

**A Comparative Study of Cognitive Behavioural Therapy and Shared Reading  
for Chronic Pain**

**Dr Josie Billington, Centre for Research into Reading, Literature and Society  
(CRILS), University of Liverpool**

**Dr Grace Farrington, The Reader**

**Dr Sofia Lampropoulou, School of English, University of Liverpool**

**Kate McDonnell, The Reader**

**Andrew Jones, Royal Liverpool University Hospitals NHS Trust**

**James Ledson, Royal Liverpool University Hospitals NHS Trust**

**Dr Anne-Louise Humphreys, University of Liverpool**

**Dr Jamie Lingwood, University of Liverpool**

**Nicki Dairs, Royal Liverpool Hospitals NHS Trust**

**Collette Holloway, University of Liverpool**

**Brooke Smart, University of Liverpool**

## CONTENTS

Acknowledgements.....	4
Executive Summary.....	5
Introduction.....	9
1. Background to the Study.....	9
1.1. Chronic Pain.....	9
1.2. Chronic Pain and CBT.....	13
1.2. Rationale for Shared Reading in relation to Chronic Pain.....	13
2. The Study.....	16
2.1. Aims and Objectives.....	16
2.2. The Interventions.....	16
2.2.1. CBT.....	16
2.2.2. Shared Reading.....	17
2.3. Research Method.....	18
2.3.1. Participants and Recruitment.....	18
2.3.2. Data Collection.....	18
2.3.3. Data Analysis.....	19
2.3.4. Ethics.....	19
3. Results and Findings.....	20
3.1. Results (Quantitative).....	20
3.1.1. Psychometric Assessment Forms.....	20
3.1.2. Pain and Emotion Diaries.....	20
3.1.3. PANAS (Positive and Negative Affect Scale).....	24
3.2. Findings (Qualitative).....	27
3.2.1. Personal Story.....	28
3.2.1.1. CBT.....	28
3.2.1.2. SR.....	30
3.2.2. Change.....	38
3.2.2.1. CBT.....	38
3.2.2.2. SR.....	39
3.2.3. Bad Feelings, Good Thoughts.....	43
3.2.3.1. Pain.....	43
3.2.3.1.1. Pain: CBT.....	43
3.2.3.1.2. Pain: SR.....	46



3.2.3.2. Seeing From Outside’: Shifting Position, Moving Levels...53	53
3.2.3.2.1.CBT.....	53
3.2.3.2.2. SR.....	54
3.2.3.3. Thinking about Thinking.....	57
3.2.4.Private Spaces.....	59
3.2.4.1.CBT.....	59
3.2.4.2. SR.....	60
3.2.5.Finding A Language.....	64
3.2.5.1.Naming.....	64
3.2.5.1.1.CBT.....	64
3.2.5.1.2.SR.....	65
3.2.5.2.Negatives.....	67
3.2.5.2.1.CBT.....	67
3.2.5.2.2.SR.....	69
3.2.5.3.Inarticulacy.....	75
3.2.6.CBT and SR as therapeutic groups.....	79
3.2.6.1.The Group-Leader.....	79
3.2.6.2.The Group.....	83
3.2.6.3. Is SR a therapy? Should it replace or complement CBT?...85	
4.Discussion.....	89
5.Conclusions and Recommendations.....	92
6.References.....	92
7.Appendices.....	96
7.1.Appendix 1. Participant Information Sheet.....	96
7.2.Appendix 2. Participant Consent Form.....	101
7.3.Measures Booklet.....	103
7.4. Appendix 4. Daily Pain Record and PANAS.....	114
7.5. Appendix 5. PANAS.....	115
7.6.Appendix 6. Record of material covered in reading groups.....	117

## Acknowledgements

We would like to thank all participants who took part in the study for their commitment and their willingness to engage with both the CBT and Shared Reading groups and the research process. Thanks are also due to: The Reader for taking part in the study; the Royal Liverpool and Broadgreen University Hospitals NHS Trust Hospital for approving the study; Liverpool Angina Management Centre, for use of a room. Finally, we are grateful for the funding and support of the British Academy Small Grants Scheme.

## Executive Summary

### Introduction

This study compared Shared Reading (SR) – a literature-based intervention developed by national charity The Reader – to Cognitive Behavioural Therapy (CBT) as an intervention for chronic pain sufferers. We investigated 1) the degree to which CBT and SR offer alternative treatment methods for alleviating the psychological symptoms of chronic pain 2) how far SR might complement CBT by providing less programmatic and potentially more long-term follow-up to CBT.

The study was conducted through a partnership between researchers from the Centre for Research into Reading, Literature and Society at the University of Liverpool, The Royal Liverpool and Broadgreen University Hospitals NHS Trust, and The Reader, a nationally recognised centre for the promotion of reading and positive mental health. The project was approved by the Liverpool Central NHS Research Ethics Committee.

### The Study

Participants with severe chronic pain symptoms were recruited by the pain clinic at Broadgreen NHS Hospital Trust having given informed consent. A 5-week CBT group and a 22-week SR group for chronic pain patients ran in parallel, with CBT group-members joining the SR group after the completion of CBT.

The project compared CBT and SR groups using mixed methods.

Quantitative self-report measures were taken before and after the interventions to assess physical/psychological changes. In addition, participants kept twice-daily (12-hourly) pain and emotion diaries as a supplementary measure of physical/psychological changes. Participants also reported on their mental and emotional state following each CBT and SR session.

Qualitative evidence was gathered via literary-linguistic analysis of audio/video-recordings and transcriptions of the CBT and SR sessions. In addition, video-assisted individual qualitative interviews with participants took place after the completion of the interventions.

### Results and Findings

Our preliminary hypothesis was that CBT would show evidence of participants 'managing' emotions by means of systematic techniques, where Shared Reading (SR) would turn passive experience of suffering emotion into articulate contemplation of painful concerns.

This hypothesis was substantially borne out by both quantitative and qualitative evidence, which demonstrated that a far greater *range* of emotional expression occurred in SR than in CBT. Where, in the CBT sessions, there was a strong emphasis on a sense of diminishment or subtraction – things 'taken away' by chronic pain – in SR, there was frequently a renewed sense of energy and vitality, sometimes of joy and celebration. This was closer to a rediscovery, via the new stimulus of the literary story, of what participants still *did* have (memories, feelings, thoughts, experiences) rather than a rehearsal or repetition of what they no longer had. In CBT, participants focused exclusively on their pain with 'no thematic deviation'. In SR, by contrast, the literature was a trigger to recall and expression of diverse life experiences – of work, childhood, family members, relationships - related to the entire life-span, not merely the time-period affected by pain. This in itself had a potentially therapeutic effect in helping to recover a whole person, not just an ill one. As one consultant put it, *'When people are in CBT, they are people with pain. When they're in the reading group, they're people with lives.'*

Moreover, the experiences elicited in SR were not 'familiar' to participants in the way the pain narratives offered in CBT often were. The processes of CBT seek to help participants to challenge and overcome negative thoughts through positive thinking. In SR, by contrast, the fiction and poetry was frequently a stimulus to forgotten, buried or inarticulate pain (emotional and psychological). The extended range of emotion expressed or experienced in SR also meant that more intensely 'negative' emotion was in evidence here than in CBT. While sometimes this was upsetting for the individual concerned, these moments of felt distress tended to have the lasting effect of making participants more engaged in the SR process. It was also notable how even difficult emotional material was described as a 'distraction' from physical pain - as though the more the forgotten pain returned, the more the familiar pain receded into the background.

Usually, moreover, the distress or upset was leavened by a cognitive capacity or discovery – a thought or new perspective in relation to a bad feeling – discovered from within the difficult emotion, rather than from outside or above it. Rather than

adopting CBT's more top-down strategy of mind over matter, this is a process of drawing into explicitness inarticulate, implicit pain. Reading fiction and poetry encourages thinking 'about' human situations from an imaginative position inside them: asking vicariously why a person says, does, feels this is one way reading literature can encourage familiar thoughts and feelings to be regarded in a new way. This process helps to achieve one of CBT's own principal aims of helping pain sufferers to shift their perception in relation a physical condition which is in itself unchangeable or incurable.

Indeed, one critical 'self-help tool' offered by SR was an extended repertoire of models for thinking about experience – models which were powerful for participants because they were not 'flat' exemplars for living (step by step how to's or bullet point strategies) but dynamically rich and complex. One key benefit for participants was that characters in fiction, or voices in poetry, offered difficult experience which could not be readily resolved or 'reasoned with'. Personal trouble seemed more normally human than a sign of something wrong or of being ill.

A further critical aspect of SR was that the facilitator was not a didactic expert in SR as he/she is in CBT. In SR, the facilitator's expertise is employed to guide the group back to the book or poem, so that the text, and not she herself, initiates discussion and triggers contributions. This matter of the book being 'the expert' and the voluntariness of contribution in SR meant, crucially, that participants could deal with difficult material in their own way and *in their own time*, rather than expression or recognition being programmatically demanded of them.

This issue of timing and readiness for change is connected to the opportunity SR offers to people to come for themselves to the kind realizations which CBT seeks to 'teach' them. This accords with the quantitative finding that improvement in psychological and wellbeing scores did not show uniform improvement. Important in this regard also, is the indication from this study that some of these realizations and articulations may be happening without being voiced. They are enabled by the public sharing of the literature, that is, but they remain private intuitions or thoughts, not directly confessional revelations.

Finally, the diversity of emotion elicited by SR was indicated across all levels of the study (from quantitative measures of positive/negative affect to qualitative linguistic and literary analysis of video-recorded sessions and transcribed interviews) by the variations and change in language use as compared with CBT. SR produced a

much wider range of vocabulary in relation to emotion and ways of thinking and speaking which were creatively new or uncharacteristic of default speech patterns. This is possibly an external manifestation of SR's potential to galvanise new messages or produce a kind of mental rewiring. This a significant consideration in a condition which is in part sustained by the over-rigidity of nervous impulses or mental pathways.

### Conclusions and Recommendations

- Quantitative evidence of emotional well-being for people suffering from chronic pain is showing improvements in mood/pain immediately after the SR session, into the evening (many report a better night's sleep) and up to 1-2 days following.
- Quantitative and qualitative evidence indicates SR's strong potential as an alternative to CBT in bringing into conscious awareness areas of emotional pain otherwise passively suffered by chronic pain patients.
- SR's capacity to encourage greater confrontation and tolerance of emotional difficulty makes it valuable as a longer-term follow-up or adjunct to CBT's concentration on short-term management of emotion.
- The ability of fiction and poetry articulately to 'find' pain at its personal-emotional source – as an involuntary rather than intended outcome - makes it an important complement to CBT's top-down procedure of mind over matter.

## Introduction

This study undertook preliminary investigations into the efficacy for chronic pain sufferers of a shared read aloud intervention developed by national charity The Reader as compared with a standard intervention for chronic pain, Cognitive Behavioural Therapy (CBT). We hypothesized that, where CBT characteristically 'manages' emotions by means of systematic techniques, Shared Reading (SR) helps turn passive experience of suffering emotion into articulate contemplation of painful concerns, and that SR might offer an alternative and/or follow-up to CBT for chronic pain sufferers.

The study was conducted through a partnership between researchers from the Centre for Research into Reading, Literature and Society at the University of Liverpool, The Royal Liverpool and Broadgreen University Hospitals NHS Trust, and The Reader, a nationally recognised centre for the promotion of reading and positive mental health. The project was approved by the Liverpool Central NHS Research Ethics Committee.

## 1. Background to the Study

### 1.1. Chronic Pain

The official definition of chronic pain produced by the International Association for the Study of Pain in 1960s describes it as

an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. It is pain which persists for more than six months.

Chronic pain is defined as pain which lasts for more than three months, i.e. after tissue healing has occurred. It is common, affecting between 10.1% and 55.2% (Harstall and Ospina 2003). The definition does offer some important insights. That it is a 'sensory' experience is perhaps obvious, though that it is 'unpleasant' is an understatement. Consultants often feel they should not use the word 'pain' in relation to these patients. What they really have is suffering. They do not have a localized symptom. Their whole life is awful. Defining pain as an 'emotional' experience is crucial. Arguably, if you do not have an emotional response to your pain, then you are probably not suffering from pain. It is not a merely physical sensation like hot or cold. If you take the emotion out of pain, it's not pain anymore. Hence, therefore, the definition's emphasis on '*potential* tissue damage'. For people with chronic pain, it is

often not the case that something is damaged, it hurts, you rest or treat it, it gets better. The pain may or may not have been triggered by tissue damage in the first place. Either way, chronic pain sufferers are experiencing something that is totally ‘inappropriate’ - they’re getting pain which is not justified by and not related to any tissue damage.

## Somatic pain processing

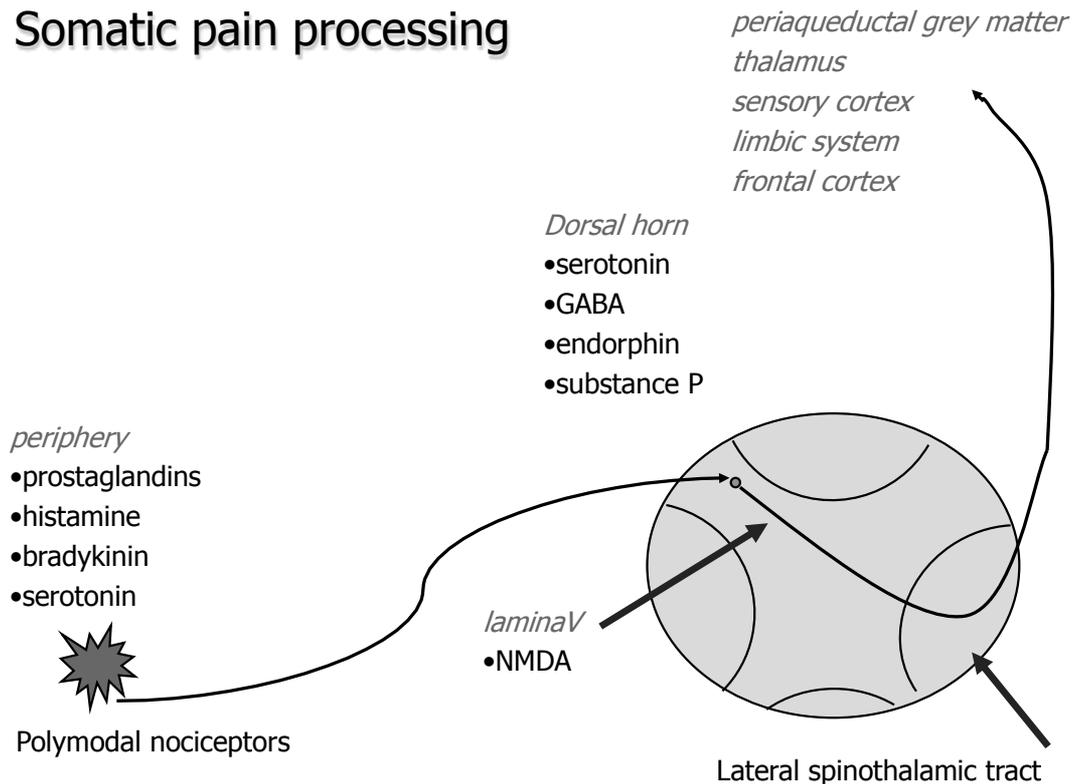


Figure 1

Figure 1 gives a crude approximation of what happens when someone hurts themselves. A person puts a finger in the fire, and that triggers pain receptors in the periphery. Already these are being influenced by hormones. For some reason that we do not understand, the pain signal goes across the spinal cord to the other side and travels up to the brain. Before it even reaches the brain, therefore, many things have been happening to this pain impulse as it travels up through the spinal cord.

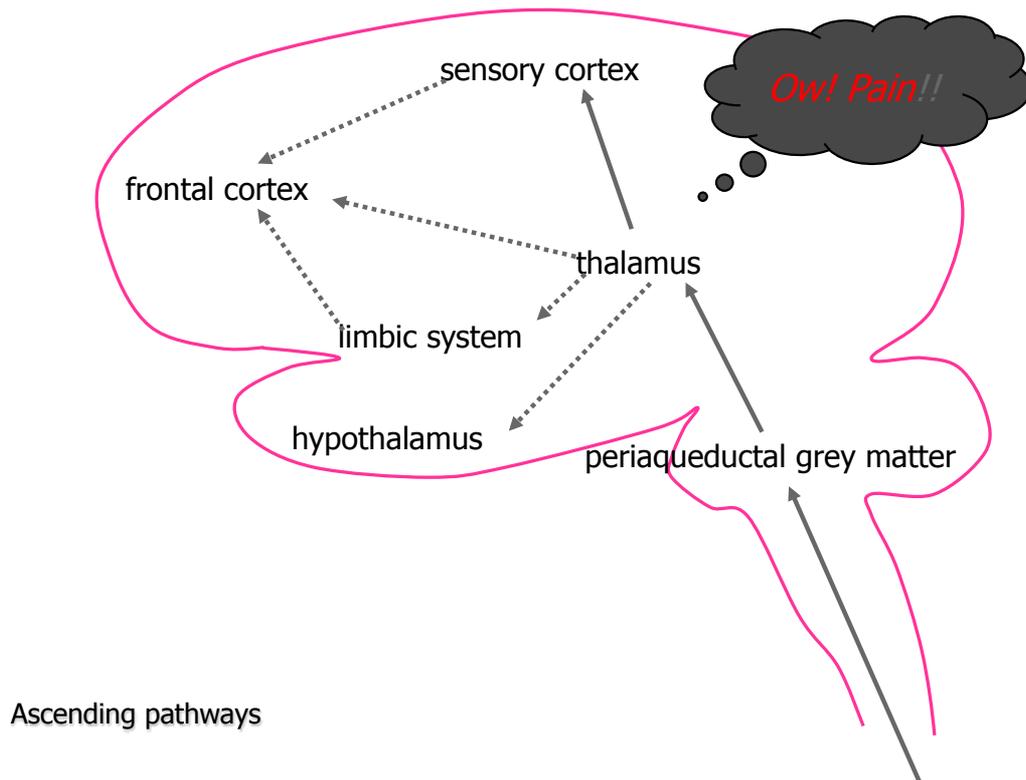
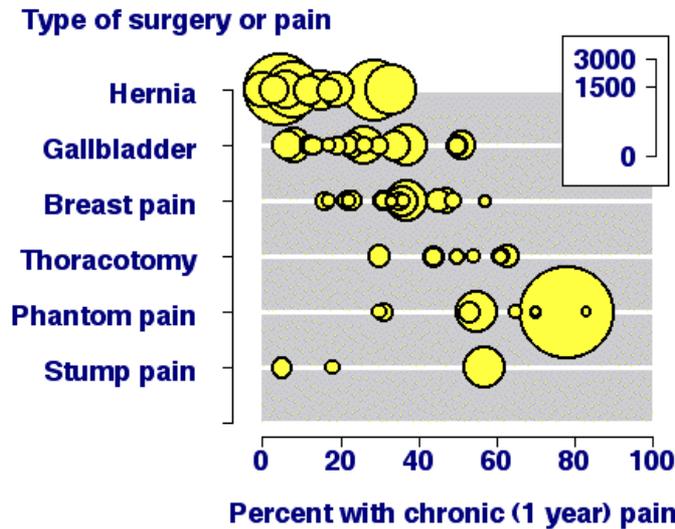


Figure 2

Figure 2 shows that, on reaching the brain, the impulse goes up to the thalamus - a sort of shunting yard for all the things coming into the brain - which decides where to send the signal. Thence, the signal is sent to many places. It goes to the sensory cortex, which registers that the finger is in the fire, that it hurts, that it must be taken out. If that were the sole purpose of pain - to signal danger - then nothing else would be necessary. But, in fact, much more is going on. The hypothalamus and the limbic system are involved as is also, crucially, the frontal cortex - the part of the brain where emotions live and where personality resides. Scans show that, in patients who have chronic pain, the frontal lobes are often much less dense in terms of nerve cells than in people who do not have chronic pain. Sometimes, if the pain is effectively treated, this density recovers again (Davis, 2011; Tracey, 2008).

# Chronic pain after surgery



From Bandolier

Figure 3

Figure 3 gives an idea of some of the ways that chronic pain can occur. For most people who have an operation, the surgical wound heals, and the pain goes away. In some people, it stays. In this graph, each little bubble is a study looking at pain which persists one year after the operation. The bigger the bubble, the more patients in that study. Most people's pain will have gone between six weeks and three months after their operation. Where it persists, there is 'phantom pain'. Eighty percent of people will have a painful phantom limb if they have an amputation. The biggest bubble in relation to breast surgery is on forty percent, and the lowest percentage is twenty. If you have breast surgery, which is predominantly for breast cancer, then there is a strong chance of persistent pain staying with you. Persistent pain is very common after hernia repair and the possibility of its occurring now appears on patient consent forms. For some reason, in certain people's nervous systems, the pain stays; it does not get better with tissue healing. There are two things strange about this. One is, why does it happen to some people and not others? And the other is, why is it different for different operations? These are currently unanswerable by medical

science. The present conclusion is that chronic pain is a reorganisation syndrome affecting the central nervous system (Henry et al, 2011).

What is certain is that pain is a subjective phenomenon. Only the sufferer can ‘measure’ the pain – by explaining where the pain is, how intense it is, how long it lasts, its quality, impact, meaning. Visual analogue scores which measure pain on a scale of 1-10 are virtually meaningless to the chronic pain patient, for whom the pain fluctuates on a daily, weekly and monthly basis. The best measure of health for pain patients – of going through ‘a good spell’ – is having more good days than bad: that’s what they are looking for; that’s ‘quality of life’. The other certainty is that pain does not occur in isolation. Sufferers are part of families and communities. Their home and work lives are affected and the deprivation they suffer is often economic, vocational and occupational as well as physical-emotional (Breivek, Collett, Ventafridda, Cohen and Gallacher, 2006).

### **1.2.Chronic Pain and Cognitive Behavioural Therapy**

Current treatments for chronic pain vary due to the cause and symptoms of individuals’ pain, but can include analgesia, surgery, acupuncture, nerve blocks, electrotherapy, physiotherapy and psychological therapies. Treatment of chronic pain by medication can cause side effects and interventional procedures can be painful in themselves. The current evidence base supports the use of standard psychological interventions, CBT in particular. Though some studies have shown CBT to provide limited benefit only (Sveisdottir et al, 2012; Williams, Eccleston and Morley, 2012), one of the most recent reviews comparing CBT with traditional treatment demonstrated that there was a small but significant initial improvement in the levels of pain, disability and mood experienced. However, at six months follow up to treatment there was only a moderate improvement in a patient’s mood (Fullen et al, 2014). CBT’s benefits, while useful therefore, are short-term. The focus of psychological treatments is to provide support which enables people to live more satisfactorily with chronic pain and to manage the interference it produces in their lives and their sense of identity (Morley, 2011).

### **1.3.Rationale for Shared Reading in relation to chronic pain**

Pain is a complex experience that affects thought, mood, and behaviour and often leads to isolation, immobility, and drug dependence. In that respect chronic pain

resembles depression, and the relationship is intimate. Pain is depressing, and depression causes and intensifies pain. People with chronic pain have three times the average risk of developing psychiatric symptoms — usually mood or anxiety disorders — and depressed patients have three times the average risk of developing chronic pain. In the first place, it was this overlap between depression and chronic pain and their common co-morbidity which justified the delivery of Shared Reading to chronic pain patients. Published studies of the effects of shared reading in community settings (Hodge 2007; Billington and Sperlinger, 2011), and in health care and rehabilitation centres (Robinson, 2008; Davis, 2009) have shown its value in relation to mental health issues. Specifically, research has shown that Shared Reading can alleviate symptoms in people suffering from depression (Billington et al, 2011; Dowrick et al, 2012) and dementia (Billington et al, 2013). Some of the aspects of Shared Reading which are cited in recent research to account for this effect seem particularly pertinent to the situation and needs of chronic pain sufferers. These elements include: literature's offering of a stimulus to mental agility and moral and emotional flexibility in a way which few activities (including other arts-related ones) demand with equivalent directness and immediacy (Billington, 2012); slowed deep thinking in intrinsic relation to personal emotion, where the text is not a two-dimensional manual but more like a voiced living presence (Billington et al, 2014); memory or recovery of lost aspects of being, where the reading matter helps bridge the gap between a current unwell self, and a past healthy self and enables integration of fragmented parts of the self into a functioning whole (Gray et al, 2016); the shared reading group setting, and the literature within it, offering a compassionate alternative (and partial antidote) to the experience of being judged, exposed, or disregarded within the world, and enabling the compression of lived experience in moments of sudden reflection and realisation (Longden et al, 2015).

