink considers the possibility that pastoral-theology anthropology and general anthropology are in some agreement in views. He says:

Voor ons geldt dat bijbelse anthropologie meer is dan soteriologie. Daarom gaan we niet uit van de polen zonde en genade, maar van een bredere polariteit die van schepping en herschepping die mee de eerste omspant. Deze verbreding lijkt ons voor een pastoraal-theologische anthropologie een noodzakelijk uitgangspunt. Daarbinnen - en daarmee ontvangen de volgende paragrafen hun plaats - kiezen we voor een trinitarische benadering vanuit 'de mens als schepsel', 'Jezus Christus de nieuwe mens' en 'de Geest en de humaniteit' (vgl. ook 1.3.). In vergelijking tot de Heidelbergse, zo kan men hieruit al aflezen, zoeken wij op alle drie punten naar een anthropologische verbreding.

(Heitink 1984:112-113).

Heitink focuses on three perspectives regarding a basic anthropology: man as a creature (the natural creation of God), Jesus in his humanness (God put on human flesh, without sin), and the Holy Spirit's function in the lives of humankind as creatures of God. Heitink (1984:127) says regarding the humanity of Jesus:

Deze 'christologie met een menselijk gezicht' is niet zonder betekenis voor een doordenking van een pastoraal-theologische anthropologie. Zij geeft ruimte voor de vraag wat de betekenis is van het leven van Jezus voor het leven van de mens, die we ontmoeten. Op de weg van schepping naar herschepping staat de mens Jezus, mens Gods, mens onder de mensen, die ons het mens-zijn naar Gods bedoeling heeft voorgeleefd.

Concerning the Holy Spirit and humanity, Heitink considers the renewing of the person in the light of Christian liberty and the fruit of the Holy Spirit, all inclusive of humanness. He says: "Van uit onze optiek zien wij de vernieuwing van de mens meer in het perspectief van Gal 5, de christelijke vrijheid en de vruchten van de Geest (vs 22) voor 'de hele mens' om hem meer te doen beantwoorden aan zijn bestemming als mens Gods" (Heitink 1984:129) The question remains, as Heitink (1984:113) puts it "naar de verhouding van de heilsrelatie die God met de mens aangaat en de helpende relatie als een tussenmenselijke relatie?" Heitink maintains that all helping professions (general anthropology) consider the human in wholeness, and the Bible speaks of the image of God

(the creature in wholeness). Both refer to the same reality. Both are concerned with the growth perspective in the wholeness of the person. The link is between creation (the creature) and new creation (renewal) (Heitink 1984:113-117).

Heitink (1984:133) says that: "Deze lijn valt niet samen met de hoofdlijn van een 'basale anthropologie', maar loopt er wel parallel mee." The biblical view of the human as creature, created by God with a destination of renewal and growth in the activity of the Holy Spirit, is parallel to the human sciences' concept of development and growth (Heitink 1984:133). He points out that there is some tension amongst all these similarities. However, it is possible to link pastoral counselling with other helping professions' ideas, and to learn from them. Pastoral counselling is concerned with the human as a whole person within the order of God's creation (Heitink 1984:119-133).

I believe that these concepts of Heitink apply not only to pastoral counselling but are applicable to pastoral work, as a whole Christian care-giving work to people in chronic pain. For the purpose of this dissertation the key concepts of Heitink's model will be used. His key ideas may be summarised as follows:

- pastoral counselling as a helping profession: is equivalent to the human sciences' helping care, in that all care is directed towards people in relation to everyday living. For me, Christian caring action, whether pastoral care, mutual care or pastoral counselling, must be given to people in chronic pain in their relevant ecostructural interactions. Heitink's model allows for this reasoning.
- pastoral care given in the light of the gospel: is concerned with growth in relationship with God, while the human sciences emphasise help given to motivate growth in the person. I consider this applicable to the person with chronic pain, since it includes God and the human relationships of the person. In other words, it addresses the whole person.
- link between creation: Heitink's reasoning that the link between creation and the new creation (renewal) is parallel with general anthropology, means that the whole person is addressed. I believe it includes the possibility that not only pastoral counselling, but pastoral work in general addresses the whole person. It also allows for ecosystemic thinking.
- owing to the anthropology's parallels, and despite some tensions, pastoral counselling can apply sociological and psychological theory and methodology that may be

considered applicable and acceptable to theology. Yet pastoral counselling still maintains its uniqueness, since it is care given in the light of the gospel.

Pastoral counselling can only be fulfilled in an encounter with another human being. I consider that encounter incorporates the idea of reciprocal dialogue, between carer and care receiver. Heitink points out that pastoral care as proclamation described by Thurneysen's model is restricted. I agree that Thurneysen's idea is restrictive, but that proclamation is part of pastoral work in all Christian caring actions. According to Heitink Keryssein is not only preaching, but also has a notion of action. It actualises the life-giving salvation in Christ, in the dialogue. This allows room for God to enter the dialogue (trialogue) during the pastoral encounter.

5.6.2. Firet's theory

Firet (1986) refers to pastoral role-fulfilment. He is convinced that the pastoral role is fulfilled in the human intermediation of God coming in the presence of his word to people, by means of kerygma, didache and paraklesis. Firet (1986:15) writes: "In addressing a congregation, in instructing the members of a church, in assisting parishioners in their problem situations there is a person who acts, not on his own, not by virtue of his own superiority - in whatever respect that may be - but in the name of the Lord of the church, and with the word of God." The idea of the pastoral role-fulfilment as human intermediation of God coming in his Word to people, I believe, is in agreement with Heitink's idea of pastoral counselling fulfilled in an encounter with another human being. The actions of a speaker, a teacher, or a counsellor are a possibility in both views.

Firet emphasises that it is not these elements in the pastoral role-fulfilment that are important. It is rather that these intermediary processes are in fulfilment of the calling of God, to make an appearance himself, in the person of the pastoral carer. God's word is revealed through such intermediation. To him faith (verb) is an action (Firet 1986:16).

5.6.2.1. *The Word of God*

According to Firet (1986:17-18), God continues with his people through history. Christ is the Word incarnate who became flesh and walked the earth, present with humankind (Jn 1:1-3). The Hebrew word used to denote that God exists is a verb which is active, implying that God is active in his presence. The Old and the New Testament point to the

action of God in the history of humankind as evident in the action of the trinity, i.e. the activity of the Father, Son and Holy Spirit amidst his created human creatures.

Firet's concept of pastoral role-fulfilment takes the action of God present by his Word to people, and applies it as the act of God in the life of the minister, who is indwelt by Christ and the Holy Spirit. Pastoral role-fulfilment is seen as the Word of God coming to people by means of the minister as an intermediary.

God is, however, not only concerned with people from a distance, but his active presence is in personal relatedness to the world, that is not static, but holds the notion of motion. God is God of the past, present and future, continually with his creation (Firet 1986:18-25).

In the event of salvation, that is the life, death and resurrection of Jesus, the word of God actualises salvation. It conveys a communicative action of God's truth, faithfulness and love towards people. Salvation actualised communicates healing, peace, righteousness and the kingdom of God. Firet is of the conviction that pastoral role-fulfilment mediates the coming of God in his Word, that pastoral role-fulfilment leads to healing and communication of salvation (Firet 1986:26-29).

For him, the actualisation of salvation means that God by his word (i.e. prophecy, signs, Christ event) continually dwells with people and moves throughout the history of all creation (time and space). God's communicative action embraces relationships and interactions (Firet 1986:31). The communicative action of God coming to his people by his Word requires a response by people, that builds a relationship in interaction with God through the actualisation of salvation. This communication action is reciprocal in relationship interaction between God and his people. These ideas of Firet are in agreement with Heitink's perspective of a practical-theological anthropology that too embraces relationships and interactions between God and humankind, and humans in relationship to one another. It may also hold the same thought of Heitink's, that of God entering into the dialogue during pastoral encounter.

5.6.2.2. Modes of pastoral role-fulfilment

Firet considered three modes of pastoral role-fulfilment, namely kerygma, didache and paraklesis. The three modes will not be discussed extensively, but to address some main considerations.

a) Mode of kerygma

For Firet (1986:44-50) kerygma is proclamation: a messenger is required as herald to impart the message of the Gospel. This kerygma creates.

- 1) Involvement: the contents of kerygma contain a message that involves humankind.
- 2) Healing: kerygma brings healing.

b) Mode of didache

Firet (1986:50-68) describes didache in various ways. He refers to it as the activity of instruction, or teaching. According to him the Old Testament uses it in association with education regarding the history of living, such as exercised in the sphere of the family. Parents were given the task to train their children in the ways of the Lord. (Prov 22:6), "Train up (hanuk) a child in the way he should go; and when he is old he will not depart from it."

Firet points out that no teaching replaces Jesus as teacher, and that the church's didache is to guide others to a discipleship to Jesus the teacher. The mode of didache is not based on a lecturer-to-pupil stance, but rather by example of a living life-style. Firet (1986:64) says: "the mandate: *Matheteusate* - "Make them into what you are yourself." In the process of discipling it is didache which unfolds the kerygma, since didache guides the way of following Jesus. Firet's (1986:67) view is that discipleship is a life in Christ in membership with the body of Christ (Gal 5:6).

c) Mode of paraklesis

Firet considers that the New Testament offers another mode of pastoral activity which may be found in the word paraklesis. Words associated with parakalein and paraklesis include to ask, to exhort, to comfort (Firet 1986:68). Firet (1986:70) writes: "In other words, *parakalein* contains the idea of an address to a contingent situation of a person or a group of persons."

The mode of paraklesis means that God enters into our situations, and the expressions of request, exhortation and comfort may be applied in God's action in entering our situation (present now). Paraklesis addresses from the point of the indwelling Christ. Paul admonishes by the mercies of God, by the name of our Lord Jesus Christ (Rom 12:1, 1 Cor

1:10). The mode of paraklesis calls for an act of response and fruit. The response to God's call to action is activated in Christ (Firet 1986:69-71).

Paraklesis is one mode of God coming in his Word to people through the intermediary of pastoral action. Thurneysen points out that pastoral work must always bring hope and be eschatological in character (Firet 1986:73). Pastoral action in the mode of paraklesis is to bring comfort and encouragement (1 Thess 5:11; Rom 15:14; Heb 3:13.), to admonish (nouthetein 1 Thess 5:14; Acts 20:31). It is to support, to equip for, to strengthen (sterizein Eph 4:11, 12) to mend, or repair, or restore (kartartizein 1 Pet 5:10) (Firet 1986:70-71). Romans 12:8, 1 Timothy 4:13, and 1 Thessalonians 5:11 all indicate that paraklesis is one of the gifts given to believers, and believers are called to exercise these actions in caring. Firet (1986:76) summarises the mode of paraklesis as follows:

In the paraklesis God comes; it is directed toward the contingent situation of a person; it makes an appeal to the salvation already received, it includes the call to return to the love of God; it calls a person out of his or her sorrow or sin to live in peace; it directs the person to the great eschatological consolation; it is a life-function of the body of Christ which lives in the fellowship of the Spirit.

5.6.2.4. Dynamics of pastoral role-fulfilment

Firet asks of what moment pastoral role-fulfilment is the intermediary. The use of language in communication is the means of clarifying and giving understanding. The Word has power to clarify, to open understanding and to bring about change (Firet 1986:93). Two dynamic moments of pastoral role-fulfilment as intermediary of the Word of God, are hermeneutic and agogic moments.

a) Hermeneutic moment

Firet uses hermeneutics in reference to pastoral action that brings the Word of God, that releases power to open up understanding.

When we speak of 'the hermeneutic moment in pastoral role-fulfilment,' we have in mind the first meaning of *hermeneia* and *hermeneuein*: that which gives

understanding. *The Word in which God comes to people is hermeneia, and when that word-event occurs in pastoral role-fulfilment, a power is at work which adds to understanding.*

(Fired 1986:96)

The Word illuminates understanding of self in the light of the Word of God. The coming of God in pastoral action includes kerygma (proclamation), didache (discipleship, teaching), and paraklesis (admonishing, encouraging, comforting) (Fired 1986:93-99).

b) The agogic moment.

Hermeneia (opening up of understanding) results in the agogic moment (that which generates change). Fired (1986:104) quotes from a study report from the Dutch Reformed Foundation for Public Mental Health: 'To proclaim is not just to "announce," there is a "directive" element in it. By its very nature - since it occurs in the midst of life - pastoral care is always agogic, directive - guidance in a certain direction.'

He feels that the report is of some importance in opening up an understanding to agogy, which may be useful for theory and praxis of pastoral role-fulfilment. The Greek verb *agein* means to guide, or lead someone. Agogic may have some meaning for pastoral care, in that God comes to people in his Word to give life. Through the intermediary of pastoral action, the Word of God brings freedom to live and God-given potentials of self to be actualised. Romans 12:2 "Be transformed ..," is possible because God has created the potential for people to change, and hence people must change. The truth of the life-giving Word of God is the potential for change. It is in the mode of kerygma, didache and paraklesis that God comes to humankind by the intermediary of pastoral action (carer) (Fired 1986:105-106).

I believe that Fired's theory of pastoral action as intermediary in the role-fulfilment of the pastoral carer, is similar to the idea of Heitink's model of bipolarity, that is, God and humankind are two focal poles. Fired also develops the idea that the pastoral carer in relationship with God will relate to humans too. It is however, much broader than Heitink's application to pastoral counselling, and, I believe, it may incorporate more levels of pastoral work. He reasons that developing humans are influenced by the context of the world they grow up in. A process of personalisation that forms the personality of the person is developed by the intentional and unintentional process of education. It is in this

process that the person is actualised. Built into the process of personalisation are interpretations of socio-cultural content. Acceptance of processes from these interpretations are based on choice (Fired 1986:143-160).

Fired (1986:161) points out that agogics rooted in interpersonal address is suitable for practical theology, as it is the form of education where the educator (nurturer) forgets that he/she is educating. Briefly, this movement involves the view of education as:

- the educator: educands are co-equal in humanness
- the educand: a person with his/her own responsibility
- education: as a counterpoint in the process of personalisation

The agogic perspective of pastoral action takes place within an interpersonal relationship of trust. It is within the interpersonal relationship between the pastoral carer and the cared for person, and God, that change may take place (Fired 1986:133). He maintains that this new mode of Kingdom existence, and the conversion (or change), is what pastoral role-fulfilment is focused on. Fired tends to include pastoral role-fulfilment into the actions of proclamation, followed by didache, and then followed by paraklesis (pastoral care: what I call pastoral work) to people in need (Fired 1986:203).

Fired addresses the content of the original meaning of the term conversion. The Greek *metanoia* may be explained as (meta) change and (nous) mind, and refers to humankind who should search and think in a new direction (Col 3:1,2). This takes place in combination with the salvation event (the coming of the Kingdom of God). Pastoral agogics is concerned with the force that sets the person in motion for change. It is the intermediary between God's re-creative activity and human existence (Fired 1986:212).

There are three dimensions to the relationship encounter (in which objective realism must be clarified) in the pastoral agogic process. The dimensions are:

- pure receptivity: numerous factors influence perception and result in selective interpretation of reality. Fired uses the term objectivity from the concept given by the Hebrew use *zedakah* (righteousness), which means pure, genuine (that is, without any bias). It is important to develop pure receptivity in pastoral action, as it engenders humility, and enables the pastoral carer to be open to understanding the person being cared for without condemnation or judgementalism (Fired 1986:212-218).

- pure discernment: is dependent on pure receptivity, as in acceptance of the other as he/she is, and adopts the proper attitude towards the person. Pure discernment will give rise to correct assessment of the situation in which help is given.
- creativity: creativity brings order into the need situation (Fieret 1986:218-230).

5.6.3. Gerkin's view

Charles Gerkin's (1984) hermeneutic theory of pastoral counselling addresses the socio-cultural setting of society. He refers to people as human living documents, a concept taken from Anton Boisen's theory. The carer and the cared for come from historical backgrounds, which influence their being (perceptions, values, norms, behaviour). Gerkin (1984:19) says, with regard to a hermeneutical perspective:

Within that broad definition, a hermeneutical perspective sees all human language systems, including both theology and psychology, as efforts to penetrate the mystery of what is beyond human understanding and make sense of it. The common mysteries of concern to both theology and psychology are, of course, human experience and behaviour.

He refers to the task of a hermeneutical theory as relating two language worlds, such as theology and psychology. As each of these language worlds point to different meaning worlds, an interpretative task is required to bring about the possibility of interchange between the language worlds (Gerkin 1984:19). Briefly, the hermeneutical theory applied to pastoral counselling is as follows:

- 1) The pastoral counsellor is a listener to stories. People seek out the pastoral counsellor to listen to, and interpret their stories. Each person's story comes out of his/her history and self-concept.
- 2) Language is the means of expression of the story in relation to relevant ecostructures (socio-cultural factors). The language worlds of the counsellee and counsellor are filled with influential images, symbols, values that are vessels of expression of feelings, and interpretations of experiences. Different language worlds (cultural settings) provide different understandings of meanings and images (Gerkin 1984:26-27).
- 3) The pastoral counsellor bears his/her own story, own language world, to the counselling experience.

4) Pastoral counselling is dialogical in a relational interaction. A process that Gerkin (1984:28) states, is: “a dialogical hermeneutical process involving the counselor and counselee in communication across the boundaries of language worlds”.

The telling of the story may be muddled, filled with distress, denials, vagueness and manipulations that indicate that interpretation of the experience has become painful and confused. The search for an expert in interpretation is a cry for help, for someone to help make sense out of an experience and assist in reducing the pain and in improving coping mechanisms.

5) An interdisciplinary interaction takes place between pastoral counselling and psychology. Gerkin (1984:33) writes:

Meanwhile, my clinical practice of pastoral counseling continued to feed my growing concern for a more even-handed interdisciplinary approach to reflection on that practice which did not subordinate theology to psychotherapeutic theory or subsume psychotherapeutic language into a heavy-handed insistence on the authority of theological word usage and God talk.

6) A fusion of horizons takes place between counsellor's and counselee's language worlds (history, story, socio-cultural world). Similarly between the theory of psychology and that of theology, to bring about correct interpretation and cognitive understanding that brings about change (Gerkin 1984:34-47).

7) Interpretation takes place as reciprocal participation to bring about self-understanding between existential ideas and the ultimate experience. The aim is to bring understanding and meaning into existential living (Gerkin 1984:53).

8) In the history and story events operative in people's lives, external and inner forces are influencing people's lives. External forces are not deterministic in emphasis, but choice is always an option (Gerkin 1984:49-51)

9) Pastoral counselling draws language and meaning from the images and symbols of biblical and theological tradition (Gerkin 1984:62).

10) Gerkin (1984) uses the imagery of life as a pilgrimage, as an organising image of human life under God. The actualisation of self within the concepts (images) of the incarnation, the kingdom of God and hope (eschatological character) is brought into the counselling session (Gerkin 1984:63-64).

Gerkin's view, although it is concerned mainly with pastoral counselling and the tussle between pastoral counselling and psychology, is closely linked to some of Firet's ideas. He uses the same pastoral theology focus as Firet, that is, the incarnation and the coming of the kingdom of God. Both centre to some extent or other on change taking place within a relationship context in assisting people to find meaning by reciprocal dialogue, within the concept of the kingdom of God and hope of the eschatological character. Firet puts forward the modes of kerygma, didache (agogics) and paraklesis to accomplish pastoral actions (pastoral carer), as intermediary of the kingdom of God coming to his people by his Word. Gerkin emphasises the humanness in the relationship between the pastoral counsellor and the counsellee. Language worlds fuse, interpretation takes place on a reciprocal dialogue level, to bring change into the need situation.

5.6.4. De Jongh Van Arkel's conceptual paradigm for pastoral diagnosing

The author (1987:183) defines a conceptual paradigm as a focused though abstract pattern that views reality as a whole and gives an intelligible and unified understanding of reality. In other words it is used to build a world view and/or a model (a tool for ordering). He points out that the idea of a new paradigm, and using new concepts from the physical sciences, are not transferred uncritically into theology. De Jongh Van Arkel concentrates on metatheoretical issues to develop a theory to address the question of the interaction of theology and psychology in the action of pastoral diagnosing (De Jongh Van Arkel 1987:183-184).

5.6.4.1. Interdisciplinary actions

He considers pastoral counselling a specific form of helping that takes place on the same level as other helping professions. Pastoral counselling uses theological and psychological theory to give insight into pastoral action. However, pastoral counselling remains a theologically based action, and must be very evaluative in using secular theories and methodology as acceptable to theology.

Pastoral counselling as an interdisciplinary rather than a multidisciplinary approach conveys the process of interaction between disciplines. A separateness, yet an overlapping and interaction, and interdependence must be experienced to be effective in the helping actions (De Jongh Van Arkel 1987:185-187). De Jongh Van Arkel stresses the need for

theology to move into the position where other sciences need and want to interact with theology to assist them.

5.6.4.2. Theological focus

The metatheoretical issue must be attended to. However, there is a condition that any metatheory is only acceptable in appropriate relations to theology's central focus. This focus must distinguish it as a theological science (De Jongh Van Arkel 1987:191). The writer points out that pastoral diagnostic models use general behaviour or development, or the life story (history) of the person as concepts to make decisions about the needs of the person. He refers to such writers as Capps and Gerkin, who talk about the story instead of behaviour as a focus point. The hermeneutical theory is used to describe pastoral counselling as an act of interpreting a story in the light of The Story (the gospel of Jesus). He writes (1987:193) that: "It is not the hermeneutical process, or the story itself which makes the interpretation theological (or pastoral) but other factors like the focus in the narrative or the fact that the interpretation is done within a theological framework. A decision must be made about where the pastor's main focus in the story will be."

The author prefers the use of the kingdom of God as normative in consideration of pastoral diagnosis. He also feels that a genuinely theological definition of the task of pastoral counselling includes methodology. He refers to Gerkin's use of theological language, which gives direction to reflective decisions in the process of pastoral counselling. De Jongh Van Arkel (1987) points out that methods of observation are related to the condition that theology's central focus is the evaluative point. Moreover, little attention is given to the influence that the methods used have on the observing process (De Jongh Van Arkel 1987:194-197).

In his paradigm for pastoral diagnosing, he uses the systems theory terms, namely holism and cybernetics. De Jongh Van Arkel maintains that reality to humans is that what is believed to have been investigated and discovered, and this shapes people's world view. The therapeutic context is constructed and maintained by the method in which data is captured, the way in which the therapist applies questions and a hypotheses into the counselling process, to assist in recognising the reality of relevant problems in the counsellee's life. By joint effort a shared reality is constructed through the epistemological beliefs they establish. This means that pastoral counsellors effect the system they are

involved in, intentionally and unintentionally (De Jongh Van Arkel 1987:198-199). De Jongh Van Arkel's view correlates with Gerkin's view that through the listener to the story and the fusion of horizon reality is realised, and changes jointly established. This also holds some of Firet's view that the educator intentionally and unintentionally influences the educand, only De Jongh Van Arkel (1987:183) refers specifically to the action of pastoral diagnosing in counselling.

According to the author (1987:200): "A diagnosing community is created as the pastor perturbs the counselee's systems with probes." In other words the pastoral counsellor becomes observer by involvement within the system and not merely an objective observer from without. It is the involvement of the pastor in the pastoral counselling system that brings about a reciprocal relationship. A circular action takes place between subsystems and systems. De Jongh Van Arkel (1987) refers to the first order cybernetics of pastoral diagnosing, as the cybernetics of observed systems, and to its complementary action as the second order cybernetics (the cybernetics of observing systems) (De Jongh Van Arkel 1987:201-203).

5.6.4.3. Constructivist approach

He (1987:206) prefers the constructivist approach and says:

I have opted for a cybernetic constructivist paradigm of knowing and understanding, albeit not in a radically relativistic or a solipsistic fashion. A or the Truth as a possible objective (even ontological) reality is not denied and replaced by an ultimate, but subjectively observed reality, as the reality. I prefer a constructivist position because I believe that the observed reality is not the reality.

From the constructivist's position De Jongh Van Arkel develops the following categories:

- a metaphorical function: this position ties in with theories of the metaphorical function of religion. The Bible speaks metaphorically about God. The faith community is inclined to use religious concepts metaphorically to give expression to life situations and convictions (private and group meaning). The metaphorical element is used as a means of communication between counselee and pastoral counsellor (De Jongh Van Arkel 1987:207-210).

- a systemic perspective: De Jongh Van Arkel (1987:211) states: "In short, systems theory refers to the functional or teleological organic interrelatedness and interdependence of dynamic entities incorporating the whole (Lines 1987:9,43,44)."
- the faith community: its corporate beliefs and values are considered within the redemptive event of Christ, from a systemic perspective, that is, a set of elements connected together to form a whole, a cybernetic network that processes information in a network of human relationships. The therapeutic process is concerned with patterns of relationship that are described by metaphors. (De Jongh Van Arkel 1987:214-216).
- holism: the therapist is concerned with understanding people in relation to their relevant (eco)structures, and the reciprocal influences. The concept of systems, subsystems, and large system (environment), as levels of a connected network that are interdependent and interact in a circular feedback motion, influencing one another, are described. Terms such as differentiation, boundaries, dynamism, equifinality, feedback, coherence and circularity are used (De Jongh Van Arkel 1987:217-238). I will not go into any in-depth discussion at this point regarding these terms, but will briefly refer to them:
 - differentiation: refers to holistic properties as not being fixed or rigid, but making room for specialisation, complexity and creativity.
 - boundaries: a permeable boundary permits distinction of a system from surrounding environment, yet allows a connectedness. Boundaries determine the openness or closeness of a system (De Jongh Van Arkel 1987: 219-220).
 - equifinality: the teleological character of an open system. The system is purposeful and not deterministic. Pastoral diagnosis is focused on goal-finding (purposeful action). Theologically the connecting pattern is faith in Jesus Christ and the Spirit of God. Through faith we are connected to everything and everyone through the Spirit. If sin is seen as a relational break (the fall), then salvation may be seen as an act of healing (De Jongh Van Arkel 1987:224-228).
 - feedback: the open system obtains its goals by positive and negative feedback. In pastoral counselling, an understanding of feedback within and between systems must be achieved, to create alternative forms of feedback into the counselling situation, to bring about appropriate change. Feedback takes place at various levels, from simple to complex. Complex systems involve a hierarchical arrangement.