Related research in the field of reading and neuroscience has suggested that the inner neural processing of language when a mind reads a complex line of poetry has the potential to galvanise existing brain pathways and to influence emotion networks and memory function (Davis et al, 2008, 2012). Together with qualitative findings that reading 'stimulates metacognition and high-level mentalisation in relation to deepened and expanded emotional investment in human pursuits (created by the book)' (Longden et al, 2015), it is possible, a recent neurological study has suggested, that some of the benefit associated with reading may come from 'diverting

individuals away from processing their struggles via ingrained and ineffective channels and towards more diverse, novel and effective reasoning options’ (O’Sullivan et al, 2015). These findings seem particularly relevant to a condition in which the nervous system produces persistent ‘pain pathways’. The hypothesis that reading can help enable a ‘re-wiring’ of kinds seems justified by existing research.

The proposed project builds upon a recent DCMS/Public Engagement Foundation sponsored pilot study by the Centre for Research into Reading, Literature and Society (CRILS), University of Liverpool. The study investigated the benefits for chronic pain sufferers of the specific shared read-aloud model developed by national award-winning charity and social enterprise, The Reader. SR is distinguished from other reading therapies in emphasizing the role of literary reading in mediating experience. Chronic pain, to reiterate, is an emotional condition as well as a physical sensation, affecting thought, mood, and behaviour. Our findings indicated that while pain levels remained steady, mental health and well-being improved across all participants. All regarded the literature read as an essential component of the SR experience and participants universally showed a preference for intellectually and emotionally demanding literary pieces, which produced closer concentration and absorbed attention, reducing awareness of pain – ‘as though the extra mental effort helped shift immersion to another level and blocked out the pain more successfully’ (Billington et al, 2014). It appeared that the mental challenge of SR created a state consistent with the concept of “flow”, whereby people can lose awareness of their physical needs and bodily state, ‘becoming more fully themselves – more fulfilled and absorbed, more vitally alive – in forgetting the self, whilst engaged in meaningful activity’ (Billington et al, 2014). Connections were also made to former work-based skills and there was a renewed recognition of the need to engage in valued ‘work’ as well a sense of comradeship which modelled participants’ previous professional or working lives.

SR, these findings suggested, helped participants to manage the psycho-emotional symptoms of pain to a degree comparable to the effect of standard psychological treatment for chronic pain, CBT. More, qualitative findings from our study, consonant with CRILS’ related studies on mental health/well-being (Billington et al, 2011, 2012, 2013), lead us to hypothesize that, where CBT characteristically manages emotions, by means of systematic techniques related to traditions of stoic practice (Evans, 2012). SR helps turn the passive experience of suffering emotion into

articulate contemplation of painful concerns. Literary reading 1) addresses, through very specific felt instances, meaning-of-life issues or sense of lost purpose, without demanding directly confessional personal exposure to those matters which conventional forms of ‘talking cure’ require; 2) enables emotional articulacy and consciousness from a depth of reflective understanding triggered by the power of the literary text, without diagnostic stigma or prescribed stages in a step-by-step therapeutic agenda (Longden et al, 2015).

## **2.The Study**

### **2.1.Aims and Objectives.**

Aims: To undertake preliminary investigations into:

- 1) the degree to which CBT and SR offer alternative treatment methods for alleviating the psychological symptoms of chronic pain;
- 2) how far SR might complement CBT by providing less programmatic and potentially more long-term follow-up to CBT.

### **2.2.The Interventions.**

#### **2.2.1.Cognitive Behavioural Therapy**

The CBT intervention, delivered by the Pain Medicine consultants, has been adapted for the particular needs of chronic pain patients. It is a group CBT model, targeting relaxation training, stress and behavioural management, and coping skills which try to manage the factors which may influence or exacerbate chronic pain suffering. CBT rests on the premise that a person’s thoughts determine his or her feelings and behavior, and thus a sustained attempt to change and inhibit negative and unhelpful thought patterns is the key to overcoming psychological distress. The therapy cannot remove the cause of suffering but helps sufferers to assess the effect that pain is having on their lives, and encourages problem-solving to reduce the impact of the pain on daily living. Altering the way individuals perceive their pain helps patients break out of a vicious cycle of negativity which may prolong or worsen their suffering. CBT also helps treat mood, anxiety and sleep disorders from which many chronic pain patients also suffer.

There is a strong neurological argument for using this therapy with pain patients. The consultant explains it in lay terms in the first session of CBT. There are specialized cells in your body, he says, whose job it is to detect and transmit pain and

nothing else. Usually pain is picked up by one of these receptors, and impulses are sent through the nervous system to the brain. What happens in people with chronic pain, however, is that other nerves are recruited into this 'pain' pathway which start to fire off messages to the brain when there is no physical stimulus or damage. 'When we look back through case notes for people who have been coming for a long time, we often see that we're treating a different area to the one we were concerned with originally, and that's because the pain wiring system has set itself up and the body's joined in with it.' But the body can 'unjoin' again. Nerve blockers (drugs) are one way; CBT is another – by getting the brain to send new messages back to the body.

### 2.2.2. Shared Reading

Shared Reading as pioneered and delivered by national charity The Reader, is a specific literature-based intervention. It is distinguished from other reading therapies (which characteristically rely on 'self-help' books) in two key ways: first, it emphasises the importance of serious, 'classic' literature and its role in offering a model of human thinking and feeling (Davis, 2009); second, the literature is read aloud so that the book is a live presence and not just an object of study (as in formal educational settings) or of chat (as in the conventional book club, where the material is read in advance of the group's meeting).

The model is based on small groups (2-12 people) coming together weekly, to read short stories, novels and poetry together aloud. The reading material ranges across genres and period, and is chosen for its intrinsic interest, not pre-selected with a particular 'condition' in mind. The groups are led by The Reader's trained project workers, who reads aloud and pauses regularly to encourage participants to reflect on what is being read, on the thoughts or memories the book or poem has stirred, or on how the reading matter relates to their own lives. Group members participate voluntarily, controlling their own involvement, contributing and/or reading aloud themselves as much or as little as they wish. Customarily, participants interact in relation to what is happening in the text itself (in terms of narrative, characters, place and setting, themes, description, language) and what may be happening within themselves as individuals (in terms of reflections about personal feelings and thoughts, opinions and experiences), responding to the shared presence of the text within social group discussion. The key elements of the model have been identified in research (Billington et al 2011, Dowrick et al 2012) as:

- the literature – a rich, varied, non-prescriptive diet of serious literature, including a mix of fiction and poetry;
- the reading aloud - making the literature ‘live’ in the room, and rendering it accessible to participants through skilful reading aloud, thus ensuring that everybody can take part regardless of levels of literacy, educational, ethnic or cultural background;
- the shared element – where the read aloud group model and the sharing of personal ideas and feelings in response to literature, is inclusive of everyone, knitting people together in both the reading experience and a supportive community.
- the weekly regularity - offering valuable continuity and structure for people whose lives may be chaotic or empty.

## **2.3. Research Method**

### **2.3.1. Participants and Recruitment**

Following ethical committee approval, participants with severe chronic pain symptoms were recruited by the pain clinic in a participating NHS Trust having given informed consent. The study included participants with any chronic pain condition regardless of aetiology.

### **2.3.2. Data Collection**

The project compared CBT and SR groups using mixed methods.

- A 5-week CBT group and a 22-week SR group for chronic pain patients ran in parallel, with CBT group-members joining the SR group after the completion of CBT. (5/6 weeks is the standard duration for CBT; 24 weeks is the minimum length recommended by The Reader and the standard duration of SR as a commissioned intervention. SR ran for 22 weeks in this instance in order to fit into the time frame of the research study.)
- Quantitative measures – Short Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), Work and Social Adjustment Scale (WAS), Beck Depression Inventory (BDI), General Health Questionnaire (GHQ), Medical Outcomes Study Questionnaire (MOS), Ryff Scale, Dalgard Mastery Scale (DMS) - were taken before and after the interventions to assess physical/psychological changes.



- Participants kept twice-daily (12-hourly) pain and emotion diaries as a supplementary measure of physical/psychological changes. Pain severity was recorded using a 0-10 rating scale, (0 = non-existent, 10 = severe), at 12-hour intervals. At the same time, participants wrote down two words to describe their feelings, using as a guide (but not restricted to) those listed on the PANAS (see below).
- Participants completed the Positive and Negative Affect Scale (PANAS) immediately following each CBT and SR session. This scale consists of words describing emotions (10 positive, 10 negative), and asks participants to write next to each word the extent to which they are feeling each emotion on a scale of 1-5 (1 = not all; 5 = extremely). In addition, participants were asked to write down two words or phrases which best described their experience on that occasion.
- CBT and SR sessions were audio/video-recorded and transcribed.
- Video-assisted individual qualitative interviews with participants took place after the completion of the interventions.

### 2.3.3. Data Analysis

Data from the physical and mental health measures, PANAS scores and the pain and emotion diaries were analysed statistically using SPSS.

Selections of the video-recordings/transcription of the CBT and SR sessions were analysed qualitatively for the emotional content and dynamic of each group by: a linguist (via a corpus linguistics approach); a team of occupational/CBT therapists; a team of literary experts.

Both quantitative results and qualitative findings were cross-referenced with the audio-recorded and transcribed video-assisted interviews with participants.

### 2.3.4. Ethics

The project was approved by the Liverpool Central NHS Research Ethics Committee, and conducted on principles of good research governance in line with the ESRC Framework for Research Excellence and the BSA guidelines for the conduct of ethical research (ESRC, 2012; BSA 2002).

### 3.Results and Findings

In what follows, participant names are anonymised. For clarity, participants SH, SY and AR figure in the CBT group and the reading-group; Participants T, K, JE, JO, P, AX, H figure in the reading group only. The session leaders for CBT are the consultants, JM, AW. The facilitator for Shared Reading is Group-Leader K.

#### 3.1.Results (Quantitative)

##### 3.1.1.Psychometric Assessment Forms

There were considerable problems with producing a statistical analysis of the data, owing to the variable amount of data across time for individual participants. While there was some variation in the scores across time, there did not appear to be any participant with a consistent pattern of change in all areas (mood, wellbeing, work, function), though there were some interesting trends in relation to individual participants.

*SR*

Participant JO, for example, showed startling improvement in general health, despite other measured parameters remaining roughly the same. Participant P also showed very marked gains in general and psychological health, and an increase in personal growth and sense of purpose in life, despite an overall increase in pain suffered and a slight worsening in general health. Participant AX, indicated improvement in mood, function, general psychological health and social support whilst he was attending SR.

*CBT followed by SR*

In line with other studies, an improvement in general health after the CBT course was shown for Participant SH. Participant AR's scores showed the same pattern and the trend of improvement continued in this case through SR (though the rate of improvement slowed over the time period of the study). For participant AR, there was significant increase in personal growth and purpose in life despite the absence of change in factors relating to work, home, and social life. Both participants SH and AX showed a small increase in wellbeing.

##### 3.1.2. Pain and Emotion Diaries

The correlation between high scores for pain severity and low (negative) scores for emotion as shown using the Pearson correlation test is highly significant:

$r = - 0.32, p < .001$

(threshold for significance is .05)

As pain goes up, emotion goes down, hence the negative  $r$  value here.

The data were analysed to give the mean pain and emotion scores across the study (the ‘overall mean’: see Figure 4 and Figure 7). After coding for each time that a person attended the reading group, the following tests were carried out for three different points in the week: Sunday evening (two days before the group), Tuesday evening (after the SR group in the afternoon), and Thursday evening (two days after the group).

	<b>Pain rating 0-10</b>		<b>Emotion (+/- scale, 1-9)</b>	
<b>Overall (24/7)</b>	Mean: 6.00	Valid N: 1665	Mean: 3.96	Valid N: 1573
<b>Sunday PM</b>	Mean: 6.51	Valid N: 81	Mean: 4.07	Valid N: 76
<b>Tuesday PM</b>	Mean: 5.69	Valid N: 78	Mean: 4.69	Valid N: 78
<b>Thursday PM</b>	Mean: 6.31	Valid N: 92	Mean: 3.99	Valid N: 84

Figure 4. Effect of day of the week in relation to attendances at SR sessions.

Pain rating after the session is lower than the mean and lower than at two days before and two days after the reading group session. Pain rating two days after is also lower than two days before the reading group, suggesting the possibility of some prolonged effect, beyond the duration of the group itself (a finding which is worth testing further in future studies). The emotion rating is also higher on the evening following the reading group than at two days before or two days after. Both of these findings – together with the words used by participants in respect of their emotion on Tuesday evenings (see Figure 5) – correlates with the evidence from the qualitative interviews, where participants frequently stated that they enjoyed a better night’s sleep on a Tuesday evening.

Tired	17	Very tired	4	Exhausted; worn out	3	Fatigue/ Fatigued	2	Shattered	1
Happy	15	Elated; delighted	2						
Good; good day	11	Very	1	Really good	1	Good mood	1		

		well							
Relaxed (chilled; relaxing day)	10	Very relaxed	1	Calm; peaceful	1	Comfortable	1	Drowsy (sleepy)	1
Irritable	6	Tense; on edge	3	Restless	1	Agitated	1		
Focused (studying)	4	Alert	1	Determined (resolute)	1	Strong	1	Proud	1
Anxiety/Anxious	3	Stressed	1	Worried	1				
In pain; painful	2	More pain; getting stronger	2						
Energised; energetic	2	Vibrant; Alive	2	Refreshed	1	Inspired	1	Excited	1
Content; thankful	2	Positive	1	Hopeful	1				
Busy	2								
Frustrated	2								
Sore	2								
Okay	2								

Figure 5. Emotion words occurring within the pain diaries, **on a Tuesday PM**, grouped roughly according to mood expressed (tired, happy, calm etc). (No = number of times.)

Bad (bad day); pain bad; down; sad; upset; drained; weary; not good; unwell; ok? not bad; tingly

Figure 6. Other words used once **on a Tuesday PM**.

Words used by participants to describe their emotions at 12-hour intervals were categorised as ‘positive’ and ‘negative’ to enable statistical analysis. 65 positive words were used on Tuesdays after SR (see Table 4). An analysis of the 65 words showed the mean score for pain at these times to be 4.46. Since this falls significantly below the overall mean of 6.00, the accompaniment of positive feeling by lower

levels of pain accords with our general finding of the correlation between pain and emotion. It also correlates with the finding that pain scores were shown to be lower overall on the evening following attendance at the reading group, along with a higher degree of positive feeling.

However, there were a few occasions when the pain score given was significantly above average, and yet the positive emotion was still able to be present. For example:

"Proud": Participant K, Session 6, pain score 8

"Good": Participant AR, Session 7 (i.e. AR's first session of SR, see figure 10), pain score 7.

"Focused": Participant H, Session 8, pain score 7.

"Happy": Participant S, Session 12, pain score 8.

"Energetic": Participant K, Session 17, pain score 8.

This suggests that it is possible for SR to produce 'good' emotion even despite severe pain. This, says Consultant AW, is a significant finding. In relation to a condition which cannot be completely cured, where pain levels, however fluctuating, will always be more or less severe, interventions which improve mood and quality of life are to be strongly encouraged: they are the only appropriate and effective 'medicine'.

The same tests in relation to the pain and emotion diaries for CBT show a different picture. Again, after coding for each time that a person attended the CBT session, the following tests were carried out for three different points in the week: Saturday evening (two days before the CBT group), Monday evening (after the CBT group in the afternoon), and Thursday evening (two days after the group).

	<b>Pain rating 0-10</b>		<b>Emotion (+/- scale, 1-9)</b>	
<b>Overall (24/7)</b>	Mean: 6.00	Valid N: 1665	Mean: 3.96	Valid N: 1573
<b>Saturday PM</b>	Mean: 7.55	Valid N: 11	Mean: 2.3	Valid N: 10
<b>Monday PM</b>	Mean: 7.59	Valid N: 11	Mean: 3.5	Valid N: 10

<b>Wednesday PM</b>	Mean: 7.59	Valid N: 11	Mean: 2.4	Valid N: 10
-------------------------	------------	----------------	-----------	-------------

Figure 7. Effect of day of the week in relation to attendances at CBT sessions.

Sore	2	In considerable pain	1		
Anxious	2				
Tired	2				
Lousy	1	Irritable	1	Down	1
Restless	1	Agitated	1		
Interested	1	Alert	1		
Relaxed	1				
Happy	1				

Figure 8. Emotion words which occur multiple times within the pain diaries, after attendance at a CBT session, on a **Monday PM**.

The scores for CBT show a pain score above the mean and an emotion score below the mean, although the emotion score is higher after the session than either two days before, or two days after. There is considerably less evidence here, as is the case with the qualitative evidence, that CBT affected pain and emotion beyond the duration of the group.

### 3.1.3. PANAS (Positive and Negative Affect Scale)

This scale consists of a number of words that describe different feelings and emotions (10 positive, 10 negative). At the end of each session, participants were asked to write next to each word the extent to which they were feeling each emotion on a scale of 1-5 (1 = not at all; 5 = extremely: see Appendix 6). In addition, participants were asked to write down two words or phrases about their experience on that occasion.

As there was considerable variability in the participants who attended each session (often owing to pain/health issues), the data have been analysed to give the mean positive and negative PANAS scores (maximum score = 50 for positive affect, 50 for negative affect) for each of the CBT and SR sessions. The validity of the mean is increased for the later SR groups which had higher attendance levels (when the CBT participants joined the SR group), with the small number of participants in CBT having the least validity. (Given the small number of participants overall, and especially in CBT, statistical analysis between the CBT and SR scores was deemed inappropriate.)

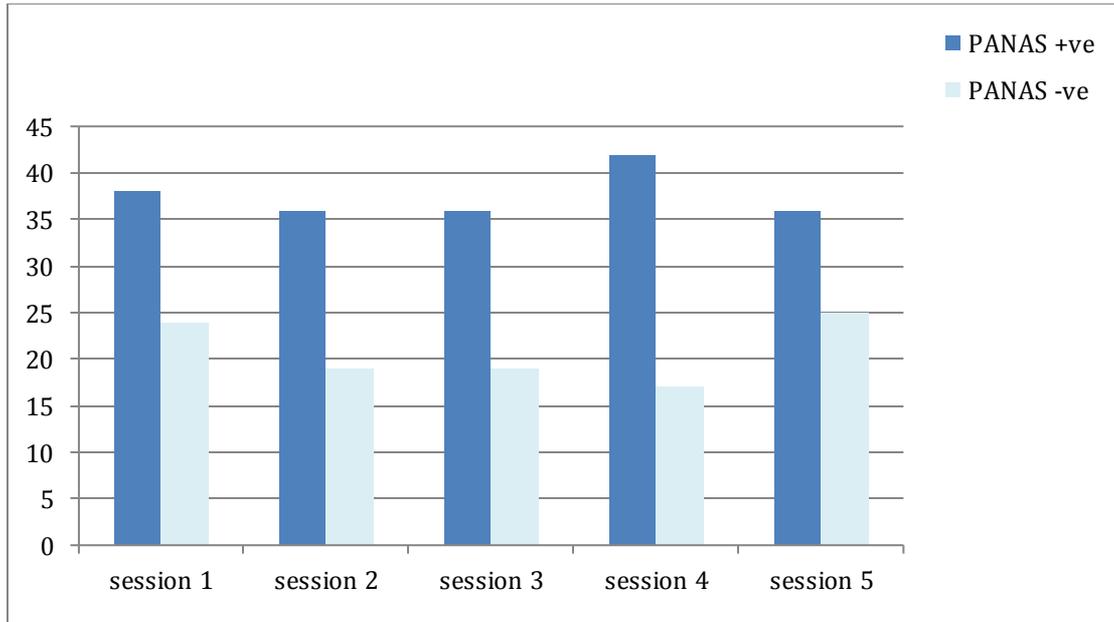


Figure 9. CBT PANAS Scores

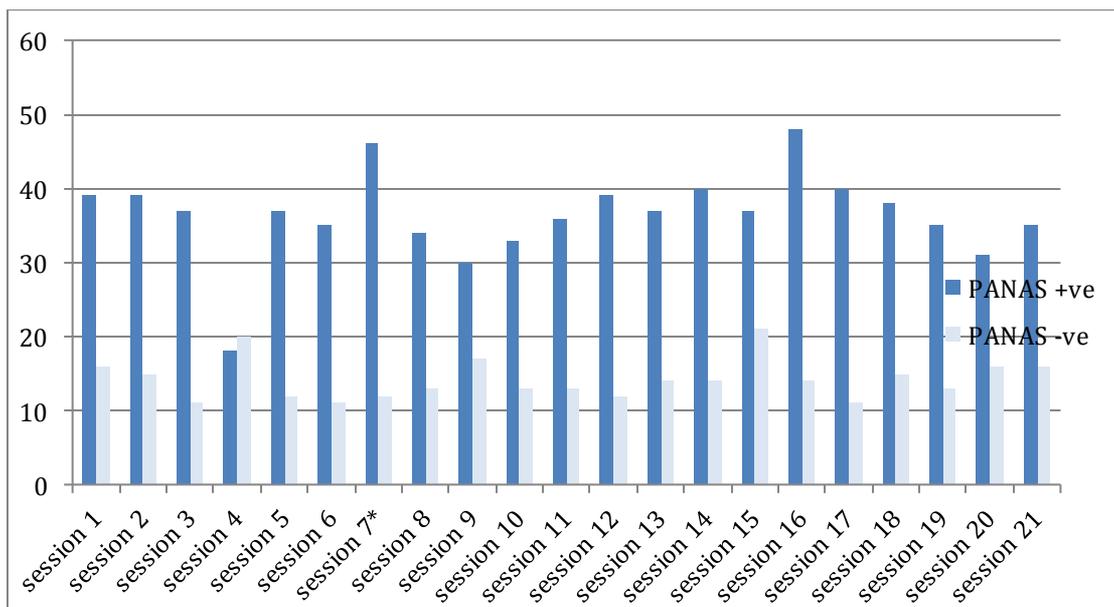


Figure 10. SR PANAS Scores (\*CBT participants joined the SR group at Week 7)

Positive emotions scored consistently higher than negative emotions in both CBT and SR (with one exception in the latter, Session 4). Although there does not appear to be any trend for the scores to alter over the time course of either group, there does appear to be a tendency for slightly higher positive PANAS scores and lower negative PANAS scores to occur in the SR group. This is consistent with the qualitative

finding of a wider range of emotions being experienced in SR than as compared with CBT (see 3.2).

This result is also consistent with the greater diversity of emotion which was expressed in the two words or phrases which participants recorded after each SR session, as compared with those recorded after CBT, even taking into account the larger number of SR sessions.

Words recorded following CBT tended strongly towards the cognitive: 'interesting', 'informative', 'educational' were the words in this category most frequently used across participants. The words were also quite narrow in range. Emotion words were restricted to 'relaxing' (by far the most common word used across participants), 'good session', 'fun', 'brill', 'relieved', 'enjoyed', 'felt good'.

In SR, 'enjoyable' and 'relaxing', along with 'happy', were still among the most popular words for expressing positive emotion but these were more often than not combined or intermixed with words showing a greater range and intensity of feeling: 'engaging', 'inspired', 'exciting', 'uplifted', 'content', 'very enthusiastic', 'involved', 'love the group'. Participants quite often related their feelings to their experience of pain: 'helped to take my mind off pain', 'distracting from problems', 'enjoyable and great distraction from pain', 'helped with pain and anxiety', 'support'. This effect seemed to be reflected in positive 'feeling' words which had a 'physical' emphasis: 'energised', 'refreshed', 'awake', 'active', 'feel motivated'.

At the same time, cognitive words were also frequently used: 'intrigued', 'interested', 'attentive', 'concentration', 'thoughtful', 'reflective', 'alert', 'determined', 'focussed', 'deep', 'understanding', 'thought-provoking', 'descriptive'. This effect might help to account for the experience of 'distraction' from pain.

Most striking were

(1) the number of occasions when positive and negative words occurred together: 'Feeling uplifted as we went on. Some sadness but feeling better, less pain'; 'Happy; sad'; 'Inspiring and good interaction. Suffered from back pain most of this session a little'; 'Relaxed a little; anxious'; 'Very sore; enjoying the book'; 'Have pain and anxiety; feel better for today'; 'Tired; thought-provoking'.

(2) the occasional use of exclusively negative words from some participants. Sometimes, the emotions seemed to be more a response to the participants' physical state: 'confused; tired'; 'difficult to focus; removed'; 'very tired; hard going today'; 'distant; tired'; 'a bit jittery'; 'difficult to focus and engage today'. At other times,

however, the responses were clearly elicited by the literature read. In Session 4, where there are relatively low scores for positive emotion and relatively high scores for negative emotion (see Figure 5), the responses were: ‘I found it quite sad’, ‘have felt emotions of the boy and father. My emotions are sad a bit down but glad; mixed emotions’; ‘Sad; Feeling down’; ‘Sad; Depressed’.

For two participants, however (as was verified by the Group Leader K’s notes and by interview in video-assisted participant interviews) this session proved, in very distinct ways, to be pivotal in releasing a more emotional level of being. (See 3.2.1.2, *Participant JE*; 3.2.5.3, *Participant T*).

It is notable that, in the only other comparable session for the elicitation of negative emotion (Session 13, see Figure 5), the words used seem overall to express greater tolerance of negative feelings - ‘Emotional; upset’; ‘Very emotional, but relaxed’; ‘Very emotional; good session’ – and this is reflected in the more usual mean PANAS score for that session, as well as in the qualitative findings. (See 3.2.1.2, *Participant JE*).

### 3.2. Findings (Qualitative)

This section reports on the types and areas of thinking which each group elicited from participants, and the modes of language in which that thinking is expressed. The findings are based on: (i) qualitative analysis of the video-recordings of the groups, which give access to thinking as it happens; (ii) transcripts of the video-assisted interviews with participants which took place at the close of the interventions; (iii) comprehensive linguistic analysis of **one** session of each intervention. The method of analysis, developed and piloted by CRILS (Longden, 2015; Kaszynska, P. 2015), applies critical skills associated with close literary thinking to the ‘live’ transcripts of people who, in the case of the reading groups, are practising such thinking. The researchers use language as ‘the main point of access to the phenomenology of cultural experiences ... to identify “moments of subtle mental change and personal break-through, cognitive revaluation, interactive mind”’. The method is able to suggest ‘how these mental processes are expressed through the participants’ own symptomatic use of language, through the linguistic traces’ (Kaszynska, P. 2015).

Instances are grouped initially under themes or subject-matter which were common to both groups and thus where modes of thinking and articulation are most justly comparable. To repeat, for clarity: participants SH, SY and AR figure in the CBT group and the reading-group; Participants T, K, JE, JO, P, AX, H figure in the reading group only. The session leaders for CBT are the consultants, JM, AW. The facilitator for Shared Reading is Group-

Leader K. Direct quotations from the linguist on the research team, Sofia Lampropoulou, are initialled 'SL'.

### 3.2.1. Personal Story.

We begin with narrative modes of expression, as a key linguistic finding of the qualitative analysis was that the telling of personal stories was a strong feature of both the CBT and the SR group. There was a marked difference, however, in the content of the stories elicited by CBT when compared with SR. This commonality of form helps particularly to highlight distinctions of matter. (The examples in this section are more expansive than in later ones to register these contrasts.)

#### 3.2.1.1. CBT

Stories in the CBT group related exclusively to the participants' common health condition and its associated difficulties. Variation occurred insofar as the subject matter of the stories related to the specific topic of the session. The first session, for example, was concerned with origins or causes of chronic illness, and participants gave accounts of how their pain began:

*Participant SH: I came out of an extremely abusive relationship, and was free for the first time in 8 years. And then over a very short period of time I've become trapped by something else. That to me feels extremely unfair, very very unfair. And as well I was extremely active, I was full-time employed, self-employed as well. I had two children, I'd walked out – well, escaped – from the abusive relationship and started again, basically. To go from that to this.*

A session on coping and managing pain prompted accounts of family responses to the illness, including the impact of loved ones' incomprehension not only of the pain but of the side-effects of the medication:

*Participant AR: My wife comes in from work and says 'Do you know you're slurring? Have you been drinking?' I say, I wish. We end up having an argument then.*

Participant SY spoke of how work helps her 'get through' and how difficult it was when helpful colleagues, out of concern and kindness, offered to do things for her:

*It's just one more thing that people take away. If everyone took every tiny little thing away, I'd just sit there and do nothing.*

When the focus was on how pain affects quality of life, participants gave numerous resonant accounts from their own experience. These accounts were not directly solicited but more invited by the group leader's strategy of using stories from his own experience and expertise as a pain physician for illustration. 'These stories initiate parallel stories on the part of the participants which share the same theme' (Linguist SL). Here is a typical instance.

Consultant JM, by way of emphasising the importance in chronic illness of maintaining the sufferer's quality of life, gave the example of a patient he treats, an 80-year-old man, suffering from angina. Still a keen gardener, his daily routine was to spend every day at his allotment, until his son, afraid of his father suffering a heart attack, had locked up the shed so that his father could no longer have access to his garden tools.

*Participant AR: It happened to me. I have a workshop at home, which I used to use – as an ex product designer – a mini-lathe, hand tools, power tools. There's a padlock on there now, I can't get at it. My son did that. As soon as you said it, I thought, I'm the chap who's had his shed locked up. Not only that, they've even sold all the tools now, in case I can get into the workshop, in case I find the key, cos they know I'm quite good at finding ways. So that has been taken away from me.*

Significantly, perhaps, Participant AR brought along to the following session a magazine article containing an extended personal anecdote from a chronic pain sufferer: 'When I read this, that's when I realized I'm not by myself, there's other people, and that gave me a little bit of a sort of hope'.

For Consultants AW and JM, one of the therapeutic functions of the version of CBT they deliver is the giving permission to patients to talk freely about their experience of chronic pain:

*Consultant AW: People who come into CBT have had a whole load of negative medical experiences with other doctors, with the system as such, and in Accident and Emergency where they're not really understood. So they come with a lot negative preconceptions. Often close ones and family members have become frustrated or irritated listening to complaints about something which seems not to be there and yet never goes away. I try hard to build trust – they have to trust that they can be open about their pain without getting any of the negative feedback they've had before.*

Participants welcomed the validation which sharing their experience brought. At interview, Participant SH, for example, spoke of the 'relief' which came from exchanging personal histories with others who were struggling not only with the same symptoms but with similar day-to-day pressures.

*Participant SH: It's getting things off your chest. I think identifying with people who are in the same boat as you, who you can talk to really helps. I require a lot of reinforcement. I feel very lonely because I don't have anybody, any significant other, so erm... I am alone. I have got an 8-year-old child. And my mum worries so much that I don't tell her how I feel a lot of the time because I don't want her to worry. So I don't tell anybody anything.*

There is evidence, too, that expressing matters in CBT was leading to greater openness with others beyond the group. Participant AR reported at interview the aftermath of recounting in CBT his experience of losing his tools:

*It was gut-wrenching. Even now. When I found out that my son had sold the tools, it took a good 18 months before I spoke to him. Even now, things are difficult. I spoke to him about it quite recently after the CBT: I pushed him on it ... He says I did it for the best dad.*

Partly because of the emphasis upon, and demonstrable importance for participants of, ‘getting things off your chest’, the stories themselves remained in the same personal and emotional area throughout CBT. ‘The chronic pain theme is consistently maintained and there is no deviation’ (SL). With the exception of Participant AR’s article, the initial prompt came entirely from Consultant JM – sometimes directly, sometimes fortuitously – and only thence from other group members. (See Group-Leader, below, 6.1.)

### 3.2.1.2. SR

In the reading group, by contrast, there was a great diversity in the subject of the individual stories elicited, and the stories were differently triggered. Most commonly stories emerged in response to the literary text, rather than being prompted by the facilitator. ‘Instead of commenting directly on the text, they come up with real-life examples that relate to the topic of the text.’ (SL)

The diverse contributions cited throughout this study, as will become clear, were very often narrative in form. This section focuses firstly on the CBT/SR participants in turn and then offers representative selections from the wider group.

#### Participant AR

Memories of work were often the subject of Participant AR’s stories, sometimes introduced by a formulation such as: ‘This story, it just reminded me’. As AR verified at interview, these stories were often remembered by him again for the first time since giving up work altogether.

In Edith Wharton’s short story ‘Mrs Manstey’s View’, the protagonist has only the back view from her New York apartment to live for, until the development of a neighbouring building obscures it. The story recalled to AR the elderly woman living on her own with whom Participant AR used to lodge when he was a long-distance lorry-driver. ‘*She used to expect me and watch for my wagon. She always knew when I was late*’. When a young couple moved in next door and built an extension, ‘*she couldn’t see any more so she didn’t know when I was coming*’. This is Participant AR’s first contribution of length in the group: it is ‘about’ his own former life and also a poignant tale of somebody else’s pain.

At a different register, Lennie's dependency upon George in John Steinbeck's *Of Mice and Men* prompted thoughts of when he was driving lorries on the continent, and would see another driver, Peter, stopped along the way.

*I'd pull in, and say 'What's up?' and he said I knew you'd be coming through. And then he'd be following all the way. It turned out he used to get lost all the time, you see. So what I think of this [pointing to the page] is that the two of them are together because they've got security with each other: there's a bond. They latch onto each other.*

Later, another group-member, Participant T used Participant AR's story as a way of understanding George's relationship with Lennie: *'You stopped for your friend at work: you were very protective towards him'*. Participant AX said: *'You were like George – you knew what you were doing where your friend didn't'*. Participants AR, T, AX are male. There was a sense in this exchange not only of something of the camaraderie they had formerly experienced at work being recreated, but of its being reproduced in a way that was not conventionally 'masculine'. At interview, Participant AX said of this moment: *'We [i.e. men] don't talk in those terms. Not generally anyway. No it is more practical situations that we talk about. It is not usually about how we feel'*.

Participant AR himself was struck at interview by how all his stories came from a time when he was fit and able to do things. He also enjoyed the fact that the stories were unexpected: *'With pain, you are anticipating all the time, you've always got to plan. You can't be spontaneous anymore, and I was always spontaneous.'*

### Participant SY

Participant SY's response to 'Mrs Manstey's View' offers an example of how the same story could prompt a wide range of personal recollections within the same participant. Her first contribution was:

*This upsets me, you know, 'cause my dad can't, my dad doesn't go out. But he knows, you know, the people going to church, he says to me Mrs So and So passes every day.*

*It quite upsets me thinking – Is that all there is for him? That he's content like that?*

Yet it is SY who, later in the same session, repeats the penultimate sentence of the story - 'Mrs Manstey's head fell back and smiling she died' - and who first recognizes that Mrs Manstey's view is *'a whole world'* and *'it's still there when she dies'*. This in turn prompted SY to talk of when she had trained as a counselor in palliative care. She remembered the difficulty of *'trying to explain to families that it's not really what they want that counts when a person is dying'*. In a further instinctive move, SY turned to Participant AR, saying: *'In CBT we had a significant discussion about how people were taking our choices away'*. Here, SY is first a grieving daughter; then the counselor who can understand the daughter's sorrow

and help modify it; then the pain sufferer herself, also able to reflect on the therapy she has received in relation to it. These are not so much ‘stories’ as very flexible shifts of position - from a person who, at interview, habitually describes her brain ‘as spongy’ following a stroke.

Significantly SY remembered this story, unprompted, in a later session, in the context of a very different story and situation - when the groups were reading of the ‘dream-building’ of George and Lennie in John Steinbeck’s *Of Mice and Men*. At interview, SY of Mrs Manstey *‘I love her’*: the stories *‘make me think about things beyond things.’*

### Participant SH

For Participant SH, rather differently, it was sometimes the case that the *same* personal histories were recounted with a marked change of tone under the fresh stimulus of the fictional story. In relation to the ‘dream-building’ of Lennie and George in *Of Mice and Men*, for example, SH told of how she and her two children had left her husband under a police escort, staying with relatives temporarily –

*Participant SH: And then we found a house, and it was like ‘We’ve found this house, and we’ll move in and it will be lovely and it will be ours, you can have your room how you want, we were making plans, we’ll be able to do this and that ...’*

*Participant T: That’s the start of moving forward.*

*Participant SH: Yeah [with animation and smiling at the recollection throughout] and then literally I got sick. Straightaway. So I’d escaped a horrible life. Could do anything and then I got this.*

*Participant P: Do you think the upset of the break-up eventually kicked off what was always there, laying dormant?*

*Participant T: Was it years of stress and anxiety as well?*

*Participant SH: Yeah – and then it was like, ‘It was all over’ and ... so frustrating.*

*Participant P: Your body kept strong while it needed to, didn’t it, while you were going through a bad time?*

*Participant SH nods affirmatively*

Witnessing this moment at interview, Participant SH recalled again the moment of ‘escape’ – *‘it was lovely it was my front door key, my front door, my house’*. This feeling of the initial joy of release was absent from the ‘CBT’ version. It is also noteworthy here that the connection and timing of SH’s illness with her prior domestic situation had been made neither by herself nor by the therapist in CBT: for the reason, as Consultant JM put it, that he *‘would not have wanted to be intrusive or indelicate, “putting words into” SH’s mouth’*. Participant P makes this link on SH’s behalf, as it were, not as a professional but as a fellow-sufferer. P’s response was described by SH at interview as ‘lovely’.

### The wider SR group

This range in the content and tenor of the personal stories told was a strong feature of SR. It was rarely the case that direct or 'literal' correspondences were made between the story and real life: the response was not one of identification with character merely. These brief instances in relation to Charles Dickens's *A Christmas Carol*, for example, show how the relationship of the personal to the text was often indirect and idiosyncratic – itself individually personal, that is.

The description of Tiny Tim's imagined death and Bob Cratchitt's sorrow over 'my little, little child' prompted Participant P to recall her mother's repeated memory from childhood of the cot death of a sibling. P's mother had remembered *'the exact look'* on her own mother's face at the moment she found the baby until her own death in old age.

Participant H instinctively related Tiny Tim's imagined death within a loving family to that of Scrooge – who dies in a 'cold' room, alone - in an earlier passage. At the same time she brought together for contrast two family funerals she had experienced – *'one filled with love and loss and real heartfelt emotion and the other – all the same people were there – it was very different, cold, we had to go the funeral, we went through all the motions'*. This is Participant H finding an example from her own life which helps illustrate why the 'deaths' of Scrooge and Tiny Tim exist in implicit contrast in the book.

In relation to Scrooge's 'carrying his own low temperature', Participant T said *'it's like he's got no heart, he's cold all the way through, he's got no feelings'*, asking, *'Why is he like this?'* Several times he spoke of a woman at his current workplace – a troubling environment for T - who was 'very cold'. *'I suppose,'* said Participant T - when some of Scrooge's former life as a 'forgotten' boy had come to light later in the session - *'people like Scrooge and the woman I was talking about, you can condemn them as horrible, but you don't know why they're like that do you? You can't understand them, but they may have reasons'*.

At such times, P, H and T were not simply talking about the 'character' in the text: rather character was for them a means or a form of practical thinking in relation to an issue in their own lives or memories.

Thinking across from fiction to life and back again, rather than straightforwardly giving an account, was a strong feature of the way personal history emerged in the SR sessions.

### Participant AX

The group were reading Tobias Wolf's story 'The Liar' in which a young boy is compulsively telling falsehoods to and about his widowed mother. Participant AX says at first:



*Is it trying to deal with the father's passing? Is he worried about the mother dying, in a curious way?*

And a little later:

*My father died when I was 8, and I remember worrying about my mum ... it was like a bit of OCD [Obsessive-Compulsive Disorder] in a way. I used to do things to protect her. It was a mild OCD that I had.*

The thread is then picked up for a while by Participant H, in terms of her own story:

*Participant H: I can sort of remember doing similar things [i.e. fantasizing like the boy in the story] when my mum died. I mean I was 23, I wasn't a child but ... and my dad was ill, he'd had a heart by-pass soon after my mum had died. But I could see myself at my dad's funeral, after having just been to my mum's funeral. So in my mind, I wasn't writing it down, I wasn't telling anybody but in my mind, I was going through those thought processes. I was kind of projecting one onto the other.*

*Participant T: When you look at it that way you can understand*

*Participant H: Yeah cos, it wasn't like – there wasn't anything wrong with me. I was grieving. I was worrying, there was a lot going on.*

*Participant T: Do you think he's trying to draw attention, so that people know what his situation is, the way he feels?*

*Participant H: You wouldn't call him an attention-seeker though – he could be saying it in genuine need. The mother over-reacts, but that could be her grief. She shuts down.*

*Participant AX: We're psychologists again aren't we?*

Participant H's thinking here is arguably closer to that of a novelist than a psychologist, imaginatively inhabiting now the 'genuine need' of the boy (as proxy for her own bereaved situation on the death of a parent perhaps), now the 'grief' and protective defences of the mother. Participant AX did not speak again until the story was almost over (when it is revealed that the boy protagonist, whose father died while his mother was not at home, had carried his father upstairs). When the boy had told his mother, she had been 'shocked and furious' to learn that the father had not died in bed.

Participant AX instinctively said: *That's where the lying started.* He resumed after another pause.

*He was young when his father died, and I know from my own experience, it leaves a massive imprint on your life. And even to this day, I've done things that is because of what happened in childhood. Nothing wrong, nothing bad or nothing terrible but ... I remember when my father died, for 30 years if I had passed an undertaker, I looked away so I couldn't see it. 'Cause I was protecting my mother.*

Narrative was elicited thus intermittently throughout the session, not formulated as a single finished story. AX's personal experience exists as a constant subterranean emotional reference point running in parallel with the events recounted in the text. AX confirmed at interview that what was subsequently diagnosed as OCD first started when his father died. Significantly, while his story comes back, references to OCD drop away. As H and T take on, unselfconsciously, the role of sympathetic 'psychologists' in relation to the boy - *Participant T: Do you think he's trying to draw attention [to] the way he feels?*, *Participant H: 'You wouldn't call him an attention-seeker though'* - it is as though AX gradually regards his own compelling need to evade unwanted truths (*'I looked away'*) as something more normal, and even bravely necessary (*'I was protecting my mother'*) than something 'wrong' with him.

At interview witnessing this session, AX said:

*To say it is a reading group, is not really a true description of what goes on. Because there is a lot of psychology involved, a lot of interpersonal thoughts and also there is a lot of 'oh I can understand that, that is how I react and perhaps I shouldn't react in that situation' because you are learning from the story. We look into how a person is reacting in the story. What do we think, how would we respond, what is he doing wrong? What is the future going to be, for that individual? It is a bit like CBT in that you are learning mistakes that you have made in the past, by things that the characters are saying. 'Oh aye that is right, I shouldn't have really done that,' so it is a bit like CBT.*

### **Participant JE**

It is a finding throughout this study that, CBT characteristically permitted expression of 'familiar' pain – the physical pain, that is, with which participants were living minute by minute, day by day. SR, by contrast, often seemed to find buried or forgotten pain. Sometimes this happening was visibly emotionally upsetting for participants at the time, and could have a negative effect on the participant's feeling about the story or poem, and about the session as a whole.

So, for example, with Participant JE's response to the scenario at the conclusion of Elizabeth Bowen's short story, 'The Visitor'. A young boy tries to know, before anyone can tell him, the news he awaits of his mother's death. 'I can't let them tell me. It would be as though they saw me see her being killed!' *He wants to be alone for the first wave of the shock – where no one can see him,* said JE and recounted how she had told her own child of his grandfather's death. *'I'll always remember, he just turned away, he just took a few steps away from me. Just for a few seconds. It was a horrible experience that. This just reminded me.'* As the session ended she said, *'I can honestly say that's the only story I haven't*

enjoyed. *I don't know what it was*'. Her PANAS score for the session reflected this experience with negative emotions scoring unusually high scores. (See also 3.1.3.)

At interview, interestingly, JE had no memory of this experience when she viewed it, as though the buried personal matter was simply buried once again. *'It's strange,'* she said. *'It took something like that - the story - to bring that memory out of me.'*

Group-Leader K related at interview how she had worried at the time about the effect of this story on JE to the extent that she hesitated over the choice of some texts thereafter for fear of producing further upset. Nonetheless, Group-Leader K felt that there was a notable increase in JE's involvement and engagement in the group thereafter: *'the release of the "bad stuff" felt like a breakthrough of kinds, "breaking the ice"'*. Participant JE herself said at interview in relation to this happening: *'Sometimes even the upset does you good. To let that emotion out - it brings something on'*.

That 'something brought on' that both participant and group leader felt, was verified by the evidence of subsequent sessions. Eight weeks later, in relation to 'Mrs Manstey's View', Jean became tearful again, saying *'I can understand this woman in a way when I look at my mum: she hasn't been out for a few years now, she's only got me, I'm an only child'*. The PANAS for this session (see 3.1.3.) was as it usually was for JE - positive feelings outweighing negative ones. Of this second occasion of being tearful, JE said at interview:

*It is funny isn't it, it is like sometimes you can read a book and next thing you are in tears, there is a sad part in it and then you can just turn - your body, your emotions - and you feel it deep inside. It is like it takes your breath away you know.*

For JE, this 'deep' emotional transmission from book to reader - the thing that did her 'good' - was a result of the reading aloud:

*It is not just the way it is written. It is [Group-Leader K] reads it ... As she is reading you can feel the emotion in her voice from what she is reading as well.*

JE's experience helps show how SR produces live and momentary happenings which, nonetheless, contribute to change over time.

### **Participant KE**

Participant KE's testimony gave further evidence that the stirring of negative emotions, memories or stories did not necessarily amount to a negative experience for participants of the SR group. When the group were reading the poem 'Dream and Thing', by Edwin Muir (see below, p. 32). Participant K told of how she had lost touch with her father when she was thirteen. *'My dream was to find him again. At eighteen, I met up with him and found him. My dream of what would be wasn't as good as what actually happened. He didn't really want to know.'* *'Don't like it,'* she said at the end of the session, pushing the poem away. Yet Participant K said at interview, where she witnessed this session again, that she felt the upset

might have been caused by the fact that she was becoming more open and autobiographical for the first time in the group.

*These sessions really, really, really helped me, especially in the beginning, because, if you had seen me at the very beginning, you would have seen a very different person, I think [Group Leader K] would probably tell you the same thing. I have slowly got stronger, and stronger and more back to me. When I said to my mum I'm starting this poem group, she nearly fell off her chair. 'I would never have thought in a million months of Sundays you would do something like that.' And, neither did I. And it has been one of the nicest experiences I have ever had.*

Participant K has not simply forgotten those instances of 'not liking it', for she has just now witnessed one of them as part of the interview. And witnessing it made K speak once more of how incomplete or 'unfinished' her experience of finally meeting her father still seems to her. It is as though 'nice' ('one of the nicest experiences') incorporates the 'not liked' elements instead of merely omitting them. As the remaining sections will show, and as the quantitative findings corroborate, the making room for negative feelings and thoughts seems to be part of what is counted 'positive' in SR by group members.