- coherence: the writer uses the word coherence instead of homeostasis, to convey stability and continuity in the midst of change (De Jongh Van Arkel 1987:229-232).
- circularity: the motion of feedback. The follow through of influences that take place within the system in interaction and interrelationships. Recursive patterns of behaviour are formed from interpersonal relationships (De Jongh Van Arkel 1987:233-2342).
- multiple descriptions: how each person thinks, punctuates the situation and interprets the punctuation, gives an broader explanation of the situation. A focus on relationships and patterns requires such multiple descriptions (De Jongh Van Arkel 1987:246-248).
- cybernetics: a theory that considers that change cannot be realised without an umbrella of stability over it, but stability will always be grounded in the process of change.
- cybernetics of cybernetics: this enables the view of the autonomy of whole systems. "It recognises the wholeness of a given realm of phenomena" (De Jongh Van Arkel 1987:253).

De Jongh Van Arkel proceeds to provide a short description of pastoral diagnosing, and refers to it as a stance. It is a stance which is taken in a Christian attitude of humility, with an openness to the transforming presence of God.

5.7. CONCLUSION

For the purpose of this dissertation ideas from some of the theological theories considered will be used at a later stage. The theories and models referred to above all have some common themes, despite approaching pastoral work from different perspectives. Some are from broader perspectives than others (e.g. Heitink, pastoral counselling; Furet, pastoral care action), but all include the relationship between God and humankind. The idea of growth in relationship with God through another human relationship in reciprocal dialogue runs through each. Heitink refers to this relationship as an encounter between the pastoral counsellor, the counsellee and God (in triologue). Gerkin believes that it is in the relationship of two language worlds that meet in reciprocal dialogue that clarity is brought into pastoral counselling. Furet also maintains that language is the means of communication, but specifically in the agogic moment. He introduces the idea of

discipleship and the process of discipling within a relationship. In other words, a relationship with God (vertical) results in a relationship with humans (horizontal), and in pastoral caring action this relationship is communicated by the body of Christ. This is very agreeable with Heitink's idea of bipolarity, and a theological anthropology parallel to general anthropology.

All the authors have a common theme of growth or actualisation of self. Gerkin and Firet speak of actualisation of self within the images (theological focus) of the Incarnation, the kingdom of God and the eschatological character of the Christian faith. De Jongh Van Arkel believes that the theological character of systemic concepts connecting pattern is Jesus Christ and the Spirit of God. The authors mentioned above hold to the teleological character of the pastoral action process (whether it is considered pastoral counselling, pastoral care, or pastoral-role fulfilment) instead of determinism. These common themes are my interest for further use in this dissertation to describe a theory of pastoral care praxis.

My own theological stance is based on the theory that communicative actions of God are revealed in the coming of his Word. I believe the theological focus of practical theology is the kingdom of God, but understood in terms of the *basileia symbol*. I believe firstly, that the relationship between God and humankind has a teleological character. In the same understanding of God's compassionate love humankind are intended to be in relationship with one another. This may be found to be consistent with Heitink's (1984) bipolar model and practical-theological anthropology stance. Secondly, that Jesus came in his humanness to relate to humankind (God's creation). The purpose of salvation was to liberate and renew humans into experiencing the love of God. The response to God's (all inclusive) love actualises salvation through Christ, and reconciles to a relationship with God and with humankind. The renewing process releases a Christian faith spirituality that is linked to the gifts of the Holy Spirit operant in the lives of believers. This is consistent with Firet's (1986) idea of Christ actualising salvation in salvation history, and Heitink's (1984) and Gerkin's concept of the relational values in reconciliation through the relationship of the humanness of Jesus to humankind. It is because of this relational interaction between God and people, and people with people that God comes to people by his Word by means of human intermediary actions. I believe that in the concept of discipleship and discipling that humans are the means of communicating in word and

action the nearness of the *basileia* by means of caring communication of the love of God. I consider the connected interrelational network of humankind embedded in the *basileia* symbol teleological in character, and to be seen in the context of the whole body of Christ. This is also consistent with De Jongh Van Arkel's (1987) idea of the faith community, and systemic thinking, only this study's approach is from an ecosystemic perspective. There is a certain concentration in this study on the story of the person in relationship with others that may be found consistent with Gerkin (1984).

CHAPTER 6

RESEARCH METHODOLOGY REPORT

6.1. INTRODUCTION

The previous chapters stated that people living with chronic pain have needs with broad physical and social implications, that climax in psychological and spiritual conflicts. Because this study bridges the medical, psychological and theological perspectives of chronic pain the research report was spread over three chapters to accommodate these various perspectives more systematically. This chapter deals with the methodology of the research and the demographic, medical and premorbid state profiles. Chapter one proposed that:

- needs increase in the lives of the person with chronic pain in ordinary daily living
- not enough is known about the influence that needs have upon people living with chronic pain in relation to their interrelations and interconnected recursive patterns within their ecostructures as discussed in chapter 3 of this dissertation
- pastoral care and counselling need to know and gain an understanding of the needs that occur in the lives of people with chronic pain

The empirical explorations of the research study consisted of three main sections, namely:

1. Profiles, which consisted of a demographic profile, a medical profile and a premorbid state profile.
2. Multiple case studies, which consisted of four respondents and one pilot study.
3. Semi-structured interviews, which included informing the respondents of the purpose of the research and using loosely structured open-ended verbal questions. The responses of the respondents were tape-recorded.

6.2. METHOD OF RESEARCH

The observer limited observations to the chronic pain experience, and what people with chronic pain felt about their experiences in daily living, in other words, the needs and feelings that occurred. My interest in this study was the perspectives of the participants.

Although the exploration covered the broad perspective of reciprocal interactions, interrelations between people in chronic pain, and their ecostructures, it only captured the subjective response (viewpoint) of the respondents (Bogdan & Biklen 1992:32).

I considered the families, the medical environment and the social environment as the relevant ecostructures of people with chronic pain. The social environment included their place of employment, church, friendship circle and social activity. Gaining insight into their experiences with chronic pain within their ecostructures was with the aim to come to some conclusion of how pastoral work should assist them to live independently and participating in society and the church. This study used mainly inductive reasoning, although it recognised that it does not lead to absolute truth (Mouton & Marais 1990:103; Dane 1990:23). I decided to use a mixed stance for this study. It is contextual in the sense that all the participants selected for interviews were from the immediate Pretoria region, and findings would relate mainly to people with chronic pain in that region. Different findings may occur in other regions (e.g. Natal) because there are different environmental and support facilities. It is, however, possible to make some generalisations because the effects of the chronic pain experience are the same (e.g. homeboundness, mobility limitations) (Mouton & Marais 1990:49-50; Bogdan & Biklen 1992:65). The researcher used in-depth interviews and participant observation to gain an overview of the phenomenon by means of multiple case studies (Dane 1990:113-117).

6.2.1. Participants

A particular pain clinic consented to assist to build up a sample of people in chronic pain, but because of unacceptable procedural requirements the researcher withdrew from the proposal to use the clinic. This meant a loss of a large group of people with chronic pain. Since there was no other chronic pain clinic available within reasonable distance of the research process, the researcher asked personnel from a hospital for names of willing participants. The condition was that the people should have had specific chronic pain problems for a period longer than six months. The researcher also approached three churches, and a helping association for possible volunteers with chronic pain problems. The relevant personnel informed the people concerned of the purpose of the study. They explained that it was from a pastoral perspective and that the study required a voluntary response from people living with chronic pain. Confidentiality and anonymity were

assured; moreover, the research report would pertain mainly to generalisations (Mouton & Marais 1990:92).

6.2.1.1. *The sample selection*

The researcher decided to use four case studies for the research, and an additional person for the pilot study (Bogdan & Biklen 1992:62-69). The list provided twenty-five names, addresses and telephone numbers. All were within the area of Gauteng, but mainly from the Pretoria and Johannesburg regions.

The researcher posted letters to each respondent on the list who could not be contacted over the phone, and phoned the others. A sample selection followed. By means of a simple random sample selection respondents were chosen but there were a few hiccups that made this selection a little out of the ordinary (Dane 1990:219-220). Five addresses were incorrect, and these people were not contacted. Four of the respondents said they no longer wanted to participate because they had experienced pain relief post-operatively.

A total of sixteen responded with a yes, and out of the sixteen four of the respondents were too far away to arrange for suitable interviews, owing to their pain circumstances. It left twelve respondents, of whom one died before the selection of a random sample. Five respondents out of a total of eleven were randomly selected. From the five, one was randomly selected for the pilot study. The sample therefore consisted of one male and three females, and another male made up the pilot study. However, the male in the original sample died during the process of the pilot study. This left three female respondents, so I chose another male who volunteered, to make up the sample of four.

A period of a year was spent in making contact per letter and phone with the five respondents selected (including the pilot study respondent). The researcher made person-to-person contact with some of the respondents from time to time, before commencing with semi-structured interviews. These efforts gained some measure of a trust relationship between the observer and the respondents (Mouton & Marais 1990:93).

6.2.2. Observer participation

It is appropriate to discuss the participation of the researcher as participant in the empirical observation at this point. By observing the interconnections of the respondents in chronic pain within their life cycle patterns of interrelationships and interactions, the observer

became part of these patterns (Van Staden 1989: 7-8; Carr 1991:11). During the relationship-building period with the respondents their life cycles and patterns of interrelationships became the observer's concern as well. The intimate and often painful reality of the chronic pain experience shared by the respondents did not leave the observer untouched. Visual signs of physical distress indicated physical pain experienced during some of the interviews. The physical and emotional pain expressed had some influence on the observer's thinking and the way of handling the interviews. The effect on the observer may have brought some subjectivity into the study despite all attempts to remain as objective as possible (Dey 1993:15). The death of the male respondent was a distressing experience for the observer, especially after entering into a closer contact relationship with him and his spouse. Involvement in attending his funeral and contact with his widow continued for some time after the funeral.

The observer was very aware that some of the respondents came with the need for counselling, but that the research design chosen did not allow for this during the research process. The distance that the observer needed to keep did provoke some participant bias from one respondent. It was, however, minimal and did not affect the data too much, but persuaded the observer to ask two leading questions (in sympathy with the respondent). This was rectified by ignoring those specific lead-on questions, and excluding them from the data analysis (Dane 1990:86). This respondent expressed some confusion at the end of the interview because of exposing emotions that had lain dormant until then. After the interview time was given to this respondent to allow for expression of the confusion. It seemed to help the respondent to recognise some matters that possibly needed to be considered and dealt with.

6.2.3. Procedure used to structure data collection

A semi-structured questionnaire was drawn up using Maslow's (1987) *Motivation and Personality Theory*. I decided to use Maslow's categories of basic needs as a frame-work as guidelines for a semi-structured questionnaire used in the interviews. The reason for using Maslow's needs theory categories was that it was the most applicable to this study. Use of the categories was to indicate acceptance of the idea of lower and higher needs evident in human beings. However, the concept of a hierarchy of needs, and the point that unless lower needs are gratified, no need in a higher category may occur, were questioned.

Rather, the path taken was the idea that there may be interchangeability within these categories. This study approached Maslow's categories with the idea that they exist as basic needs in humans life cycles, but that they do not necessarily occur in order of a specific sequence. It does however, acknowledge that basic needs for survival become a priority in the life patterns of humans, and their gratification of utmost priority. Maslow (1970:153-162) maintains that only at the stage of self-actualisation is growth motivation possible, and that all the other levels of needs are based on deficiency motivation. However, I do not believe that growth motivation is utterly dependent upon the gratification of such needs. I tend to agree with Frankl's (1978) idea of the possibility of growth despite need deprivation. My exploration of the phenomenon of chronic pain included the question whether despite deficiency of a need gratification, growth motivation may occur and self-actualisation be achieved. In other words, whether it is possible for a person to self-actualise (show potentiality growth) despite deprivation of the lower needs. The reason for this approach was that the insight gained would influence the pastoral work (pastoral care and counselling) approach to the plight of people with chronic pain.

6.2.3.1. Procedure of data collection

Owing to the sensitive nature of the research, interviews were structured according to each respondent's unique situation. It was this factor that made the observer very much a part of the process of observation. The observer had to be sensitive to the circumstances and needs of the respondents observed. Sensitivity applied especially to the time-phase development of their pain condition during each interview. It necessitated recognition of the respondents' individual needs and circumstances at the time of their interview(s).

a) Interview techniques

Semi-structured interviews were entered into with each respondent. The observer used pre-existing categories from Maslow's (1984) categories of needs, and then applied them to relevant ecostructures of the person with chronic pain. A loosely structured questionnaire was used as a guideline, but not necessarily in sequence of categories (see appendix 1 for sample). The semi-structured questions were used with a sensitivity to the interviewed person's experiences, feelings and coping mechanisms at the time of the interview. It was very evident that three of the five respondents interviewed (including the pilot study

respondent) needed counselling, and that their situation was very painful and sensitive (Dey 1993:97-98; Bogdan & Biklen 1992:68).

Only one observer interviewed each respondent. The interviews were tape-recorded and took an average of 70 minutes for each respondent. Owing to the circumstances at the time of interview the place of interviewing each respondent differed. One respondent was interviewed in her own home as she was not mobile outside the home at the time. Three of the respondents were interviewed in the home of the observer since it was more convenient for them. Two of the respondents were interviewed over two interviews because of time restrictions, while the other two were recorded in one interview owing to sensitivity to their needs. To ensure anonymity each respondent received a code name, and confidentiality was a priority. The observer briefly explained the aim and purpose of the study and the intentions of the interview to each respondent before asking them to sign a consent form (Bogdan & Biklen 1992:96-100). Each respondent agreed to sign their consent for the research under the conditions written on the consent form (see appendix 2 for sample).

At the beginning of each respondent's first interview I explained that I wanted to hear their story of their experiences with chronic pain. I then informed them that the questions dealt specifically with the experiences they went through in dealing with physical limitations and changes in life-style (if any) during the postmorbidity state. I told them that I was interested in their needs and feelings that occurred during their experience with chronic pain, including their experiences with relationships. I felt the necessity to prepare the respondents for the possibility of questions that might explore sensitive areas of their lives. I also informed each respondent that if any question caused them distress they did not need to answer those questions if they so chose. Each respondent consented to the use of a tape-recorder during the interview after an informed account of the function and management of the tape-recordings was given (Bogdan & Biklen 1992: 100-101).

The semi-structured questionnaire contained headings rather than specific questions, and from the headings questions were asked during the interviews. The purpose of the questions was only to prompt the respondents to cover the material applicable to this study. Interviewing the respondents in this way gave a loose structure to the interviews without restricting the respondents too much. It also allowed for a variety in their stories (of their chronic pain experience) and for a wider scope for data collection. Questions

asked of each respondent followed according to their story, hence the questions did not always follow a specific order. However, the main contents of the questionnaire (formulated from the specific headings) were covered in each interview. The observer asked necessary questions very casually and with sensitivity to the respondent's feelings, since this stance was less threatening to the respondents (Bogdan & Biklen 1992:98-99).

I decided to use the above method after using a more formal questionnaire structure for the pilot study. I discovered that the respondent showed some participant bias in the second interview, since he answered some questions as though he was trying to make a specific impression. I realised that the questions were too specific, and perhaps a lead-on to a specific view, because the respondent was complying with that view. The structuring of the questionnaire and the approach to the interviews were changed in a specific attempt to keep the interviews as open as possible (Dey 1993:86). A demonstration of the steps taken to structure the questions for collecting data during the interview follows below:

STEP 1 A list of the headings of Maslow's basic needs was drawn up.

Physiological Needs; Safety and Security needs; Belongingness and Love Needs; Cognitive Needs (Self Actualisation Needs)

STEP 2

Questionnaire structuring process (for pilot study)

Physiological needs → Physical needs Home activity; Hygiene and Diet care; Mobility Limits.

*A number of detailed questions were structured for each subcategory, which resulted in a long questionnaire and many lead-on questions. It was plain that the pilot respondent responded to the leads, and especially the second interview was at times taking on the form of a specific impression. I decided to change the format of the questionnaire to a more flexible one.

STEP 3 After the pilot study the categories and subcategories were modified once again to form headings. Questions were asked, where necessary, from the headings during the interview to ensure that data was collected within the framework of the headings. Beside each heading a list was drawn up to indicate the type of material expected to be covered.

6.2.4. Data analysis

Firstly, an analysis of the demographic, medical and premorbid state profiles took place. They are shown in table form for the sake of an easy general overview of the respondents.

6.2.4.1. Demographic profile

A demographic profile of the four respondents followed. Each respondent received a code name since it expressed the personalisation of the respondents more adequately. The first two names are Afrikaans, which indicate that these two respondent's language spoken in the home was Afrikaans. The last two names indicate that English was the language spoken in the home. The distribution of the full sample before random selection were from Rustenberg, Johannesburg and Pretoria. All of the respondents chosen by simple random selection came from Pretoria city and suburbs.

Table 6.1.

<u>Details</u>	<u>Pre-morbid State</u>	<u>Post-morbid State</u>	<u>Details</u>	<u>Pre-morbid State</u>	<u>Post-morbid State</u>
<u>AGE GROUPS</u> 20 -30years..... 31 - 50 years..... 51 - 60 years.....		... 2 ... 1 ... 1	<u>MARRIAGE STATUS</u> Single..... Married..... Divorce proceedings.....	.... 1 3 0	.... 1 2 1
<u>SEX</u> female..... Male.....		... 3 ... 1	<u>ACADEMIC QUALIFICATIONS</u> A Degree..... A Diploma.....	.... 0 3	... 1 ... 3
<u>CHILDREN</u> Ina Anna Pam Sam .....	.... 0 0 0 0	... 3 ... 0 ... 2 ... 1	<u>CHURCH AFFILIATION</u> Dutch Reformed Church... Roman Catholic Church.... Assembly of God Church...	.... 2 1 1	.... 2 1 1
<u>LIVING ACCOMMODATION</u> Own house..... Own flat..... Rented room Parents home.....	.... 3 0 0 1	.... 2 1 1 0	<u>OCCUPATION</u> Ina..... Anna..... Pam..... Sam.....	<u>Premorbid</u> Nursing Sister Student Student/ horticulturist Artisan fitter and turner	<u>Postmorbid</u> Home executive Hospital Chaplain Telesales clerk Unemployed/fitter and turner.

6.2.4.2. A medical profile

RESPONDENT: INA

PREMORBID STATE

Fifty-six year old married female. Duration of marriage 32 years.

Accommodation: Owned a plot , but owing to intrusion on her safety the family moved to a house in built up suburb in February 1995.

She very seldom needed to visit a doctor except for minor ailments. She led an active life in good health.

She was first a student nurse and later qualified as a nursing sister before she got married.

DETAILS POSTMORBID MEDICAL HISTORY

ONSET INCIDENCE:

Injured her back lifting a patient. - Hospitalised for five days.

Constant pain started in 1959.

She had back pain after that but continued to work. She met her husband and they married, and she stopped working.

She fell pregnant (1962) and the back pain got increasingly worse. She had three babies. The pain worsened with each pregnancy.

HOSPITALISATION AND OPERATIONS:

1972 operation to lower backnot successful. - 1973 operation to lower back.

1991 third, fourth operation to back eight days apart. - 1993 fifth operation to neck and sixth and seventh operation to the sacro-iliac joints.

MOBILITY AIDS

Walked with crutches for various periods. At present limited walking and wears a back brace for support.

LIMITATIONS

During the period of pregnancies and operations she was not able to drive her car. At times she had to use crutches to walk and at times had long periods of confinement to bed.

Third pregnancy complete bedrest for five months. Fourth pregnancy complete bedrest for seven months.

The pain was persistent with varying levels of intensity of pain. She is able to walk, sit, stand for short periods only.

RESPONDENT: PAM

PREMORBID STATE

Twenty-five year-old married female. She seldom attended any medical environment before the accident.

DETAILS OF POSTMORBID MEDICAL HISTORY

ONSET INCIDENCE

October 1990 she injured her back and leg in a work-related accident with a motor-cycle. She was treated for her leg injury, but the back injury was not diagnosed at the time. She went back to work and the pain worsened. In January 1991 she was diagnosed with a herniated disc in the lumbar region. She was in traction in hospital for ten days. She decided to have a baby before any operation. During the pregnancy in 1991 to 1992 the pain was constant and severe. The pain worsened after the pregnancy.

HOSPITALISATION AND OPERATIONS.

1991 in traction in hospital for ten days. 1992 Operation to lower back.

1994 After another accident in a small truck the vertebral fusion broke down but as she was pregnant she was confined to total bedrest from 28 May 1994 until August 1994. She was operated on and again had a further two months of total bedrest.

LIMITATIONS

She was at bedrest for a period of five months. During this time no sitting was allowed. She was a qualified horticulturist working outside, and from 1990 until December 1991 was confined to office work.

July 1995 she was medically boarded from horticulture.

Her standing and sitting is restricted to short periods only.

RESPONDENT: ANNA

PREMORBID STATE

Thirty year-old single female. Accommodation: lived with her parents. Later university residence and at present lives in a duplex flat which she will own in time to come. She was born without a left hip joint and with an underdeveloped left leg. She was hospitalised on numerous occasions to try to correct the hip displacement.

DETAILS OF POSTMORBID MEDICAL HISTORY**ONSET INCIDENCE**

She was born with a congenital hip displacement (no hip joint) and an underdeveloped left leg. Her pain became chronic from 1983 onwards.

HOSPITALISATION AND OPERATIONS

1965 operation to hip at eight months old. - 1984 operation to left hip ... four weeks in hospital.

1984 and 1985 second and third operations to hip. - 1988 and 1989 fourth and fifth operations to hip.

1988 traction for 3 months. - 1990 operation. Hip transplant.

MOBILITY AIDS

Walked with crutches. In 1980 electric wheelchair until the end of matric.

Hand wheelchair in first year at university.

1986 An artificial limb was fitted. 1988 to 1989 used crutches as the wheelchair and artificial limb were taken away. Since August 1990 started walking with the artificial limb again.

LIMITATIONS

Had long periods of hospitalisation. Also a period from 1988 till August 1990 when she was limited to crutches but was also unable to sit. The pain was constant since 1983 and limited her sitting, standing, walking ability. Used a bed to lie on while attending lectures during university studies. Since 1990 the pain has been more controlled and relieved. At present she has pain intermittently only.

RESPONDENT: SAM

PREMORBID STATE

Forty year-old married male in the process of divorce. Before he was diagnosed with gout at the age of 17 years he seldom attended medical care institutions.

DETAILS OF POSTMORBID MEDICAL HISTORY

ONSET OF INCIDENCE

His first attack of gout was in his big toe at the age of 17 years.

The major pain episode started at the age of 28 years with pain in the hip, knees and feet. Since then he has had frequent attacks, at least twice weekly.

MOBILITY AIDS

He sometimes uses a cane to assist in walking.

LIMITATIONS

Short periods of bedrest (a few days). Difficulty in walking, standing. Unable to get up at times. Morning stiffness and pain which lessens on moving about. The pain worsens during the day owing to long standing at work.

6.2.4.3. Premorbid activity state profile

Table 6.3.

ACTIVITY	INA	ANNA	PAM	SAM
Home involvement	Own housework and housekeeping. All own home financial management. Gardening, cooking shopping and drove own car.	Lived with parents. Had tasks to do in the house. Looked after some farm animals. Farmwork tasks and responsibilities.	Very active with studies. Own house work. Gardening, cooking, shopping, drove own car. Financial home management.	He lived a bachelor's life. Did his own cooking, house keeping, cleaning, and financial business.
Family relationship	A good relationship between her and her husband when they married (before pain worsened).	A close family relationship.	A close relationship with her husband.	Parents were very supportive, caring. A good relationship between siblings. Three brothers and one sister.
Social involvement	Active in the Hospital Christian Fellowship. Active in church, Sunday school teacher. Service attendance. A small circle of good friends.	Active in a number of societies. Active in the church Services, meetings and camp attendance. A close group of friends and activities with them.	Active in a number of outdoor sports like hiking, horse riding. Attended services and meetings at church. A small circle of good friends.	Was very active. Played sport like rugby, tennis, ice-skating. Involvement in the church's services and meetings. A good active relationship with friends.

6.2.4.4. Analysis of the interviews

As already mentioned, a rough framework of categories from Maslow's headings of basic needs formed the first level of structure for data collection. During data analysis a further

modification of categories took place for the categories to reflect the data (Dey 1993:97-98). Then a back-and-forth motion proceeded to take place between the categories and data to refine the process of criteria selection for data analysis (Dey 1993:99). I used Maslow's definitions of the main categories (each basic need) to decide on the criteria for inclusion and exclusion of data. A-back-and-forth movement between data and categories was exercised once more. This back-and-forth movement of refining categories continued throughout the analysis process (Dey 1993:130-133). The continual modifying and refining process between data and categories provided a data allocation that revealed something of importance about that data, within that specific category (Dey 1993:135).

STEP 1 Data categories were refined in the data collected and each category and subcategory defined.

Physiological and Physical				
Home activity * e.g. Includes requirements to cope with home. Possible topics: house work, child care, driving car .	Mobility limits * Definition given	Intimacy Family *	Social, Church, Work activity *	Hospital environment . *

STEP 2

To allow for organising the databits systematically I decided to use some of Maslow's (1984:42-45) partial list of phenomena that are determined largely by the gratification of needs. This step provided for the streamlining of data to pursue specific lines of enquiry. It also provided for the splitting and splicing of categories and databits. Not only were the categories subdivided but data was assigned to relevant categories and subcategories after coding (Dey 1993:130-133). The idea behind arranging categories in this manner was that it allowed for comparisons within a subcategory and prepared for later comparisons between categories (Dey 1993:134-136).

STEP 3

The use of Maslow's description of each of his basic needs allowed for databits allocation according to conceptual relevance and usefulness for further analysis of data (Dey 1993:137-139). Some of the phenomena largely determined by gratification of basic needs as described by Maslow (1984:42) provided a platform to measure the relevance of data to particular categories (Dey 1993:140-147).