What was particularly striking from the testimony of these participants was how these old stories felt like new experiences, and how often, as we saw AR and JE explicitly recognize, they were freshly and involuntarily triggered by the literature:

*Participant T: Sometimes it is just a word or, a sentence. It's funny, we must carry all these things around with us, all these stories, and it just needs a word to bring it forward doesn't it?*

*Participant K: Strange isn't it – it brings things out in you that you would never normally talk about.*

Participants often remarked at interview that they spoke of things in SR that they could not recall ever having spoken of before, in either therapeutic/counselling sessions, or socially, with friends or family. The personal story elicited in SR is distinctive, it seems, not only from CBT but from most other available forms of personally expressive discourse.

\*\*\*\*\*

The following three sections – **2) Change 3) Bad Feelings: Good Thoughts 4) Private Spaces** – are concerned with issues which were purposefully tackled in CBT and which emerged also in SR. They are areas, therefore, where the content of personal story and participant contribution are most directly comparable.

### 3.2.2. Change

#### 3.2.2.1. CBT

The value of CBT, say Consultants AW and JM, is that it focuses on changes in perception in relation to circumstances or issues which cannot themselves be changed or cured. As AW put it: *‘There is an end in sight for people who are terminally ill; there is no foreseeable end to the suffering of those living with chronic pain.’*

But AW and JM also recognize that finding a capacity for such inward change in relation to outward circumstances is often itself a slow and emotionally painful process. CBT *‘barely scratches the surface’*, they say. But it is a start. For many pain sufferers, CBT might be the first space they have had directly to confront and reflect upon the often dramatic changes which pain has wrought in their lives. Consultant AW: *‘There’s no-one with chronic pain who wasn’t without it at some stage in their life.’*

The first session indirectly invited such reflection by asking participants to ‘define’ their pain in their own terms and illustrations. This led to an expression of many of the negative changes which the onset of pain had produced:

*Participant SH: I’m defined now by my pain; prior to this I ran my own business; I am not who I was before my pain.*

*Participant SY: People say to me, I’m not the same. Cause I’ve always been the wild child. I was very outgoing; now my friends think I’m not me. My family think I’m not me anymore.*

*Participant AR: I think people remember me for what I used to be able to do. I used to be a party animal and some people think oh isn’t it a shame you know.*

There was a strong sense not only of a relatively reduced or diminished life, but also of stasis, both literal/physical and psychological:

*Participant SH: It’s the inactivity ... social and physical ... you just stay in one place.*

*Participant AR: You start thinking, crikey, I’m just popping pills: I never took tablets before.*

Expression of the will to change in relation to the future was a feature of Participant A’s discourse, and less often of SY’s.

*Participant SY: Your pain’s a journey.*

*Participant AR: There’s gotta be – I mean, I’m looking for an alternative [to the drugs]. You come to groups like this as an alternative way of moving forward. That’s my ultimate goal: all these drugs – you start to rattle.*

Participant AR also recounted how his pain started in his lower limbs, spreading to his arms and hands, with the result that he could no longer use a manual self-propelling wheelchair, and was now reliant on an electric one.



*You try and do things – and my way of doing it is to try to re-activate the nerve-endings - I go swimming, to try to regenerate something. I got into a rut when I took each day as it came. Now I try to have as many good days as I possibly can.*

In addition to not knowing ‘*how long will I be on the tablets*’, anxiety and fear about further degeneration of her condition was strong in SH’s discourse:

*Participant SH: I don’t do anything with music anymore. I used to run concerts, I used to put them on and I was bloody good at it, and now I don’t even go, let alone put them on. It was my life. I loved it. It made the day job worthwhile. I can’t even speak to people about it anymore generally. I just avoid everything.*

What CBT seemed to offer participants was the opportunity, capacity and permission to express what they experienced overall as a sense of subtraction, ‘*of every tiny little thing being taken away*’ as Participant SY put it.

### 3.2.2.2. SR

#### Participant SY

In the reading group, the story which possibly elicited some of the most poignant reflections on changes from the past to the present - and where there was recourse to words (like ‘degeneration’ for example) which cropped up in this context in CBT - was David Guterson’s short story ‘Arcturus’.

After many years, Carl, the protagonist, has run into Floyd, his boyhood best friend, now ‘loused up and rusty ... a fat old man’. Relating this to a ‘shock’ she had recently had in meeting up after a long separation with an erstwhile friend, Participant JE said: ‘*It’s like he doesn’t want the past to be brought to meet the present*’. It’s like ‘*a memory he does not want to have,*’ said Participant P.

But when Carl involuntarily recalls a river trip the two had taken together as adolescents, Participant SY responded enthusiastically to the description of their being taken by the current through rapids - ‘*a pair of spilling, rushing teenagers. It was beautiful and terrible at once. He had no control anymore.*’ Re-reading these sentences aloud, Participant SY said: ‘*This is very exciting isn’t it? I felt like that when I was eighteen.*’ The tonal register is recognizably more buoyant than the nostalgic regret which characterized SY’s reference, in CBT, to having once been the ‘wild child’.

It is SY who responds to this next passage towards the close of the story. Carl is recalling telling Floyd, ‘*I would die for you. If I ever had to.*’

But now it was night years later. The sun had set already, the stars were out. Nothing is going to change here, Carl thought – even though most things had changed already. And he wished he had never seen Floyd. He wished it had never happened.



Nobody needed that kind of reminder. Nobody deserved a jolt like that.

‘Isn’t that so *sad*,’ said Participant SY Sally, immediately, with a quick vivacity of tone. Afterwards she recognized clearly all the reasons why Carl would wish away the jolt: the sight of Floyd, she said, ‘*makes him realize how old he is himself*’; ‘*Carl can’t reconcile in his mind the way things are to the way things were*’. There is an emotional energy in SY’s instinctive response to the sadness of the situation and in her astute recognitions of Carl’s depressing ‘realizations’, which, nonetheless, is not itself ‘sad’ or depressed – rather the opposite. It is another example, as witnessed in the examples of participants’ personal story, of how SR can confound the usual expectation or assumption that ‘positive’ and ‘negative’ are definitively separate categories.

Participant SY next went back in the text, to read the paragraph immediately preceding the one quoted above, recounting the river trip the two boys had made years ago in adolescence:

It had been a sweet journey, he thought now. He didn’t want to forget about it ever. Even the ridiculous promises had been sweet. He *would* have died for Floyd back then. He’d been dumb enough and young enough for ridiculous things.

Participant SY here disrupts the story’s *straightforward* sequence - moving one paragraph from its position preceding the later paragraph of regret - to bring back what is good. ‘*It’s the innocence that he can hardly stand to remember*,’ she says. It is as if SY becomes, momentarily, the protagonist, altering the given, and not letting the innocence or the memory give way wholly to sad outcomes.

### Participant SH

This latent energy or appetite for change was also a feature of SH’s response to Elizabeth Jennings’ poem, ‘Resemblances’.

Always I look for some reminding feature,  
Compel a likeness where there is not one,  
As in a gallery I trace the stature  
Of that one’s boldness or this one’s grace.  
Yet likenesses so searched for will yield none;  
One feature, yes, but never the whole face.

So every face falls back into its parts  
And once-known glances leave the candid look  
Of total strangeness. Where the likeness starts  
We fix attention, set aside the rest,



As those who scan for notes a thick-packed book,  
Recalling only what has pleased them best.

And doing this, so often have I missed  
Some recognition never known before,  
Some knowledge which I never could have guessed.

When Group-Leader K re-read the first two lines of the poem -

Always I look for some reminding feature,  
Compel a likeness where there is not one,

Participant SH asked immediately:

*Are you looking for normality? You just want something that's familiar. It's the familiarity - he's saying if you just go for the familiar, what about the new and exciting: you miss a lot. 'Compelling a likeness.' It's like saying, **that's** [pointing] like **that**, making it fit what's known already.*

It is noteworthy that SH's tone and syntax is one of questioning. In CBT her formulations were characteristically negative as well as expressive of matter that was certain and familiar: 'I am not who I was before my pain'; 'I don't do anything ... anymore .... I can't even speak ... about it anymore'. More, in this instance, SH uses 'you' where 'I' is normal in CBT. 'In CBT,' says linguist SL, 'the coordinator uses the generic "you", whereas participants use "I". SL says of 'generic/ impersonal 'you':

*Impersonal 'you' can mark a transition from the specific to the general, presenting an event in more general terms, not as happening once to one person but as happening generally to a category of people. To this end, shifts from 'I' to 'you' are particularly useful as they signal a change of perspectivisation and potentially of categorisation of the participants as members of a group/ culture - often, in SR, a transition from the protagonists' mental state to the speakers' own emotional state. It also shows the speaker's direct involvement with the text: something specific from the text world is transferred to the real world in the form of a generic claim. (Davis et al, 2015)*

The process of SH's thinking in SR – where the thought develops through questions, pauses and often a struggle for articulation, as well as from the singularly personal to a 'shared' emotional experience - is markedly distinct from her habitual 'CBT' mentality and syntax: 'I am not', 'I don't', 'I can't'. More, at this instant, things don't just *'fit what's known already'* in SH herself. Instead, this is thought about 'normality' expressed in a way which is not the norm for SH and which seems to be happening at a whole new level: *'if you just go for the familiar, what about the new and exciting: you miss a lot'*. Here - to use the final lines of the

poem – SH is ‘moved/Beyond the likeness to look behind’ and ‘beyond’ what is habitual and familiar in every sense.

### The Wider SR Group

This intuitive responsiveness to the possibility of change was a feature of the reading group as a whole. It was especially notable in relation to Charles Dickens’s *A Christmas Carol*.

### Participant P

Towards the close of the reading of *A Christmas Carol*, the Ghost of Christmas Yet to Come grants Scrooge a vision of his own deathbed - ‘He lay in the dark empty house, with not a man, a woman, or a child, to say that he was kind’. Scrooge wills a reversal of his fate: ‘Assure me that I may yet change these shadows you have shown me by an altered life?’ Participant P pointed to the words ‘kind’ and ‘altered’:

*Isn’t this sort of like someone writing a story, and reading over what they’ve put in the story and then – [energetically] they go back and – and alter it. The phantom is showing that the future can be changed if it wants to change.*

*Group Leader K: That’s a lovely way of putting it.*

*Participant P: (quoting) I hope to live to be another man.*

‘And *alter* it’ is a message new-fired, like a regenerated nerve impulse, triggered by the text’s ‘change these shadows ... by an altered life’.

### Participant JE

At the close of the story JE was struck by the word ‘strive’ - and how you might compare Scrooge’s ability to alter his future to someone who had come close to death and had been given a new lease of life.

*I suppose it’s the change in perception that’s important. ‘I am not the man I was.’ For the future you’ve got to learn from your past, even the smallest things can teach you. He’s learned not just who he was but who he needs to be.*

Consultants JM and AW were struck, on witnessing these instances, by how the very premises upon which their version of CBT is built - that one can learn to adapt to new circumstances by shifts in perception – are not imposed upon participants here but discovered by them personally. *Consultant JM: ‘They find what they need to know in their own way, as if it is coming from themselves individually not from outside.’*

### Participant T

On Scrooge’s joyful recognition that he will live truly to alter his life, he exclaims: ‘I don’t know anything. I’m quite a baby. Never mind. I don’t care. I’d rather be a baby’:



*Participant T: It's a new experience for him – being happy. It's like an exaltation – all his emotions are coming out.*

*Participant JE: Like he can't control them you mean? It's [quoting from the book] 'laughing and crying in the same breath' isn't it? I remember doing that when my first grandchild was born.*

*Participant T: I sorted out something for my daughter's friend in India – a certificate she needed – and my daughter was a bit like that when I phoned her.*

*Group-Leader K: It's elation really isn't it? It's just like an awakening.*

*Participant T: It's like being given a second chance. You don't very often get the chance to alter the course of your life. It's an amazing thing really. [PAUSE] Does anybody in the group feel like that sometimes – cause, we're all in pain and that can make you feel down can't it? And depressed. But then you'll get a day where, for some unknown reason, you feel, not too bad. It's when you achieve something and you finish it. Like the certificate today. Sorting that did lift my spirits.*

*Group-Leader K: Is it like that movement in the sentence – 'maybe' to 'will be'.*

*Participant T: Yes. It's like the recognition of the truth and belief that this thing's gonna happen. Sometimes I think, when something good happens – like Scrooge here, it's like walking in a dream but you know it's real. 'I'm light as a feather.' You can imagine him, he's had an injection and the colour's come back into him from black and white.*

The group applauded when the book was finished, half for Scrooge's, half for their own accomplishment. Not only a belief in the possibility of change but excitement and joy itself are palpable here. There is nothing comparable to this sense of joyful release in CBT. It points to one key difference between CBT and SR: SR begins to make a change in the reader here precisely by not demanding one, except from Scrooge. The *story* achieves CBT's ambition of putting the same person in a different place.

### 3.2.3. BAD FEELINGS, GOOD THOUGHTS

#### 3.2.3.1. Pain

##### 3.2.3.1.1. Pain: CBT

In the final CBT session, Consultant JM demonstrated the importance of overcoming 'negative thoughts', especially when something triggers a 'flare-up' of pain. Negative thoughts give you negative emotions, Consultant JM explained, and the pain gets worse again. There is nothing to be gained by instinctively 'fighting it'. On the contrary, the adrenalin produced by the distress of resistance only recreates the pain, as in a vicious circle.

For the patient's own sake, therefore, blind resistance needs to be replaced by something closer to tolerant acknowledgement, if at all possible. The only 'hope' is to think differently about what cannot otherwise be changed. The necessity of combating negative thoughts is thus where the aims of CBT and the needs of chronic pain sufferers directly coincide and where the rationale of CBT for chronic pain is most clear.

In the early CBT sessions, there were numerous bad thoughts about bad feelings, as Consultants JM and AW purposefully encouraged participants to vocalize their experience. *'Sometimes people who have never communicated with each other come up with the same analogies for pain: it's like having hot pins stuck in me, it's like walking on cotton wool, it's like electric shocks, it's like ice cold water dripping down my arm: you have to use language to try and get it across to people.'* Asked to define pain in the first CBT session, these responses from participants were typical:

*Participant SH: It hurts. It's lonely. I think it's lonely because nobody understands. I feel very alone. I feel very, very alone with it, in as much as I can't even describe properly how it feels.*

*Participant AR: It depresses you. You lack motivation; you lose your self-esteem. Your family, they see you, but they don't know your discomfort. In constant pain, you're there with them, but you're just switching off.*

*Participant SY: It affects your socialization.*

Consultants JM and AW continued to support and enable this expressiveness:

*The vast majority of what we've come up with here, that we feel it's important to get in when we're trying to define pain, it's to do with emotions isn't it – fear, anxiety, low mood, anyone get angry? anyone get frustrated?*

*Participant SH. A definite 10 out of 10.*

*Consultant JM: What about avoidance?*

*Participant SH: I avoid anything that would cause me to be in more pain. So things like housework, cooking a meal, very much take a back seat, because I know I'd suffer for it the next day. I don't go anywhere I have to walk for any length of time, because I know it can put me in bed for a week afterwards. I avoid an awful lot of things, which then feeds into the low mood, the frustration, and the anger and fear. Because I feel I'm letting my child down. He'd love to go to the zoo, and I won't walk round a zoo.*

*Consultant JM: It sounds as though you're feeling guilty.*

*Participant SH: There's a lot of guilt there, yes.*

There is a strong emotional vocabulary here – fear, anxiety, anger, frustration, guilt. It is notable that all of it is supplied by Consultant JM, who writes the words on the white board at the front of the group. The first step to overcoming negative thoughts, Consultant JM has

explained, is recognizing them. The work the participant and client carry out together here is that of explicitly naming and specifically identifying feelings - frustration, anger, fear, guilt – which might otherwise be suffered rather than understood and experienced amorously as ‘pain’.

The next step in the process is learning how to challenge negative thoughts. In the penultimate session of CBT, the participants have been introduced to breathing and exercise/relaxation techniques by an occupational therapist. Consultant JM explains that some people make use of pre-prepared mantras for when they catch themselves thinking negative thoughts. *‘They think “Well, hang on, I’ve been here before. I’ve been through it. I’ve always managed to get through it eventually no matter what happens.” Some people cling on to that thought.’* Alternatively:

*There’s a nice image which somebody once told me - some people think in pictures rather than words – they used to imagine themselves as a sapling in a hurricane which, you know, bends and bends and bends and bends. As soon as the hurricane is over, the sapling comes straight back up.*

Participant AR was particularly responsive to the challenge of positive thinking:

*It reminds me of being in the army. They always talked about negative thoughts and when you go into operational theatre you’re always told to think positively. So if you’re going down a road and the bridge has been taken out, you were told to think the bridge was still there. Because if you knew the bridge was out you’d turn round and go home. Instead of thinking of all the things that can go wrong, think of all the things that could go right. But – it’s easier said than done. You start thinking positive but as soon as you go out and hit the first hurdle - And if you’re already in a lot of pain anyway ...*

Participant SH was explicit about being less ready or prepared for this step:

*Participant SH: I went into a shop today and saw the news headline, and that filled me with so much horror, because it said ‘cold snap on the way’ and I just know that I’m going to be in agony. It’s not that it’s a self-fulfilling prophecy. I just know the week is going to be a bad week.*

*Consultant JM: Any other worries just now?*

*Participant SH: That you’re not going to get better. Like this forever.*

*Consultant AW: Yes, there’s the getting worse part of it as well.*

Consultants JM and AW both felt that moments like this which could seem merely ‘redundant’ within CBT, were part of a process which helped SH ‘start thinking of herself, opening her up so that she was in more receptive state within the reading group’ (see 6.3 below).

### 3.2.3.1.2. *Pain: SR*

References to pain and the participants' common health condition was quite frequent in the reading groups sessions, though the triggers were often indirect or unpredictable. The following examples – two relating to poetry, two to narrative – are representative of the kinds of discourse around pain which reading evoked. These particular examples are chosen because they offer examples of feelings being turned into tolerable thoughts about them – CBT's aim and method.

(i) One of the few works which dealt with physical pain directly in *SR* was David Guterson's short story, 'Wood Grouse on a High Promontory Overlooking Canada'. The younger brother of a Vietnam war veteran recounts the latter's killing of a bird in order to put it out of its misery:

'I'm going to finish this pain,' Gary said. 'God forgive me.'

There were tears in his eyes I hadn't figured on.

He put his boot on the dying bird's head – the sole over one alert, clear eye – and ground it suddenly into the rock while the wings gave a last frenzied shudder. They fluttered out to their full span spasmodically in the moment just before she died.

'That's it,' Gary said, not ashamed of his crying – just crying now while he spoke to me. 'That's all it is. That's all there is to it, Bud.' ...

He went on crying. He cried with no shame. He cried in a way I didn't think it was possible.

The response to this moment was almost visceral from participants who covered their eyes or instinctively turned away. '*Anything to do with animals hurts me.*' Then the group worked together sympathetically to 'diagnose' Gary's problem. '*He's depressed.*' '*Is this post-traumatic stress?*' '*Maybe he needs someone to talk to take all his pent-up feelings away.*' '*People don't talk about it. My grandfather was a PoW for 5 years. He didn't say anything about it at all. Other people told my grandmother what he'd done in the war.*'

This prompted sympathetic identification and appreciation of how much more usual it is to '*keep everything in, not wanting to talk about it*', and how the slightest word can touch off uncontrollable emotion: '*he's letting his feelings out in the crying isn't he?*' '*When you've been bottling something up – it could be the pain that you're in and someone may just look at you or just say a word to you and the next thing you're crying. It's just that release isn't it?*' There followed serious interest in getting beneath the diagnosis - how killing the bird had released a pain in Gary which could not be 'finished', but which was complex and not all negative:

*Participant SY: Do you think what he's seen in the war has transferred onto the poor bird? You're wondering whether he's actually killed as well.*



*Participant AX: He must have done. He's very courageous here though isn't he?  
Cause he doesn't enjoy doing it.*

*Participant P: Is he ashamed to say to his brother that he has killed someone?*

The group is here drawing out into explicitness the veteran's implicit inarticulate pain.

*Participant P: Gary may not be in physical pain, but he's in pain with his emotions.*

Participant SY says enthusiastically, 'Yes, that's good. That's good.' Participant AX asks P here to repeat it. A 'good thought', the group agree. The germ of this good thought was the almost unbearable vicarious experience of intolerable pain.

Witnessing this instance, Consultant JM said:

*This is one of the crucial ideas we try to sow in CBT - that pain is not only a sensory thing or a problem with physical wiring: it's also an emotional thing. If you take the emotion out of pain, it's not pain anymore, like hot or cold.*

(ii) Laurie Sheck's 'Mysteriously Standing' affected certain members of the group because, by contrast with the Guterson story, it does unfold inner pain into articulacy. The poem was re-read by Participant H:

All the fiercer and lawlessly irregular

These intervals of withdrawal where I am a burned field

And above me the sky is thickening and clouding.

In that field, little Stonehenge of the heart

Mysteriously standing, its distinct construction odd and injured in this yellow

Light. If I say I was flexible, was harmed, was cleansed, was helped, was deeply  
marked,

I still can't understand what I have been. Doubt falls in me falls through me

A rough and intricate hazard. The mind carries an austere

Inwardness that will not put out its eyes.

At first the poem prompted recognition:

*Participant H: I can see myself in this poem, definitely. When I've withdrawn it is because I'm empty, I'm done, I'm exhausted. I've given everything I can give. You're kind of switched off. And I've got to kind of like come out, take time, rebuild and then come back in, to life into the world.*

*Participant K: I do what H does. You withdraw totally [hand gesture], 'cause you're physically and mentally drained, and you just can't do it anymore.*

*Participant T: Left like – barren.*

After a third reading, the group noticed specific words:

*Participant T: 'little Stonehenge' – is that like a kind of a feeling that's been there for a long long time.*

*Participant K: Re-reading 'These intervals of withdrawal where I am a burned field' – that's a really really really good way of describing yourself sometimes isn't it*

Consultant AW commented on how this goes beyond the 'naming' they used in CBT – fear, guilt, avoidance. These nouns – like 'pain' itself - can begin to restrict the subjective richness and individuality of the experience they objectively name. There is a danger that they can impoverish not only a pain sufferer's language but his or her vital energy. Participant K's 'really really really good' – in its vivacity of tone and thought – is notably separate from the suffering she recognizes and feels at another level. This gives to her, as it were, a 'good' thought about her own bad feelings.

Participant H responded most to this part of the poem. She noticed, she said, the 'strange placing' of the words when she read the poem out loud:

Mysteriously standing, its distinct construction odd and injured in this yellow

Light.

*Participant H: I thought that was strange how 'Light' kind of went across the line, the yellow light. It's a strange placing. It's like the light's separate from the withdrawal isn't it. It does really separate the two – it comes after.*

This is an explicit example of how poetry – in its 'strange' lineation and placing - does not simply help to provide a new language: it also disrupts conventional or habitual thought patterns, making these 'strange' or newly-perceived too.

*Participant H: That withdrawal ... you can't articulate it so it's as though you don't understand it, cause you can't express it. But [PAUSE] I don't think that's a weakness. I was having difficulty with 'flexible'. If you're deeply marked and you're down, how can you be flexible? But you can be in your mind, in your way of thinking. And if you've withdrawn to rebuild, that's a flexibility of thought isn't it. Cause you've not just kept going kept going kept going kept, you've thought 'well hang on I need to just step back a minute. So I suppose you've flexed your way of thinking, you've flexed your outlook.*

This seems a critical example for demonstrating how SR can help achieve the shift out of default mind-sets which CBT is seeking.



*Consultant JM: Some of the things we spend hours trying to ‘teach’ in CBT come out here on their own. They’re more convincing learnt this way because the patients get there on their own’.*

(iii) Norman Nicholson’s poem ‘A Pot Geranium’ at first describes the view from a high window.

And now, like a flight of racing pigeons  
Slipped from their basket in the station yard,  
A box-kite rides the air, a square of calico,  
Crimson as the cornets of the Royal Temperance Band  
When they brass up the wind in marching. The kite  
Strains and struggles on its leash and unseen boys,  
In chicken run or allotment or by the side  
Of the old quarry full to the gullet with water,  
Pay out on their string a rag of dream,  
High as the Jubilee flagpole.  
I turn from the window  
(Letting the bobbins of autumn wind up the swallows)  
And lie on my bed.

Participant AR, the former CBT participant is now in his sixth week of SR, where he has not said very much until this session (see p. 29) and has been very quiet so far in relation to this poem. Here he has been showing signs of wanting to speak for a few moments, as if waiting for the right time.

*Participant AR: That bit in brackets - [reads] ‘(Letting the bobbins of autumn wind up the swallows)’ – I think it’s the wind swirling the leaves [arms mimic the movement] the leaves swirling up and the swallows are caught up in the leaves. I used to see that when I used to pull into Gretna, the services there – all the swallows. I used to sit for hours watching.*

A moment later, Participant AR, for the first time, offers to read the next few lines of the poem:

I lie in my bed. The ceiling  
Slopes over like a tent, and white walls  
Wrap themselves round me, leaving only  
A flap for the light to blow through. Thighs and spine  
Are clamped to the mattress and looping strings  
Twine round my chest and hold me. I feel the air



Move on my face like spiders, see the light  
Slide across the plaster: but wind and sun  
Are mine no longer, nor have I kite to claim them,  
Or string to fish the clouds.

*Participant H: 'the looping strings / Twine round my chest and hold me' – I can link that to pain, and how it keeps you in place.*

*Participant JE: It's like becoming cocooned in pain.*

*Participant H: [soft tone] It's like all the dreams have gone.*

*Participant JE: The freedom's gone*

*Group Leader K: We've got that 'but' though. [AR nods.]*

But there on a shelf  
In the warm corner of my dormer window  
A pot geranium flies its red balloon,  
Nor can the festering hothouse of the tropics  
Breed a tenser crimson, for the crock of soil,  
Six inch deep by four across,  
Contains the pattern and the prod and the pulse of life,  
Complete as the Nile or the Niger.  
And what need therefore  
To stretch for the straining kite? – for kite and flower  
Bloom in my room for ever; the light that lifts them  
Shines in my own eyes, and my body's warmth  
Hatches their red in my veins.

*Participant AX: Well this is like when you're in pain, this little bit here isn't it. Where Dr AW always says to me, if you're in really bad pain, think, it's not going to last forever. There will be a bright light at the end. So you've got to think about that. So this is similar to that.*

*Participant H: That there is still life.*

*Participant JE: That's what gets me about the geranium, you know, 'Contains the pattern, the prod and the pulse of life'. I think that's lovely that.*

*Participant AR: And the joy of seeing the kite has been assimilated into the geranium. I like that.*

It seems good that AX recalls the doctor's good advice: it seems even better that AR, who almost seemed to know that advice already in CBT, should be finding a different route to it here.

Here are the final lines of the poem:

My ways are circumscribed, confined as a limpet  
To one small radius of rock; yet  
I eat the equator, breathe the sky, and carry  
The great white sun in the dirt of my fingernails.

*Participant H: It's got – wider. Now it's gone to the breadth of existence, anything and everything is all there for you.*

*Group Leader K: How do you get that when 'My ways are circumscribed, 'confined .../To one small radius or rock'.*

*Participant AR: Those two last lines, that's me [re-reads] ... that just takes me back to what I used to do. I used to love driving. As I came off the ferry at Dover, and I got onto the A16, and I'd just, do what I do in the wheelchair now: sheer relaxation, and sheer sort of 'Look what I've got in front of me. That's where I breathe the sky'.*

*Participant H: I access it by reading.*

Momentarily, AR's wheelchair is emotionally connected to AR's past, rather than being the most visible symptom of his disadvantaged present: more it is, for a second, a *means* to peace in the here and now - suddenly itself an *advantage*. These shifts away from default attitude and usual language – '*I breathe the sky*' - are involuntary happenings, not intended outcome. This seems to point to one key difference between the 'therapeutic properties' of reading - where thinking begins from below upwards - and the programmatic expectations of formal therapy where thinking is suggested by another, top-down. Witnessing this moment at interview, Participant AR said:

*The poem is saying everything is there combined for life. The geranium starts off as a small thing and then its life goes on and on doesn't it? See, that is what I mean by triggers. Participant H had been so quiet, and then suddenly she sort of came alive. There are little moments like that where you are just quite subdued and then bang, it is like the light comes on. And you can feel that happening inside like a connection.*

(iv) Doris Lessing's short story 'A Sunrise on the Veldt' tells of a fifteen-year-old teenager, hunting before dawn with all the courage and excitement of his youth, who hears a terrifying

scream of pain. He finds a small animal, a trapped and injured buck, writhing and jerking convulsively as it is eaten by ants.

It grew quieter. There were small twitches from the mass that still looked vaguely like the shape of a small animal.

It came into his mind that he should shoot it and end its pain; and he raised the gun. Then he lowered it again. The buck could no longer feel; its fighting was a mechanical protest of the nerves. But it was not that which made him put down the gun. It was a swelling feeling of rage and misery and protest that expressed itself in the thought; if I had not come it would have died like this: so why should I interfere. All over the bush things like this happen; they happen all the time; this is how life goes on, by living things dying in anguish. He gripped the gun between his knees and felt in his own limbs the myriad swarming pain of the twitching animal that could no longer feel, and set his teeth, and said over and over again under his breath: I can't stop it. I can't stop it. There is nothing I can do.

Participant T spoke for the first time in this session.

*'He gripped the gun between his knees and felt in his own limbs the myriad swarming pain of the twitching animal that could no longer feel.' He gets the pain while the buck can't. If you see something like that, you're taking on the pain and the feelings of that animal aren't you? You're taking them on – because [Participant T presses his fist against his chest] you can **feel** the pain.*

Participant T was clearly in some physical discomfort as he spoke – shifting in his chair, his eyes screwed up, his face wincing. 'It's sickening,' he continued, grimacing at the word as he repeated it: 'Sickening'. After a little while, he said that he too had seen death.

*I've smelt death as well. That's a horrible thing. It was in an abattoir. It was in Australia and part of what was on the whole a good time in my life. But that abattoir was horrific, it really was. I think what made it even worse - the thing that played on my mind was - the innocence of the animals. They were sheep and they were ... standing there – but they weren't tied up or anything. They could walk around. And one by one, they had their throats slit, while the others were just - watching. And it's like they never processed it, the dumb animals, there was nothing they could do about it. And the fact that they weren't trying to escape or anything – That's what played on my mind, for a long, long time. The feller that was doing it, said to me, the more you do it, the better you get. It was nothing to him.*

Group-Leader K: [points to the text] It was nothing to the man used to killing the sheep but here in the story it's different isn't it? The boy says 'There is nothing I can do'.

*Participant T: Yes I know. But seeing the sheep in that abattoir, I don't think I've come to terms with that really. It's played on my mind. I haven't been able to reason with it, you see.*

This is an important example of how SR does not seek to avoid or overcome 'bad' feelings – through a process of mind over matter. Rather it allows the story to express what *cannot* be 'reasoned with'. This is crucial, said Consultant JM: *'You can't necessarily be sure with chronic pain that everything's going to be all right. Things are perhaps never going to be all right.'*

Group-Leader K reported that Participant T *'found it hard going through the PANAS form today, due to the mixture of feelings he had – distinguishing between them one by one and giving a number'*. Participant T said himself towards the close of the session:

*That's a great story. It was good that it sort of brought a few things back that I didn't like, disturbing things that I've witnessed. But it also reminded me of some of the good things when I lived in Australia. The smells, and the freedom, seeing nature in the wild and that.*

Perhaps this mix of unresolved feelings, recognized as such, is a clue to why SR works in this context. Literature's tough *uselessness* in the face of experience - its power to hold together a life-content without expectation of final coherence – is perhaps what makes it *useful* for those who know they must live without answers or resolutions. Participant T said at interview: *'I always look forward to the group because I knew it will get my mind working and it will help me that way to get through the fog'*.

### **3.2.3.2. Seeing From Outside': Shifting Position, Moving Levels**

#### **3.2.3.2.1.CBT**

One key strategy proposed by the CBT sessions for overcoming negative thinking was making a conscious effort to view experience from a different perspective or level. Reflection upon experience was quite a strong feature, as we have seen, of the CBT session, and there was appreciation from participants of the value of reflective distance. Participant AR remarked:

*It's quite cool that someone is seeing you from the outside, cause sometimes you just get that blinkered view – every day you get up and every day is well either going to be a good day or a bad day.*

At interview, AR said that CBT had helped him to see that in fact -

*I was coping too well, shouldering a lot, trying to go into my pre-pain mode. At some stage something has got to snap. So I've learned to pace myself.*

Participant SH instantly recognized what Consultant JM meant when he spoke of 'pain's

vicious circles' - how resistance causes further pain:

*The avoidance feeds into my low mood, which feeds into the frustration, the anger, the fear.*

At interview SH spoke of how CBT had helped her to make these connections for the first time:

*Your low mood and the pain hold hands with one another, they're interchangeable.*

Occasionally, however, the consultants would directly suggest viewing experience from a different level or perspective, and this sometimes met with resistance.

*Consultant AW: How do you feel about acceptance?*

*Participant SH: You mean accepting that this is how it is and I've got to live my life with it?*

*Participants SY/SH (almost in unison): I'm not anywhere near that, no.*

*Participant SH On a scale of 1-10 I'm probably at minus 10.*

*Participant SY: Me too.*

Consultant AW felt on viewing this exchange that he and the participants understood something different by 'acceptance' at this moment.

*For us [AW and JM] acceptance isn't giving in. It's about accepting you have chronic pain, and that you have to change your life in some way to deal with it. But you don't have to say, 'I've got the pain, that's it, I'm never going to get better'. That's not what acceptance is.*

Consultant AW's hunch was corroborated by SH's response to this moment at interview:

*I don't accept that it can't be helped. I think to accept is almost like lying down and dying isn't it? You accept it, you just let it happen, whereas if you don't accept it, you still fight it a little bit.*

The difference (real or apparent) over the meaning of 'acceptance' is perhaps produced in part by the explicit 'naming' of attitudes or emotions which is an essential part of CBT. (See p. 46 and 3.2.5.)

### 3.2.3.2.2. SR

There is a striking difference between Participant's SH's language, attitude, tone and demeanour, in this example, twelve weeks into SR, when the group are reading Edwin Muir's 'Dream and Thing'.

This is the thing, this truly is the thing.

We dreamt it once; now it has come about.

That was the dream, but this, this is the thing.

The dream was bold and thought it could foretell

What time would bring, but time, it seems, can bring



Only this thing which never has had a doubt  
That everything is much like everything,  
And the deep family likeliness will come out.

*Participant SH: 'I see that 'family likeliness' [pointing at the poem, re-reading and thinking hard for a few seconds] as the similarity between the dream and the reality. Because it's saying the dream was bold and in time it would come to fruition, it would happen. We thought that when it arrived it would be excellent, amazing and change our lives for forever. But ... it was what it was. It didn't do anything. It's like someone all excited at starting their own business – really exciting, but then when you get down to the nitty-gritty of the job – the money's not coming in ...'.*

Group-Leader K re-reads some of the poem:

We thought the dream would spread its folded wing;  
But here's a thing that's neither sick nor well,  
Stupid nor wise, and has no story to tell,  
Though every tale is about it and about.  
That is the thing, that is the very thing.  
Yet take another look and you may bring  
From the dull mass each separate splendour out.  
There is no trust but in the miracle.

*Participant SH: That's saying, in the business situation, you haven't got anything at the minute – don't have any clients, we're not bringing money in. If you look at it from that point of view that's quite [grimaces]. But if you think at least we've given up our boring jobs and been able to do this, this and this. You can separate these things into individual parts. And you can see you've achieved quite a lot even though you haven't got a client yet. You know - you've been successful in setting up a website, you've set up the pathways to money coming in. Look at what's gone right, not what's gone wrong. And trust in that, and it will happen. I mean the reality could surpass the dream.*

SH eventually comes back round to the thought she initially had in relation to that word which puzzled her - 'likeness': that the dream is inside the thing that is, if only we would look. It's hard to believe this is the same person who believed her capacity for acceptance of the need to adjust to her situation to be *minus* 10 out of 10.

\*\*\*

The capacity for participants to ‘flex’ their thinking, to use Participant H’s term, in relation to new material and perspectives, is one of the strongest features of SR. Here are two further examples, relating now to Participant T and Participant P.

Reading Elizabeth Bowen’s short story, ‘The Visitor’, Participant T - as observed by Group Leader K and powerfully attested by T at interview (see below, 3.2.5.3.) - was particularly attuned to the child’s anxiety about the impending news of his mother’s death. ‘*The loss is going to be a great big thing in his little life; I think I’d want to run and hide, want to escape*’. Participant T was also responsive to the boy’s awkward self-consciousness and embarrassment in relation to his emotionally inarticulate father.

But, towards the end of the story, when the little boy expects his father to tell him the terrible news, his father holds out to him instead, a picture-postcard from his aunt, depicting the bay of Naples: ‘Blue sea, infinitely smooth and distant ... Behind the land, behind everything, the clear fine line of a mountain went up into the sky ... This was the blue empty space, Heaven, that one came out into at last, beyond everything.’ Participant T then said:

*I’m thinking about his father as well ... the little boy doesn’t know how his father’s thinking. But I think the father can see, you know, what’s happening with the little boy. It’s like his way of being able to give the child comfort. You really feel for the father don’t you.*

Both in the course of the story, and here in the same single moment - ‘I’m thinking about his father *as well*’ - Participant T is split between his own child and adult selves, his separate son and father roles, and (as we shall see below, 3.2.5.3.) his own hidden and acknowledged needs. But this is not just ‘personal’ thinking or identification with separated characters. Rather, this thinking is in imitation of how the writer herself is dispersed among separated centres of being, effectually separated worlds, who are nonetheless held together in the same world as in the same story. This ‘feeling for’ is really deep imaginative thinking, a creative act.

Another form of flexing is when story or poem allows familiar thoughts and feelings to be regarded in a new way. So with Participant P. Now almost sixty and unmarried, P has had cerebral palsy from birth. An injury 30 years ago, while caring for her alcoholic mother, left her further disabled. Here, the group are reading Thomas Hardy’s ‘The Oxen’ – a poem which invokes the myth of cattle kneeling in their pens on the night before Christmas:

So fair a fancy few would weave  
In these years! Yet, I feel,  
If someone said on Christmas Eve,  
“Come; see the oxen kneel



“In the lonely barton by yonder coomb  
Our childhood used to know,”  
I should go with him in the gloom,  
Hoping it might be so.

Participant P said: *‘Isn’t it more or less saying it’s something we all wish did happen. It’s such a nice innocent story, you **want** to believe it.’* P then related this to *‘having faith in the injections’* she was given, or in her doctor’s ability to hope. The idea of hope is often discouraging for this group, and something about which they are cautious. Participant K: *‘We all know it is dangerous to hope’*; Participant AX: *‘Hope is sometimes a way of controlling people. Hope is not the be all and end all’*. Participant P does recognize that hope is compromised in the context of the poem: *‘something we wish did happen, you **want** to believe it’*. But hope – now called ‘faith’ - is still valued by Participant P, at second thought. Neither the session, nor the poem have demanded that she feel it. The feeling seems at once more brave and more poignantly fragile because it is not something she is directly encouraged or *expected* to feel.

### 3.2.3.3. Thinking about Thinking

A further phenomenon of SR was the strong interest and engagement in thinking about *thoughts*. George Saunders’ ‘The Falls’ produced extensive and sustained thinking in this area. The opening offers the interior monologue of the doubts and anxieties of an unremarkable family man as he walks to collect his children from school.

Was he some kind of worry-wart? It worried him. Why should he be worried when all he was doing was going home to enjoy his beautiful children without a care in the world, although on the other hand there was Robert’s piano recital, which was sure to be a disaster, since Robert never practised and they had no piano and weren’t even sure where or when the recital was and Annie, God bless her, had eaten the cardboard keyboard he’d made for Robert to practice on.

At first there was a strong tendency among participants to ‘diagnose’ the protagonist. *‘He needs diazepam. Hasn’t got mental health problems has he?’ ‘Very OCD.’ ‘There’s people like that, worrying all the time – always having afterthoughts – thinking they’ve said or done the wrong thing.’ ‘He’s letting too much get into him, can’t switch it off.’* Several participants expressed a sense of recognition. Participant JE: *‘You’re anxious, you’re trying to listen to everyone at the same time. Sometimes you’ve about 3 or 4 different voices going round in your head, all coming at you at once.’* Participant P: *‘Especially when you’re on your own –*

*it's like a merry-go-round, always coming back to the same place.'* Participant K: *'I could feel it inside of me - it was getting me all agitated.'*

A second protagonist is introduced (also via interior monologue), jogging along the river at the same time, dreaming of being a writer. This person, participants agreed, was more 'self-assured and self-confident'. But his thoughts also seemed 'exaggerated.' *'Is he a fantasist?'* asked Participant P. Being 'better' in the head actually now looked 'worse', and compulsive thinking more normal. Participant H: *'You never really stop thinking do you? If you wrote all your thoughts down, everything you were thinking, and someone read them, they might think you were agitated when you weren't. You might think you were, if you could hold a recorder to your head, what would it be like?'*

But still, said Participant T, who had been silent and pondering throughout this discussion, *'Has he really got anything to worry about? He says himself "Why should he be worried ... without a care in the world". It escalates, it's like his thoughts aren't real. Does he have time to think about things he needs to? How can he concentrate on something important when he's got all these thoughts?'* It is almost a relief to Participant T, when the protagonist has the 'first thought of the real' as T puts it as he sees two girls in a canoe in danger of drowning. *'For once he's acting on what needs to be done rather than thinking about it.'*

What is interesting about this session is that it helps to satisfy CBT's own aims. The story sets in train, without ever requiring it, a sustained period of 'thinking about thinking' – about the nature, form and quality of habitual thoughts, about what is 'real' or what is 'exaggerated'. The story indirectly fostered here both acceptance of troubled thoughts as normal and a recognition that even 'normal' thinking can sometimes be in need of some form of help.

One critical 'self-help tool' that SR seemed to offer, in fact, was an extending repertoire of models for thinking about experience. One generic sign of this was the way that group members would begin to find connections not only between their own experience and the books, but across the different works, as though these had become a new mental reference point. Sometimes, powerful connections would be found between the story and the poem within a single session. Yeats' 'Lake Isle of Innisfree', as the next section will show, had a particular resonance for participants coming after George and Lennie's dream of an ideal place in *Of Mice and Men*. Over time, however, it was observable that new poems and stories called to mind works previously read together in the group. Participant SY, for example, remembered keenly the protagonist's emotional clinging to the view from her window in Edith Wharton's 'Mrs Manstey's View' in relation to Christina Rossetti's 'Shut Out' which was read many weeks later. These are examples in miniature of what literary reading can offer across a life – a wide range of human models for thinking and being.

But these models of thinking appear to have been powerful for participants because they are not ‘flat’ exemplars for living – step by step how to’s or bullet point strategies - but dynamically rich and difficult to process quickly or ‘pin down’ as one participant put it at interview.

### 3.2.4. Private Spaces

#### 3.2.4.1. CBT

The penultimate CBT session had covered means of relaxing or distracting from the pain (in preparation for formal, specific instruction in relaxation technique delivered by an Occupational Therapist as part of the CBT programme).

‘What do you do to help with your pain?’ asked Consultant JM. There was general talk about opiates, especially fear of their side-effects. Participant SY described how she fainted whilst holding in her arms her ten-day old grand-daughter. There was also some anxious quizzing of Consultant JM about medication and its dangers. The group exchanged experiences of acupuncture, massage, tens machines, marijuana, briefly spoke of how they used rest or distraction (crosswords, gardening, listening to music, painting) as a form of self-help. Participant AR explained that, taking up regular swimming, he has lost 13 stone in weight.

*For me it’s just – once I’m in the water, it’s great. I find on the days when I’ve got excruciating pain, I really give it, pull down with my arms and all that. It’s quite euphoric when you get out. For the first hour after the swimming, I feel absolutely brilliant and then it just [gestures a downwards slope] during the day. I try to go every day, but for the past month, I just haven’t had the get up and go.*

For Participant SH and SY, the main ‘distraction’ is going to work.

*Participant SY. I’m in constant pain all the time like everyone. Someone with a pain score of 8 would normally be in bed, asleep, but I’m running up and down. I’m constantly trying to distract myself from the pain.*

Further conscious ‘techniques’ for not letting pain get the upper hand were proposed by Consultant JM. One such was ‘re-interpretation’, where, it was explained, ‘you try to make the painful stimulus into something else, like the lovely warm glow from the sun on a hot beach’. This was close, participants said, to the ‘meditation’ or ‘tripping out’ which participants had previously tried with only limited success.

There were practical and tangible results from this session and the instruction from the occupational therapist on ‘relaxation technique’ which directly followed.

*Participant A: I do that all the time. I was kind of doing a little bit before. That sort of reawakened me to it. Mainly the breathing, you know, when you sort of breathe in*



*slowly, control it, hold it, just let it out slowly. I tend to do my relaxation when I come back from swimming.*

For Participant AR, these combined practices were crucial to his sense of well-being. ‘*There is a glow afterwards,*’ AR said at interview.

### 3.2.4.2 SR

Notable in SR was how distraction or relaxation ‘techniques’ were individually and involuntarily remembered, without ever being offered, as in CBT, as a specific learning task. There follow three brief representative examples of how the story or poem was a stimulus for participants either remembering or having a sense of peace, relaxed contentment or private space.

(i)The group were reading the opening of Doris Lessing’s ‘A Sunrise on the Veldt’, which describes a teenage boy’s getting up before the dawn, leaving his home-farm behind for the chilly wild, ‘shutting his teeth hard against a violent desire to shout his triumph’:

Suddenly it all rose in him: it was unbearable. He leapt up into the air, shouting and yelling wild unrecognizable noises. Then he began to run, not carefully, as he had before, but madly like a wild thing. He was clean crazy, yelling mad with the joy of living and a superfluity of youth.

*Participant K: Do you know I can understand that, ‘cause where I live, it’s all farmland and on the very very very rare occasion I’ll take the dog for a walk and especially in the winter, it’s icy cold, but you feel quite exhilarated. I really like walking in the dark. There’s no real sense of time. You don’t know what’s going on around you. You don’t need to know. It’s a really good time to reflect, I think, as well.*

*Participant H: I used to love taking the dog first thing in the morning. I liked the feeling of being the first up.*

*Participant T: It’s a sense of achievement – that you’ve grasped the day. And you’re the only one there.*

*Participant H: [Re-reading] ‘There is nothing I can’t become, nothing I can’t do; there is no country in the world I cannot make part of myself.’ ‘I contain the world’.*

*Participant T: He seems to be really living life doesn’t he? He’s not conforming to anything – he’s got nothing to worry about. It’s idyllic.*

*Participant K: Or maybe this is his free time, his free space, when he can do whatever he wants and doesn’t have to be whatever he is in the real time.*

*Group-Leader K: Can you think of a time when you felt anything approaching this?*

*Participant T: I felt that way before I went to school.*



*Helen: I felt that way every time I went camping. I was just out and alive.*

*Group Leader K: 'Out and alive'. Like Tony's 'grasping the day'. [Re-reading from the story] 'the joy of living and the superfluity of youth'. Even when you're older you can find some of that inner freedom.*

What is striking here is that the session made something last – something that the participants variously call 'peace' or 'freedom' or 'really living' - which they 'rarely' have now or which they feel they have lost: 'I used to love'; 'I felt that way before'. Freedom of this kind seems to Participant T to belong to youth before the transition to adulthood, and to Participant H to before the onset of illness. But there was no mere nostalgia about this. 'Out and alive', 'grasping the day'. Group Leader K repeated these utterances instinctively because of their sudden and vital energy, and the way they made the exhilaration H and T speak of powerfully present, just as the story did. No longer in first youth, and severely disabled, they're in touch here with moments, 'free spaces', when they have felt most alive. Participant T, moreover, was reminded that he can indeed still access that 'inner freedom' as a regular part of routine life. *Participant T: [on walking his wife to her night shift]: 'It's peaceful: there's no one around, it's quiet, you haven't got any distractions, you can collect your thoughts.'*

(ii) The passage in focus here is from John Steinbeck's *Mice and Men*. George is depicting for Lennie, the simple-minded friend whom George protects, their dream of a future in which they can cease wandering from ranch to ranch and settle on land of their own:

*'We're gonna have a little house and a couple of acres an' a cow and some pigs. [...] We'll have a big vegetable patch and a rabbit hutch and chickens. And when it rains in the winter, we'll just say the hell with goin' to work, and we'll build up a fire in the stove and set round it and listen to the rain comin' down on the roof.'*

First the text produces a reminder of formal and studied self-help techniques – of the kind which might be learned and practiced in CBT.