I have included an example of the process of the analysis as demonstrated in the first subcategory *home management* under the category *physiological and physical needs*. This

is to give some idea of the method that this study followed to come to conclusions regarding the analysis of the data.

Table 6.3. Example of method used in arranging of databits

HOME MANAGEMENT: Home management was subdivided into subcategories housework or maintenance; home economics; child care. Only an example of the process of data allocation will be demonstrated under the first subcategory's first subdivision. Only one respondent's reply will be shown .

Case Name	Home Management or Maintenance
PAM	<p><u>Question:</u> And um..., with regard to the changes which occurred with you, um..., within the house?</p> <ol style="list-style-type: none"> 1. Um..., he had to basically drive me around to where I had to be. 2. Do all the heavy work, and sometimes he would come home in the evening and hadn't done anything because I had just been too sore and too uncomfortable to do anything. 3. Um..., like when I have to ask him to over weekends to help me carry the heavy laundry basket. 4. During the week I would have to divide it into three and would do three trips. <p><u>Feelings:</u></p> <p><u>Question:</u> How did you feel about the fact that you were not able to do it yourself?</p> <ol style="list-style-type: none"> 1. Frustration, anger, um..., sort of why me? 2. OK it is not a very nice thing to say but at that stage I was very angry with God. 3. I felt why was he punishing me (voice shaky, wants to cry, tears in eyes). What have I done wrong. 4. I felt very sorry for myself (laughs). 5. Um..., you will probably hear in my voice that I am very emotional at the moment, I am very near tears. Um..., I get that way when I talk about it.

Data was analysed and allocated in the above manner for each respondent. Each respondent's data was compared with that of the others within the specific subdivisions of the category, and later across the subdivisions. Further into the research analysis comparisons were made between main categories (Dey 1993:153-197).

CHAPTER 7

RESEARCH FINDINGS REPORT

7.1. INTRODUCTION

7.2. RESEARCH FINDINGS

This chapter attends to the results of the analysis in brief account with some examples of the respondents' responses. Some findings were briefly summed up, and some conclusions formulated. A more in-depth evaluation follows in the next chapter.

Before coming to any conclusion whether need deficiency was present or needs increased, it was necessary to establish what effects chronic pain had upon the respondents, in association with the specific category that the data reflected. Next, I considered the effects of the effects (or the snowball effects) upon the unit(s) (the subsystem e.g. the household, family, friends, ecetera.). From the information gathered on the effects of chronic pain on the life (and lives) of the people, conclusions were drawn as to the feelings and needs that occurred in the respondents' experiences with their pain. It brought me to some conclusion regarding Maslow's (1987:42-45,75-79) criteria suggestion for measuring need deficiency of the overall category. It allowed for preparation in establishing further links between the main categories for the formulation of a final conclusion. It then allowed for the consideration of consistencies with previous research literature, and opportunities to note any new avenues for further research exploration (Dey 1993:155).

I decided to examine the data and to report on the findings in association with the developmental stages and time-phases of chronic disease that Rolland (1989:433) suggested. I have used the idea in an adapted form for the chronic pain experience as referred to in chapter 3. Headings of the developmental stages were specifically used for this purpose.

Under each developmental stage headings subheadings associated with the respondents' eco-structures were use. This allowed for the measurement criteria for needs deficiency according to chapter 4 of this dissertation and Maslow (1987:42-45, 75-79).

Some of the responses of the respondents are given below under the development stages and time-phase headings and their relevant subdivisions.

7.2.1. Stage of onset

According to Rolland (1989:439), this stage is often experienced as a crisis situation (crisis time-phase) in a chronic condition process. Relating to the person with chronic pain it is a stage in the developmental process of the condition that may commence with an acute situation. There are numerous readjustments that take place in this crisis phase.

The examples below were transcribed directly from the tape-recordings with no changes made. Examples of responses of one of the respondent's crisis phase were as follows:

Table 7.1. *The physical home management*

PAM	<p>"My parents were very supportive after the first op. They had my baby with them and I stayed with them for two months, until we had a major blow-out, and I packed my things and came home."</p> <p>"It really affected my dignity."</p> <p>"You had to rely on (husband) to bath me, which I found was very (pauses, fumbling for words), not nice."</p>
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Table 7.2. *Work and finances*

PAM	<p><i>Pam spoke with intense emotions, and flushed face when she said "...I spent a lot of time studying within my field, which was very stupid because I should have studied in another field because at the time I did not realise that I would not be able to do my career anymore."</i></p>
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Table 7.3. *Family relationships*

PAM	<p>"and that made me feel very inferior, very insecure, and very frightened. Like a bunny dodging down a rabbit hole, or something like that, it was very upsetting, extremely emotional (cries)." (Pam was speaking about the sexual intimacy that was curtailed at this phase)."</p>
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Table 7.4. *Social and church participation*

<p>All the respondents were unable to participate socially as they were hospitalised during this period. It was only Pam, however, who experienced a lengthy confinement period at this stage of the pain process, or time-phase.</p>

Table 7.5. *Feelings and emotions expressed*

<p>Pam expressed feelings of frustration, anger, helplessness and loss of dignity. She felt upset, insecure and inferior in association with the role expectations in the home.</p>

7.2.1.1. Summary

Three of the respondents began their pain experience with an acute onset which gradually became chronic, while one respondent experienced more of a gradual onset. Ina was hospitalised for a few days only, and the pain worsened gradually from then onwards. Sam was still in his parents' home, and he gradually started a pattern of relapses. Pam injured her back in an accident.

What was of interest when exploring the crisis time-phase was that three of the respondents merely glossed over this aspect. It was only Pam who gave any detailed recollection of this period, but even then it was still minimal. The observer felt that it may be due to the time lapse that the respondents spoke more about the recent events. It was noted that Pam had experienced the shortest duration of the course stage of development of the chronic pain experience, and this was possibly why she recollected the circumstances more than the others.

A summary of the pattern of some of the needs evident in the onset stage follows:

- role expectations fulfilment need
- freedom from fear and anxiety needs
- achievement needs, and the need for mastery and control over life
- participation needs
- needs for support, love and belonging
- dependency needs

7.2.2. The course stage of the chronic pain process

The chronic course of the pain (and/or associated disease) may be progressive, stable or relapsing (episodic), with a variety of consequences occurring (Oates & Oates 1985:104-107; Rolland 1989:450-454). The readjustments of the interim time-phase are applicable to this stage in its three forms (Rolland 1989:439-440). In this dissertation the progressive and the relapse entities are grouped together, since the description of these time-phases given in chapter 3 overlap considerably. The stable form was dealt with separately.

7.2.2.1. Stability in the chronic pain process

Stabilisation of pain control and disease management occur in this stage as referred to in chapter 3 of this dissertation. A more stable predictable management of daily living takes place within the physical circumstances. All the respondents spoke about circumstances that fitted into this stage. Some examples of responses follow below:

Table 7.6. Home management

SAM	<p>“definitely, being stuck at home and, and, er..., and I..., not that I am a messy person, but I get on with things and I, if I’m at the sink, I might spill water as I am washing you know. My wife gets very (emphasised with a shake of the head) upset with that.”</p> <p>“...when you don’t have money it is quite frightening because you don’t want to spend money on fixing your car because you are scared that you won’t get work.”</p>
PAM	<p>“I’d take care of the baby the best I could. She was fed and dried, and that sort of thing. He had to bath the baby, um..., he still does with the second baby.”</p>
INA	<p>“It goes in stages...when I haven’t someone to clean my house I also do it in stages, sometimes it takes me a whole week to get it finished (laughs).”</p>

Table 7.7. Employment and finances

SAM	<p>“I find it difficult to walk sometimes, and the pain you know, it does affect your work because you can’t think straight sometime, as well you know.”</p> <p>“All my saving are gone really.”</p>
PAM	<p>“(Sighs hard) angry, um..., very upset, very hurt, because like I said horticulture was my life, horticulture is what I always wanted to do. I was doing it and I live for it.” um..., and I’m frustrated by not being able to do it, and I really want to get back to it.”</p> <p>“...now I’ve got to accept that they are sitting next to me smoking and I stink like an ablution factory by the time I go home.”</p>
ANNA	<p>“and wherever I work I can go, I can walk, I can ride, I can get to as close as possible. I don’t have any problems there.”</p>

Table 7.8. Family relationships

PAM	<p>“and I also find it difficult not being able to pick up my little girl. She’s now nearly 4 and she also wants Mummy to cuddle her..., and that sort of thing.”</p> <p>“I lost my husband. I’m not the wife I’m supposed to be...”</p>
INA	<p>“Hy was baie ondersteunend gewees, hy het my gehelp so ver as hy kon by die tye dat hy by die huis was.”</p> <p>“Ek sal sê dit het my geaffekteer..., dit het my hartseer gemaak (tears in eyes). Want ek het besef, (clears throat) jy weet sy is maar 'n klein kind om daardie verantwoordelikheid te dra (long pause, and looks down to the ground).”</p>
ANNA	<p>“I saw my parents as very special and sent from God.”</p>
SAM	<p>“Geewiz I wish I could spend more time with him. I get so frustrated sometimes and so heart sore.”</p>

Table 7.9. Social participation and friendship circles

PAM	<p>“They all sort of thought well you don’t come and visit us so why the hell should we come and visit you type of thing “ (voice tone aggressive).</p>
SAM	<p>“yes they are still, they have always been the same. I’ve been lucky I’ve got good friends hey,</p>

	hooo. Ja always the same never changed (laughs).”
INA	“Ek sal, sê er..., ek het baie vriende verloor, wat er..., ek dink wat nie dinge kon aanvaar nie en wat dit nie kon verwerk nie.”
ANNA	“I had lovely friends throughout from school and onwards. I had lovely friends. Friends accepting me for what I am....So I can say I had a lot of friends and I did use my friends for my sanity.” (said of one group of friends). She also referred to another group of friends who did not respond to her needs for acceptance, she said “because I couldn’t go with my friends all the time they ended up leaving me out, letting me stay home...” Observer: <i>How does that make you feel, how did you feel?</i> Incompetent, left out, half a person, not good enough to go with them. Maybe they are ashamed of me”

Table 7.10. Church participation

PAM	“I felt if it goes on much too long then I get very fidgety, and uncomfortable, because I can’t sit for very long, and I need to get up and move around a bit, while I am sitting.”
INA	“Dit is net dat ek kan nie lank staan nie, ek kan nie lank sit, ek kan nie baie loop nie. En dit voel vir my ek is altyd bang ek hinder die mense, jy weet.”
ANNA	“but I sat there so that people don’t see me sitting on the chair with my legs on the chairs, and shifting all the time to get a position that I am comfortable in.”
SAM	“you know, if they know what’s going on. So at least you feel that they care you know.”

Table 7.11. Feelings and emotions expressed

<p>The respondents registered emotions and expressed feelings like: frustration, anger, hurt, fearfulness. They expressed feelings of low self-esteem, feeling depersonalised, and feelings of rejection. Some of the respondents also expressed joy, pleasure, excitement, and tenderness.</p>

a) Summary

I was surprised to find that many of the respondents reacted as strongly to threatening changes in their relationships with old friends as they did to threats to family relations. Even Ina and Anna who had stable family belongingness and love needs gratification, verbalised distress at the loss of friendships, feeling left out, rejected and at the loss of the freedom of choice. There were, however, expressions of joy and appreciation for old friends who stood by through thick and thin.

The employment and financial circumstances proved interesting, since Sam attached far more importance to his employment status associated with home economics and the provider role. Pam placed the importance on her work status more in association with achievement needs, and the need for home comforts. Anna was comfortable as a student

still enjoying the parents-child role relationship, while Ina felt financially secure as her husband provided adequately for the family.

Some of the needs evident in this stage are as follows:

- role fulfilment needs
- financial needs; employment needs; security needs
- basic survival needs
- cognitive needs
- belongingness and love needs; self-esteem needs
- need for church and social participation
- need for physical safety

7.2.2.2. Progressive/relapse stage of the chronic pain process

In this stage of the chronic condition process there may be episodic loss of pain control management, or regression of the associated disease with various implications. There may also be a combination of both. A recursive transition between crisis and non-crisis situation referred to in chapter 3 of this dissertation, may take place. It also fits into the interim phase referred to by Rolland (1989:439-440). There was so much data from all the respondents during this stage that only minimal examples of some of the responses will be shown to illustrate the kind of similarities, or differences that occurred.

Table 7.12. Home management

INA	<i>Ina</i> explained how she prepared herself and the family “...ek het heelwat voorraad, er..., kruideners en allerhande huishoudelike goeters gekoop by die tye wat ek sal, dinges, met lang tye lê. Ek het voorraad gekoop sodat sy (husband) inkopies het net beperk gebly tot vleis, en melk...”
PAM	“Um..., to get rid of the limitations, to get rid of the pain, to just be myself and do what I want to do when I wanted to do it, and have to rely on somebody to pick up the heavy bucket to go and hang up the washing. Or, wait for someone to come and pick up a plant in the nursery. You know I wanted to do it myself, because that’s what I am like.”

Table 7.13. Employment and finances

SAM	“You have to force yourself to endure pain. Your family needs it, that’s it. And I feel also that I’ve damaged my joints now because I’ve walked on them when I shouldn’t have, but I needed to.” “To do with work, yes, because you worry about it you know. Your family needs food and you are responsible as the man to provide for them.”
ANNA	“Yes coming late in a class and not being stared at wishing I will go back out where I came from.” She then referred to the change that had occurred during the years she studied theology

	“in theology they always tried to help me....some of the classes they even present to me in the office, I could go to any lecturer and ask him to help me with this....and then I got permission to put a bed in class...”
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Table 7.14. Family relations

INA	“Ag..., ek sal sê omdat my man en my kinders was daar gewees....dit het my moed gegee om nog aan te gaan en te sry, en so te se van dag tot dag aan te gaan.”
SAM	“and through that I’ve lost the family. I think like, if you can’t be, (stammers) also like if you want to go and have a game of squash or tennis with the wife, and you’re not able to cope you’re just, you can’t, you just can’t do it (his voice takes on a high note towards the end).”
PAM	“Um..., I would have liked to have been able to speak to him about it. ....I needed somebody to talk to, and he was just not there for me to talk to, so I had to speak to somebody else, and that I find very difficult as well (tearful).”
ANNA	“and he saw what looked painful to him, and I was his sister, and he loves me, and I think seeing me there feeling helpless was causing him frustration and his anger, and he took it out on me.”

Table 7.15. Social participation and friendship circles

INA	“dit het my, er..., lewe baie affekteer want ek was nie baie mobiel gewees. Ek was baie in die bed met die gevolg dat dit het my baie tot my kamer beperk.”
PAM	“the new friends got to know me with my limitations so they accepted me better with my limitations than what the old friends did, who are used to the old Pam.”

Table 7.16. Church participation (and involvement by the church)

SAM	“nothing, nothing. We always had to go and visit them. If we wanted help then we had to go and visit them. Or I would have to.”
INA	“I think I need company, I need the (pauses trying to find words) die aandag van die kerk, want dit was definitief nie daar nie. Hulle was nooit omtrent teenwoordig nie. Dis asof hulle my eenkant toe geskuif het.”
ANNA	“The people knowing me, the ministers knowing me, the ministers coming to hospital to visit me. Sending me cards, even coming out to my mother’s farm to visit me, so I felt safe and secure in the church.”

Table 7.17. Hospital participation

ANNA	“My Mum was the one staying with me especially the days of my operations. She had to change her life-style at that stage to come and sit with me, to be with me...” “at that stage (pause) I wanted to die, I wanted to die. I was thinking of all weird and wonderful ways to kill myself....but I don’t think ward 2 believed me....”
SAM	“ like I said if I go in the morning at 7 o’clock I get in at 11 and by the time you’ve got medicine maybe you are lucky if you get home at 12.”

Table 7.18. *Feelings and emotions*

The respondents in varying degrees all expressed feelings of confusion, hurt, anger, frustration, distress, depression, humiliation, loss of confidence, loss of self-worth, a sense of helplessness, hopelessness, rejection, while on the other hand all also reported feeling supported, loved, cared for, respected in some way or other.

a) Summary

The needs lacks seemed more apparent in the relapse phases (owing to the disease process, or operative measures) of the their pain experience. The two respondents with the longest duration of chronic pain appeared better able to recall their experiences with some objectivity, and showed visible emotional reactions only when they spoke of something that had a marked impact upon them. The respondent with the shortest experience with chronic pain expressed strong emotional verbal and non-verbal reactions. There was considerable subjectivity to most of the data expressed. I assumed it was because this respondent was still in the initial process of rehabilitation. It was also noted that although Sam's duration of chronic pain was long, he was in a crisis phase in his marriage relationship and he showed a strong subjective emotional response to some things.

Mobility limitations appeared to be the reason for considerable loss of social and church participation, especially for three of the respondents. The losses experienced in social and church activities seemed to have a strong influence on the emotional state of the respondents, since they responded with increased body language. Three of the respondents were unable to attend church during the periods of being bedbound and homebound, but they all said that when they were more mobile they could not sit for long in church. Sam on the other hand, referred to his social limitations in the area of sport activities that became non-existent. It was also of interest that he felt he had lost his family because he was inactive in sport. It was obviously the means that had formerly given them a sense of togetherness.

I found the dynamics that took place with each respondent's reply to questions of what they felt they needed rather different from my expectations. I had expected them all to know what their needs were, and to have labelled them to some extent, but this was not the rule. When Sam was asked specifically what he thought his needs were he kept replying that he didn't know, and that such questions were difficult to answer. Ina and Anna were more definite in their answers. Ina immediately responded by saying she needed someone

to help her, and especially in the bedbound and homebound stages. Anna placed a lot of importance on needing understanding and consideration. It was noted that Anna spoke of her needs in association with her friendships and her activities in the university during her studies, and not within her home (parents' home) situation. Pam showed some confusion between what she wanted and what she felt she needed. The differences in the response between Pam, Sam, Ina and Anna were possibly due to the time-phase that they were in during the developmental situation of their chronic pain.

7.2.3. Outcome and incapacity stage of the chronic pain process

Rolland (1989:436) refers to the various outcomes to the course of chronic disease. Limitation of life-style, disabilities, various motor or sensory deficits and numerous losses are included in this stage (losses and complexities time-phase), which is also applicable to the chronic pain process as referred to in chapter 3 of this dissertation.

All that was applicable to the two other stages applies to this stage as well. The observer has placed the losses, the gains that the respondents expressed, and their feelings about their needs regarding their spiritual relationship under this stage. However, it must be noted that these entities overlap into the other stages and time-phases of the chronic pain condition.

I have dealt with the aspect of the respondents' spirituality more fully since it was clearly an important aspect in their living with chronic pain. It was noted with interest that each respondent linked what took place in his or her relevant interconnected subsystems with God. I have considered spirituality specifically within the context of a Christo-centric perspective of the Christian faith, (the data collected took that direction).

Table 7.19. Response to spirituality (in the above mentioned context), losses and gains

<p>PAM</p> <p><u>1. Premorbid state:</u> She was involved in activities in the church. She said she had a good relationship with God after accepting Jesus into her life in her teenager years.</p> <p><u>2. Postmorbid state:</u> <u>2.1. Emotions experienced in general:</u> Hurt, anger, frustration, anxiety, afraid. Feeling no good as mother, wife, lover. Feeling rejected by in-laws, husband and friends. Feeling rejected by church. Feeling depersonalised through loss of independence, loss of dignity, loss of freedom of choice, loss of freedom to express herself.</p>

Feeling isolated even when people were present.

2.2. Feelings towards God

2.2.1. Anger and rejection.

- “OK it is not a very nice thing to say, but at that stage I was very angry with God as well. I felt why was he punishing me (*voice shaky, wants to cry, tears in eyes*). What have I done wrong.”
- “I’d lived, I’d done what I had to do from my side and then God punished me in this way, and in the beginning I totally rejected the religious people that came around.”

2.2.2. Depression and confusion

- “There was times when I used to, you know, say that I wished I had died in the accident because I can’t handle this any more.”
- “I was making it (stammers) it made me feel horrible, but I was making it difficult for everybody because of the way I was feeling. I was very worried. I was very scared.” (*memo: Pam was referring to the period in hospital, when she feared for her unborn child, and missed her daughter. She was in an emotional state as she puts it*).
- Pam was very down about her work circumstances.

2.2.3. What she felt she needed.

- “So I never built up a relation with the new priest as opposed to the old one.um..., ja I would have liked to have been more, um, to have been closer to the priest in the area at the time because I needed the support, um..., that backing, you know, someone to talk to, someone to explain to me why and someone to help me deal with my attitude towards God when it all happened.”
- “it would have helped me to cope with it better, and would have helped me to deal with my anger towards God and my, um..., hurt and being upset.”

2.2.4. Drawing closer to God and the help received:

- “as time progressed I started to realise, but hang on a minute I don’t think God was punishing you, it was just one of those things that happened. I started working it through...”
- “the next time I went to hospital I actually listened to people who came to talk to me.”

Field note: Pam spoke about some Christian voluntary worker at the hospital who helped her when she was all confused. She helped her to come to the point of talking to God again. She talked about renewing her faith again and finding forgiveness with God. The lady must have made an impression on her because she spoke about her with tears in her eyes.

2.2.4. Finding meaning of life

For Pam it was the birth of her second baby that helped her.

- “when I saw this perfect little baby girl I realised she was really a gift from God, and he gave her to me to bring me back to him. That to me was, I think, the turning point...”

SAM

1. Premorbid state:

He was actively involved in his church for 18 years. He said he asked Jesus into his life when he was in his teens.

2. Postmorbid state:

2.1. Emotions experienced in general:

Hurt, frustration, anxiety, fear.

Feeling no good as a husband and father in providing for his family.

Feeling rejected by his spouse, his church and Christian friends.

Feeling useless, guilty, isolated.

2.2. Feelings towards God

He married in his spouse’s church which caused some friction with his own church. He stopped going to church (own) and drifted away from God.

Sam denied feeling angry with God, and instead he tended to feel guilty.

2.2.1. Self-blame, guilt and deserving:

- “did I feel angry with God (gives a little laugh). No I don’t think I’ve been angry about that. I always felt, you know, like I am a sinner so I deserve it, you know (pauses, laughs) so I can’t get angry with God for that.”
- “I felt that, well, I felt that I was just out of his love. You know that I’d fallen away and, you know that the Bible says that if you fall away then it is impossible to get back to God.”
- “I did not believe that I could be close to God.”

2.2.2. Depression and confusion

- “I was an oxygen thief as far as I was concerned. So that was it.”
- “I really believed that I got to the point where he (God) could not reach me...”
- **Sam had attempted to commit suicide by stabbing himself and cutting his wrist.** Sam: “I wasn’t bleeding fast enough (pauses) you know, (pauses) I kept thinking to myself. Totally depressed (silence) and like I couldn’t, you know, like this is the end.”
- “You know that he is real but you can’t sense that He is there you know (pauses) but he is there, but it is just that you have lost track, you know.”

2.2.3. What he felt he needed:

- “I needed to get back to God...I just didn’t feel I was getting anywhere. You see I was praying to God, but nothing was happening. I wasn’t (stammers) I was still out of work, I was perpetually out of work. I just couldn’t get my life on track.”
- **Field note made: There seems to be a great deal of guilt. I got the feeling that he wanted counselling. When he left he said it was a relief to talk about it.**
- **Field note: He spoke off tape that he had formed a mistrust for people, and that it hurt that his Christian friends were not there for him, and that the church distanced itself from him instead. He went back to his old church once again, and it seems that a new minister was helping him.**

2.2.4. Drawing closer to God:

- “...because once I had given my life back to God things have got right again.”
- “I got to a point where I didn’t persevere, but God really is the things (pauses to think) He has really been the overcomer. If you can accept him by faith he can help you. So your faith actually makes you, um..., an overcomer.”

2.2.5. What he felt gave meaning of life again:

Memo: Sam now goes to two churches in an attempt to get as much of church as he possibly can, according to him.

- He laughingly said “I’m still fighting, hey, praise God for that hey. No I think with God you can overcome, er..., (laughs) any odds if you have got God with you.”

INA

1. Premorbid state:

Ina was involved in the Hospital Christian Fellowship. She and her family were involved in church activities. She said that she had a strong relationship with God.

2. Postmorbid state:

2.1. Emotions experienced in general:

Hurt, frustration, heartsore and useless.

She felt down and depressed at times and cried just to relieve the tension.

Ina said “helpless (laughs) quite helpless and sometime you, er..., feel, um..., what can I say. You are not needed any more, you are just shifted aside, you are not of any use any more.”

2.2. Feelings towards God

2.2.1. Anger

- “ag..., ek sal sê ja baie keer het ek kwaad geword (becomes silent).” **Observer: kwaad vir?** Ina: “Vir God ja, maar ek het later besef dit is sy manier om nader om aan hom te bring. En dit is miskien er...,

dit het my en my man nader aan mekaar gebring....”

- “Ag..., ek was partykeer opstandig, vra hoekom, maar ’n mense kom daarvoor. Jy berus jou in dit.”

2.2.2. Depression and confusion

- Ina spoke of feeling down and depressed at various stages of the chronic pain process. She felt very lonely and depressed when her family had to go to the various church meetings without her.
- “In 1991 after that I can feel it taking hold of me. You feel so useless.” Another time she identified her needs when she felt depressed by saying “I think company (she was stating what she needed) with the loneliness and the (pauses, and lowers her eyes, and her voice) then I felt depressed.”
- “Omdat een oomblik voel ek so na aan God en die volgende oomblik het ek so pyn dat ek voel dat God het my gelos. Jy weet, hy is nie daar nie. Hy het my vergeet. En dan as ek weer beter voel dan dink ek wel hy het tog my, dinges, gebed gehoor. Hy het tog my pyn gehelp. ’n Mens voel baie verward, want dit kom en dit gaan, dit wissel al die tyd.”