*Participant SH: It's like a 1930s form of mindfulness, isn't it? You know when you sit there doing the meditation, your eyes shut and you try to feel your toes in the sand on a warm beach.*

*Participant P: That's what you're told to do when your pain's bad. 'What was your best holiday? - imagine how relaxed you were on that holiday.' And it does help.*

*Participant SH: Just like here [pointing to the text]: you visualize a better world, and a better life and it calms.*

Now, through the effect of its own resonance, the text is stimulating reflection on how reading itself is a form of self-help:



*Group Leader K: [re-reading] ‘They all sat still bemused by the beauty of the thing, each mind popped into the future when this lovely thing would come about.’ What does that feel like?*

*Participant SH: Exciting and content and just ... good! [energetically].*

*Participant H: I don’t think it matters whether it’s going to happen or not I think it’s like their version of like me reading. When I read, I go into the story, I escape, and I’m not thinking about whatever’s going on around me – it’s like it’s a brain-break. I’m not thinking about [lists current distractions] I’m focused on what’s happening in the book. And this is their version of it.*

*Group Leader Kate: Brain-break – is that like another space to be in? Another space that George has brought into the room through his words almost?*

‘Brain-break’ is self-evidently here neither mere escapism nor merely an ‘empty space’. The words Participant H reads from the book, like the words George speaks from within it, are not experienced as mere fiction or fantasy but as creating a powerful alternative reality – like a separate dimension. Participant SH emphasized at interview that when she said ‘good!’, these were ‘good thoughts’.

(iii). In this final example the group are reading W. B. Yeats’s ‘The Lake Isle of Innisfree’:

I will arise and go now, and go to Innisfree,  
And a small cabin build there, of clay and wattles made;  
Nine bean-rows will I have there, a hive for the honey-bee,  
And live alone in the bee-loud glade.

And I shall have some peace there, for peace comes dropping slow,  
Dropping from the veils of the morning to where the cricket sings;  
There midnight’s all a glimmer, and noon a purple glow,  
And evening full of the linnet’s wings.

I will arise and go now, for always night and day  
I hear lake water lapping with low sounds by the shore;  
While I stand on the roadway, or on the pavements grey,  
I hear it in the deep heart’s core.

*Participant T: It’s like it doesn’t matter where you are: your dreams are inside. Sometimes you can go through life and you’re just sort of going through the motions.*



*Participant K: It's your inner dreams – it's the lake of your inner dreams. It's the things that you wish you can do, wish you could go there now.*

*Participant AR: Set the mind free.*

*Participant H: I don't think he's physically going.*

*Participant K: I think it's internal.*

*Participant H: It's like you go to your happy place.*

*Participant T: It could be like a dream that she knows is not gonna be achievable but you still dream it [energetically gesturing].*

When Group Leader K re-read the poem aloud, Participant JO – who, months into SR, had never read aloud before - started to read along with the group leader. 'I like the last verse,' she said, and re-read again the final three lines. 'The water lapping against the shore – it's lovely.' Witnessing this moment at interview, Participant JO said:

*Oh yes I remember that yes. I did love it yes. I just love that poem, that part. The waters you know yes, and the waves. I thought it was a very restful poem. I thought and I couldn't resist reading it myself. I couldn't you know it really got into me really.*

It really 'got into me' is JO's way of describing how the sensory subject, mood and rhythms of the poem, especially thus read aloud, transmitted themselves to her almost biologically. The half-physical, half-incantatory effect of the poem was felt by others:

*Participant H: Very restful isn't it. And when you relax it does drop on you, doesn't it? From your head, down your body. If you're very stressed it takes a few waves till you relax. You do feel it from top to bottom. Stress builds up, relaxation drops down.*

*Participant T: [re-reading] 'I will arise and go now, for always night and day' – It's like the rat race and all the usual sounds just fade away - just left with your thoughts, gone deep into yourself.*

*Group Leader K: Your own Innisfree.*

*Participant T: It could be like a form of meditation like when you go into yourself. Not really aware of anything around you. That could be why this group is good. It's a distraction from everything around you and to a certain degree from your pain.*

*Participant H: I think there's a big difference between us at the end and at the beginning of the group each week. 'Cause we all come in quite chatty, go out chilled. You let go a little bit don't you?*

*Kate Group leader: So we've been to Innisfree this afternoon?*

Participant P said at interview, reflecting on this poem, and the benefits of SR in general, that she always feels relaxed and gets a better night's sleep after the reading group on a Tuesday:

*I have a good GP and he is really really great and [Consultant AW] can give you all these injections. But sometimes you just need something to take it away.*

Participant T, who said he always found it difficult to read on his own - *'I felt like reading a book was a waste of time because I couldn't take it in'* – spoke at interview of the 'uplift' he feels after attending SR:

*If you are studying a poem or a story you can get these pictures in your mind sometimes that you wouldn't normally get. And erm ... you can sort of take them away... you know, if you try to relax or you know when you go to bed of a night-time, you can have that picture in your mind that you got from the poem or story. It is just really good. It is even away from the group. What you have tried to absorb can come out later or help you as a distraction from all these things spinning round in your mind that you want to get rid of.*

### 3.2.5. Finding A Language

#### 3.2.5.1 Naming

##### 3.2.5.1.1. CBT

In CBT, said Consultant JM,

*We try to validate the pain. A lot of people have been told it's all in their head - we need to get that idea out of the way.*

As we have seen, CBT encourages the identification of emotions suffered in response or in relation to pain. Quite a lot of the names are (helpfully) supplied by the CBT facilitator – fear, guilt, frustration - as a way of helping patients to think about their somatic condition rather than being simply subject to it. This process was greatly valued by CBT participants, not least because they feel some pressure to name their feelings to others:

*Participant SH: When I had an assessment [for disability benefit] in my home, the person just couldn't empathise. They have their own terminology: is this chronic illness or is this mental illness – that's what they want to know. There are no grey areas. So they'll lump you into one or the other. And it's frustrating because you can't accurately describe what is wrong with you.*

*Participant AR: I always used to struggle when a doctor said 'Describe the pain' or 'Describe how you feel'. Describing it to myself, I struggle. I would say 'It kills me', but then you have to look for ways and means to tell other people – it just becomes a mish-mash.*

*Interviewer: When you are looking for a way describe how you feel, is that because you want to be able to say it to a doctor or someone assessing you, or is it for yourself as well.*

*Participant A: It's both – definitely.*

The consultants are aware, nonetheless, that their ‘didactic’ approach can tend to impose a vocabulary and may even begin to limit its range. Nouns like fear, guilt, avoidance might be essential not only as a first step in recognition and acceptance of a difficulty, but in externally ‘holding’ damaging inner emotions. Yet there is equally the danger that these objective ‘thing’ words, through public repetition or familiarity, can become an automatic language and default attitude which hide the suffering reality which they contain. As with the word ‘pain’ itself when it becomes a settled part of one’s mentality, there is a danger that these definitive names can impoverish not only one’s language but one’s sense of oneself *subjectively*.

### 3.2.5.1.2. SR

There were repeated instances in the reading group of participants probing emotional states rather than taking them simply for granted - findings which, again, are consonant with the quantitative results which showed far greater diversity and complexity of emotion in SR as compared with CBT. The issue of guilt, for example, came up – albeit in a very distinct (sexual-emotional) context - when the group was reading Carol Shields’ short story, ‘Mirrors’, a complex tale about a married couple, now middle-aged, who have always chosen to live without mirrors during the holidays at their summer house. They arrive at the house soon after the husband has had a secret affair with a younger woman:

His wife danced through ahead of him ... She always felt lighter at the lake, her body looser. This lightness, this proof of innocence, doubled his guilt. A wave of darkness had rolled in between what he used to be and what he’d become, and he longed to put his head down on the smooth pine surface of the kitchen table and confess everything.

There was one comfort, he told himself: for two months there would be no mirrors to look into. His shame had made him unrecognizable anyway.

*Participant AX: Most of us look in the mirror for a physical reason; for him it’s a psychological thing. Oh ‘this is what I’ve done to my wife’. Facing the mirror reminds you what you’ve done, and that’s a continual thing.*

*Participant H: Not looking in the mirror is one way of not facing his shame. You don’t want to see that disappointment looking back at you.*

*Participant P: Feeling it and seeing it in his own face are two different things aren’t they? When you look in the mirror, you are seeing what other people see. You feel the guilt inside and you think other people will see that in you. Seeing it makes it real. You can’t close your eyes and pretend it isn’t happening.*

‘Guilt’ – the key noun of emotion in the passage - is successively replaced by ‘a psychological thing’ or ‘reminder’, then by ‘shame’ and then, more surprisingly, by

'disappointment'. The shift to the latter is accompanied by a shift from 'he' to 'you, - almost a substitute for 'we' in this instance (see above, 3.2.2.2., p. 40). The experience of the emotion, as the group more nearly approach it - vicariously yet almost in the first-person - is not simply one nameable thing here: indeed, it is *two* 'different things', says Participant P, according to whether you 'feel' or 'see' it - 'face' it, that is, as if it were an external judge. Moreover, guilt seems to have a different manifestation again for Participant P, in a later session. In relation now to *Of Mice and Men*, P says of Carlson's wiping his pistol with a cloth - when he has shot dead Candy's dog at Candy's request - 'cleaning his gun is a way of cleaning his guilt: it's atonement'.

Careful defining of emotional states was a common feature of the SR discourse. When, in *A Christmas Carol*, for example, Scrooge approaches a shrouded corpse, and feels 'a secret impulse' to disclose the face, Participant T says:

*That impulse is like a trigger to say 'I know what this is'. Secretly he knows the body is him, but if he lifts the sheet to look he's got to admit it. **Knowing and admitting are not the same.***

When Scrooge says of a young carol-singer, 'I wish ... but it's too late now ... I should like to have given him something: that's all' -

*Participant JE: Regret isn't it.*

*Participant K: I don't think it's regret: I think he (PAUSE) realizes what he's become.*

*Participant H: Is it realization **through** regret?*

In this painstaking definition and re-definition of the emotional field generated by the text, familiar nouns and verbs – admit, know, regret, realize – begin to have a new moral power and emotional 'size'. This is in imitation of Charles Dickens' own language in *A Christmas Carol* where common and 'tiny' goodness is made to matter again.

At other times, words were found to have meanings or associations which were opposed to their customary or default sense. When George kills his friend Lennie at the close of *Of Mice and Men*, the act is not violence but 'love':

*Participant JE: He loved him, he saves him all that pain.*

*Participant K: That's quite a deep love in a sense because he's spared him.*

When Participant H instinctively puts together the deaths of Tiny Tim and Scrooge (see p. 32) she says:

*They're different because Tiny Tim was loved, and Scrooge was so – you want to say 'Scrooge-like' but it's hard to say when you're talking about the person Scrooge. The word has become part of our language – you know, it's an expression we all use and we all know and understand but you've got to be a bit more - specific - when you're talking about him, the man.*

*Participant P: Yes, he was the first Scrooge.*

There is important work going on here of rescuing a stereotype from reductive sterility and recovering its individual or original meaning. Words often have this fresh quality in SR – either through the recovery of ‘first’ meanings or through the discovery of vital new ones. So, when the group was reading R. S. Thomas’s poem, ‘For These’: ‘I ask’, the speaker says -

neither too late

Nor yet too early, for what men call content,

And also that something may be sent

To be contented with, I ask of Fate.

*Participant K: I don’t know whether you can remember a time when you’ve felt content.*

*Participant AX: Don’t we feel content when we’ve had - when you’ve been in real pain, and it’s going on for hours and hours and hours, then it goes away. Oh it’s a real lovely feeling that.*

*Participant SY: It’s a happy feeling. Somebody who hasn’t had pain wouldn’t understand it.*

*Participant T: [re-reading] ‘neither too late nor yet too early’. Could it mean he’s not ready for death maybe, because while you still want something you’re living aren’t you? So if you’re still living maybe you’re not content. Can anyone give an example of when they’ve actually felt content: you can be content maybe briefly can’t you? To be content all the time, I don’t know whether that’s possible really.*

Here, contentment is not held forth as a straightforward aspiration in a life: rather, it emerges anew first as one of the privileges of chronic illness (*‘it’s a real lovely feeling’, ‘It’s a happy feeling. Somebody who hasn’t had pain wouldn’t understand it’*) and then as a kind of death-in-life: *‘if you’re still living maybe you’re not content ... To be content all the time, I don’t know whether that’s possible really’. ‘Perhaps it’s not possible,’* said Participant T at interview of this moment, *‘if you’re really still alive’*.

These may not be ‘original’ thoughts. But they are not stale, tidy generalizations or truisms merely: rather they are thoughts which are felt or realized as if for the first time by coming emergently through participants’ immersion in the vital and individual experience of the protagonist or poem.

### 3.2.5.2. Negatives

#### 3.2.5.2.1. CBT

The personal stories – like the discourse generally - in the CBT sessions were often characterized by a language of lack. Even where stories were being told for the first time in

the group, there was a sense that their implicit influence was already rigidified in some way, in danger of confirming stasis rather than encouraging change or movement, and reinforcing perceptions of self which were already established or ‘fixed’:

*Participant SH: My little boy sees active Mummy and then sees sleepy Mummy and then he'll go, 'Oh you're being lazy today aren't you?' And that in itself is not very nice. He doesn't seem to understand and realize ... I don't want my son thinking that I'm just lazy.*

*Participant AR: The family call me, I'm the irritable bugger now.*

*Participant SY: I can't be sick. My mum and dad can't see that I'm not well. It's not within their parameters of what they perceive me as.*

Consultants AW and JM see part of the task of the pain programme to get sufferers out of these rigidified mindsets. But they are aware, in part through re-visiting the sessions on video and in transcript form, that a language of ‘subtraction’ persists over the sessions.

*Participant SH: I agreed to go to an occasion with some friends about 6 months ago, but then, as it got closer and closer, and I couldn't sleep, stressed about it day and night, worrying I was going to let myself down. I very very very very very nearly didn't go.*

*Participant SY: When my son got married. I got myself into that much of a state I was unwell all day at the wedding. When everyone's there, you don't want to be there really.*

On one occasion, when Consultant JM was asking about people's methods for distracting themselves from pain, Participant SH said.

*I take more painkillers so as to be able to work. I always loved my work – catering; it was my life. I came out of an extremely abusive relationship and was free for the first time in eight years. Now I've become trapped by something else. If I could switch it all off and not worry about having to get up and go to work that would be better. But financially it would be crippling. So I'm sort of semi-crippled one way or the other but at least we're living.*

*Consultant JM [concerned]: Crippled is a very strong word.*

The consultant is understandably a little alarmed here. ‘Crippled’ feels too negative a word for SH to apply to herself – especially in view of that thought ‘If I could switch it all off ... that would be better’ - and it is a ‘name’ which JM would responsibly wish to discourage SH from using in relation to her disability.

### 3.2.5.2.2.SR

The word ‘cripple’ is used by Participant SH again in SR - in relation to Lennie in *Of Mice and Men*. ‘He sees himself as a cripple’ she says. ‘That’s because others see him as a cripple,’ says Participant P (herself disabled from birth). The group comes back to some of this thinking when Crooks explains to Lennie that he can’t play cards with the other farmhands because he’s black. ‘Crooks scowled, but Lennie’s disarming smile defeated him.’

*Participant SH: That was lovely that. Lennie doesn’t see him as black, he sees him as a person.*

*Participant P: Lennie doesn’t see anyone as anything different. He hasn’t got the venom.*

*Participant SH: Yeah, Lennie sees everyone as equal I think and I think that’s because he doesn’t have the - intelligence to actually know the difference. Not that stupid is really the right word. He doesn’t see him [Crooks] with the stigma that everybody else sees. He doesn’t know that he should have prejudices.*

*Participant AX: It’s a child’s mentality. Must be nice to be like that – like a permanent child.*

*Participant P: But vulnerable – people take advantage, don’t they? Crooks can talk to Lennie about his childhood when he was happier, because they’re both outcasts.*

*Participant SY: Yes. Crooks is in that place where he can talk to Lennie and say things he wouldn’t say to another white man.*

*Participant P: He wants to talk to someone who isn’t going to remember and understand.*

In this working through of the significance of Lennie’s ‘crippled’ state and status, all that Lennie ‘hasn’t got’ (the ‘venom’, the ‘intelligence’) is turned into something other than mere lack – something closer to a virtue. Lennie’s disability, without ever ceasing to be a weakness and vulnerability, is recognized and valued for being not just a *disadvantage*: there is a plus here as well as subtraction.

This alternative valuing of ‘not having’ is echoed in the different ways in which negative syntax occurs in SR as compared to CBT. In CBT, negative formulations characteristically have the structure ‘I don’t’, ‘I can’t’, ‘It’s not’. The instances which follow concentrate on the representative example of Participant H. Though this participant was not in the CBT group, she is an important test case for studying ‘negative thoughts’, given that her health condition deteriorated markedly during the course of SR, and her life circumstances were at the same time adversely affected by a reduction in her disability allowance.

Here is a cluster of five examples here, spread across the period of the group. In this first example, Participant H comments on this moment from the opening of *A Christmas Carol* where Scrooge is first spooked by the vision of Marley's ghost:

Before he shut his heavy door, he walked through his rooms to see that all was right. Nobody under the table, nobody under the sofa. [...] Nobody under the bed, nobody in the closet, nobody in his dressing-gown.

*Participant H: I like the way he says 'Nobody ... Nobody' instead of saying 'He checked under the bed'. There's an emptiness to nobody isn't there, somehow. Like there should be a body there, but there isn't. I don't know, it seems more absent, and empty space.*

*Participant T: So this is how he feels, isn't it? It's describing his feelings? Loneliness maybe?*

At interview, Participant H herself was struck by her manner and tone as she said, 'I like the way':

*It is actually something that is not that likeable, it is not like a good thing. His emptiness and his loneliness, is actually quite a bleak subject. I think it's because 'Nobody' gives you the atmosphere and the emotion, without having to detail every little part of it. It gets it all across - all in one way.*

H noticed at interview how frequently she was, as she put it, '*knowing things by what they are not, not by what they are*'. Of Scrooge's treatment of his nephew, who welcomes Christmas 'as the only time ... when men and women seem by one consent to open their shut-up hearts freely, and to think of people below them as if they really were fellow-passengers to the grave and not a race of creatures bound on other journeys', Participant H said, intuitively extending the text's metaphor, '*it's as if Scrooge isn't even on the train*'. And she added: '*But he is – we're all moving toward the one thing we can't avoid*'. Of Scrooge's shutting out the world, and repelling human contact, Participant H said, '*he's become like the ghost really*', and of Scrooge's trying to hide from the light: '*He can't unsee the things the shadow's shown him*'.

In these examples, the negative is not opposed to the positive but an indirect and unstraightforward way of getting to the heart of the matter: 'He isn't even on the train'; 'He can't unsee'. These are deeply literary formulations not only because they are creative in their use of metaphor and even in the coinage of a new word ('unsee'), but because they find meaning in the 'un's' – the places often ignored by conventional language or definitive category.

So for example, when the protagonist in David Guterson's story says, on killing a bird in pain, 'That's all it is. That's all there is to it, Bud', and H struggled with how the

difference between life and death is, incommensurately and simultaneously, a tiny and an immense change:

*Participant H: It's that fine line between life and death [drawing an imaginary thread between her fingers]. You either are or you aren't. And that is all there is. But – I don't know. There's more to it than 'That's all there is', 'You aren't'. It's a bigger issue than that.*

So, too, in this example, when, some months later, the group are reading Rainer Maria Rilke's 'Evening':

the lands grow distant in your sight,  
One journeying to heaven, one that falls;  
  
and leave you, not at home in either one,  
not quite so still and dark as the darkened houses,  
not calling to eternity with the passion  
of what becomes a star each night and rises;

*'It's about everything that isn't,'* Participant H said.

*There's everything you can be and there's everything that you're not, and they're both there at the same time. That's why it's called "Evening", not "Night".*

Participant H likened the scene of the poem to the time just before sunrise when she most likes to walk, 'getting up before the world'.

*'It's a space between dark and light - my brain-space. I get that from reading too.'*

This latter example is a clue to how H's intelligently creative use of a negative syntax – 'You are or you aren't', 'It's about everything that *isn't*' – is much more than a technical matter. What really generates this syntax is the inhabiting, in reading, of an alternative 'brain-space', as H calls it - a dimension of thought between ordinary fixities.

Participant H herself was eloquent about what is really at stake here, when the group were reading of Scrooge's confrontation with his own past self in *A Christmas Carol*. H was at first keenly aware of the challenge of this new level of vision or perspective:

*When we said at the beginning, does he know he's changed - you can see the difference, now. He's looking on it, he's not in it. It's different when you're looking on.*

When Scrooge is forced to 'look on' at his own corpse, it is H who recognizes that this kind of thinking is not only new and hard but almost impossible:

*Wouldn't you explain yourself - alive? Like, he doesn't want to see himself as a corpse, would any of us want to see ourselves - gone? It's not something that we naturally do. It goes against all our basic instincts to consider ourselves dead, gone*



*or forgotten or anything like that. You wouldn't naturally assume that the corpse is you. It's against your primal wiring I suppose. It's not a natural way to think.*

Here, H not only but practices ('Wouldn't you explain yourself - *alive?*') but describes the kind of non-'natural' or non-default thinking which we have seen reading producing in her. It is a mode generated by literature's own capacity for making possible a perspective or 'space between' solid matter that is not usually available in ordinary life.

Helen's description is the equivalent, from within the reading group itself, of Consultant AW's and JM's hypothesis as to why reading can be particularly beneficial to chronic pain sufferers.

In the first session of CBT, JM had explained in lay terms how there is a strong neurological argument for using psychological therapy with pain patients. To re-quote:

*When we look back through case notes for people who have been coming for a long time, we often see that we're treating a different area to the one we were concerned with originally. That's because the pain wiring system has set itself up and the body's joined in with it, recruiting other nerves into this pain pathway and firing off messages to the brain. But the body can 'unjoin' again. Nerve blockers (drugs) are one way; CBT is another – by getting the brain to send new messages back to the body.*

Witnessing selections from the SR sessions at interview, AW saw the potential for those 'new messages' to be both more frequent and more galvanically vital in SR. He also felt the 'rewiring' might affect a part of the brain that is particularly neurologically significant in chronic pain.