2.2.3. What Ina felt she needed in times of confusion:

Ina often referred to the periods of bedboundness. She felt very lonely when her husband and children left the house. She also referred to the times when her family went to the church meetings and she felt isolated at home. She obviously felt the need for company and social intercourse. On a number of occasions when asked what her church could do to help her, or what she felt she needed she replied that they could come and visit. Another time she said they could keep her company, or come and drink a cup of tea. She felt that even a phone call would have made a difference.

- “Ek het gevoel as die predikant my meer kom sien, en meer kom vra (pauses to think) om meer te verduidelik en miskien meer lig kom werp op my vrae. Of miskien my meer gerus te stel. My man het probeer help so ver as wat sy kennis (stammers) gaan. Ek meen ek sal beter gevoel het as die predikant miskien meer belangestel het in my en meer kon help in daardie opsig.”

2.2.4. Drew closer to God and finding meaning of life:

Ina spoke about the pain keeping her close to God because that was a time of her greatest need.

- **She explained** “and then you relax for a time, and then you know suddenly pain strikes and then you know where God is. But now I am constantly, er..., aware of him. So it also bring you closer to God.”
- **When asked if she had gained anything through the experience of pain** Ina promptly said “soos ek gesê my geloof het, dinges, het dieper geraak, ek sal sê die gehegtheid tussen my man en my kinders, het definitief meer gebonde gewees as andersinds.”
- **When asked if she had any difficulty finding meaning to life she replied** “ja beslis. Dit is vir my asof die lewe partykeer geen sin gehad het nie, en hoekom moet ek aangaan as daar soveel pyn is. Hoekom moet ek dit verdra. Hoekom moet ek elke dag soveel pyn hê. Dit is asof ek dit nie, er..., mooi kon verwerk nie. Maar, ag..., die volgende dag is dit ’n bietjie beter, dan het ek weer moed gekry. Dit het maar baie gewissel.”

ANNA

1. Premorbid state:

Anna grew up in a Christian family. Her father was a deacon and later an elder in the church. She belonged to numerous Christian and church activities.

2. Postmorbid state:

2.1. Emotions experienced in general:

Hurt, frustration, anger, anxiety, and terrifying fear (during one hospitalisation period).

She felt rejected by her fiancé and some friends.

She felt depersonalised at times.

2.2. Feelings towards God:

She spoke of many times when she became angry with God, and especially in times of stress and chaos in her life cycle.

- “I got very upset with God. I remember my grandmother who was a wonderful Christian, saying once that when you pray to Jesus for something you want, pray believing with you whole heart that you will get it, and you will get what you want.” She then spoke about her praying and believing for healing but

it did not happen.

- “An incident at a camp but the theme there was God loves you as you are, and God made you very special....and that’s where my turning point came, basically a re-acceptance of God.”
- She fell and broke her knee and there was the possibility that she would have to discontinue her studies, as the artificial limb would not fit. She said “ and they will have to amputate my leg, and I was very upset with God. I didn’t read my Bible. People were not allowed to pray for me. My parents didn’t dare say the word God in front of me.”

2.2.1. Depression and confusion:

Anna went through a period in the hospital which terrified her. She experienced strong feelings of humiliation and felt depersonalised. She became extremely anxious, disoriented and in the process attempted to commit suicide.

- Anna’s words were “at that stage (silent for a moment) I wanted to die, I wanted to die.”

The observer made a memo: What caught my attention was that in this negative happening in the hospital the minister from her church intervened into the hospital situation. He phoned the doctor and explained why she was behaving as she was, and persuaded the hospital personnel to allow her to be nursed at home. The medical team agreed, and she experienced relief from her fear and depression.

2.2.2. What Anna felt she needed

Anna was very definite about what she needed. At the time of the hospital incident she felt she needed to be left alone to work through her grief she felt when her fiancé left her. She felt that she needed understanding and empathy, and to be believed.

She also spoke of the need to be held, to be prayed with and to be encouraged by people sharing with her. She also felt very strongly that a promise that was given to her, when she reached a certain goal should have been honoured, since it destroyed her spirit when it was not kept.

She spoke of numerous times when her spiritual - emotional needs were met by her parents, the minister, her Christian friends and by listening to the church service over the radio.

2.2.3. Drawing closer to God and finding the meaning of life:

When she was asked who was of help to her when she experienced losses in her experience with pain:

- “my parents and friends, and both of them together with God, because I saw my parents as very special and sent from God. And also the friends that stayed with me the whole time.”
- “I would start asking the question what’s the meaning of life. If life means pain all the time how will I handle the future, if the future means more pain than I have now. Yes I did have times like that.”
- “because if there is one person that learned something from my life there was meaning to my life, so now I must carry on, because if there’s one there can be more.” and “um..., I think that’s what kept me going on was the knowledge that God doesn’t care whether I get 50 or 80 as long as I am doing my best.”

a) Summary

When the respondents talked about their experiences with “losses and gains” in the process of living with chronic pain the similarities in feelings and emotions were amazingly similar. What was of interest was that the emotions were associated with events that happened in the interconnected interrelations, and interactions within the relevant eco-structures of the respondents. In turn the feelings and emotions were associated with God. For the respondents, God was considered very relevant to their daily needs and the consequences which occurred when their needs were threatened. Each went through periods of struggling to keep faith in God. The anger with God, and feelings of rejection,

or rejecting God, and doubting God's love for them was found to be consistent with the research literature previously referred to in chapter 2 under 2.3.7. of this dissertation.

Losses had a profound impact upon the respondents and their family subsystem for various similar reasons, but often with different emphasis of importance. This was found to be consistent with the literature discussed in chapter 4 of his dissertation.

A summary of some of the progressive/relapse element of the course stage, and the incapacities stage was as follows:

All the needs that were experienced in the stable form of the course stage increased in the relapses of pain control or disease regression periods. Particularly the need for mastery and control over life, the cognitive needs, self-esteem needs, basic survival needs, showed evidence of a marked increase.

7.2.4. Summation of results

The results confirmed that:

- needs increased during all of the chronic pain process
- needs occurred during the different developmental stages (and time-phases) of the chronic pain process, with various consequences
- needs increased even more in the relapse stage

Pastoral care and counselling must gain more insight into the needs of people with chronic pain in relation to their ecostructures, since the knowledge gained will influence the way care is given.

CHAPTER 8

EVALUATION OF THE RESEARCH RESULT FINDINGS

8.1. INTRODUCTION

As previously discussed, Maslow's (1987) needs theory categories were used in the collection of data, and as an instrument of measurement for analysis of the data. The Summary of the results of the research analysis confirmed that the respondents' needs increased, especially during specific stages of the chronic pain process. It was also proposed in chapter 6 that:

- needs for survival become a priority in the patterns of humans and their gratification is of utmost priority
- needs gratification does not necessarily occur in a specific sequence, although lower and higher needs do exist
- growth motivation is possible despite need deprivation

The importance of this evaluation according to these points is that it will influence the final theory of a pastoral praxis in giving care to people in chronic pain. The consequences of needs deficiencies, needs gratification and the increase in the needs indicated by data analysed are discussed under the various main abstract needs categories. The responses of the respondents were compared to Maslow's (1984:42) by-products of needs gratification, and specific headings according to Maslow (1987:18-26,75-79). It was done with the awareness that an abstract classification, rather than a categorising list was the purpose of using Maslow's *Theory of Needs*.

8.2. EVALUATION OF THE RESPONDENTS' NEEDS

8.2.1. Physiological and physical needs

All of the respondents expressed verbally, and by means of body language, facial expression and voice tone various levels of frustration, aggression and physical discontentment. Their responses to their physical limitations gave little indication of a sense of well-being. However, the levels of emotional response during the telling of their stories did vary.

Mobility limitations became the main over-arching category in the process of analysing data reflecting physical management of the home, social, church activities and self-care. It was obvious that mobility limitations had an extensive influence, since any management of these physical activities depended largely on the mobility of the person (Dey 1993:136).

8.2.1.1. Mobility limitations

a) Bedboundness and homeboundness

All the respondents, at various stages of their pain experience, endured bedbound periods. Each had similar feelings about these periods of confinement to bed, yet each expressed their feelings differently, and from different perspectives. Ina and Pam spent periods of five to seven months at total bedrest. During these periods they were unable to attend to their hygiene and dietary care needs, but were assisted by their spouses with the most basic tasks like bathing (bedbathed), going to the toilet (using a bedpan). Ina's spouse prepared her meals, which were left beside her bed when he went to work, and she was alone. Her response was more objective and matter-of-fact in recalling the details. Pam spent some of the bedrest period with her parents who assisted her, while her spouse fended for himself in their own home.

It was interesting to note that Sam spent much shorter periods at bedrest (a few days with each relapse) but the relapses were frequent. Although he had shorter periods of confinement to bed he showed signs of frustration and conflict that he experienced as a threat to himself. Sam's interview consisted to a great extent of expressing his anxiety and fears about his employment status, and how it affected his home environment in particular. His response was consistent with the conflict in choosing between goals referred to by Maslow (1987:76-79). His reactions revealed a reaction to the obstruction of his goals as family provider. He described being torn between going to work or entering into the sick role during the relapse stages of his gout attacks. His family required finances to satisfy basic survival needs, but working increased the pain, which made it difficult to walk and stand, and tired him not only physically, but also mentally. Whatever choice he made ended up in the thwarting of needs. He needed to rest (enter a short sick role) to achieve reasonable pain control, and health well-being to maintain employment. Yet it was the absences from work that lost him his employment.

The observer felt that the findings showed a number of simultaneous needs deficiencies, but not necessarily in order of a specific sequence. There seemed to be a confusion of needs deficiencies, and Sam was unable to identify which was of the highest priority to him. What Sam was expressing seemed to be consistent with Murray's theory of the fusion of needs, and what he calls subsidiation of needs referred to in chapter 4 of this dissertation. Sam's need for achievement being fulfilled in the role of provider was thwarted, since the specific motive of employment was not realised. The way Sam spoke indicated that he felt highly frustrated since he saw the motive of working as the means to the need for achievement (role of provider as expected breadwinner), to fulfil the need for finances and to fulfil the basic survival needs of his family.

What was intriguing to the researcher was the almost snowballing effects and interconnected interactions between the needs (or needs deficiency) themselves and the needs lack and their consequences. The consequences of the increase in needs and needs deficiency were like a chain reaction that demonstrated the relational network of the ecosystems paradigm referred to in chapter 3 under 3.3.1 and in chapter 5 under 5.6.4.3.

Anna's confinements to bed were of long duration, but she was with her parents, and especially her mother gave a lot of her time caring for her. She told of an incident when she was in hospital and was upset, and her mother helped her wash her hair. Anna indicated contentment, enjoyment, and feeling comfortable with her mother's attention and help. It was a response to a mother-daughter relationship that had lasted through all the years, since she was born, and possibly the reason for her feeling so comfortable. Pam's reaction to dependence on others was very different to Anna's in that she felt her dignity was threatened in hospital, since she expressed with some aggressiveness her feelings about the procedures carried out in the hospital. Although her needs were to be dependent while she was bedbound she felt that her independence was threatened. It was noticeable that she no longer spoke in the first person when relating this experience, and spoke very rapidly with many hand gestures. Her response suggested that although the needs of body hygiene were met, she experienced an onslaught to her dignity. Maintaining dignity (associated with self-esteem) was more important to her (Maslow 1987:6,77).

b) Role reversal and role expectancies

Pam also experienced changes in her intimacy with her spouse. She indicated by her body gestures that became aggressive, and her voice tone that considerable confusion and conflict regarding their sexual relations occurred. She spoke very rapidly and emotionally, revealing that owing to the limitations placed on them during the post-operative period she could not be a wife to her husband. That period of limitation on her sexual activity seemed to affect their sexual intimacy from then onwards. For Pam the threat to sexual intimacy concerned not only abstinence (and later unsatisfactory sexual activity) but also her role as wife. She expressed frustration at feeling rejected and isolated from her husband. Her spouse's response was to tell her not to worry, but since he did not share his feelings with her in talking about the problem she felt more insecure and anxious. Pam's response seemed consistent with Rogers' theory of the self-concept, and the conditions of self-worth referred to in chapter 4 of this study. Pam felt very strongly that she was unable to fulfil the role expectancies of society (the role of wife and lover) and she expressed feelings of guilt and uselessness.

The lack of mobility encroached on what each respondent considered to be their role in the home. Anna as a single person was living at home with her parents, and then in university residence. Home care for her was not that important. Later when she moved into her own flat she was at the stage of intermittent pain episodes only and managed to care for her own home. The other two respondents experienced much more frustration and greater needs regarding managing their house work or home care. Many of their struggles to adjust seemed to come from the role expectations that they had for themselves.

Sam also felt the role responsibility strongly, and felt that in management of the home he had failed his family. However, for him, as previously shown, failure was associated more with home economics. It was interesting that the respondent for the pilot study (a male) revealed the same pattern of role responsibility placed firmly upon home economics as priority needs. In the field notes the observer wrote: Sam's verbal response indicated that his failure to provide for the home and the family (due to work loss) led to separation and divorce proceedings. He felt this was the reason why he was separated from his son. When speaking about his child his voice became very husky and he was close to tears.

Both of the respondents who were mothers felt the plight of their children growing up in the chronic pain scenario very keenly. It appeared to have caused them much heartache

and feelings of guilt. The needs lack associated with the role expectancies appeared to have far-reaching consequences for all the respondents, since all experienced various degrees of low self-esteem.

Through the long years of experience with chronic pain Ina appeared to have established some sort of awareness of the developmental and time-phase element of her chronic pain condition. She sometimes managed to prepare herself and her family in advance for the most trying time-phases of the condition. It warranted specific notice, since the threat of disruption of life-style during the relapse phase became less important as she seemed to redirect her goals by anticipating and preparing for such events (Maslow 1987:6,75).

Pam became confused between what she needed and what she wanted. When it was suggested that she was saying that she actually needed assistance with heavy objects, yet she felt she wanted to do for herself what was physically impossible, she replied that she agreed, but she wanted to do it herself also. The observer's interest revolved around Murray's (Meyer, Moore and Viljoen 1989:273-284) idea that needs activated at the same time may conflict with each other causing distress to the person, and Maslow's (1987:78) threatening conflict theory. It appeared that Pam's need for achievement and independence conflicted with her need for assistance (need of dependence). She had to choose between what she needed physically (dependence) and what she wanted, which was threatening to her. Hence the choice still meant deprivation of her independence, control over her life, and achieving her goals despite having her needs for assistance (dependency) gratified.

Ina showed the same conflict when she wanted to drive her car to go shopping but she feared that she would be unable to get back home again. She showed conflict between the need for achievement and the harm avoidance need. It was obvious in telling their stories that it was frustrating, distressing, and the conflict caused considerable anxiety for each of them.

c) Social and church participation

Mobility limitations appeared to be the reason for considerable loss in social and church participation, especially for three of the respondents. The losses experienced in social and church activities seemed to have a strong influence on the emotional states of the respondents, since they responded with increased body language. The importance placed

on a perspective of living seemed to direct the different responses of the respondents. I took note that in Ina's premorbid state she was not particularly involved in social activities. Her social participation was mainly confined to church activities and to her work situation. In contrast, Pam's premorbid state social activities were far more outdoor-oriented, like horse riding, hiking, and visiting people at a distance. For Pam, outdoor activities were important and any discontinuation or changes in these activities threatened her independence, physical image and achievement ability.

What was interesting was that in response to questions on participation in the church, Ina had far more to say than Pam did. The importance emphasis was reversed. It appeared that Ina placed more importance on church participation, because her involvement in church activities was her social participation to a large extent. Also the family's togetherness was tied up in church involvement. Pam felt a responsibility to bring her children up in the ways of the church, but her husband did not feel the same responsibility. Pam still tried to teach her children the Christian belief at home, and could arrange for them to go to Sunday school. Therefore, for Pam, not getting to church was because she could not drive there, and because she was unable to sit for long. Ina, however, expressed far more loss, hurt and loneliness.

8.2.2. Safety and security needs

Safety and security needs were considered from the point of view of physical safety and vulnerability to physical danger. Then emotional needs associated with safety and security in all of living were given attention. Maslow's (1987:18-19) rough categorisation of the safety needs was referred to. They are security, dependency, protection, legal protection and the need for structure. Further needs are freedom from fear, anxiety and chaos. There is also the preference for the familiar. Saturation of the safety needs are evident when there is no longer any sense of feeling endangered (threatened).

The researcher did not refer to safety needs only, but included security needs, which meant that physical safety was not the only consideration. Security needs that were considered were financial stability, employment certainty, any changes that occurred in family roles and social changes. These included changes in the person's environment that threatened freedom from anxiety, fear and chaos (Maslow 1987:42-43).

8.2.2.1. Physical safety

The need for physical safety was an aspect that few of the respondents addressed. The only respondent to speak about feelings of vulnerability regarding physical safety was Ina. She experienced a break-in at her previous house (situated on a secluded plot) when she was alone at home during a bedbound phase. She was flung to the ground, which caused damage to her back that had recently been operated on. After the experience her husband sold the plot and they bought a house in a built-up residential area.

Ina expressed feeling safer with houses close by. The observer noted in the field notes: The house has burglar guards on every window. The front and back entrances of the house have security gates. The entrance gate to the property had to be unlocked to let the observer in. The house was situated so that there was easy access to a front and back view of the house from inside. My thoughts on entering were: this house has really been made safe. She had laughed nervously and said that her nerves were on edge when referring to the incident in the old house. She also felt helpless and afraid as she was unable to run away or protect herself from the assault. Ina, however, appeared to be comfortable in her new home with the security protection installed.

8.2.2.2. Emotional security and safety

When questioned about their feelings regarding security and safety, the other respondents all referred to emotional insecurities associated with work, hospital and role changes. For two of the respondents changes that occurred in the workplace, posed a considerable threat. It was of interest that Sam was constantly referring to his work, but the importance of work to him was specifically financially-oriented. This was emphatically connected to his role expectancy as provider/husband/father. The changes and instability in his employment status, due to frequent absence, were frustrating and stressful to him. It affected much of his daily functioning, and he made statements such as “when I was out of work, and I didn’t eat after this suicide thing....”

Sam had lost his work, and for four years could only find casual work for short periods. He had long periods without work in-between. His financial state degenerated. It was noted that although Sam was working again, he still revealed the same anxiety that he did when he spoke about the time he was unemployed. He arrived for his interview in a rusty, battered car that made a great noise. He referred to it with a laugh as a bucket of bolts.

During the interview he said things were improving a bit financially. The implication of the unemployment and financial struggle, he felt, resulted in his wife leaving him and he was going through divorce proceedings at the time. He was living in a rented furnished room. Sam spoke with grunts of laughter, moving about in the chair, and often looking up at the ceiling.

It was very noticeable that the developmental process of his chronic pain (and gout attacks) created chaos in his employment situation. This in turn destroyed his financial security and destabilised his family's relationships. Sam showed strong evidence of threatening frustration and conflict levels (Maslow 1987:75-77). The observer took note that Sam constantly blamed himself and spoke as though he deserved what had happened. He was constantly worrying whether his present work (of the last six months), would remain permanent. He seemed to have lost confidence in his ability to keep a job, or to do something well. It was evident that the need for mastery and control over his life was prominent and his non-verbal, as well as verbal communication expressed his emotional pain. The snowball effect that took place because of the changes in Sam's work situation again caught the observer's attention. Numerous needs increased, and needs deficits also occurred (almost like an explosion). Sam appeared to place extreme importance on his employment status. This was possibly because he felt deprived of the goal objectives that employment brings: stability, because it gives financial status, and role fulfilment, which is associated with self-esteem, respect, and gratification of the basic survival needs of his family. The effect of the instability caused by unemployment (due to the chronic pain) deprived him of these advantages and left his need for love and respect unsatisfied. He felt rejected, and isolated from his family instead. The isolation from his family, as he saw it, was devastating.

Again the plight that his work situation brought was of interest in the light of the pilot study (male respondent whom I will call Pilot). The pilot study revealed the same patterns. Pilot lost his business, was declared insolvent, lost his house, and his family had to move to a rented house. Pilot's wife stood by him, but the role changes in the home tore the family apart in their struggle to survive the work and financial losses experienced. Both Sam and Pilot experienced overwhelming threats to their basic survival needs. Money was scarce, and they felt that the most basic needs of their families (feeding the family) were threatened. They both expressed intense frustration (Maslow 1987:75).

It was intriguing to find that Pam responded as strongly to the changes in her work situation, but the threat to her employment well-being was different from that of Sam. Although her survival needs were not threatened as much as Sam's, she also felt that the financial loss affected her marriage relationship. The financial state and its influence on her marriage were important to Pam. However, it was interesting to note that Pam also attached great importance to her studies, which she felt had been wasted since she was unable to use her qualifications. The need for achievement was obviously threatened, despite her achieving the goal of completing her studies.

It seemed that Sam was more engrossed with the financial lack because the very basic survival needs of his family were threatened, while Pam was frustrated by the lack of finances, but more engrossed with the need for achievement and creativity. Pam felt she had studied to qualify in horticulture to fulfil her need for the outdoors, space and beauty. She revealed as much of an intense threatening frustration about this, as she did about the financial loss. It is possible that, since Pam's very basic survival needs were not drastically affected, the higher needs for security in achievement, and the need to experience the goals of an outdoor work, were stronger (Maslow 1987:56-58). The difference the two respondents revealed to the employment and financial threat was in line with Murray's belief that needs present differently in people. He considers it important for pinpointing individuality (Maddi 1989:285-287). Pam showed a whole chain of need deficits when referring to her financial state. She clearly linked her need for financial gain to her studies, her qualifications, and for the purpose not only of financial gain (to give comfortable living), but also to be in the outdoors, to appreciate nature, beauty, and to have a sense of accomplishment. All these needs finally connected to the roles in the home needs, like motherhood, wife, lover and so on. What Murray referred to as the fusion of needs, and subsidiation of needs seemed operant in Pam's concept of living (Meyer, Moore & Viljoen 1989:273-284).

It was clear, however, that for both Pam and Sam, chaos in the organisational values of their family living were severely frustrated. Both experienced threatening conflict in their needs for stable (satisfying) employment, and stable financial circumstances, which resulted in family disorganisation and relationship destabilisation. This happened although, as previously noted, they experienced this from different perspectives, which were very similar in some ways, yet different in others.

The contrast between Ina and Anna in comparison with Sam and Pam seemed to back the premise (previously made by me) that the individual circumstances of people with chronic pain has a marked influence on their need situation. Ina stopped working when she got married. She felt that there was no real changes due to the financial status in the home. Her husband remained the provider of the home and she displayed a sense of well-being about this. Even when asked what she thought she had lost through the effects of chronic pain she referred to loss of friends, independence, but not to any financial loss, whereas Sam and Pam referred frequently to financial losses. Financial stability may possibly have had an influence on the stability of the reversal of the role in Ina's home. The observer noted with interest that in association with the role reversal experiences in the home, Ina was more distressed about her children having to take on early responsibilities than she was about her husband taking on home care activities. It was difficult to establish from the data whether this was due to the financial stability in the home, or due to the stable relationship in their marriage. The observer felt that it was probably due to both. It was noted that although their home management circumstances were disorganised (and chaotic in relapse phases) yet their relationship as husband and wife, parents and children was stable. She did express feeling guilty and helpless that the children had to take such early responsibilities, but also said that it brought the family closer together.

Anna also did not express any lack financially, because her parents supported her. It was apparent that she experienced a sense of safety and security in the parent-child relationship. For her, a threat to her safety need was interpreted as anything that threatened her goal to achieve her study plans. She felt threatened and expressed frustration when her lecturers lacked understanding of her mobility problems and the relapse phase difficulties. The positive effect was interesting to observe when she started studying theology. She received consideration, empathy and assistance with her physical needs that helped to accomplish her study goals, and she expressed relief with a sense of well-being. In the first incident it was obvious from the tone of her voice and her facial expression that she felt robbed of her dignity, while in the second incident she had regained her dignity. She constantly referred to the need to be understood and shown empathy. Anna also differed rather vividly from Sam and Pam, since she fulfilled her goals in her studies, and she furthered the achievement as she commenced working as a hospital chaplain. She

expressed contentment in her work circumstances in general. It must be noted that by this time Anna was still experiencing chronic pain, but of a more intermittent nature.

8.2.2.3. Familiarity with hospital

It was surprising to me that three of the respondents described their hospital experiences as fairly positive. Ina expressed that it was distressing to be hospitalised and lose her independence, whereas Pam did feel strongly about losing her dignity owing to some of the hospital procedures. Sam once again spoke of the hospital experience in association with financial deficiency. For him, the lack of money meant long hours of waiting to see the doctor, and then a long wait to receive his medicine. The procedure itself resulted in loss of work time, and threatened his employment situation.

Two of the three respondents felt that their families had more difficulty adapting to the insecurities that hospitalisation brought. These insecurities were due to the unfamiliar environment of the hospital and the inconvenience of trying to run a home, work (or attend school) and visit the hospital. Pam felt that the hospital had given her husband specific help and support in giving him counselling. She also expressed gratefulness to their kindness in feeding her spouse, and allowing him to visit for longer periods. She expressed feeling insecure that her daughter was unable to visit and relief when this was rectified. Anna told of a very negative incident in hospital which stemmed from a former fear of the hospital environment. She felt that the staff lacked empathy, and she described a time of fear, acute anxiety and depression that led to her attempting suicide.

The experience had a firm impact on Anna, since she talked for a long time about the incident with her face flushed, and she spoke rapidly with many arm gestures. She said she felt humiliated and degraded during this time. Fortunately the other hospitalisation periods were positive experiences which helped to ease the anxiety.

There were numerous social changes that occurred in each respondent's circumstances, which resulted in insecurities about social activities and relationships. I decided however, to analyse this with the data for belongingness and love needs, since there was an overlap of these needs with one another.

8.2.3. Belongingness and love needs

Maslow's (1987:20-21) understanding of the need to belong, to be loved and to love was referred to. He referred to the love needs as giving and receiving affection. When the love needs are unsatisfied the person may express feeling the absence of friends, spouse, or children (the absence of familiar, or significant people) and will yearn for relations with people in general. Isolation, loneliness, ostracism, rejection, and a sense of not belonging will be prominent. The belongingness needs seem more difficult to define, but Maslow referred to events such as disorientation due to increased mobility, being without roots, and being torn from one's group (family, neighbours, church, friends). The need to identify with group goals and triumphs, and the feeling of having a place are important requirements in the need to belong. Belongingness also brings feelings of loving, being loved and being worthy of love (valued), and the ability to give love (Maslow 1987:43,44). This research discussed the need for belonging and love under three subsystems relevant in the ecosystems of people with chronic pain. These subsystems are the family, friends, church and God.

8.2.3.1. *The family*

Ina spoke only of her immediate family, that is her husband and three children. She indicated a very strong sense of belonging and togetherness within the family. All that she said of her husband revealed evidence of a sense of deep respect, trust and a sense of well-being with their relationship. The observer noted that Ina felt secure in feeling respected and cared for by her family, and she seemed able to accept their actions of caring and support more readily. It was very obvious from the manner in which she spoke of her family, and the way her voice tone and facial expression softened when talking about her husband, and her eldest daughter especially, that they were a closely bonded family.

Anna had a very similar experience. Her relations with her family within the parent-child role expectancies remained stable. She spoke more frequently of her mother who seemed to be her main support in presence, since she spent much of her time with her in periods of hospitalisation. She spoke with respect and tenderness in her voice when speaking of her mother and father. It was evident that she felt secure in belonging, and being loved by her parents. Her enthusiasm when speaking of her parents expressed her ability to trust and to love them.

She referred to a post-operative time when she was scared and sore and needed her mother. She spoke of her mother as somebody to be there, to lean on. She took comfort in her mother with whom she could cry, and who would scold her when necessary, but also hold her. What caught the observer's attention was that Anna's brother, who was younger than her, felt threatened by the hospital procedures, and although he reacted negatively towards her she felt secure in his reactions. She responded in an elder sister role of understanding and caring. What interested me regarding Anna's response was that the belongingness and love needs appeared to be well satisfied within the family circle. Her response seemed to support Frankl's (1978:36) view that the human's motivation is meaning in life. It was clear that Anna considered her parents' support and caring as motivation for finding meaning in life.

The observer noted with curiosity that both Ina and Anna, although they had varying degrees of immobility deficits and physical needs (like hygiene needs, activity needs, and self-management care needs) both felt very secure in giving love receiving love, and belonging to their families. The observer felt that they both felt a sense of, and expressed that the caring support of their families gave them a sense of meaning of life, despite all the physical needs impairments. In other words, values were given preference over needs (Frankl 1978:105-106). Although Ina experienced role reversal in her relationship with her husband because of her physical needs lack, the goal of family togetherness was of greater value to her (and her husband) and was maintained despite trying circumstances.

Pam and Sam were very similar in their circumstances and their experiences with chronic pain. It was apparent that their needs for belonging and love within the family situation were very threatened. As formerly pointed out, the family situation for them both was radically disorganised and chaotic, which destabilised family security. Destabilisation may have resulted because in both the respondent's circumstances employment held great importance, and financial well-being was more threatened, (especially for Sam). It must be noted that Anna and Ina did not really experience financial loss, and Ina had given up employment to get married. However, Anna did reveal that she attached importance to her studies, and saw the limitations that resulted from chronic pain as a threat to her achieving her study goals, but the threat was removed when allowance was made for her limitations. Pam experienced a lack of support from her spouse's family. She felt rejected by them, and very threatened when they criticised her decision to continue with her pregnancy,

against what they felt was their better judgement that an abortion was safer. She displayed a deep sense of being torn from her roots in the family, which she felt was due to chronic pain and the changes that the limitations brought to her life. She felt extremely threatened in her belonging to her own family (parents and siblings) and to her in-laws, moreover to her husband. It was of interest to observe that Pam felt rejected by her family because they felt she should have an abortion in view of the operation to her back. Pam had said that she chose to have her baby, and that motherhood was very important to her. She expressed severe frustration and conflict. The observer's attention was drawn to the fact that Pam's insecurities regarding family belongingness were wrapped up in the role expectancies. She felt useless as a wife, lover to her spouse, mother to her children, and she responded to any suggestion that threatened these concepts (that highlighted her inadequacy as she saw it) with an aggressive defensiveness. This was found to be consistent with Roger's theory of self-concept and defense mechanisms referred to in chapter 4.

It was evident that the time-phase between the relapse phase and the rehabilitative phase (in the post-operative recovery stage) was a period of increasing threatening frustration and conflict for Pam. Her irritation indicated that she felt the need for belonging and loving support from her family, but she also revealed a feeling of dehumanisation due to the loss of her independence. What was of interest to this study was that Pam seemed to show an intense reaction to a threat to her freedom and independence. She indicated that it was not only the lack of freedom of doing, but also the lack of freedom of expression that irked her. She was unable to do what she wished to do and people (loved ones) expected her to accept this, and did not listen to her reasons for objecting to help. During her interview her voice tone, facial expression and body language suggested intense angry anxiety. Her strong reaction suggested that she felt her freedom was threatened. According to Maslow (1987:22-23), freedom is a precondition to basic need satisfaction.

The threat to her freedom possibly increased her sense of disorientation within the family structures. Her difficulties concerning sexual relations with her spouse increased this disorientation, since she felt that she was unable to be a lover (in others words to express her love in satisfactory sexual activity). It appeared that Pam felt the need to receive the expression of love from her spouse, and especially that she needed to express her affection and love (Maslow 1987:21). It was obvious that sexual intimacy meant far more to her than just the fulfilment of physical sexual desire. Lack of sexual fulfilment appeared to

deprive her of feeling a sense of belonging, being loved and giving love. She frequently expressed anxiety and fear at the possibility of losing her husband.

Sam also experienced an upheaval in his home, but as a result of losing his work and the loss of financial and role expectancy status. He felt that chronic pain alongside the disease relapse phases had deprived him of respect, belonging and acceptance that the status of the role of provider gave. He felt that the inability to maintain employment due to mobility difficulties and frequent absence from work deprived him of respect, love, belonging and participation in the family.

8.2.3.2. Social and church participation

The field note that the observer made was: when Sam speaks about the church situation in his life his voice tone, gestures and facial expression attempt to shrug the whole thing off, but at the same time I feel a sense of him feeling he deserved being ignored. When the tape-recorder was switched off he began to express that he felt hurt and let down by his Christian church friends. He also conveyed some feelings of confusion, since he tried to excuse them because he had grown cold towards God, yet on the other hand he had needed help and it was not forthcoming. He seemed to be showing signs of tiredness, and difficulty to concentrate and to express himself. I switched the tape-recorder off, but he suddenly began to talk more about the church. It was obvious that he felt rejected by his church, yet guilty because he also felt he deserved it since he had drifted away from God.

The need for church participation, and especially involvement from the church (either church) was very obvious. The thing that caught the observer's attention was that both churches seemed to be uninvolved in the plight of the family. What stood out was that Sam felt that they were not interested in him, because they did not know what was going on in his life. He interpreted it as the church not caring about them (his family).

It was evident that Pam experience a marked change in her relations with old friends. I noted once again that her premorbid state activities were more of the outdoor type, and her old circle of friends were associated with the outdoors. It was possibly because her outdoor activities ceased that these friends also moved out of her life.

When Pam spoke of her old friends she moved through a number of emotions evident from her tone of voice, the pace of speech and her body gestures increasing or decreasing, and sometimes she was tearful. However, it was noted that when Pam spoke of her new

friends there was a big change in her attitude. The field note the observer made expresses the change of attitude that occurred: these people must have made an impression on her as her voice tone softens and her facial expression lights up.

It was very noticeable that Pam constantly referred to her premorbid state, but also with irritation, impatience, sometimes with anger, and much conflict of feelings. She referred to it (what was and what is): in connection with herself, (what she used to do, what she wanted to do now, but could not do), in connection with her marriage and family (what she had lost in role functions), and with regard to her friends. The observer felt that Pam was still in the process of trying to come to terms with the changes in her own physical body and life-style demands. It appeared that she was still in the process of grieving and mourning the losses resulting from the restrictions that chronic pain brought that is consistent with literature referred to in chapter 2 of the dissertation.

Pam appeared to need more individual help from the minister than she felt she needed church fellowship. She felt that the difficulty in mobility and uncomfortable sitting in church made it too difficult to attend church much. She seemed to take comfort in her own efforts in taking on the responsibility of teaching her children about God and arranging for them to attend Sunday school. She attended church when she could, but felt that she did not fit into any movements in the church.

Ina expressed very similar feelings about losing contact with old friends. Ina had maintained a small circle of friends in her premorbid state, but said that when she made friends then it was a deep relationship. Ina experienced the loss of some old friends. What was of interest to the observer was that Ina indicated that she had come to an acceptance that many of her friends had lost contact with her. She did not mention feeling isolated or lonely when referring to her friends. She did answer that two of her friends were a great help to her, when asked who was the most help to her. It is possible that these two friends gave her enough of a sense of belonging and being loved so that she did not associate loneliness too strongly with the loss of other friends. However, there was an intense sense of not belonging and isolation that she associated with her church. The observer did note that Ina had placed far more importance on the church as the family's social activity. Her needs for social belongingness were firmly entrenched in the church, and the family's togetherness was also entrenched in participating in church activities. She felt robbed not only of belonging to church, but at the same time of her identity with her family. She

could no longer attend meetings at the church, but her family still attended the meetings. She indicated that she felt extremely isolated when her family had to go to meetings without her, and also that the family felt her absence just as strongly. In any reference to this situation Ina expressed her feelings of isolation and loneliness at being left out of the family's interactions with the church. She made frequent references to the fact that she felt discarded, useless, helpless, and that she did not feel she belonged to the church. It seemed that Ina's hurt at not being able to participate in the church fellowship was enhanced by her family's participation, together with what she referred to as the church's not remembering her. In view of her feelings it must be noted that previously Ina had been actively involved as a Sunday school teacher for ten years, and involved in a number of church meetings.

When asked what her needs were, and how the church could have helped, Ina's replies were constantly referring to the need for social intercourse. She constantly revealed the need for church fellowship. She also interpreted their absence as evidence of their lack of caring for her. She felt depersonalised, a member who did not exist for them. The observer noted that she was speaking of her former church when the family lived on the plot. They had moved house and were living opposite their new church (for the past four months) and Ina said that they seemed to show much more interest. The new church's minister had already made a number of visits. *When she was asked how this made her feel*, Ina replied with a smile "ag..., dit laat my beter voel, dit voel ek is nog'n mens, ek is nog 'n lid van die kerk. Dit laat my meer menswaardig voel."

Anna's experience proved similar in some ways, yet also with some differences from the other respondents. Anna's parents were very involved in the church, and later her father became an elder of the church. She experienced support from her church in many ways that she expressed with a sense of well-being.

Since Anna had a disability from birth she grew up with friends who only knew her with her disability, and she expressed experiencing close contact and loyalty from four friends from childhood. As she mixed with new friends in the university setting she spoke of two groups of friends. The one group of friends she spoke of with a happy excited facial expression. She also referred to another group of friends who did not respond to her needs for acceptance. Interestingly when Anna was asked what she needed from her friends at that stage, she immediately compared the one group of friends to the other group. The one

group obviously made her feel accepted and approved of while the other group, she felt, disapproved of her because of the restrictions chronic pain brought. It was noted that her self-concept was also associated with the approval or disapproval of others. Concerning the one group of friends from whom she experienced positive regard (by others) she expressed that she felt needed and special, while with the other group who she felt disapproved of her, she said she felt like half a person. According to Rogers (Meyer, Moore and Viljoen 1989:380) the process of gaining others' approval or disapproval is a requirement for a conscious development of the self-concept. Anna's reaction seemed consistent with Rogers' idea, since she verbalised comfort or discomfort to her self-concept when comparing the two groups of friends.

8.2.4. The need for self-esteem

Maslow (1987:45-46) divides self-esteem needs into two categories, namely the self-esteem needs associated with the individual's achievements, efficiency, capability, confidence and independence and secondly, the needs associated with the esteem of others, honour, dignity, appreciation and social status.

It was found that the need for self-esteem overlapped into many of the circumstances of the respondents. It was a need that frequently appeared to be directly or indirectly influenced by:

- the thwarting of goals: for example, when Sam was unable to provide for his family he felt useless, worthless and an oxygen thief. Consistency was found with Murray's *goal-directed needs theory* discussed in chapter 4 of this dissertation.
- the importance of the emphasis placed on circumstances: for example, Pam placed marked importance on the role expectancy of wife and lover in association with sexual intimacy. She felt inferior, frightened because she did not measure up to the role expectations. The researcher found this consistent with Maslow's *need motivation theory* (1987:6).
- the need for approval by others and by one-self was consistent in each respondent: when need for the approval of others was not satisfied, this caused feelings of uselessness, helplessness and rejection. Positive approval by others showed visually during the interviews, since the countenance and attitude of the respondents changed (voice tone, facial expression were joyful, softened and enthusiastic). They expressed

feeling wanted, loved, special and included while an unsatisfied need for self-approval led to frustration, condemnation, self-blame and guilt. When this need was satisfied the respondents revealed self-confidence, courage and hope. This was found to be consistent with Roger's *self-concept theory* in chapter 4.

- their own values: in a given situation their own values gave or took away meaning of life as illustrated by them placing the value of family togetherness above the need for independence and fulfilment of the role as home executive. Frankl's *theory of meaning of life motivation* referred to in chapter 4 appeared to be operant.

During the analysis of data the observer noted that it was like listening to a whole chain of events that constantly linked to the self-concept of the respondents, with constant patterns of recursive feedback into the ecostructures of the respondents. Also of interest was the close association the cognitive needs were given with the self-concept. It was noted that any thwarting of such needs as the need for further learning (study), making decisions, resolving problems and independence, were expressed as a sense of loss of confidence by the respondents. Feelings of indignation, anger, helplessness, feeling stupid, inadequate and a sense of depersonalisation were attached to the respondents' explanation of the thwarting of cognitive needs they experienced.

8.2.5. Growth motivation needs

As previously stated, Maslow (1987) believes that growth motivation of the self-actualisation process is reached only as basic survival tendencies are gratified (need deficiency motivation). Only then, according to him, will the goal state be sought after by the person. Hence to Maslow a tension-free state (homeostasis) is required for happiness or well-being to be achieved. Self-actualisation is mainly preconditioned by the lower needs gratification except for exceptional people on rare occasions.

The question that was in the observer's mind while listening to the respondents' stories was whether growth can occur in such circumstances. This was followed by the thought during the analysis of the data; are there any signs of growth in the respondents' stories despite their needs lacks? This dissertation took the approach of summarising the findings above based on the various personologist's theories discussed in chapter 4. Consistencies with some of the theorist's ideas were found, when comparisons were made between needs

lacks experienced by the respondents and their behavioural responses. Some conclusions regarding the above questions are discussed further on in this dissertation.

Maslow maintains that needs are hierarchical in process, and this means that growth motivation may occur only once deficiency needs are gratified. Self-actualisation is a process that is accomplished when choices are made (psychological) to give satisfaction to physiological demands. This means that the psychological needs (higher needs) are dependent on the physiological needs (lower needs) for self-actualisation to take place.

Murray and Frankl differ in their views, since for Murray needs occur in variety and sometimes simultaneously in the human's life and they include higher and lower needs. The self-actualising process is one of goal directiveness, in the person striving to achieve self-actualisation. Frankl believes that the motivation of meaning of life lifts the human being above need deficiency motivation, and that growth motivation is possible despite grave need deprivation. Rogers maintains that inherent potentialities in a person are meant for actualisation of self, but he places great emphasis on the need for approval of significant others to accomplish growth in potentialities. The three above-mentioned theorists therefore differ from Maslow's idea of a hierarchy of needs gratification to achieve self-actualisation discussed in chapter 4.

Firstly, the understanding of self-actualisation, or actualisation of potentialities was used as each theorist used it as described in chapter 4 of this dissertation. Secondly, the researcher's understanding of self-actualisation (or the actualisation of the self) is as discussed in chapter 5 under 5.5. Hence, this dissertation considers actualisation of the self from a theological perspective. I consider the human being created in the image of God, and with God-given potentials that must be actualised. This means that this study considers the development (or growth) of potentialities in humans from an anthropological stance, as well as a theological stance. This approach allows for the possibility of growth in the fallen state of humankind and for growth in the actualisation of salvation through Jesus Christ (Christocentric perspective). The idea is consistent with Heitink's (1984:113-133) concept of bipolarity, and Firet's (1986:31) theory of actualisation of salvation by means of God's Word (chapter 5:5.6.1.; 5.6.2.1. of this dissertation).

8.3. CONSISTENCIES WITH OTHER RESEARCH LITERATURE

The results of the findings of the analysis of the data previously maintained that needs did increase in the respondents' life cycles in living with chronic pain. It also stated that these increases in needs fluctuated during the developmental stages of the chronic pain process, and had far-reaching consequences for the people with chronic pain. What was also noted, however, within the need lacks, or need deficiencies that occurred in the lives of the respondents was:

- the importance of values: often the importance, or the value, the respondents placed on the circumstances (or goal objective) meant that threatening frustrations (or conflicts) occurred that directed the behavioural responses. It was this element that presented the similarities of circumstances between the respondents, but also presented the differences in needs. This was found to be consistent with Murray's belief that needs present differently in people and give the individuality of the person (Maddi 1989:285-287). It was also found to be consistent with Maslow's (1987:76) idea of a goal object consisting of two meanings for the individual. This has implications from a theological perspective since the differences that lead to the individuality of the person must be considered by pastoral care and counselling. It already indicates that care to people with chronic pain has a certain corporality, but at the same time each person is unique and must also be considered in the light of this.
- the positive responses: there was evidence of frequent positive responses from the respondents despite very basic needs deficiency. The increase in tension sometimes seemed to motivate the person to higher or other goal values. Sam, who experienced basic survival needs lack still revealed evidence of goal directiveness and a higher need of God. This seemed more consistent with Murray's theory that numerous higher and lower needs are operant simultaneously in humans' lives in their striving for well-being. Also, that a tension reduction process is necessary for motivation and not a tension-free state that Maslow believes in. This also seemed to be consistent with Frankl's theory of finding meaning of life, and Rogers' concept of growth motivation discussed in chapter 4 under 4.2.1.2.; 4.2.2.3. and 4.2.2.1. The importance to practical theology is the potential of growth motivation. Pastoral care and counselling would need to consider ways of caring for people with chronic pain that will encourage growth and goal-directedness.

- higher and lower needs: the data revealed strong evidence that there was a mixture of lower and higher needs operant in the lives of all the respondents, but no specific sequence of order could be established. The findings appeared more consistent with Murray's theory of needs considered in chapter 4 under 4.2.1.2, and Meyer, Moore & Viljoen (1989:273-284). It was also found to be consistent with an ecosystemic perspective discusses in chapter 3 under 3.3.-3.4.4.; and chapter 5 under 5.6.4. There was evidence of some lower needs that were gratified specifically, and higher need then occurred that was consistent with Maslow's hierarchy of needs theory. However, this pattern was not the rule in the all the data. The mixture of lower and higher needs and a chain reaction was more prevalent. The ecosystemic concept indicated in these findings holds importance for pastoral work to apply care to people with chronic pain from an ecosystemic perspective. The ecosystemic concept then holds certain implications and challenges for the church. Further discussion on this point follow in chapter 9.
- the self-concept and understanding God are closely linked: it has some influence on the way pastoral work must approach people with chronic pain in bringing care to them. All respondents' data was found consistent with Rogers' theory of the self-concept considered in chapter 4 under 4.2.2.1.

8.4. SUMMARY

The premises referred to at the beginning of this chapter in the light of the findings of the empirical study are as follows:

- the need for priority of survival needs gratification: there was evidence that indicated that when the basic survival needs were experienced as deficient, gratification was of utmost priority. Two of the respondents revealed patterns of this as they became fixed on circumstances concerning these needs. However, the researcher felt that the scope of this study was too limited to give findings beyond that there was evidence of this premise. An opportunity for further research may be considered from this perspective, since it may be an area that could contribute considerably in giving care to people with chronic pain.

- needs gratification: is not necessarily in order of a specific sequence, but lower and higher needs exist. The difference between lower and higher needs was evident from the data of all the respondents. However, there was evidence of connected interrelations and interactions between needs, but not necessarily in a sequence of order (hierarchy). The respondents seemed to indicate more consistency with Murrays's theory of needs occurring simultaneously and in a mixed form.
- growth motivation: is possible despite need deprivation. The respondents all revealed a goal-directiveness even when some of them experienced deficiency of the lowest needs. There was evidence of a striving towards higher goals by all respondents. I was inclined to be in agreement with Murray and Frankl in this consideration. However, the scope of this research was too limited to come to any adamant conclusion. Further research is required to explore the depth of this concept, since this would contribute considerably to the way care management to people with chronic pain is activated.

8.5. CONCLUSION

8.5.1. Final confirmation of evaluation of findings

Evaluation according to the respondents within the scope of this study.

- needs increased during all the developmental stages of the chronic pain process
- needs showed a marked increase in the relapse/progressive stage especially
- the increase of needs had a strong impact on the ecosystems of people with chronic pain

8.5.2. Findings revealed for possible avenues of further research

Findings revealed in part by the empirical observations are possible avenues for further research, but these go beyond the limits of this study.

- the rehabilitation process: this was expressed as being a very long process. It was evident that there were numerous relapse stages with increasing and changing losses and complexities (time-phases). Rehabilitation seemed to be more of an on going and constantly changing process. This area of the chronic pain experience seems open for research that may prove a promising contribution to the management of living with chronic pain.

- the ecosystems interrelations and connected interactions with subsystems of people with chronic pain: this seemed to have extensive consequences in the chronic pain scenario. The researcher was very aware that this study merely touched the very “tip of the iceberg”. The implications that limited mobility had for the various interactions and interrelations of the respondents and their relevant ecosystems were complex. The interconnected recursive patterns and recursive feedback between various subsystems were very apparent. This study was able to touch on this, but there appears to be considerable valuable insights that may be gained from further research. The researcher felt that any condition where people are homebound or bedbound (e.g. chronic disease, quadriplegia, the elderly) will benefit from any research relating to mobility limitations.
- self-concept and God: it was very apparent that the relationship between God and the self-concept was closely connected. The respondents placed considerable importance on their relationships with God as relevant to their living circumstances. The researcher felt that this concept may warrant further research that may be found beneficial to the church and to any chronic pain management care team.

8.5.3. Matters of interest

- a matter of interest to the researcher was the language used by the respondents: the respondents all made similar, but peculiar use of language. Their use of words and ways of structuring sentences were not always correct. This seemed to be more prevalent in the respondents who had a longer duration of chronic pain. It occurred irrespective of what language was spoken. The researcher felt it may have something to do with mental and physical fatigue, or lack of social participation and social intercourse.
- respondents' stories: the research revealed that people with chronic pain need to tell their stories from their point of view. It was apparent that there were a great deal of similarities in needs, but also a good deal of differences of importance experienced with different consequences for the respondents. This also gave individuality to each respondent's situation.

8.5.4. Contribution of research findings to practical theology

- from the point of view of the respondents: it was clear that from the point of view of people with chronic pain, that pastoral care and counselling needs to gain a great deal more insight and understanding into the plight of these people. The limits of this study was participant perspective only, but it was obvious that other perspectives are required to come to a fuller conclusion.
- theory and praxis: it will contribute to a theory of pastoral care and counselling praxis to people with chronic pain.
- homeboundness: it will contribute in considering care given by any homebound ministry of the church.

8.5.5. A final word

The short-comings of this research were considered to be the following:

- perspective: the research was taken from a specific perspective that may have led to some observer participant bias. However, every attempt was made to remain as objective as possible and to avoid being biased or prejudiced.
- the interviews: they should have been shorter, probably 30-45 minutes on average.

CHAPTER 9

A PRAXIS THEORY OF PASTORAL WORK

9.1. INTRODUCTION

The problem premise of this dissertation was that needs increased during the daily ordinary general living of people enduring chronic pain. The experience with chronic pain also prevented these people from social and church participation. It is this obstruction to church and social participation that called for pastoral care and counselling to find out more about the needs of people with chronic pain. It was noted that the results showed that needs increased in the process of living with chronic pain. The needs increased even more during the relapse stage during the developmental process of the chronic pain condition, without, or in association with, related disease regression. The respondents were found to have an assortment of needs (lower and higher), mainly occurring simultaneously. All of Maslow's (1987) needs categories were operant in the respondents' lives. This means that the physiological and physical needs, the safety and security needs, the belongingness and love needs, moreover the self-esteem and cognitive needs, were all inadequately met at some stage of the chronic pain experience.

This chapter deals firstly with the circumstances in the chronic pain process revealed in the research findings. Secondly, the main more precise needs are discussed, and thirdly, their various outcomes according to the respondents' stories. Applicable to these three elements, a discussion follows of the respondents' experiences with their ecosystems when needs increased.

A discussion follows of the various elements of thinking on ecosystems that are relevant to this study and to the chronic pain scenario. The importance of the conclusions of the discussion is considered in association with caring actions of pastoral work to people with chronic pain. I considered the question: Why is an ecosystemic perspective important when it comes to applying care by pastoral work to people with chronic pain? The outcome of such consideration leads to a theory of praxis for caring activities in pastoral work to people with chronic pain. Tabulation of the most prevalent circumstances, the outcomes of the circumstances and the feelings expressed with the most emphasised needs follow below.

9.2. PREVALENT CIRCUMSTANCES, OUTCOMES AND NEEDS

Table 9.1.