*Consultant AW: This is a personal thought: there is some evidence but not a lot. I think a lot of chronic pain is determined by how your frontal lobes are functioning. Certainly people with chronic pain have much less neuronal density in their frontal lobes. Of course that is where is your personality is, and so you can see the pain causing a sort of more inner or inward looking. The fact that reading must work on that sort of level, the frontal lobe personality level - possibly this is freeing up the frontal lobes a bit. If so, there will be a sort of virtuous circle going on, in place of the old self-reinforcing and diminishing one. The reading will increase wellbeing and, therefore, that will increase the appreciation of reading the literature and so on.*

One can almost recognize the 'freeing' from default wiring in those tiny instances when, for example, Participant P sees the possibility of change, or when Participant SH says that Lennie and George's dream of a better life feels 'Good'. Something like that dynamic expansion is palpable here, when SY is reading the final stanza of Rilke's poem, 'Evening'. The distant lands, the poem concludes,



leave you (inexpressibly to unravel)  
your life, with its immensity and fear,  
so that, now bounded, now immeasurable,  
it is alternately stone in you and star.

SY ‘loves’ the words ‘immensity’ and ‘immeasurable’ in the final stanza, without knowing why. ‘*What is immeasurable?*’ she asks. So also, when JE reads the same poem through the eyes of the protagonist (the damaged Vietnam veteran) of David Guterson’s story, ‘Wood Grouse’, which was read in the same session. ‘*The poem reminds me of what that soldier in the story must be feeling. It’s like someone’s lying there and there’s just peace. They’re not hearing the war. Just looking up at the black sky and it’s clear.*’ Reading the poem through the broken soldier’s eyes is an important imaginative leap taking JE into what she called the ‘limbo’ world of the poem, between fallen and saved, ‘not at home in either one’.

But it seems crucial that these leaps happen not simply in relation to the new literary material, but in relation to old or stored personal pain – as is clear in these two connected examples concerning Participant P.

Emily Bronte’s poem ‘Domestic Peace’ begins:

Why should such gloomy silence reign,  
And why is all the house so drear,  
When neither danger, sickness, pain,  
Nor death, nor want, have entered here?

We are as many as we were  
That other night, when all were gay  
And full of hope, and free from care;  
Yet is there something gone away.

*Participant P: Do you know what it reminded me of, the feeling after my mum died, when she’d gone from the house ... when she went something went with her, a feeling.*

Some weeks later, something in the area of this personal memory is re-fired by Christina Rossetti’s poem ‘Shut Out’:

The door was shut. I looked between  
Its iron bars; and saw it lie,  
My garden, mine, beneath the sky,  
Pied with all flowers bedewed and green:



From bough to bough the song-birds crossed,  
From flower to flower the moths and bees;  
With all its nests and stately trees  
It had been mine, and it was lost.

[...]

So now I sit here quite alone  
Blinded with tears; nor grieve for that,  
For nought is left worth looking at  
Since my delightful land is gone.

A violet bed is budding near,  
Wherein a lark has made her nest:  
And good they are, but not the best;  
And dear they are, but not so dear.

*Participant T: All the nice things you can't have, you know you can't have, though you can see them.*

*Participant SH: Like prison.*

*Participant T: Like death.*

*Participant P: Is this a graveyard or a garden? It gives the impression it's both. It reminds me of a cemetery. It reminds me of going there on father's day and there's so many flowers and you see the bees and see the moths and you see the birds trying to get the flowers. I know it's a morbid thing. But it's not morbid to me – I like to do it. Going to the cemetery to my mum and dad.*

*Group Leader K: What's she's looking at from behind the iron bars does look beautiful doesn't it – 'My garden, mine, beneath the sky,/Pied with all flowers bedewed and green.'*

*Participant P: [re-reading from the middle of the poem] 'Give me, then,/But one small twig from shrub or tree;/And bid my home remember me/Until I come again.' It's like paradise.*

*Participant T: [quietly] Paradise lost.*

Contextually, T's words do not correct or betray P's thought: rather they complete it, rhyming in with her thinking, like a poem concluding itself. In this instinctive leap, what is 'negative' – something lacking or lost – is suddenly transmuted into a precise and almost beautifully fulfilled idea. It is perhaps in thus working on personal matter that can seem merely hopeless,

redundant or regrettable that the galvanic power of SR - its capacity to create a virtuous circle in place of a vicious one - is most essentially transformative.

### 3.2.5.3 Inarticulacy.

In Edith Wharton's short story 'The Visitor', the group read of a young boy whose mother is dying, and who doesn't want to hear the news that she is dead. He hears a large clock 'tick out':

Sixty of these ticks went to make a minute, neither more nor less than sixty, and the hands of the clock would be pointing to an hour and a minute when they came to tell Roger what he was expecting to hear. Round and round they were moving, waiting for that hour to come.

*Participant T: I used to look at the clock when I was a child and try to will the second hand to stop. [Laughs quietly]*

*Group Leader K: Why, was that because of something you didn't want to happen?*

*Participant T: Yes [rubs his face and looks down, no longer smiling]*

Momentarily, silence yawned open around T's 'Yes'. The silence felt full of something amorously unnameable – bigger and emotionally too powerful to be fitted into words.

Seeing this moment at interview, Participant T said:

*At that minute I feel a little bit upset. I felt as though I wanted to cry but I was laughing instead. I think maybe I had some understanding of how the child felt because I remember how I felt [PAUSE] I suppose it was completely different to the situation in the story but sometimes things unlock - open certain doors, those doors to maybe old memories that you - you prefer to keep locked shut. He didn't want to know. He would rather have those doors shut.*

There is a strong sense that T's thoughts and feelings at this moment lie outside or anterior to the purview of self-regulation and conscious control. For that reason they would be beyond the reach also, perhaps, of the standard precepts of a therapeutic programme. CBT's emphasis is on mind over matter. Here the opposite happens. Something subterranean, some residuum of experience seems unconsciously to seek, in these few brief seconds – 'Yes' - a form of realization.

Later in the interview, Participant T talked of the trauma of being subject to a long period of abuse when he was young:

*The way things were when I was a child. Everything was a secret really. [...] I was just locked into what was going on and in a dream world and I suppose the dream world part of it was like an escape from the reality of what was actually going on at that time.*



*And probably I felt safer being in a dream world and I probably didn't want to know. I didn't really want to know what was happening to me.*

The story did not simply stir 'painful memories', T said. *'The pain is still there, locked away inside.'*

*Interviewer: I am just thinking as well that ... those two things, the chronic pain and the trauma of the abuse they are both sort of hidden things aren't they?*

*Participant T: Yes. No one can ever see them.*

The trauma which T could not bear to face in childhood remains unpurged in adulthood: as the interviewer suggests, it is - like his chronic pain itself - a hidden, 'secret' thing. What T values about the reading group is that he can express some of what is normally 'locked in' or never 'seen':

*I am a very nervous person. I do find it very difficult to express myself normally you know, and I think, I mean, I am not fantastic at doing it but in my own way I can see that the reading is helping me and I am actually having a go, to – to make sense of things. Just to see that there are feelings in the words the way they should be brought out. It helps things, certain things, to stay in my mind whereas otherwise they would be just lost, completely lost forever. Things can be lost forever. So you become incapacitated with this.*

What T's 'Yes' signified was the sudden retrieval of deep personal matter which demanded expression, however minimal and strugglingly inarticulate, in order not to be merely hidden, lost or forgotten. But his testimony also shows how the literary text's explicit, pre-formed articulation might be sufficient in itself: *'Just to see that there are feelings in the words the way they should be brought out.'*

This evidence from the post-group interview gives retrospective power to moments like this, for example, from the final session of the study, where the group was reading the conclusion to *Of Mice and Men*. Lennie, the child-like man, has inadvertently killed the wife of his employer, Curley, and has fled in panic:

The sun streaks were high on the wall by now, and the light was growing soft in the barn. Curley's wife lay on her back, and she was half covered with hay.

It was very quiet in the barn, and the quiet of the afternoon was on the ranch. [...] The air in the barn was dusky in advance of the outside day. A pigeon flew in through the open hay door and circled and flew out again. [...]

As happens sometimes, a moment settled and hovered and remained for much more than a moment. And sound stopped and movement stopped for much, much more than a moment.



*Participant P: There's a stillness. It's frozen. Like when something bad happens – it's a suspended moment in time.*

*Participant AR: It's like slow motion.*

*Participant SY: Lennie's in shock isn't he? He's stunned.*

*Participant T [who had been quietly thoughtful during the early part of the discussion]. I think it's because you can't believe it's happening. You can't take it in. It doesn't seem real. [covers his face.]*

*Group Leader [helping out] Even though Lennie's gone, we're left with the scene.*

*Participant T: We're left looking at that feeling, that atmosphere in the barn. That's the feeling Lennie has got inside himself.*

*Participant P: With the pigeon flying in and the advance of day – isn't that showing you that life goes on? Nature just going about its daily business.*

*Participant T: Life continuing as it normally does. People saying hello and going about their business as if this bad thing hasn't happened. Lennie must be feeling this can't be true, it can't be real. [Visibly struggling to find the words as the group leader notices.]*

*Group Leader K: He knows everything's changed forever. But the rest of the world doesn't. You can't quite believe the world's carrying on.*

*Participant T: They could be talking to you and you don't hear a word they're saying. You could see the world going on as normal but what had happened to you might feel unbelievable, you know, hard to accept.*

Participant T said at interview:

*It is a big problem for me that I can't keep hold of everything, but while I am in that group the way [Group leader K] does it, where we read a couple of paragraphs and then go back and talk about it - it gives me time to come through the fog. Normally I wouldn't be able to do that: I would be lost.*

What the reading and the facilitator demonstrably do for Participant T is 'hold together' two distinct experiences: on the one hand, the feeling that trauma leaves behind 'inside'; on the other hand, the further trauma produced by having to carry on, *with* that inside, as though one were just the same. Yet at no point is this confessionally exposing or explicit. T is not 'put on the stop'. Nobody knows why this resonates personally for him, not even the facilitator. This is what we might call '*implicit therapy*', doing its own work hiddenly in the moment of reading, and only known to have been therapeutic through recognition afterwards.

Here is a final instance of this deep, secret work.

JO, one of the older members of the group, a widowed grandmother, and by far the quietest and most passive, became particularly and unusually animated and in need of speaking out in relation to Elizabeth Taylor's short story 'Flesh'.

A middle-aged married woman, taking a Mediterranean holiday as part of her convalescence following an illness, has an affair with a widower, who had cared for his wife during her 'long, long illness'. When they spend the night together in a shabby hotel, 'he thought disloyally of the dead – of how Ethel would have started to be depressed by it all, and he would have had hard work jollying her out of her mood.'

*Participant JO: I think, with his wife always being ill, I don't think he's really enjoyed - I think this – this is one of the best – he's really enjoying this because he's never had it before. With his wife being ill, and she's so with him, this woman that he's with now. I think he's realizing what might have been, what's he lost really, what he hasn't had.*

Watching this moment at interview Participant JO said:

*I think that is the most I have ever said in the reading group. Yes I have never spoken as much as I did. That is how I know it must have really got to me, the story.*

She repeated the words she used at the time:

*What might have been. Because his wife was so ill and this younger woman, what he is having with her, which he didn't have you know. Could I have had that, with her really ... and now it is sort of gone. And that it is really, you know, what might have been, you know, what might have happened.*

JO then recalled an episode from her youth, when she had fallen in love with an older man, a sailor, who put an end to the relationship when he went away to sea: '*Of course I was broken-hearted: really, really devastated.*' Later he was sorry, but JO herself had moved on. '*Yes, well that's what might have been with me. Had he not finished with me would I have continued with that relationship? And I don't know.*'

This doesn't feel like an account of lost chances merely, but of some potential richness in JO's life partially retrieved if only for the moment. Speaking of herself at another age and stage of life brings out of her someone just as real as the elderly widow who speaks. Something of this vital recovery, we can infer, was what was happening, unconsciously and implicitly, in the live moment of reading within the group. 'It's as though,' said Group Leader K, 'the story touched a vital spring'.

Perhaps a very great deal of what happens in SR must remain thus hidden from view. Perhaps that is also part of its special power.

### 3.2.6. CBT and SR as therapeutic groups.

This section is derived from the evidence of the interviews primarily, where the participants, the consultants and the group leader were asked directly to reflect on their experience of CBT and/or SR. Across all of the interviews and the linguistic evidence, the ways in which the two groups were led and the ways in which they characteristically operated were key distinguishing factors.

#### 3.2.6.1. The Group-Leader

*Consultant AW: Jim and I are quite didactic. We encourage interaction and participation and we get it. We like people to interrupt and talk. But we stand in front of them. We put things on a white board. We are basically imparting information. Everyone is looking in one direction and will focus things back to me and [Consultant JM], for an answer. Whereas in SR [Group Leader K] does the reading and then let's everyone discuss it. It's much more dynamic and fluid.*

Consultant AW's assessment of the group-leader's role and stance in CBT was confirmed by the evidence of the linguistic analysis:

The discussion is, in general, quite involving with consistent agreement, repetition and collaborative overlaps between participants. However, there is a clear distance between the coordinator and the participants. The coordinator is an out-group authority figure. He is constructed as expert and often dominates with expertise knowledge. (SL)

'The two facilitators are working in completely different areas,' said Consultant AW:

*In CBT, we are talking about the understanding of pain, medical facts basically, and practical things – improving quality of life. In this sense, CBT operates on a much more straightforwardly 'intellectual' level. Whereas SR is working at a much more emotional level.*

Certainly, the evidence from participants and from the linguistic analysis is that the role of the facilitator is much more complex in SR.

Among participants, there was general agreement that in both CBT and SR, the facilitator was crucial in creating the 'atmosphere', 'bringing people together' and 'getting the best out of people': 'relaxation' and 'engaging' were words frequently used in relation to CBT facilitation. But in the case of SR the atmosphere was created multi-dimensionally and always in relation to the literature.

#### Reading Aloud:

*'It is not just the way it is written: it is the way [Group Leader K] reads. She is fantastic, she really is. And, it is all there as she is reading, you can feel the excitement in her voice from what she is reading as well. You can feel it deep inside.'*

*'I've never read poetry before. I've connected with the poetry because it is read aloud. Reading it aloud, I don't know, it seems to resonate.'*

*'I sometimes read aloud in the group but only after [Group-Leader K] has read it. I don't like it till she has read it. I'm reading along and already thinking and feeling the poem as she reads.'*

*'It is just cold words on the page until [Group Leader K] has read it. It doesn't have any passion, or really any meaning. It often looks indecipherable.'*

*'When the books are read aloud things become more 3D and more alive. The words, certain words, sort of like jump out at you.'*

*'It creates a stillness and peace in the room.'*

There are three critical consequences of the group leader's expert reading aloud. First, there is the creation of atmosphere ('peace and stillness'). The second is that poetry and fiction, read carefully and caringly, come alive - become accessible - either for the first time or for people whose reading habits have lapsed as a result of illness:

*I didn't think I'd stick it. I've never been a reader. And when I look at myself I can see how hard I'm working at reading in the group. I'm amazed really.*

*I used to read a lot, and then I stopped. When I went to pick up a book my attention span was limited. I would read a couple of pages and then that was it. And I would lose patience with myself. I became more of a skimmer than a reader.*

The third crucial aspect of the read-aloud model for participants was variously described as the power of the words to 'jump out' or be felt 'deep inside' (see above, p. 10). 'It got into me' was (quiet) JO's expression. Sometimes the 'getting in' happened when participants read aloud themselves. On hearing herself (on video) reading aloud 'Mysteriously Standing' (see above, p. 46), particularly the line 'In that field, little Stonehenge of the heart', Participant H said:

*That quiver in my voice is because I was a bit overcome. I felt it – the words - as I was reading it.*

### 'Reining in':



*'Sometimes [Group Leader K] has to rein us in of course. It is not a criticism, but sometimes we go on and on about something which is not related to what we are doing.'*

*'I love the way [Group Leader K] does that you know when we are saying something and she sort of... brings us back. She is brilliant doing it.'*

This a feature noted particularly by the linguistic analysis:

The coordinator makes consistent connection with the text and tries throughout (through successful, intrusive interruptions) to direct the conversation to the fictional story. (Linguist SL)

Consultant JM and Group Leader K reflected on their role as leaders or 'directors' of group discussion thus:

*Consultant JM: Something I deliberately do in CBT if someone's sitting there saying nothing, is encourage them to speak. I get worried about the lack of contribution. You try to encourage them to get involved without embarrassing them or putting them on the spot. That concern just doesn't seem to be relevant in SR.*

*Group-Leader K: I have to guard against the idea that everybody must 'have their say'. I have to bring people in, of course. But I have to trust the book or the poem to do that. That's why I always try to make sure that its presence is felt more than anything else. That way, even if someone doesn't speak often, there's still the possibility that they will be reached.*

Participant JO proved a touchstone for both the SR group leader and the consultants in this respect. Consultant AW: *'JO frequently says to me how much she gets out of SR, so even though she is quiet, she is definitely right in there with it. It actually doesn't matter if she doesn't speak: she's still participating.'* Consultant JM: *'JO says nothing but she loves it. She's in it. You don't have to be verbally participating to get something from it.'*

Group-Leader K seems to be modelling a different kind of 'democracy' to JM's encouragement to participants to become involved:

*Group-Leader K: When people are doing individual thinking work, I try to make a little pause or space around them so that they can have time with it and so that others can appreciate it as well. And hopefully, by noticing what I can do, other people can start doing it - they can copy what I do.*

There is quite a strong sense from the excerpts we have seen that, while the group leader does need to be 'in charge' of the discussion, the group members do more or less co-facilitate.

Sometimes this is through verbal direction ('Do you think it's because ...?', 'Is that why ...?', 'Has anyone ever felt ...?'), but often it is simply by leaving 'space' for others.

### 'Not a therapist'

In SR, says linguist SL, it is 'the text which initiates discussion and triggers contributions,' as distinct from the facilitator doing so in CBT. This phenomenon of the book taking on the expert-facilitator's role - even as the facilitator's role in SR is to enable the book to do just that - is the main feature which distinguishes the SR group-leader from the conventional role of the therapist in the view of participants.

*Participant H: 'When you read something or say something there's no return to the therapist. There's no why, what, when, where, who - 'Well why don't you', 'how did you feel', 'why did you do that'. There is none of that. There is just, in this moment, I feel this and I am thinking about this. This relates to my life at this point because of ... and then that is it.'*

*Participant AR: '[Group-Leader K] listens but she doesn't - therapise isn't a word is it. But she doesn't kind of make it feel like therapy. You don't get sort of a grilling on it, you don't get told what to do next time but you are given that time to explore whatever, you are getting through at that time. You are not asked to relate personally to it: you just do.'*

The return to the book in SR, as opposed to the 'return to the therapist' allows a personal relation which is entirely voluntary and discovered by the participant at their own pace and in their own time, rather than programmatically. It is not that the facilitator does not ask direct questions, however. Sometimes, as we have already seen, she does so to inadvertently powerful effect (see above, p. 74). 'Explicit questions - "How do you feel?" - are, says linguist SL, one key way in which the facilitator draws people into the text. Of course, that is the point. The text is the primary mediator; not the group leader.

But SR seems to strike a very delicate balance - one that can't be stipulated for in advance - between democratic voluntariness and leadership. There are delicate 'pushes' or aspects of guidance or probe. The choice about whether or not these pushes are made seems itself to be almost what might be called a 'literary' one, to do with the quality of human attention to what is going on, a matter of carefully reading what is involved. But, as we have seen, questions such as 'Has anyone ever felt like that?' 'What does that make you feel' are also questions occasionally asked unself-consciously by the participants themselves. Naturalistically and unobtrusively, they partly take over the role of the facilitator at such

times. The co-ordinator's role in SR is a hybrid one – somewhere between leading and handing over.

### 3.2.6.2. The Group

The participants who joined SR after CBT made direct comparisons between the two groups in terms of dynamics:

*Participant AR: What worked in CBT was the informality of it. It was such a friendly atmosphere. It was very frank. But we weren't as animated in CBT as we are in the reading group. Sometimes in SR we are all talking at once, but we are all hearing what everybody has to say. No one is dominating. It's a bit like an opera. The parts will all be singing at the same time, and you have a baritone solo over there and the tenor will come in and they are all singing their own part, like in counterpoint harmony. It's incredible really; it is quite unique.*

Consultants JM and AW were struck by the same phenomenon in SR:

*Consultant JM: They're all coming at things from a different angle. The thought processes aren't identical, the language isn't identical. They're saying different things and thinking different things – they have individual impressions and they're finding their own way. But it feels like it's all coming together. There's a clear bonding. A kind of mood. I suppose they're all in the same place in a way, emotionally, because of the book*

*Consultant AW: It's really dynamic isn't it? I didn't expect it to be as dynamic and animated. And yet sometimes you can see the dialogue is almost in the same rhythm as the poem isn't it? Their minds are operating along the same lines as the poetry.*

This diversity and heterogeneity, which is nonetheless held together by the emotional resonance or syntax of the literary work, explains the linguistic finding that:

In CBT, there is more construction of in-groupness between participants (through agreement, repetitions and collaborative overlaps) compared to SR where there is not much agreement or collaborative overlap between participants. (Linguist SL)

In fact, to judge from the testimony of SR participants, the 'in-groupness' in SR – what AR calls 'harmony' - happens at a much more implicit level.

Here is how Participant SH compared her experience of CBT with that of SR:

*Participant SH: You know you are not on your own. That's what I got from CBT. And [the consultants] were very very supportive. But it was the medical professionals there, and the patients here. Try as best we could, it was still a 'them and us' scenario. Where in the reading group we are all equal.*

Asked to expand on this sense of equality, SH said:



*It is very different to normal having a chat with someone. And I think it is because as we talk through different books, poems, short stories whatever it is, we all at different times - we open ourselves and we are vulnerable. And we share very personal things. And it is not very often about pain - funnily enough it is very rarely about pain. But there is that - we open ourselves to the group and say look this is how I am feeling. And everyone is ok with that and there is never a judgement. There is never the therapist, in the room if that makes sense. We don't necessarily all bare our souls every week, erm... but at different times we bring different things and I think that, there is like an unspoken bond between us because of that. And maybe that is why we pick up on each other's cues and things because, because we have been vulnerable and we have opened ourselves to each other and say you know, this is the real me. Which you don't do when you are just having a cup of tea. You bump into someone at Sainsbury's you don't kind of bare your soul. The only people you do that to is very close friends, partners and therapists. But there is always a, a comeback to whatever you say whereas in this there isn't. It's not leading towards anything. You may never talk of it again, because it won't relate to the next bit you're reading.*

This offers a back-fill to what every SR participant said, in their own way, about 'an unspoken bond':

*'We're not a group, we're a little team you know.'*

*'A bit like we are brothers and sisters maybe.'*

*'I feel like I am part of a little family.'*

*'We're a little community, a little serious community.'*

*'It's quite telepathic really.'*

Interestingly, only Group Leader K connected the distinctive quality of the SR group experience to participants' common suffering of chronic pain:

*There is a kind of intimacy - a kind of, taken as read intimacy, which creates a - carrier almost for what is going on in the group. That bond of intimacy, which isn't always explicit feels, quite palpable in the group. It is almost like a sort of intuitive shared experience that they have had, though they don't necessarily know the details of one another's pain. It is bodily, at a cellular level almost. That sounds a bit strange but the physicality of being in the room, the physicality of suffering or living with the pain, and thinking with the pain. There is some kind of physical bond which is, which feels different to me, than in other groups that I have led.*

The common sharing of pain seems more powerfully to foster a sense of belonging when it is thus implicit in SR, than when it was explicit in CBT (valued as that explicitness clearly was). But Group Leader K felt that it mattered that the explicitness in relation to pain had already happened, either in CBT or, for other participants, in other therapy groups or counselling:



*That type of talk where people speak in a very direct way about their situations had perhaps already happened for most people in the group. That had been got out of the way, off the agenda, and we didn't need to revisit it in quite that form again.*

### 3.2.6.3. Is SR a therapy? Should it replace or complement CBT?

This final section, then, looks at the relation of SR to the therapeutic agenda of CBT (and indeed other psycho-social treatments). It looks at two specific and distinct participant experiences of a CBT/SR package for chronic pain (those of SH and SY), but also draws in the relevant testimony of all participants in the study.