MAIN CIRCUMSTANCES	OUTCOMES AND FEELINGS	NEEDS
<p>1. MOBILITY a. bedbound periods b. homebound periods c. sitting, standing, walking limitations.</p>	<p>Anxiety, pain, isolation, rejection, loneliness, depression. Frustration, anger.</p>	<p>Mastery and control over life. Need for dependency, yet independence where possible, or to be included in making a choice.</p>
<p>2. LOSSES Role expectations status. Physical and emotional security. Employment and financial status</p>	<p>Family relations destabilised (or closer); fear, anxiety, depression, suicide attempt, or suicidal thoughts. Unresolved conflict.</p>	<p>Need for achievement and mastery and control over life. Need for freedom of choice. Need to be loved, and to give love.</p>
<p>Self- esteem.</p>	<p>Loss of confidence; some loss of cognitive ability; depersonalisation; depression.</p>	<p>Need for achievement. Need for mastery and control. Need to belong.</p>
<p>Social and church participation.</p>	<p>Isolation; lack of social intercourse; feeling discarded; excluded; rejected; depersonalised (one person felt included and wanted by the church). Friendship relations destabilised.</p>	<p>Need to be included, to belong, to be loved, to give love. Need for achievement, for recognition and respect. Need for freedom of choice.</p>
<p>Meaning of life</p>	<p>Anger with God; feeling rejected, unloved by God. Conflict, confusion; isolated; feeling useless; no good. Eventually feeling loved and cared for by God; drawing near.</p>	<p>Need to belong, be loved by God, and to love God. Need for some understanding or some clarity.</p>

9.2.1. Spirituality of the respondents

In agreement with chapter 7 of this dissertation spirituality is considered as the responses expressed by the respondents of their experience of God. From a pastoral care and counselling perspective spirituality was considered as the human's experience of God (anthropology perspective), that which gives the expression of action, thoughts, feelings and meaning in the individual's daily living. Consideration was given to how the respondents understood and expressed their daily living in their relationship with God, and the meaning that this gave to them (De Jongh Van Arkel 1989:19-29; Fin 1990:42-45).

This dissertation took the perspective of spirituality associated specifically with the Christian faith that included a relationship with Jesus Christ as redeemer of humankind, which is Christocentric in perspective.

9.2.2. An ecosystemic perspective of the respondents' experiences

Figure 9.1.

A diagrammatic view of the ecosystemic perspective that came out of the data may be illustrated as follows:

Imagine that the border demonstrates an elastic band stretched around the circles attaching them to one another. Each illustrates a subsystem of the individual with chronic pain. The whole unit illustrates the ecology of the individual. ↗ Illustrate that the society's system surrounds the subsystems. The subsystems are within the whole. Follow the three diagrams as they illustrate that when one subsystem is affected the whole is affected, and visa versa.

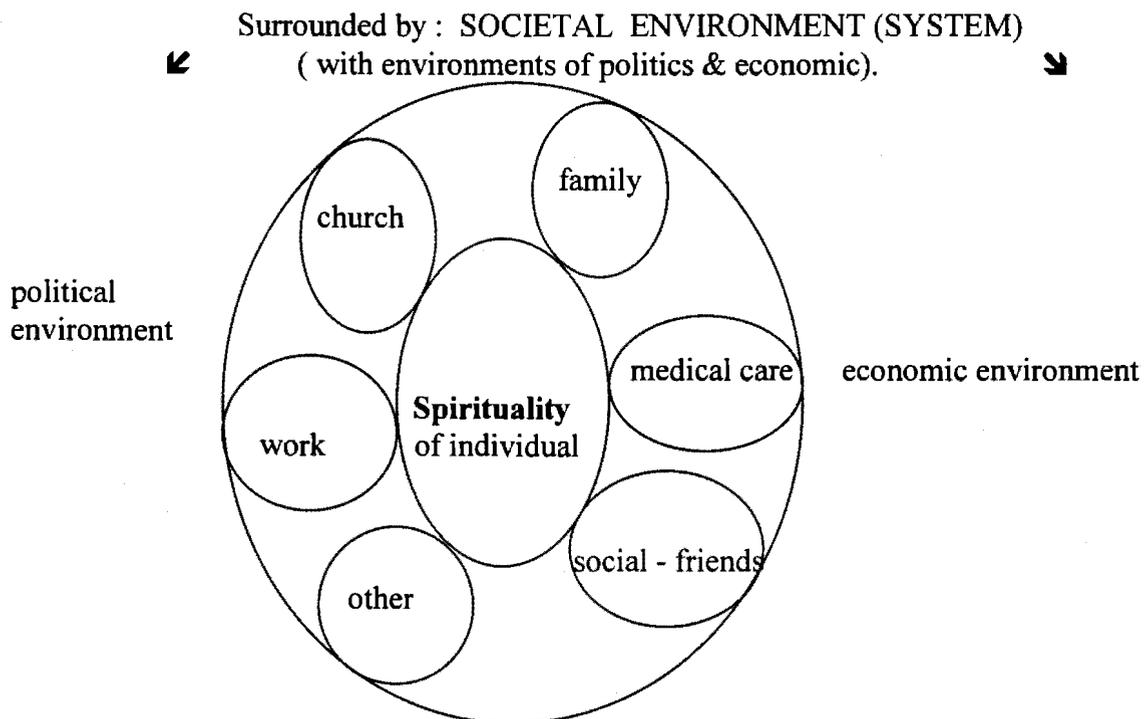


Figure 9.2.

Moving one or more of the circles; for example, moving the family circle inward, will result in all the circles being released inwards by the elastic band. The whole unit is affected, including the surrounding area as it too will collapse inward.

Surrounded by : SOCIETAL ENVIRONMENT (SYSTEM)

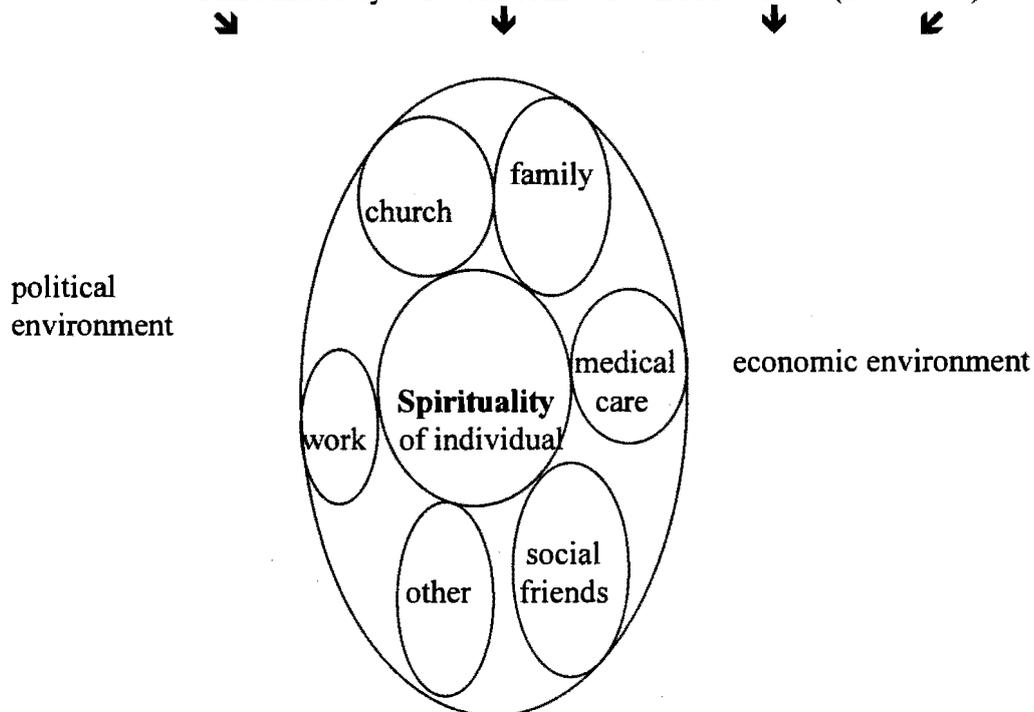
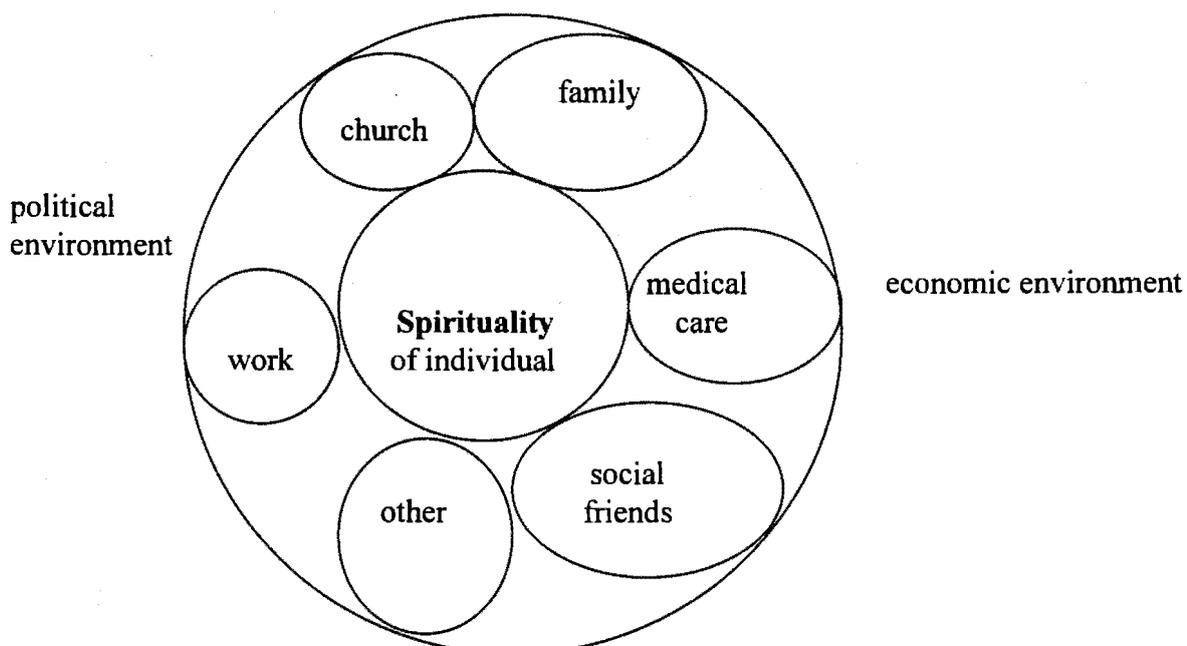


Figure 9.3.

When stretching the elastic band by moving one or more of the circles outward, the whole unit expands and presses outwards.

Surrounded by : SOCIETAL ENVIRONMENT (SYSTEM)



If the circles are understood as representing the relevant ecostructures (subsystems) of the individual experiencing chronic pain within the whole of society (system), it very roughly illustrates just how connected, interrelated and interdependent the whole system is.

Whatever circumstances influence any of the connected subsystems, also influence each subsystem to some degree or other. In the same way it has an impact on society and the surrounding environments, and vice versa. The needs of the respondents in the findings of the data may be illustrated in the same way. Any needs of the individual influenced the various subsystems, and vice versa. In the same way needs appeared to be interconnected in that a snowballing effect was mostly demonstrated. In the diagram spirituality was placed in the middle of the circles to illustrate that the research findings showed that the respondents saw their spirituality as relevant to their daily living circumstances.

The researcher felt that the findings revealed:

- systems: there were connected interrelations, interdependence in the interactions between the subsystems, with one another, and between the subsystems and the system as a whole to the environments and the reverse was also demonstrated
- needs: increase or deficiency showed the same connected interactions between the needs of the individual and the circumstances of the individual, which in turn influenced the ecostructures
- feedback: constant recursive feedback loops between circumstances and needs were revealed
- feedback: constant recursive feedback loops between subsystems and subsystems between subsystems and the system as a whole occurred

For example, Sam, who had frequent regressive attacks of gout and relapses in his pain control state demonstrated the following pattern:

Sam experienced frequent relapses of gout attacks and increased pain, which prevented him from working. The frequent absence from work meant loss in salary and ended in loss of employment, which resulted in a loss of financial income. The financial insecurity affected his ability to provide for his family's most basic survival needs, which developed into a major family relationship crisis. Hospital attendance increased to assist in bringing control management to the disease process, but increased the burden of financing medication. Increasing anxiety occurred, since loss of valuable time resulted in absence from work. In the process self-esteem, self-worth was lost, since needs for various role status expectancies were experienced, because work loss prevented fulfilment of the provider role (and so on, and so on). There did not seem to be a beginning or ending to the

whole process of patterns. It was rather a recursive feed back-and-forth-motion that occurred.

A connected interrelations network could be seen from the findings of the respondents, a relational network that revealed patterns of recursive feedback loops that either stabilised or destabilised the network. This was consistent with the literature discussed in chapter 3 under 3.3. and 3.3.1. of this dissertation, and De Jongh Van Arkel (1987:207-210).

9.3. A THEOLOGICAL FOCUS IN AN ECOSYSTEMIC PERSPECTIVE

The theological focus of this dissertation is the kingdom of God. However, it does not refer to the kingdom of God in association with a monarchy of God that may distort the essential meaning of this focus. Kingdom in association with a monarchy conveys an authoritarian attitude with restricted freedom of choice. Van der Ven (1993:69) points out that the desire of the king to bring liberating joy and happiness is lost because of the authoritarian connotation of the phrase 'the kingdom of God.'

To discuss the Christocentric perspective, and the hope found in the eschatology of the Christian faith tradition, this dissertation uses the Greek word *basileia*. Van der Ven (1990:69) prefers the use of the term "the *basileia* symbol", since he feels that it conveys God's being as king that stimulates an engagement and participatory praxis. He refers to the "*basileia* symbol in the communicative praxis of Jesus himself" that inspires the listener to commitment, and to new aspects of meaning of God's *basileia*.

There are multiple references and significance given to the kingdom of God, but generally these references may be divided into two classes: what may be regarded as present and means suffering for anyone entering into the kingdom of God (2 Thess 1:5) and secondly, that which is seen as future and associated with glory, and reward (Matt 25:34; 13:43) (Vine 1985:294). Van der Ven (1990:70) considers the function of the *basileia* symbol throughout the Judaic history, and concludes that the multiple interpretations of *basileia* are due to its meaning being dependent on the time and circumstances in which it operates. He emphasises it as a socio-historically functioning symbol, and so it carries a changing socio-historical meaning (Van der Ven 1990:71). The life and teachings of Jesus bring together two main traditions in the *basileia* symbol. It brings together traditions of

creation (God's compassionate love for humankind) and salvation history (Van der Ven 1990:71-73).

Jesus' teachings consisted of words and deeds. He conveyed the inclusive love of God to all humankind without any exceptions. He brought God's compassionate love for humankind, that offered salvation as the freedom of choice for all humankind.

In this dissertation the *basileia* symbol forms the basis for a binocular metatheory of ecosystemic theory and communicative action theory in bringing pastoral care to people in chronic pain.

9.3.1. The *basileia* - the love of God

The coming of the *basileia* expressed in the compassionate love of God for his creation (humankind) was brought to humankind in the words and deeds of Jesus, and in the redemptive event of Christ; moreover it may be seen as ecosystemic in action. God's love for humankind, and his intention to come to humans on these terms in a relationship with humankind may be seen as God's purposeful intention (*teleos*) for his creation. Within the same concept of God's compassionate love humans are intended to be in relationship with one another. God created humans intending them to fellowship with him (as creator), and with one another (as God's creatures). The relationship with their creator is not separate from their relationship with one another (Heitink 1984:110-111). There are connected interrelations and interaction that occurs between God and his people, and people with people. They differ from one another, but are not separate from one another, and are rather interdependent on one another.

The *basileia* urges humankind to a response to the gift of salvation actualised in Jesus Christ, through the freedom of choice that reconciles (to a relationship) with God, and fellow humankind. The freedom of choice is without exception and is inclusive of all people. God communicated his love to all humankind by his Word revealed in salvation in the event of the cross, hence God extended his compassionate love to humankind without exception.

The *basileia* incorporates a relationship between God and his creature (humankind). God's love for human beings wants to bring them into a reconciliative, relational fellowship between them and God. Jesus spoke of the coming of the kingdom of God, and in deed he actualised the kingdom of God in the act of salvation. The redemptive action of

Christ in his death and resurrection ushered in the kingdom of God into existential living of humankind (Furet 1986:26-29). Salvation actualised in people's lives brings reconciliation to God, and reconciliation between humankind. The human enjoys the freedom of choice to respond to God's gift of salvation.

Elements of ecosystemic thinking were evident in the relational network of the respondents' experiences with chronic pain and the circumstances from which needs occurred. Elements of ecosystemic thinking are also seen in the above discussion of the *basileia*. The threads of ecosystemic reasoning concentrated on in this study are considered from the above discussion and are as follows:

- the open system: which is understood as a system that enables growth due to interaction between connected interrelational beings, and with their environment.
- cybernetics of cybernetics: which form a relational network between subsystems and subsystems, and their interrelational interactions with the whole (system) and environments. Associated with this are the ideas of feedback and holism.

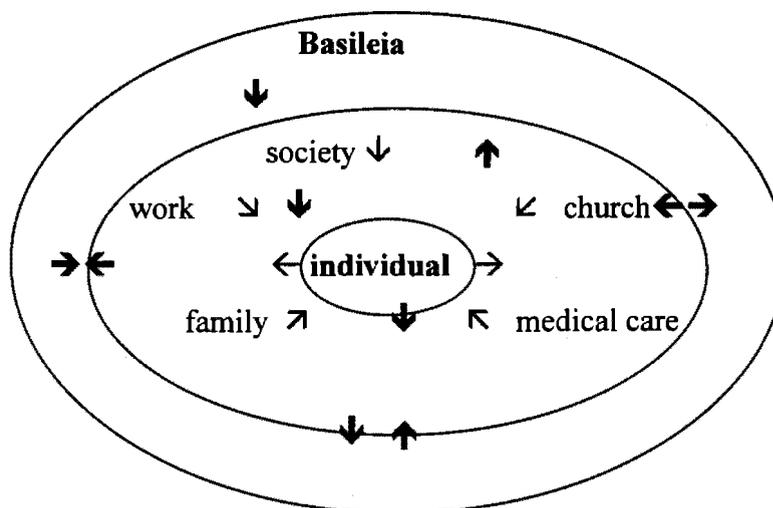
A back-and-forth motion of information within a relationship of interdependence occurs within the whole and between subsystems. It is a feedback that stabilises or destabilises in the face of change. I prefer the term cohesion instead of homeostasis. Cohesion may be maintained even in disorder and makes room for an adaptation to change (Hunter 1990:256-257).

Holism is the concept of the connected interdependence in interrelations and interactions. A circular feedback motion occurs between the environment, the system and the subsystems, and vice versa.

- complementary: which means that a phenomenon may be observed and described from a number of perspectives in forming a balanced whole.
- language: which is ecosystemic in that connected interactions between disease process and person, between person and associated relevant ecostructures are considered.

Diagrammatically it may be illustrated as follows:

Figure 9.4.



9.3.2. The coming of the basileia in pastoral care and counselling

The respondents' stories of their circumstance in living with chronic pain expressed an ecosystemic movement that occurred in their relevant ecology as explained in chapter 3 under 3.4. and 3.4.1. This movement had a strong influence on the various relevant ecostructures, e.g. the family in destabilising it, and on a larger scale the social economical system was influenced, since job loss meant revenue loss. The physical, cognitive and affective responses of the individual were closely linked to the ecosystemic consequences. The question was raised: What has this to do with practical theology? Even more to the point, what importance does the ecosystemic movement hold for giving pastoral care and counselling to the person with chronic pain?

9.3.2.1. *An ecosystemic movement*

The first point that this study noted was that in understanding people with chronic pain in relation to their ecostructures a far wider scope of caring actions had to be considered. No longer could care to people with chronic pain be centred on the individual. Secondly, it requires a greater involvement by pastoral carers and counsellors than visitation, counselling, prayer and scripture reading. Strong indications for the need of a pastoral social praxis became evident.

Before discussing how a pastoral social praxis may be understood, and the various utilisation of such a praxis, the concept of an ecosystemic movement was addressed. I

have used the term “ecosystemic movement” in association with the description of an ecosystemic perspective to people in chronic pain as given in chapter 3 of this dissertation. I used the term to describe or explain the connected interrelational interactions of the system in a larger context and the interdependence that occurs in the relational network. The ecosystemic movement referred to in this study is the movement that occurs when circumstances and behavioural responses influenced the various relational network structures. The illustration of the elastic band referred to in Fig. 9.1, 9.2. and 9.3. demonstrates this movement. Any following reference to the ecosystemic movement is according to the above explanation.

This dissertation considered pastoral care and counselling to the person with chronic pain in association with the coming of the *basileia*. The theological foundation of this study is the communicative actions of God revealed in his Word (Furet 1986:17-18). Through Christ the revelation of God is brought to people (Pieterse 1990:224). The revealed Word of God continues to be communicated to his people (in, and through the body of Christ), through the function and actions of the Holy Spirit (1 Cor 12). To come to an understanding of bringing the *basileia* by means of pastoral work, the concept of the body of Christ and to be a disciple was explored.

a) Discipleship

In considering the implications of the idea of discipleship I referred to the living relationship between Jesus and his disciples. According to Vine (1985:316), *mathetes* (a noun) literally means a learner. The word is derived from *manthano*, which is to learn, from a root, *math-*, which indicates thought accompanied by endeavour. It denotes someone who is a follower of another’s teaching. In scriptures such as John 8:31; 15:8 the term “disciples” refers to being imitators of their teacher, which means that a disciple was an adherent to the teacher’s teaching, and was not only a pupil (Vine 1985:316).

Furet (1986:58-63) describes Jesus as a teacher, but different from the usual Jewish idea of a teacher such as the scribes. The difference was that the teachings of Jesus astonished the crowds, and he taught with authority (Matt 7:28-29; Luke 4:32). According to Furet (1986:59), Jesus authenticated his doctrine by healing the sick, casting out demons and saving sinners. Jesus was different as teacher in that he called his followers into discipleship whereas the rabbinical students made application to their school. They were

taught by their rabbi, and the relationship took on a teacher-to-student stance. Jesus called his disciples to enter into the *basileia* and to be imitators of him, their teacher. Fiert (1986:63-64) points out that Jesus established that he is Lord, and the disciples his servants (Matt 10:24) and that in discipleship lies the idea of a relationship that is bound to Jesus personally.

When considering the disciples of Jesus within the coming of the *basileia* as described by Van der Ven (1993:70-73), Jesus' teachings combined the creation theology (Matt 6:25-33) with the eschatology. The wisdom theology of creation referred to the Sovereignty of God, but within the *basileia* symbol it mainly referred to the love of God for humankind that is all-inclusive, the compassionate love of God for humankind that called all to enter the joy of the *basileia*. Schillebeeckx (1974) expresses this more explicitly when he writes: "Jesus' life and teaching tell us that the kingdom of God is approaching and that it brings salvation for all without exception, especially to the poor, the weak, the outcasts, the unjust and the sinners" (Van der Ven 1993:72).

Van der Ven (1993:73) points out that connected to Jesus' proclamations of the nearness of the *basileia*, was the element of humankind's response to this proclamation. He writes: "the wisdom sayings put forth a radical claim to a new standpoint, and the parables contain the shocking call to conversion and commitment" (Van der Ven 1993:73). He maintains that the Lord's prayer gives forgiveness coupled with man's forgiveness of fellow humankind.

Jesus' communication in proclamation, and in the communicative actions of his life culminated in the actualising of salvation which brings the nearness of the *basileia* to people (all-inclusive). It offers commitment to the joy (of God compassionate love of all humankind) in the symbol of the *basileia*. Jesus called his disciples to this commitment and he commissioned them to go and make disciples. In Matthew 28:19-20 it is written, "Go therefore and make disciples of all the nations, baptizing them in the name of the Father, and the Son and the Holy Spirit, teaching them to observe all that I command you:..." (N.A.S. Bible). It is a commission for commitment to communicate the nearness of the *basileia* as imitators of Jesus, that is, to live the *basileia*. The response to the proclamation of the *basileia* is a commitment to discipleship to Christ, which means living the kingdom of God in relevance to everyday existential reality (Van der Ven 1993:73).

If discipleship is a commitment in response to proclamation and actualisation of salvation occurs, and if discipleship means to be imitators of Christ, then the people of Christ (the body of Christ) have an obligation to proclaim Christ. They are also responsible to teach the teachings of Christ, and by communicative actions of compassionate love to bring Christ to people.

It is apparent from the above discussion that I consider the idea of discipleship as the coming of the kingdom of God realised in response to salvation actualised in Christ. It means a commitment to be imitators of Christ in communication and action. This means that followers of Christ live the kingdom of God (the all-inclusive love of God) in daily existential, living reality. The people of God, living in discipleship in Christ, are members of a local body of Christ commissioned to “go and make disciples....” (Furet 1986:67).

b) The church - the body of Christ

Considered in the light of the discussion above discipleship, discipling and the body of Christ cannot be separated from one another. The *basileia* offered in the compassionate love of God for humankind in salvation history and in creation theology traditions incorporated communicative actions of telling, teaching and caring. They are functions found in the concept of discipleship, discipling and the actions of the body of Christ in the functions of the gifts of the Holy Spirit.

Responding to the coming of the *basileia* the believer makes the choice of taking the responsibilities of discipleship and discipling others. In the action of discipleship elements of God’s love for humankind, freedom of choice, reconciliation and responsibility may be found. In the action of discipling elements of the compassionate love of God expressed between people to people, freedom of choice, reconciliation, healing and growth are evident. It is in discipling others that the body of Christ is built up, and builds up others (Eph 4:12-16). The communication of the nearness of the *basileia*, and the response to it is not one of burdensome, slavish obedience, but rather one that liberates and gives joyful freedom (Van der Ven 1993:74). The parables Jesus told (Matt 25:14-30; Luke 15:12-16) identify God’s love in granting freedom to humankind. Jesus’ actions of miracles of healing and casting out of demons were actions that brought freedom to the people. The believers as the body of Christ have a calling to be responsible imitators of Christ, and so

to bring love, reconciliation between humankind, liberation that gives freedom for healing and growth.

i) The responsibility of the body of Christ

What are the responsibilities of the body of Christ in bringing the kingdom of God to people through caring communicative actions? Three functions of the body of Christ communicate the nearness of the *basileia*, namely proclamation, teaching and caring actions. This is consistent with Firet's (1986) idea of pastoral-role fulfilment, but he used the term modes instead of functions. This study used the term function, and instead of a pastoral-role fulfilment perspective I chose a practical-theological ecclesiological stance, that included the priesthood of all believers.

A practical-theological ecclesiology was considered that viewed the function of pastoral work within the body of Christ in relevance to the concrete existential daily situation (Pieterse 1991:37). The purpose in following this trend was with the idea to promote better action in giving care to people with chronic pain, by the body of Christ. The researcher is aware that such a stance infers that the pastoral caring action of the church is not separate from proclamation and teaching when considering the *baseleia* in association with discipleship and discipling. Functions and actions were mentioned previously, and require clarifying, since there is a difference between the two.

ii) Differentiation between functions and actions

Functions are specific tasks (associated with specific roles), with specific descriptions applicable to the tasks. Actions involve the carrying out of the tasks (Heyns 1992:324-325). I believe that the caring or pastoral function of the body of Christ is not separate from the kerygma and didache. I understand the kerygma, didache and the paraklesis as each containing a pastoral movement that is the responsibility of the body of Christ. Pastoral work are the various types of caring activities given by the Christian faith community as stated in chapter 5 under 5.3, in this dissertation. The primary concern of this dissertation is the paraklesis function, but a secondary concern is that kerygma and didache are considered intricate parts of pastoral work.

iii) Structures of the body of Christ

The way the functions and the actions of the functions are structured in the body of Christ determines the actualisation of the actions and effectiveness of the function. Structures have to do with the way that the functions of the body of Christ are organised (Heyns 1992:331). Structuring of pastoral work's functions have a priority place in this dissertation. The way pastoral work is structured in the body of Christ determines the effectiveness of caring (with relevance to this study in its care for people with chronic pain). The way the body of Christ should function in its pastoral work and the organisation of the structures of the church is a priority to Christian caring. The structures of the church require specific planned organisation to carry out these functions effectively.

9.4. AN ECOSYSTEMIC APPROACH TO PASTORAL WORK

Practical theology reflectively and critically ponders the communicative actions in service of the gospel (Firt 1986:26-31; Pieterse 1991:37). This dissertation is specifically about the communication of pastoral caring actions to people with chronic pain in their ecosystems. To be effective in their caring actions the body of Christ needs to introduce a measure of integration into the structure of its functions. I have borrowed an idea from a diagram from Heyns and Pieterse (1992:14) and adapted it to illustrate how the functions of pastoral work overlap into the other functions of the church.

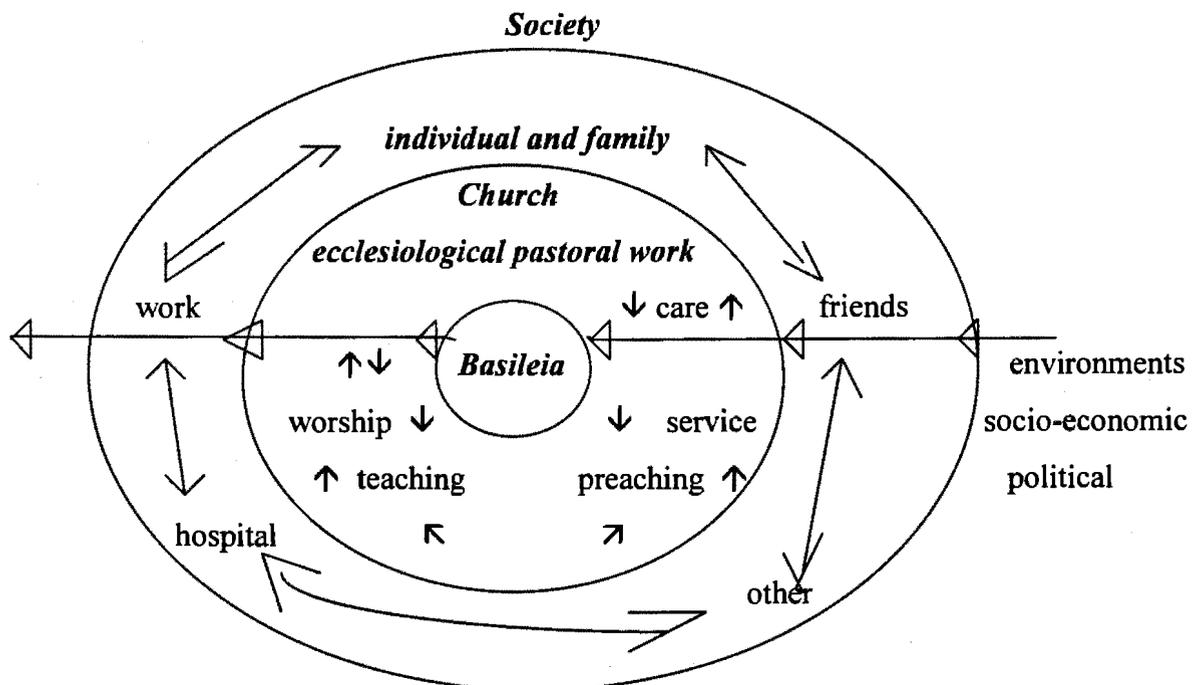
Table 9.2. Illustration of the three kinds of Christian care are in relationship to the other functions of the church.

FUNCTION AND ACTION	KERYGMA		DIDACHE	PARAKLESIS
Function of: Pastoral work	koinonia (fellowship)	leitourgia (worship and celebration)	(instruction)	diakonia (service); care
Actions of:				
Mutual care	X	X	X	X
Pastoral care	X	X	X	X
Pastoral counselling	x	x	X	X

X indicates a greater link and interaction, while the x indicates a lesser interaction link. Note that I have grouped koinonia and leitourgia with kerygma; didache is alone; and diakonia is grouped with paraklesis (care).

Another way of looking at the connected interrelations and interactions of the system (the church) and its subsystems (its functions) and how it operates with other subsystems within society (whole system) is shown in the following diagram. This demonstrates the ecosystemic movement previously spoken of, but in a wider context.

Figure 9.5.

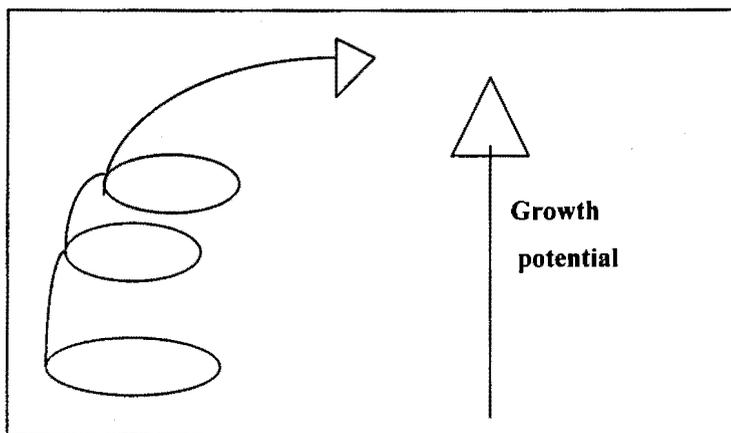


There is a recursive feedback loop of information between each subsystem within its system. For example the Church in its practical-theology ecclesiological approach to the functions of pastoral work feeds information back and forth by communication and action between the other functions (or subsystems). The individual and his/her ecostructures are involved in an interrelational connected interaction between the subsystems by means of a recursive feedback loop motion. Each system does the same among others and with the whole system (society) and the environments. There is a constant back-and-forth flow of interaction and information that influences the whole and each subsystem as illustrated in the diagrams, figures 9.1. to 9.3.

This means that what happens in the church in giving care to people with chronic pain influences them and their relevant ecosystems. What happens to people with chronic pain influences the body of Christ. For example, when care is lacking to these people they frequently become absent members, but also their input of the gifts of the Holy Spirit becomes non-existent. For Christian caring by means of pastoral work to be effective then the cybernetic of cybernetic stated in chapter 2 must flow positively to cause change, change that produces growth to people with chronic pain, and growth to the body of Christ. The process illustrated in figure 9.5. must be embedded in a process that spirals upwards and produces growth.

Diagrammatically it is illustrated as follows:

Figure 9.6.



The above argument brings me to the conclusion that the body of Christ's obligation in bringing the *basileia* to people through caring communicative action primarily requires organisational expertise. This study proposes that organisation of the structure of the functions and actions of pastoral work is an all-inclusive practice. It includes a pastoral perspective in preaching, fellowship, worship, service and teaching functions of the body of Christ. Therefore this dissertation maintains that the structures of the church must be organised in such a way that the pastoral caring actions of the church are included in the other functions mentioned. Suggesting the above immediately raises the question how a practical-theological ecclesiological approach may achieve such a process.

To answer the question requires exploration of the various concepts of ecosystemic theory and communicative theory as a binocular metatheory of a practical-theological ecclesiological approach to pastoral work in caring for people with chronic pain.

9.4.1. A cybernetic of cybernetic

Chapter 3 of this dissertation under 3.4.1 describes cybernetics as that which forms a interrelations network between subsystems and subsystems. Recursive patterns of interaction occur between the subsystems, the system and the environment. Cybernetic of cybernetics enables a view of the autonomy of the whole system (De Jongh van Arkel 1987:253). In this study, the recursive patterns of interactions are seen as a relational network, which is the whole (system). This network is connected with an interdependency between each element (subsystem) within the system, during interaction with one another, the system (whole), and the environment. I refer the reader back to figures 9.1 to 9.3. to illustrate the connected interactions that occur. It is in such ecosystemic movement that change occurs. Feedback in a circular motion with the whole introduces positive or negative effects to change. Cohesion within the whole is necessary to bring stability in the face of change so that change may become a positive feedback within the relational network. The open system achieves its goals by positive and negative feedback (De Jongh Van Arkel 1987:229-232).

The body of Christ in its function of pastoral work, and its actions of pastoral caring is an open system because it is a human relational network of communication of information in word and in actions. The nearness of the *basileia* is also an open system as a relational network between the body of Christ, in its connected interactions incorporated in discipling, and in interaction between human beings. This study previously maintained that discipling means discipleship. In other words, to be able to disciple another person means knowing God in the frame of reference to the wisdom theology of creation, and salvation history theology. This notion is consistent with Heitink's (1984:20-23) model of bipolarity described in chapter 5 of this dissertation under 5.6.1.

In the description of the concepts cybernetics of cybernetic, feedback in circular motion and cohesion are used to develop a practical-theological ecclesiological praxis theory of pastoral work in caring for people with chronic pain. This includes approaching people with chronic pain, the local body of Christ and the kinds of pastoral work within an ecosystemic framework. This study has already dealt with creating the picture of these people within their ecosystems and the consequences of their network of interrelations and interactions. It has explained the ecosystemic movement between the needs of these people and its consequences in chapter 8, and in the beginning of chapter 9. The

theological ecosystemic movement of the *basileia* in association with a practical-theological ecclesiology stance was argued as understood in chapter 9 under 9.2. and 9.3.

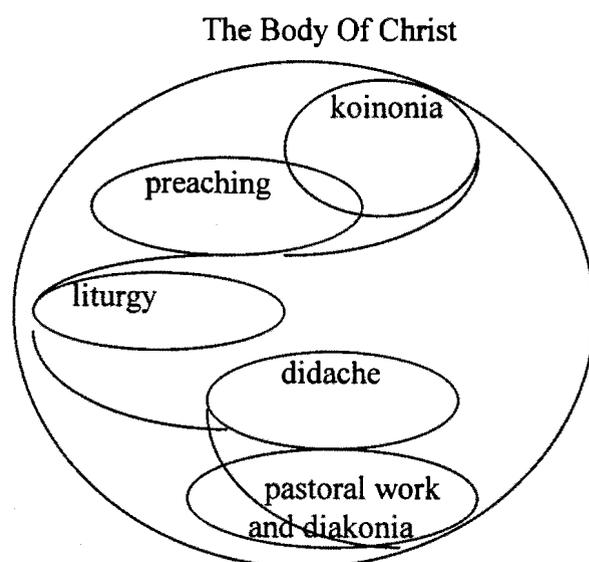
What remains is to describe more precisely how this study visualises the ecosystemic movement between the subsystems of the church. However, not only what takes place must be described, but also how this movement may be deliberately utilised for more effective pastoral work caring actions to the person with chronic pain in a larger social context.

9.4.1.1. Manifesting functions in the local body of Christ

Heyns (1992:324) pointed out that practical theology's ecclesiology theme is the functioning of the church. This dissertation took the trend of considering how the various functions in the body of Christ interact with one another in the *basileia* symbol. It was specifically concerned with pastoral work actions. Hence, the various functions of the body of Christ are primarily considered in association with pastoral caring actions.

I referred to the three previously proposed communicative functions of the body of Christ, namely kerygma, didache and paraklesis. This study considered ways of utilising pastoral caring perspectives in the functions of the whole body of Christ.

Figure 9.7. *An illustration of the body of Christ as a system (the whole) with its various functions as subsystems of the whole.*



The idea of the spiral effect is to give the impression of connected equality, and not a hierarchical structure. The order of functions named in the circles are interchangeable.

The diagram is used with visualisation of the circles as balloons that float and are not fixed. The spirals are bands of string. It illustrates that the functions in the body of Christ are connected, interrelate, and are interdependent on one another in interaction when communicating the nearness of the *basileia*. Confining the balloons into too small an area has an effect on all the balloons, and some of the balloons might even “pop” (a negative affect). Giving the right tension allows the balloons to float up and down bumping against one another in the blissful motion intended for balloons (a positive effect). Even if a wind blows (change in motion) the balloons will move about on their strings but will still fulfil their function as party decoration. The balloons are all different colours, but equal in their purpose to decorate, and so the colours are complementary in the whole of the party decorations.

By this very simple analogy an attempt is made to convey the ecosystemic movement that should be understood in the local body of Christ’s functions. The same ecosystemic movement should take place between the church (system) and the ecostructures of the people with chronic pain, when giving care to these people.

9.4.1.2. How to give care to people with chronic pain

Previously in 9.3.1, threads of ecosystemic reasoning relevant to this study were defined, namely: the open system; cybernetics of cybernetics; holism; circular feedback; complementarity and language. The structuring of the functions, and actions of the church are considered in association with these ideas, plus the idea of cohesion and equality.

In its functions and actions the body of Christ must remain an open system. It must remain a relational interacting system that allows for growth by stimulating and motivating growth.

It was previously pointed out in this study that the functions of kerygma, didache and paraklesis are all connected, interacting functions of the body of Christ with an interdependency upon one another. Pastoral work has perspectives of kerygma and didache although its priority is communication of caring actions. In the same way kerygma and didache contain perspectives of pastoral caring, but they also function according to their priority tasks. Their common purpose in the *basileia* is to communicate in different ways the compassionate love of God, and to make disciples. In the responsibility of this purpose the various functions in the body of Christ are equal.

In this common purpose there is a complementary action that takes place in this equality, but it is noted that a differentiation is retained. The equality between what I will refer to as the various functions subsystems of the church is much the same as the balloons. They were all balloons with the purpose to decorate the party, yet they were different in colour, but complementary to the party. The various functions (subsystems) are equal in their purpose to communicate God's love to humankind, but in different ways in association with the gifts of the Holy Spirit. This common purpose and differentiation allows for creativity, for specialisation, yet also for overlapping of actions. It means that there are boundaries to consider, but the boundaries are not rigid (De Jongh Van Arkel 1987:219-220). They may rather be seen as semi-permeable membranes, or with a flexibility like that of a balloon.

The questions that must be answered in view of what was written above are: how can the perspectives of pastoral caring that are also the responsibility of the other functioning subsystems of the body of Christ, be utilised? How must the specific kinds of pastoral caring actions operate in the lives of people with chronic pain to motivate growth?

In answering these two questions a number of ideas came to mind, and they are as follows:

- structure
- organisation and management
- leadership and delegation
- social context

a) Structure

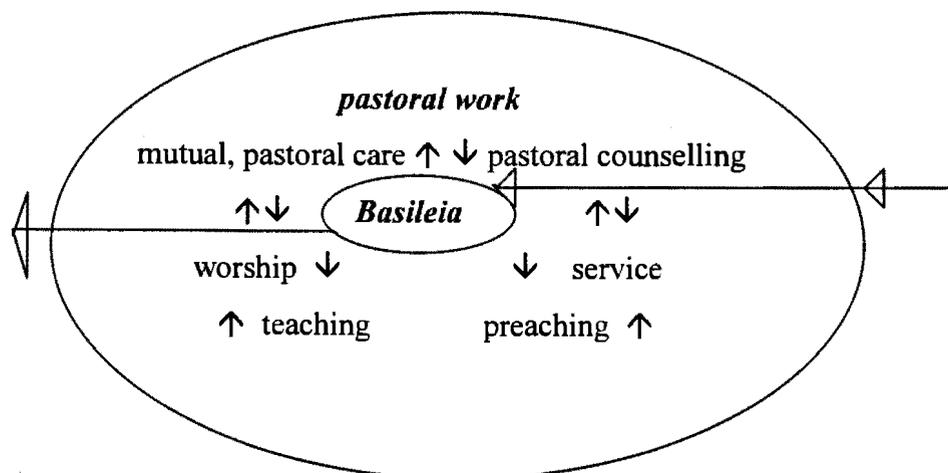
Heyns (1992:330) writes that structures are the means through which God encounters human beings. Previously I stated that practical theology is about communicative action. Without structures the actions of the three main functions and their subfunctions cannot operate effectively in furthering the *basileia*. The questions that this dissertation proceeds to answer in association with the questions mentioned above are: How must the body of Christ function in giving care? How does this fit into preaching, instruction, service and worship celebration?

These two questions lead to considering how the local body of Christ should be structured to fulfil the function of caring. The concept of the functions of the local body of Christ was previously portrayed in figure 9.7 as the whole (system) being the body of Christ, and

the functions a subsystem in the whole. In the caring actions of pastoral work, the structures must be implemented that achieve the goal of holistic caring actions. It is only when the function of pastoral work goals is anticipated in a holistic frame of reference that relevant and effective Christian caring is imparted to another human being. From the researcher's point of view the ecosystemic movement, and its consequences in the life cycles of people with chronic pain, that the study's empirical observations gave, calls for more inclusive Christian caring.

Previously I wrote that preaching should have a pastoral perspective as well as a prophetic (or proclaiming the gospel) perspective. Nichols (1987:2-7) writes that preaching is too often in the rut of pure proclamation, and that the pastoral caring influence is frequently ignored and separated. He refers to what he calls restoration preaching as related to proclamation preaching. In this study the ideas of holism, equality, cohesion and complementarity were introduced. I believe that unless the church grasps these principles of cybernetics of cybernetics Christian caring actions will remain fragmented in a fast-changing society. Fragmentation prevents the goal achievement of holistic caring actions and satisfactory caring experience by the receptors of care. Pastoral work need an ecclesiological caring approach for the body of Christ to give effective Christian care to people. The diagram below indicates the connected interrelations and interaction between the relational network of the body of Christ's system.

Figure 9.8. The local body of Christ



The arrows indicate the recursive back-and-forth movement of information, but in a circular motion during interaction between the connected subsystems (functions).

However, it is not enough to realise the importance of the interactions and overlapping of the various functions, but it is also important to realise that organised structuring is required to achieve the goals of the functions. Communicative action without management directive becomes empty. The goals of pastoral caring actions by the body of Christ are to communicate caring action effectively, in word and deed to people. However, unless the pastoral caring function of the church is brought into the structures of the church, and unless organisational and managerial skills are applied, the caring actions of the body of Christ will lose its commitment. To creatively free the pastoral caring perspectives in kerygma, didache and paraklesis functions in the local body of Christ require organisational skills that tailor the perspectives of pastoral care into the structures of these functions.

b) Organisation and management

The saying that everybody's responsibility becomes nobody's responsibility is a very real reminder of the folly of lacks in managerial skills. In organising its functions the local body of Christ needs to direct its actions of caring within the whole system, and between the different types of care found in pastoral work. However, it is more important to start with the overall management of the caring function of the whole. How the whole is managed will influence management of each kind of pastoral care action to people with chronic pain.

i) Management of the function of pastoral work

The church resides in a social context, and it communicates and acts within the parameter of the values and norms of the society in which it is resides. If it did not do this, then communication of gospel information by word and deed would not be possible. That is not to say that the local body of Christ compromises Christian values. However, meanings in a society are obtained from communal beliefs, values and norms (Van der Ven 1993:73-74).

I consider the local body of Christian believers structures of organisation analogous with a large thriving corporate business. A large business system does not thrive on its own automatically. Neither is its success dependent on it just happening to achieve its goal in some haphazard way. The backbone to success is its leadership qualities, and the right

utilisation of these qualities. Any thriving business concentrates on its top management structures and their leadership abilities.

To organise the Christian caring actions in the structures of the church requires leadership qualities and wisdom. It needs someone with insight into pastoral caring action to organise care actions in a holistic manner. The scope of this study does not allow for an in-depth explanation of leadership qualities, nor does it allow for going into lengthy descriptions of ways that pastoral caring perspectives integrate into the other functions of the church. Rather, the idea of the ecosystemic movement within the whole and applying theories of organisation of the structures of the church are addressed. The internal communicative actions of pastoral care are addressed, and then the outward actions of care.

The need, I believe, is to organise a system into the structures of the local body of Christ that:

- introduce constructive means to assess caring need situations in the church and the community
- utilise all the connected interacting subsystem (functions and structures) in the local body of Christ as feedback structures for imparting caring information
- draw up goals for caring communications
- systematically plan the caring function of the local body of Christ with a continual back-and-forth flow of feedback to evaluate the implementation of caring actions and to direct or redirect care goals
- develop constructive evaluative control measures to ensure that the best care is given
- identify patterns of growth in caring structures of the church or status quo, or stagnation
- report on feedback and give recognition and gratitude where it is earned

ii) Organisation of pastoral work within the body of Christ

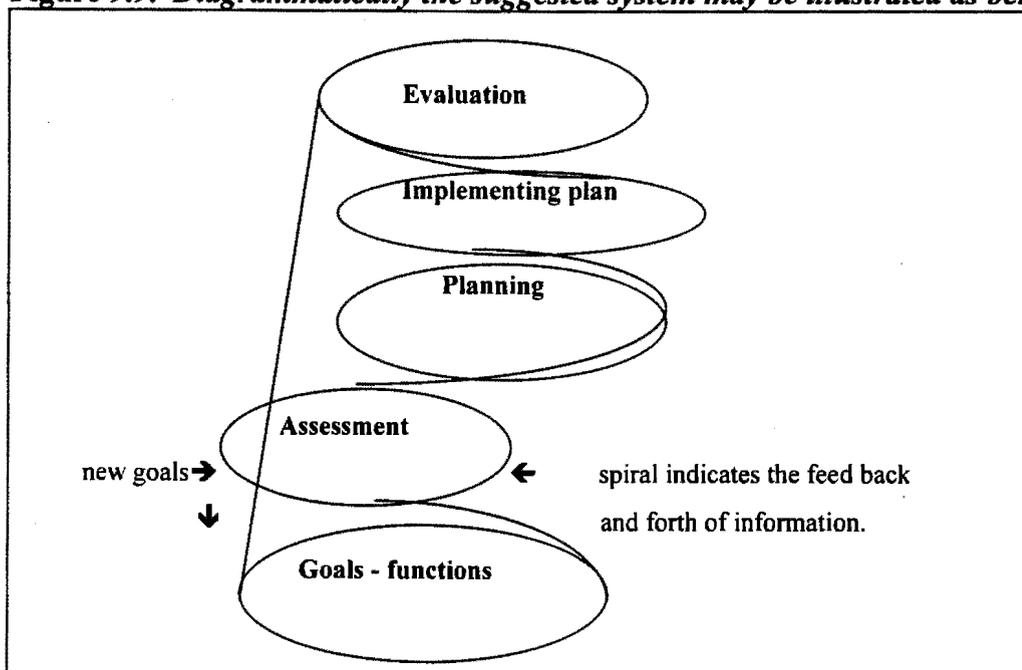
This study holds to the necessity for precise goals setting and planning mechanisms to enable the most holistic approach to the caring perspective of the church. It is obvious by now that the approach of this dissertation is an all-inclusive one. All the believers are considered potential care givers in the light of the gifts of the Holy Spirit (1 Cor 12)

operant in the notion of the priesthood of all believers. This is also operant in the concept of discipleship and discipling as described in this study.

Definite people need to be selected as organisers and to manage people involved in caring actions, and also to organise ways of care communication through the medium of the other functions such as kerygma (and worship, koinonia), didache and paraklesis (and diakonia). I do believe that the clergy have a role to play in the top structure of leadership and organisation, but not necessarily as the top management person. There may be people in the body of Christ with various levels of expertise in organisation and management who may be utilised. It is obvious from what was written above, that in the more expert caring functions and actions, qualified persons participate in their field of expertise.

An organised system of care must be introduced. This study gives some brief ideas and suggestions for a system. The long term goals of the functions of pastoral work must be established. Then assessing the needs in the situation of the individual in their ecosystemic interactions begins the process of goal setting. For this study it entails assessing the needs of people with chronic pain in connected interactions with their family, work, friends, hospital, church and within society's environments. The next steps in the process are planning and implementation of the plan, and these are then followed by evaluation in a continuous circular motion of feedback.

Figure 9.9. *Diagrammatically the suggested system may be illustrated as below.*



The above process is one that is a constant flow back-and-forth of information between the stages of assessing, planning, implementation and evaluation.

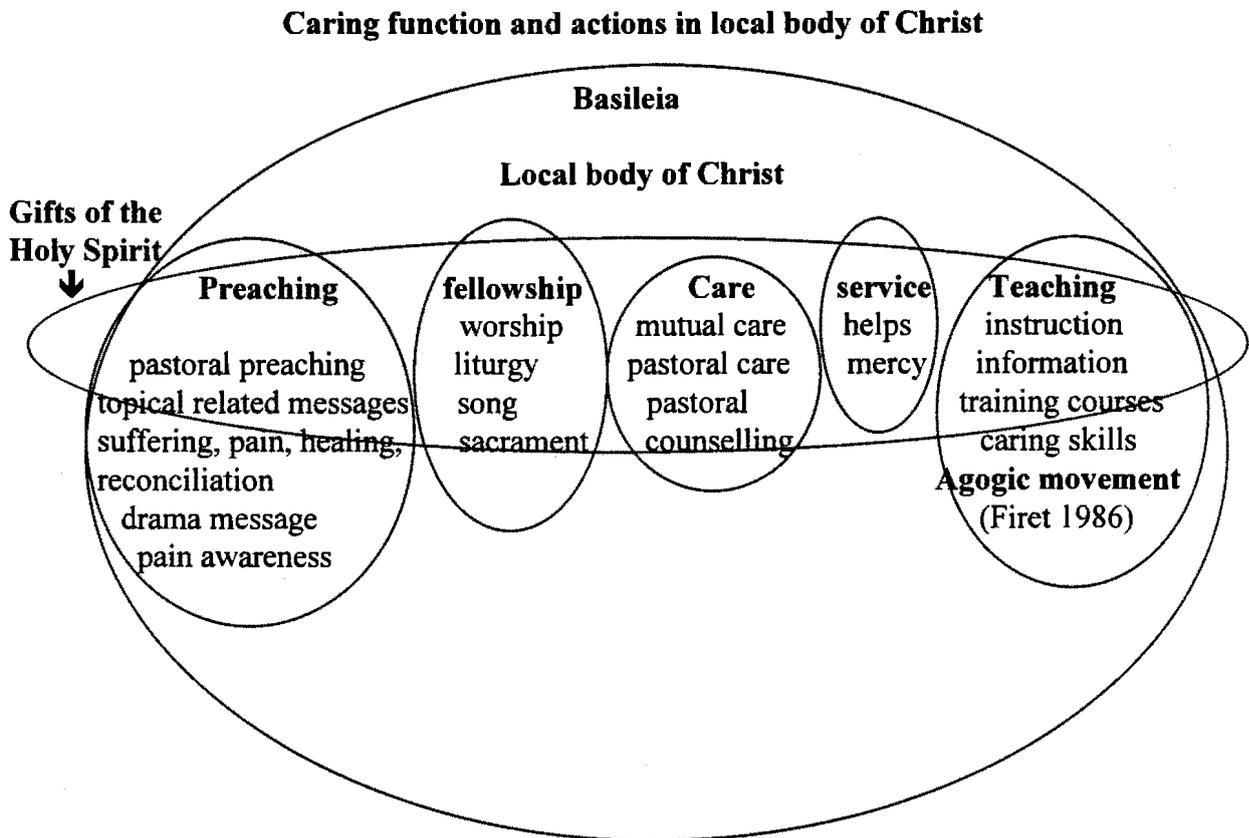
ii) Implicating the interconnected subsystems

With the key management personnel in their strategic positions, liaison should take place between the connected interacting subsystems of the body of Christ, and the personnel concerned. The subsystems referred to are the preaching with fellowship, worship and celebration, care, service and teaching functions and structures of the local body of Christ. Each subsystem has a caring perspective to it to a greater or lesser degree. For example, the paraklesis function is concerned with communicating caring action as its major purpose, whereas preaching would probably communicate caring action with the purpose of informing. Preaching however, would only take the caring perspective and by methods of informing create an awareness of needs, such as preaching on the topic of pain and suffering. In this sense the preacher would often use metaphorical language to give expression to existential living with pain.

The function of didache may become a little more involved in instruction with various courses and training facilities in providing skills of various kinds of care. Its major action in the perspective of care given by the body of Christ would be to inform, to bring an awareness, and to equip with caring skills.

These perspectives of care should be incorporated into, and operative in the fellowship, worship and celebration structures of the congregation. It is in this way that each subsystem interacts within the whole body of Christ. If preaching or one of the other structures fail to communicate their caring perspective in some way, the whole body of Christ is affected. All or some of the subsystems are also affected. For example, if the preacher never spoke on the topic of care needs, the congregation may become insensitive to the care needs of others, and at the same time the paraklesis function of the church takes on an extra load. The end result may be ineffective caring functioning of the body of believers. In this interrelatedness and interdependence, teleological interaction of the whole occurs. I have attempted to illustrate the systemic perspective and the cybernetic network process of information within an open system concept of human relations below.

Figure 9.10. Illustration: The connected interactions and interdependency between the subsystems in the local body of Christ and ways in which they may communicate caring actions



A constant circular motion of feedback loop between the different functions in the communication of care within the church takes place. Cohesion and complementary movement take place. Boundaries are there but allow for integration of functions and actions. The circle around the middle is to indicate that the gifts of the Holy Spirit are operant in a communicative caring functioning in the body of Christ.

It still remains for these various functions mentioned, to integrate the care perspectives into the liturgical and fellowship activities of the local body of Christ. It is only by responsible foresighted strategic organisation in the structures of the church and liaison between the various role players, that the caring function of the body of Christ can be empowered. This dissertation suggested that the idea of Figure 9.9. may be used as a method that allows for such a strategy. It is also a means to maintain management in obtaining the goals of an upward spiralling growth potential in the pastoral work function of the body of Christ. It further means that an organised continual interaction and recursive circular motion of feedback of communication actions and flow of information

must take place between the various functions in the local church. An organised structured caring functioning by the church is more effectively implemented with systematic carefully planned care that integrates the various kinds of caring actions described in chapter 5 of this study. The suggested method of organised management and control of caring activities and care workers was based mainly on social values and acceptable norms of management principles. It described the responsibility of the body of Christ from a social point of view. Is it, however, convincing enough to motivate the pastoral work (the faith caring function) of the body of Christ to more integrated, more interrelational and interdependent interactions within its own role players, and between the other functions of the local church? I am convinced that the church has an intricate role to play in society. The body of Christ in the *basileia symbol*, spoken of by Van der Ven (1993) discussed previously in this chapter, was commissioned to go and make disciples. The ideas of discipleship and discipling, I believe, were not only a commission of proclaiming, but also a communicative action realised in the caring activities by the local body of Christ (James 1:22-27; 2:14-18). In consistency with Furet (1986) I believe that the local faith community are mediators of communicating the *basileia symbol*, also by caring actions operant in the gifts of the Holy Spirit. Ephesians 4:8-16 speaks of the gifts of the Holy Spirit in the context of building up the body of Christ. The paraklesis' (caring) actions and structures are means of motivating building up the body of Christ. The motivating force released in the caring action within the Church is the compassionate love of God. The love of God is an all inclusive act, which directs caring actions to all. In other words, the love of God is filled with a compassion that motivates the communication of this love to an all-inclusive society in the concept of discipleship and discipling.

This brings the study to the point of the outward caring actions of the body of Christ.

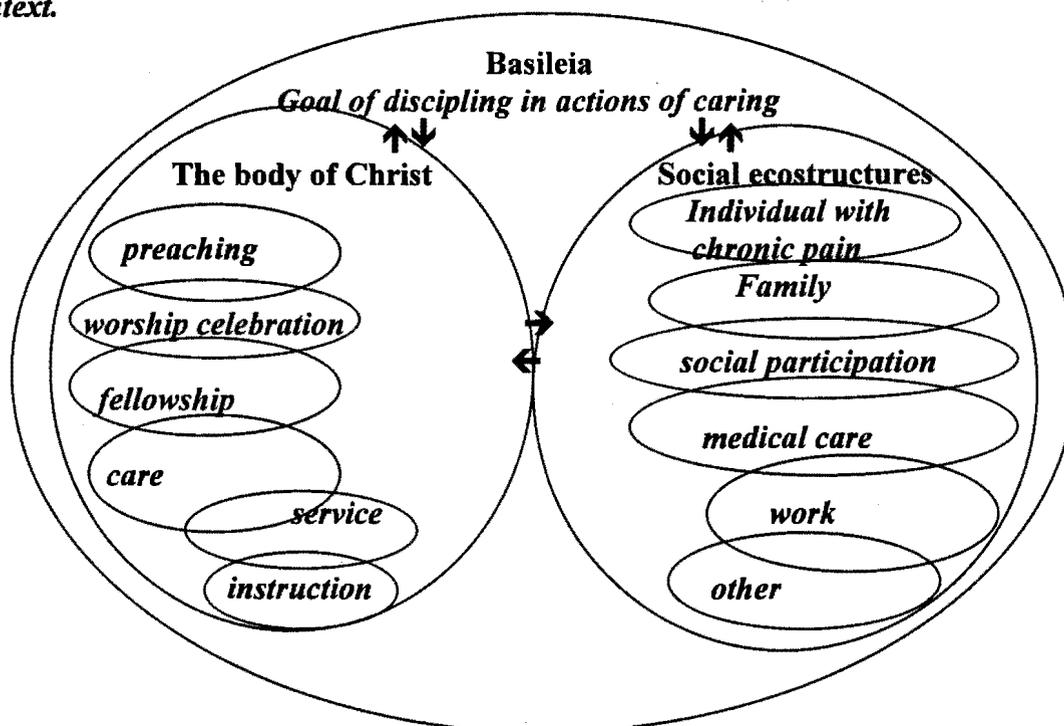
iv) Pastoral work in society

While considering the social context of pastoral work, the framework taken from the consideration of a theory more focused on social values, must be kept in mind. The idea of the systematic, strategic, organised management referred to previously, also applies here in managing and controlling care given to people with chronic pain in their social ecosystemic interactions. In this section my concentration, however, was more on the

theological norms and values in describing the process of caring actions by the body of Christ in society.

This study proceeded to deal firstly with the caring process of the body of Christ within the social context of people with chronic pain and secondly, with the ways the body of Christ can give care to people with chronic pain. Diagrammatic illustrations followed by an explanation of each process was the most effective way to describe these processes.

Figure 9.11. *An illustration of the caring process by the body of Christ in the social context.*



This dissertation referred specifically to the all-inclusiveness of the *basileia* symbol. God's love for humankind is with compassion and without exception. Even in a fallen state God's love extends to all human beings. Jesus in the act of salvation died for all humankind, and he arose again victorious over sin for all humankind. All humankind are included in the event of salvation. In the same manner the body of Christ are committed to discipleship in response to the purposeful act of salvation; purposeful in that the actualisation of salvation brings reconciliation and healing. In responding to Christ the purpose of reconciling in the relationship between humankind and God takes place. In the reconciliation of relationship interactions the purpose of healing occurs (Isa 53:5). The idea of healing is that it restores and brings freedom for growth potential.

The body of Christ is also committed to discipling in like manner to the purposeful reconciliative action that is in salvation history. In reconciliation the relationship between God and the believer is restored, and this reconciling process reconciles the believer to humankind. Hence, it is the process of reconciliation that frees the believer to a joyful response of obedience to communicate the Word of God to other humans; what Fiset (1987:18-25) calls "means of intermediary action."

The Christian faith community are called to go and make disciples and communicate in word and deed the principles of reconciliation (restoring relationships, healing, freedom and growth) to humankind without exception. In other words, no individual or group of people, no matter how insignificant they may appear against the masses of other groups, is excluded.

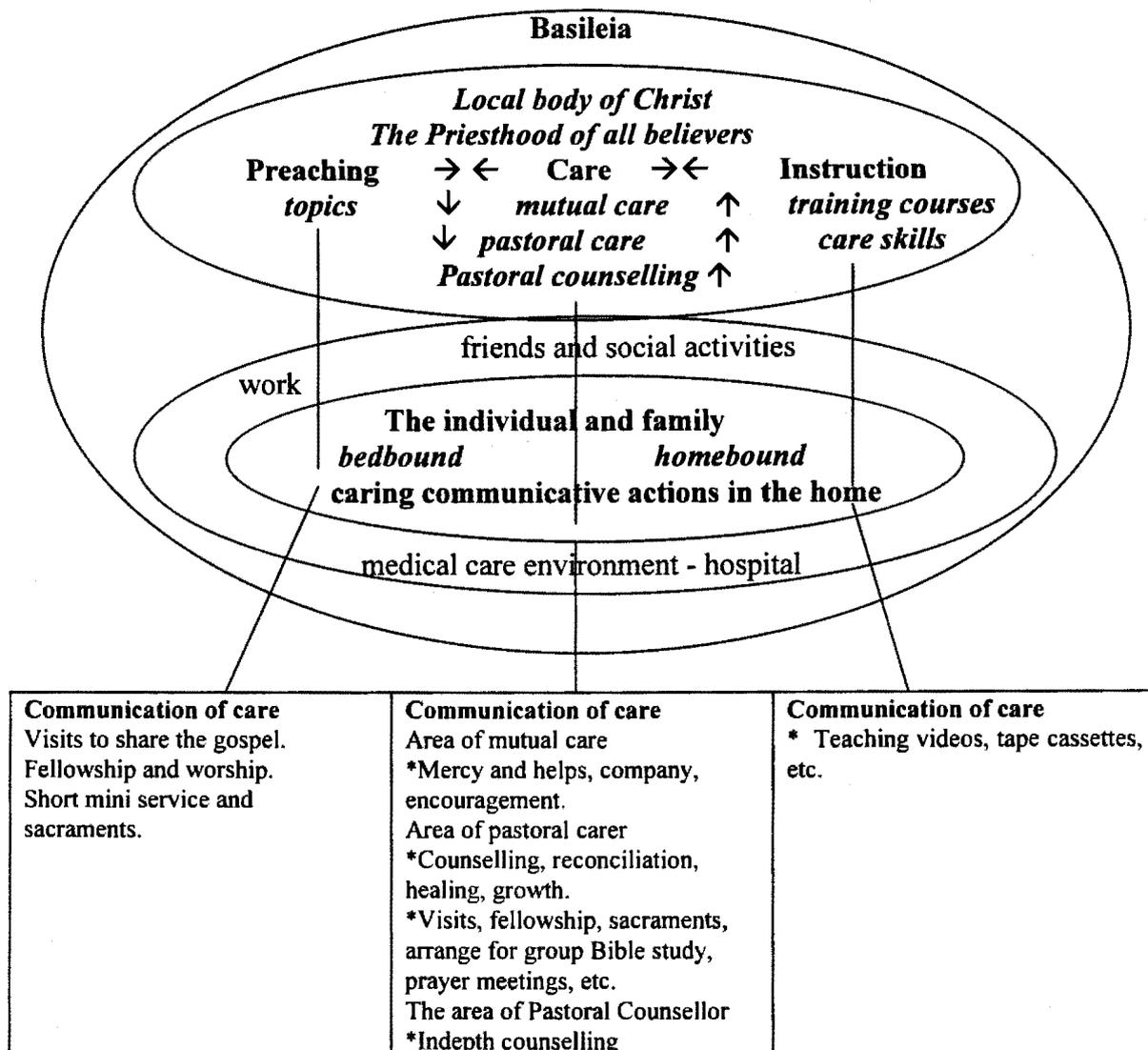
The diagram figure 9.11 attempted to illustrate the connected interdisciplinary interactions within the local body of Christ in the action of caring and the interrelational interactions with the people in chronic pain in their social ecostructural context. The term interdisciplinary is considered to mean a co-operative relationship between the functions, structures, and actions of the local body of Christ (Van der Ven 1993:97).

v) Ways of caring by the body of Christ to people with chronic pain

Considering the results of the empirical study of the respondents I stated that the needs increased especially during the relapse stage of the developmental process of the chronic pain condition. During this time-phase long periods of being bedbound or homebound were common experiences of the respondents. During the stable stage mobility limitations which extended from being homebound to limitation like sitting, standing, walking and driving a car, were common occurrences.

The complexities and losses time-phase appeared to be staggered throughout the pain experience. The losses experienced by the respondents resulted in various degrees of low self-esteem, a sense of depersonalisation, a sense of non-belonging, isolation, depression and destabilisation of relationships and finances. I have approached considering the ways of caring for people with chronic pain by centring on these few main aspects. It is beyond the scope of this dissertation to enlarge any further. The diagram below specifically relates to bedbound and homebound periods.

Figure 9.12. Illustration of ways of caring for people with chronic pain in relation to their ecosystems, by the local body of Christ.



The diagram in figure 9.12 is to give a sketchy idea of some of the ways that pastoral care action should be utilised by the local body of Christ in communicating caring by word and actions to people with chronic pain. It is obvious from the diagram that during some time-phases of the chronic pain condition caring activities need to be brought into the homes of the people with chronic pain. It is also obvious that the various church functions, actions and structures are connected interrelating interactions and interdependent upon one another in communicating care. The feedback circular flow is clearly essential for recursive patterns of behaviour to form from the interpersonal relationships within the body of Christ to direct caring actions. An understanding of feedback between the subsystems and

systems must be achieved to be able to introduce new forms of feedback that create growth in change.

Communicating caring actions by the body of Christ are more than the three types and levels of pastoral caring actions written about in chapter 5 of this dissertation. However, it is apparent from the above diagram that these three types of caring activities, and caring roles in levels of expertise are the major caring actions, with the greater motivation of caring goals to people with chronic pain. It is also important to note that loss of the connected interdependent relationship of the caring perspectives in the other fields of the church and lack of interaction prevent efficient care, since care becomes disjointed.

From an ecosystemic perspective it is clear that the way Christian care is communicated in word and action has an impact on the whole body of Christ. Repercussions occur and affect not only the individual, but also the body of Christ. Purposeful reconciliation, restoration, healing and facilitating freedom for growth potentials are normative theological values, and expectations of the body of Christ in its calling to discipleship. The need for a proper systematic organised management of communicating the activities of the whole body of Christ is essential. The considerations, previously discussed, of strategising a caring system that is ecosystemic in perspective and truly interdisciplinary in action is essential. Essential in that it provides a method of viewing the caring functions, actions and structures from a more holistic insight. Recursive circular feedback is required to provide complementary and cohesion elements into the caring communicative actions and structures of the church to ensure change that stimulates and motivates growth.

9.5. SUMMARY

The commencing intention in this study was to take the avenue of attending to a narrow scope of pastoral work actions only. The intention was to concentrate on the three kinds of pastoral care and their levels of expertise. However, as the empirical study continued it became apparent that a far wider scope of attention was required. While identifying some need areas in the lives of people living with constant pain the ecosystemic movement previously mentioned was strongly evident. It made me question why the ecosystemic movement in the chronic pain scenario was so impressionable, and what this means for

pastoral work in the local body of Christ. It was the pondering of these questions that led the outcome of this study to approach pastoral work from a much wider perspective.

The need for a far greater effort of interdisciplinary interaction within the local body of Christ, and the need for much greater public awareness to be created through information and instruction was apparent. It was interesting that except for one, all the respondents in the empirical observation group felt they desperately needed caring support from the church in some form or other, but felt they did not receive it. It was also of interest that they felt depersonalised and depressed and that their self-concept suffered because of this. The one respondent who experienced supportive caring from her church was the daughter of an elder in the church. The question lurks there: Could this have made the difference? That cannot be answered with any adamancy without further research, including the church's perspective. Another matter of interest was that the one respondent who was a hospital chaplain, when asked what the church should be doing to assist the person with chronic pain struggled to answer the question. The respondent mentioned Bible reading, prayer and visitation.

This study left me with the clear impression that pastoral work caring action must be a far more integrated and interdisciplinary interaction that is well-organised and maintained by the local body of Christ. All pastoral work in caring for people with chronic pain holds the importance of systematic organisation from an ecosystemic perspective within the inner workings of the church. It is also necessary for such an approach to include the ecosystemic movement perspective of the individual and the outward working of the church. Caring for people with chronic pain should ensure growth potential even in need deprivation situations where needs cannot be relieved. This study has indicated that the psychological theories of Murray, Frankl (mainly) and Rogers (to some degree) were considered important, especially from a pastoral care point of view. They allow for the idea of growth potentials in the human being that may be found acceptable to theology.

The three kinds and levels of expertise of pastoral work action, and role-players were not the central concentration in the analysis and findings report of this dissertation, the reasons being as already stated above. However, it is sufficient to say that mutual care, pastoral care and pastoral counselling must be in an ongoing process of organised referral management. By the term organised referral management I mean that the actions of care require a back-and-forth circular movement of information, and correct assessment with

referral between the types of caring actions (and role-players). All the actions of the various types of pastoral work care may occur simultaneously or separately or even time-phased. However, goals, feedback, active interdisciplinary interaction that are organised and maintained are vital requirements to aid in giving effective care. People with chronic pain need to be helped to manage their pain to decrease needs pressure. It was very prominent in the empirical research findings that people with chronic pain took a long time to rehabilitate, because frequent relapses caused further losses, and a continual process of re-adjustments. Adjustments to life-style changes were almost a constantly changing process.

It was apparent from the research findings that needs for mutual care support, needs for more complex pastoral caring and needs for in-depth counselling were strongly evident. The scope of needs that occurred ranged from transport needs to companionship and comfort, from the need to talk about the anxieties of living with chronic pain to needs for social and spiritual participation, from the need to have someone listen to their stories to finding some assistance in management of their pain by control of life-style changes. Previously I inferred that the involvement of the local body of Christ should be more than prayer, scripture readings and visitation. This study has revealed that the ecosystemic movement at play in the chronic pain scenario suggests that this is a serious thought to take up in further research.

9.6. CONCLUSION

9.6.1. Where to now?

I do not think that there is much more to say than that there is a lot more in the way forward in terms of further research. This research has touched the tip of the iceberg only as it should be obvious by now that any chronic condition that causes life-style changes, or long-term rehabilitation, or lengthy periods of bedboundness and homeboundness will have similar needs. It means that a larger group of people are at risk to the loss of church participation. Finding ways of caring for such people to ensure their continued, or beginnings of belonging participation in the local body of Christ are needed. Finding ways of the church being involved in their ecostructures interrelations to enhance spirituality, and meaning of life opens for far reaching research possibilities. I end with an analogy:

Paddy the donkey is a hard-working animal. However, for Paddy to remain a hard-working donkey certain physiological principles need to be consistently abided by. Paddy the donkey must be fed to gain strength to pull the cart. But whatever goes in must come out, otherwise Paddy will not be able to take anything in for further sustenance. He'll only grow more and more tired until he drops.

For Paddy to be a strong effective vital donkey he needs the co-operation of his owner to feed him. He needs the right food to go through him, otherwise a blockage might occur that can destroy him. Good food needs to go in, to go out, for more sustaining food to come in. All this is done by responsible, caring, wise management, co-operation and feedback. Whether feedback (intake, output, intake) takes place or not determines Paddy's effectiveness.

Not that the local body of Christ can be likened to a donkey, but the idea of circular motions of feedback of information in an interrelational interacting body of Christ needs wise management principles to enable healthy effective communicative acts of caring.

Appendix 1

INTERVIEW

NAME:CODE:.....

SEX:..... AGE: SINGLE: MARRIED: WIDOW/ER: DIVORCED:

DURATION:

ACCOMMODATION: HOUSE FLAT: ROOM OTHER

OWN RENTED

FAMILY: CHILDREN AGES LIVING AT HOME

Other dependants at home:

OCCUPATION: BEFORE

IMMEDIATELY AFTER PRESENT

MEDICAL HISTORY (STORY) : (relate incidents to years e.g. 1987/ or six years old).

Year started :

OPERATIONS : type; year; success.

LIMITATIONS/ DISABILITY :

AIDS :

VISIBLE DISCOMFORTS / EFFECTS :

ACTIVITY HISTORY BEFORE:

HOME MANAGEMENT :

upkeep

INVOLVEMENT WITH FAMILY AND RELATIONSHIPS :

roles

financial

caring; providing

SOCIAL INVOLVEMENT :

activities

friendship circle and activities

church activities

church involvement by family

church involvement with family

relationship with God

WORK CAPABILITIES :

colleagues relationship

activities

after work involvement

QUESTIONS :

In the process of having constant pain : (try to relate to years, stages.)

1) What would you say your physical experiences were?

Disability; limitations; Homebound periods Social activity restrictions; Church participation; Accessibility.

2) What would you say your emotional experiences were?

Confusion, anger, guilt; distress; self -concept.

3) Can you describe how you were affected mentally?

Fatigue, concentration.; work; church; family; self-concept

4) Would you say that the pain experience had any spiritual effect on you?

Church; God; family;

5) Life-style changes : What sort of changes occurred in your life-style after the pain began?

Family; finances, family and own reaction to change.

6) SOCIAL CHANGES : What changes have occurred in your social life?

activity; restrictions; non-participation;
accessibility; facilities.

7) HOSPITAL : What effect has hospital involvement had upon your life?

Family coping; own coping; security; insecurity; positive; negative.

8) CHURCH : What sort of changes have you experienced with regard to church activity and participation?

Positive; negative; homebound; visits; activity: decrease; limits;

9) GOD : How do you feel about God in your experience with constant pain?

anger; guilt; grief.

10) Friends : Have you experienced changes in friendship relationships due to the process of pain?

losses; attitudes; sick role

11) WORK : Tell me a bit more about your work situation.

changes; limitations.

12) Losses : Tell me about the things that you feel you lost in the process of living with pain?

self-esteem; confidence; concentration; isolation; control; trust

13) FUTURE : What do you feel about your future?

14) EXTRA:

Do you feel that you have gained anything through your experience with pain?

What would you say was the greatest hurt to you in your experience with pain?

Who do you think kept you going? (persevering)

Tell me how you felt in the periods that you were homebound.

Appendix 2

This research is towards a Masters Degree in Theology at the University of South Africa. My aim is to try to understand how the person who experiences chronic pain feels and what his/her needs are with regard to the chronic pain experience. The purpose of the study is to develop a pastoral care and counselling theory in pastoral care and counselling as guidelines for the church to give more extensive caring help and involvement to people in chronic pain.

I intend to do this by means of tape-recorded interviews. These tape recordings will be transcribed for the purpose of data analysis. They will however, be dealt with strict confidentiality and any data used will be generalised. A code name will be given to your recording and your name will not be used anywhere at all. I need your consent to interview you, and to use data gained from the interview in a generalised way for the research purpose.

CONSENT:

Igive my consent to be interviewed, and for the interviews to be recorded and used for research purposes. I understand that all data will be treated with strict confidentiality and in no way will I be identified, or personal information disclosed.

Signeddate.....

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