SH underwent CBT before SR. Of her CBT experience, SR said there had been some very tangible practical benefit:

*From these sessions with the doctors I have actually had my medication changed at my request because one of the medications erm... I was taking something called gabapentin which didn't agree with me and I didn't think it was having any effect. Since then I have seen the pain doctor and they have weaned me off gabapentin and put me on to another one, which worked in the same way.*

SH was aware, too, of how CBT had better helped her to cope with her pain, in mind as well as in body:

*In the early stages, when we are writing everything down on the flip chart, and asking about how it feels, it made me think about what hurts more, and I think that coupled with going on the new medication, I can feel that the general aches and pains aren't as painful now. But now I am finding that the knees hurt more, because it is not that the knee didn't hurt before, it is just that only the knee hurts where the whole the leg hurt before. So that, it is like... it is like the noise has been turned down, and only the things that really hurt are now being heard, where everything hurt before – general aches and pains which were really bad.*

'From an educational point of view,' SH said, 'I got a lot out of it':

*One was a course to teach us what pain was, and, you know it was a really massive thing to realise that most of our pain is emotional.*

What really worked for SH in SR, as we have seen, was that the kind of speaking and listening that goes on in the reading group is unlike any she has found elsewhere, especially as part of 'treatment':

*When you go to see your GP, I feel that they listen to the very first thing you say and latch on to that, but don't listen properly or fully because as soon as you have said the first thing, they have already started typing; they are not listening to everything else you say. In SR everybody listens to what everybody else has to say.*

SH reiterated her sense that she had *'benefited a lot – definitely'* from the silent emotional sharing within SR. *'There have been times when people have cried or got upset and there is like an unspoken comfort reaching out to them.'* But she said:

*It's not just emotional. It takes your mind to a different place for two hours once a week and that is a massive thing when you have so much going round your head. Often those thoughts are whirring around and have nowhere else to go. At least in a reading group you can talk about them. And I sometimes get a different way of thinking you know from sort of looking at something from a different point of view.*

Consultant JM and Consultant AW felt that the evidence of SH's testimony was that CBT and SR might best be regarded as a treatment 'package' for chronic pain.

*Consultant AW: CBT gives pain sufferers a new way of looking at their pain, and that's something that can be built on. SR helps people to build on it particularly well, I think.*

*Consultant JM: Some of the things we're trying to achieve in CBT – there are things you plant the seed of and they come out in a different way, in an emotionally realised way in SR. You might think it's lost because the CBT course is over, but actually what SR seems to do is either bring things back or make them more individually 'have-able'.*

The example that 'shouted out' to JM was when participants were talking about a pain threshold.

*It actually came across – somebody made the point – that that invisible threshold can change. I spend hours trying to get people to understand that. What I try to bring out, is that where that threshold is – coping, on the one hand, or having a really bad time and not coping, on the other – there are extrinsic things that have absolutely nothing to do with pain. There's a whole heap of other things that go on that make it worse for you. It's that kind of broad and rounded understanding that SR helps to give.*

*Consultant AW: It's really that CBT is a good preliminary to SR – like a primer.*

This conclusion was verified by the experience of SY, the only participant who became part of the SR group *before* taking part in CBT.

*Participant SY: I don't know whether I was fully involved in CBT do you know. I wasn't too sure what I was supposed - I mean I wanted to go in it but I wasn't too sure that I understood what we were doing, why we were there. It was of no consequence really in some respects because nothing has happened from it. It felt really negative. I was negative. I don't know what it was. I went into CBT with precon... a preconception that this was going to help me with my pain and blah this and blah that and I went in and I come out with nothing.*

Asked how this compared with SR, SY said:

*I like the atmosphere in the room you know. I have absolutely thrown myself into the reading group 100% as if you can see. What is the word, whole-heartedly. I threw myself into CBT about 10%. Maybe the problem with CBT is that it is not personally engaging. It has to concentrate on what is wrong. And you're expected to talk about what is wrong.*

The effect of what SY calls 'personal engagement' or 'whole-heartedness' here was crucial part of what was therapeutic in SR for SY

*when I throw myself into it, my anxiety goes away, my pain recedes. I feel relaxed and happy*

as for most participants:

*'Most of the time you are there you sort of forget. You get that involved in what you are reading or in the conversation you forget, 'my back is hurting me today'.*

*'You forget about yourself. You forget about who you are, and the pain, you forget that. But in another way, you remember things in a really deep way.'*

*You sort of disappear into the story. It's not doing away with your pain, but you are getting involved so much in the story and in what people are saying, the pain sort of numbs itself.'*

This form of relaxation or thoughtful 'forgetting' has real and tangible impact upon the quality of life for chronic pain sufferers, sometimes expressed in terms of SR's calming effects:

*'I always get a better night's sleep after the reading group'*

*'You always feel more relaxed on after a Tuesday afternoon'*

*'As soon as I got home last night I was asleep in the chair - all the weights of the world gone'*

Often SR is felt as an energising influence:

*'I get quite a sense of euphoria from these groups.'*

*'You need that sort of impetus to get you out of your inertia. Everyone says that for the following few days after that group, everything is great. By the weekend, by Monday you are sort of dipping again. And then Tuesday comes along and [SR] is something that I am looking forward to knowing that it is going to help me.'*

*'When I come out of the group I feel a little bit erm... uplifted erm... you know that was an achievement just to do that. I have noticed this, where before the group I*



*wouldn't do anything at all. I do find enjoyment difficult. Even if it is just for a couple of days, it is well worth it to me because I am achieving something then. Getting out more with the dog even. Then I think afterwards I have got satisfaction out of that or enjoyment which I have not had before.'*

Many participants talked about SR quite definitely as an alternative 'treatment'.

*The fentanyl numbs the pain but [...] it numbs all your other senses as well. It is a quick, easy fix but it's not **the** fix. So I think of this now as my way - I am looking at alternatives to rattling with tablets. I was just so shocked at the early [SR] clips how ill I looked. And in the later clips there was one where I looked so well and I was functioning better. And I thought well that's the stark reality - from being at point A and then point B - how much the benefit was there.*

*When the injections wear off I get this pain in my side and it feels like a knife stuck right in me. I feel as though my mood has lifted after being to the group, and afterwards I can feel as though I will have a good day. Maybe the next day even. Yes, it, it can feel like, for a while, maybe a few days, like an injection of enthusiasm.*

*Yes, well I class this as treatment. I mean [Consultant AW] deals with the injections, the pain that side but this helps to deal with the nervous side, of the condition.*

Consultant AW agreed:

*When people are in CBT, they are people with pain. When they're in the reading group, they're people with lives. What SR tends to do is to find other bits of people that are not to do with pain. It doesn't target anything in particular – that's its strength. And we know that pain is essentially an emotional thing which is why it is important that SR is operating on a much more emotional level than CBT. It looks as though CBT will be of most help if it precedes SR. You'll get benefit from SR whichever way round you do it.*

Consultant JM could see a danger, however, with making SR formally a part of pain treatment or therapy:

*It's wonderfully open-ended. It doesn't claim to do anything or expect anything of anybody. It's not saying the book will do this or that for you. It just says, let's see what happens. So I would be worried about people perceiving it as prescribed treatment.*

#### 4. Discussion

Our preliminary hypothesis was that CBT would show evidence of participants 'managing' emotions by means of systematic techniques, where Shared Reading (SR) would turn passive experience of suffering emotion into articulate contemplation of painful concerns. This hypothesis was substantially borne out, especially by the qualitative evidence. But we found, at the same time, that CBT and SR offered complementary opportunities for the expression of emotional material and that these distinct encouragements were valued by participants in different ways and for different reasons.

CBT allowed participants to exchange personal histories of living with chronic pain in ways which validated their experience (where family members and health professionals were often at best uncomprehending, and, at worst, unsympathetic in relation to a condition for which there is no obvious or visible 'cause'). However, in CBT, participants focused exclusively on their pain with 'no thematic deviation'. In SR, by contrast, the literature was a trigger to recall and expression of diverse life experiences – of work, childhood, family members, relationships - related to the entire life-span, not merely the time-period affected by pain. This in itself has a potentially therapeutic effect in helping to recover a whole person, not just an ill one. As one consultant put it, '*When people are in CBT, they are people with pain. When they're in the reading group, they're people with lives.*'

Moreover, the stories elicited in SR were not 'familiar' to participants in the way the pain narratives offered in CBT often were. Stories told in SR were often previously untold, or to do with forgotten, buried or inarticulate pain (emotional and psychological) rather than 'known' pain. Where the stories were the familiar ones which cropped up in CBT also, they tended to be understood and told from a new perspective – thus helping to achieve one of CBT's own principal aims of helping pain sufferers to shift their perception in relation to a physical condition which is in itself unchangeable or incurable. It is notable how often, even difficult emotional material was described as a 'distraction' from physical pain - as though the more the forgotten pain returned, the more the familiar pain receded into the background.

This finding in relation to personal story resonates with the key finding from both quantitative and qualitative evidence which demonstrated that a far greater *range* of emotional expression occurred in SR than in CBT. This finding is all the more crucial given the emotional (as opposed to physical) basis of most chronic pain. Where, in the CBT sessions, there was a strong emphasis on a sense of diminishment or subtraction – things 'taken away' by chronic pain – in SR, there was frequently a renewed sense of energy and vitality, sometimes of joy and celebration. This was closer to a rediscovery, via the new stimulus of the literary story, of what participants still *did* have (memories, feelings, thoughts, experiences) rather than a rehearsal of, or repeated thoughts about, what they no longer had. This disrupting or reversal of the individual's normal narrative about, or settled attitude

towards themselves, is a phenomenon which occurs frequently in SR and across participants. We think this has to do with how, in SR, people are not simply telling stories, but thinking *in* stories - often backwards and forwards through time, so that life is not just seen as before and after, as in the CBT narratives, but more dynamic than that. There is not just the 'I' who once could do things but can do them no longer – there is the 'I' who recalls experiences that can still be inhabited as if it were the same person who now remembers them.

At the same time, the extended range of emotion expressed or experienced in SR also meant that more intensely 'negative' emotion was in evidence here than in CBT. The processes of CBT seek to help participants to challenge and overcome negative thoughts through positive thinking, an especially valuable skill in dealing with common triggers for distress and with 'flare-ups'. Thus, CBT sessions tend not to focus upon how a person became ill, or where coping mechanisms fail, but on coming to terms or dealing with the fact of illness itself. In SR, by contrast, the fiction and poetry was frequently a stimulus to memory or expression of difficult emotional material. Sometimes this was upsetting for the individual, and often the group, at the time. These moments of felt distress tended to have the lasting effect, however, of making participants more engaged in the SR process. More usually, the distress or upset was leavened by a cognitive capacity or discovery – 'a good thought about a bad feeling' as we have called it - where something good or at least better than the negative experience is discovered from within it, rather than from outside or above it. It was striking how often the vital energy of expression and tone was at odds with the bad experience spoken of. As with the recovery of forgotten pain, this was a process of being able to turning something inside out. Rather than adopting CBT's more top-down strategy of mind over matter, this is a process of drawing into explicitness inarticulate implicit pain.

This relation to difficult and painful experience in SR seems to have been produced both by the stimulus of the literature and by its mode of delivery. Reading fiction and poetry encourages thinking 'about' human situations from an imaginative position inside them: asking vicariously why a person says, does, or feels this or that is one way that reading literature can encourage familiar thoughts and feelings to be regarded in a new way. Indeed, one critical 'self-help tool' offered by SR was an extended repertoire of models for thinking about experience. One generic sign of this was the way that group members would begin to find connections not only between their own experience and the books, but across the different works, as though these had become a new mental reference point. Participants rarely simply discussed the 'character' in the text: rather character was for them a means or a form of practical thinking in relation to an issue in their own lives or memories. But these models of thinking appear to have been powerful for participants because they are not 'flat' exemplars for living – step by step how to's or bullet point strategies - but dynamically rich and difficult to process quickly or '*pin down*' as one participant put it at interview. Indeed,

one key benefit seemed to be that characters in fiction or voices in poetry modelled difficult experience which could not be readily resolved or ‘reasoned with’. Personal trouble seemed more normally human than a sign of something wrong or of being ill.

One key aspect of SR – and this was agreed upon by all participants and facilitators in both interventions - is that the facilitator is not the didactic expert in SR as he or she is in CBT. While the facilitator’s approachability and friendliness in CBT was crucial to the relaxed atmosphere, the role was always that of an instructor. In SR, the facilitator’s expertise is employed to guide the group back to the book or poem, so that the text and, not she herself, initiates discussion and triggers contributions. This matter of the book being ‘the expert’ means that there is no compulsion to speak, on the one hand, while there is always the opportunity for participants to co-facilitate, on the other - to ‘take over’ for a while the direction of the discussion. One key aspect of the facilitator’s role was her expert reading aloud of the fiction and poetry. Most participants reported on how it was the literature coming alive as a sensory event in the room – a present personal-emotional voice – which ‘got through to them’ or ‘into’ them, and this element seems essential, therefore, to the recovery of buried emotional matter. The opening up and sharing of levels or dimensions of experience not normally visited helped to create in SR the kind of implicit bonds which one builds with family, team members, or work colleagues. The voluntariness of contribution in SR also meant, crucially, that participants could deal with difficult material in their own way and *in their own time*, rather than expression or recognition being programmatically demanded of them. This issue of timing and readiness for change is connected to the opportunity SR offers to people to come for themselves to the kind realizations which CBT seeks to ‘teach’ them. This accords with the quantitative finding that improvement in psychological and wellbeing scores did not show uniform improvement. Important in this regard also, is the indication from this study that some of these realizations and articulations may be happening without being voiced. They are enabled by the public sharing of the literature, that is, but they remain private intuitions or thoughts, not directly confessional revelations.

Finally, the diversity of emotion elicited by SR was indicated across all levels of the study (from quantitative measures of positive/negative affect to qualitative linguistic and literary analysis of video-recorded sessions and transcribed interviews) by the range of language used as compared with CBT. In the latter, the personal discourse generally - like the stories generated in the CBT sessions - was often characterized by a language of lack. The first step to overcoming negative thoughts in CBT was encouraging recognition of them – the explicit naming and identifying of feelings (frustration, anger, fear, guilt) which might otherwise be suffered amorously as ‘pain’. Yet the consultants were aware that their ‘didactic’ approach tended to impart a vocabulary rather than generating participants’ own, and may have been as much limiting as enabling of emotional recognition or expression.

There is a danger that words like fear, anger, guilt – like pain itself – can be a shorthand for very complex feelings which naming itself helps to mask or reduce. SR produced a much wider range of vocabulary in relation to emotion and ways of thinking and speaking which were creatively new or uncharacteristic of default speech patterns. This is possibly an external manifestation of SR's potential to galvanise new messages or produce a kind of mental rewiring; this a significant consideration in a condition which is in part sustained by the over-rigidity of nervous impulses or mental pathways.

## 5. Conclusions and recommendations

- Quantitative evidence of emotional well-being for people suffering from chronic pain is showing improvements in mood/pain immediately after the SR session, into the evening (many report a better night's sleep) and up to 1-2 days following.
- Quantitative and qualitative evidence indicates SR's strong potential as an alternative to CBT in bringing into conscious awareness areas of emotional pain otherwise passively suffered by chronic pain patients.
- SR's capacity to encourage greater confrontation and tolerance of emotional difficulty makes it valuable as a longer-term follow-up or adjunct to CBT's concentration on short-term management of emotion.
- The ability of fiction and poetry articulately to 'find' pain at its personal-emotional source – as an involuntary rather than intended outcome - makes it an important complement to CBT's top-down procedure of mind over matter.

## 6. References.

- Billington, J., Dowrick, C., Robinson, J., Hamer, A., Williams, C. (2011). An investigation into the therapeutic benefits of reading in relation to depression and well-being. [Online] Available: <https://sites.google.com/a/thereader.org/uk/get-into-reading-downloads/files/TherapeuticbenefitsofreadingfinalreportMarch2011.pdf?attredirects=0&d=1https://sites.google.com/a/thereader.org/uk/get-into-reading-downloads/files/TherapeuticbenefitsofreadingfinalreportMarch2011.pdf?attredirects=0&d=1>, [27 Feb 2013].
- Billington, J. and Sperlinger, T. (2011). 'Where Does Literary Study Happen?', *Teaching in Higher Education*, Special Issue, Leaving the Academy, vol. 16, no. 5, pp. 505-16.

- Billington, J (2012). “‘Reading for Life’: Prison Reading Groups in Practice and Theory’]. *Critical Survey*, vol. 23, no. 3, pp. 67-85.
- Billington, J., Carroll, J., Davis, P., Healey, C., Kinderman, P. (2013). A Literature-Based Intervention for Older People Living with Dementia. *Perspectives in Public Health*. Special Issue, Arts and Health. doi: 10.1177/1757913912470052.
- Billington, J., Davis, P., & Farrington, G. (2014). Reading as participatory art: An alternative mental health therapy. *Journal of Arts & Community*, 5, 25-40. doi: 10.1386/jaac.5.1.25\_1
- Billington, J., Humphreys, A.L., Jones, A., McDonnell, K. (2014). A literature-based intervention for people with chronic pain. *Arts & Health: An International Journal for Research, Policy and Practice*. doi: 10.1080/17533015.2014.957330
- Breivik, H., Collett, B., Ventafridda, V., Cohen, R., & Gallacher, D. (2006). Survey of chronic pain in Europe: Prevalence, impact on daily life, and treatment. *European Journal of Pain*, vol. 10, pp.287-333.
- Davis, Karen D. (2011). Neuroimaging of pain: what does it tell us? *Current Opinion in Supportive and Palliative Care*, 5: 116-121.
- Davis, J. (2009). Enjoying and enduring: groups reading aloud for wellbeing. *The Lancet*, vol. 373, no. 9665, pp. 714 – 715.
- Davis, P., Thierry G., Martin, C.D., Gonzalez-Diaz, V., Rezaie, R., Roberts, N., (2008). Event-related potential characterisation of the Shakespearean functional shift in narrative sentence structure. *NeuroImage*, vol. 40: 923-931.
- Davis, P., Keidel, J., Gonzalez-Diaz, V., Martin, C., Thierry, G. (2012). How Shakespeare tempests the brain: neuroimaging insights. *Cortex*, vol. 48, no. 5, pp. 21-64.
- Dowrick, C., Billington, J., Robinson, J., Hamer, A., Williams, C. (2012). Get into Reading as an intervention for common mental health problems: exploring catalysts for change. *Medical Humanities*, vol. 38, pp. 15-20.
- Evans, Jules, *Philosophy for Life and Other Dangerous Situations* (London: Ebury, 2012).
- Fullen, B.M., Blake C., Horan S., Kelley V., Spencer O., Power C.K. (2014). Ulysses: the effectiveness of a multidisciplinary cognitive behavioural pain management programme-an 8-year review. *Irish Journal of Medical Science*, vol 183, no. 2, pp. 265-75.

- Gray, E., Kiemle, G., Billington, J., Davis, P. (forthcoming, 2016). An Interpretative Phenomenological Analysis of the Experience of Being in a Reader Group. *Arts & Health: An International Journal for Research, Policy and Practice*. doi:10.1080/17533015.2015.1121883
- Harstall C., and Ospina M. (2003). How Prevalent Is Chronic Pain?" *Pain Clinical Updates, International Association for the Study of Pain*, XI (2): 1–4.
- Henry, D.E., Chiodo, A. E., Yang, W. (2011). Central nervous system reorganization in a variety of chronic pain states: a review. *The Journal of Injury, Function and Rehabilitation*, 3(12): 1116-25.
- Hodge S., Robinson J., Davis, P. (2007) Reading between the lines: the experiences of taking part in a community reading project. *Medical Humanities*, vol. 33, 100-104.
- Kaszynska, P. (2015). Capturing the vanishing point: Subjective experiences and cultural value, *Cultural Trends*, Vol 24, no. 3, 256-266. doi: 10.1080/09548963.2015.1066077
- Longden E., Davis, P., Billington, J., Corcoran, R. (2015). Shared Reading: Assessing the intrinsic value of a literature-based intervention. *Medical Humanities*, 0:1–8. doi:10.1136/medhum-2015-010704.
- Lumley, M. A., Cohen, J.L., Borszcz, G.S., Cano, A., Radcliffe, A. M., Porter, L. S., Schubiner, H., Keefe, J. K. (2011). Pain and Emotion: A Biopsychological Review of Recent Research. *Journal of Clinical Psychology*, 67(9): 942-968. Doi: 10.1002/jclp.20816.
- Morley, S. J. (2011). Efficacy and effectiveness of cognitive behaviour therapy for chronic pain: progress and some challenges. *Pain*, vol.152:S99-S106.
- O'Sullivan, N., Davis, P., Billington, J., Gonzalez-Diaz, V., Corcoran, R. (2015). "Shall I compare thee": The neural basis of literary awareness, and its benefits to cognition. *Cortex*. doi:10.1016/j.cortex.2015.08.014.
- Sveinsdottir, V., Eriksen, H.R., Endresen, S. R. Reme (2012). Assessing the role of cognitive behavioural therapy in managing chronic nonspecific back pain. *Journal of Pain Research*, 5: 371–380.
- Tracey, I. (2008). Imaging pain. *British Journal of Anaesthesia*, vol. 101, 1: 32-9.
- Williams A.C.D.C., Eccleston C., Morley S. (2012). Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database of Systematic Reviews*, Issue 11. Art. No.: CD007407. doi: 10.1002/14651858.CD007407.pub3.



## 7. Appendices.

### 7.1. Appendix 1. Participant Information Sheet.

#### Participant Information Sheet

### Comparing Get into Reading and Cognitive Behavioural Therapy for Chronic Pain

#### Royal Liverpool/Broadgreen Hospital and University of Liverpool

You are invited to take part in a research study. Before you decide whether or not you wish to take part it is important for you to understand why the research is being done and what this involves. Please talk to others about the study if you wish to.

This sheet tells you why the study is taking place and what will happen if you take part and gives you more detailed information about the conduct of the study

Please ask us if there is anything that is not clear, or if you would like more information, and take time to decide whether or not you wish to take part.

#### What is the purpose of this study?

There is already evidence to suggest that reading groups have health benefits for chronic pain sufferers. However, this is the first study to compare shared reading groups with an established intervention for chronic pain – Cognitive Behavioural Therapy. We hope that the information from this study will support the continuation and spread of reading groups in health care settings.

The aim of this research is to involve people suffering from chronic pain in a study to explore: (i) what happens in Shared Reading and in Cognitive Behavioural Therapy in terms of group behaviour and conversation; (ii) what are the similarities and differences for individuals in the experience of taking part in Cognitive Behavioural Therapy and Shared Reading; (iii) what is the effect on physical and emotional well-being of taking part in these activities; (iv) whether there is benefit to patients when Cognitive Behavioural Therapy is followed up by Shared Reading.

#### Why have I been chosen?

You are a Royal Liverpool Hospital Chronic Pain Clinic service-user and you have shown an interest in taking part in a Shared Reading group and/or Cognitive Behavioural Therapy course, and/or you have been identified as a suitable participant by a health professional.

#### Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep, and be asked to sign a consent form at the start of the research study. You are still free to withdraw at any time and without giving a reason.

A decision to take part, or withdraw, or not take part will not affect the standard of care you receive.

## **What will happen to me if I take part?**

### *Questionnaire*

If you decide to take part you will be asked to complete a confidential questionnaire with the researcher before the start of the Shared Reading sessions and/or Cognitive Behavioural Therapy course, and then again when sessions are completed. This will include questions about your health and well-being as well as questions relating to your mood, how you feel about yourself and your personal situation and some aspects of your lifestyle (eating, exercise, work habits for example).

As the questionnaire is quite detailed, it will be completed in private interview with the researcher, who will guide you through the question booklet. The process should take approximately 45 minutes. The interviews will take place at Broadgreen Hospital. (NB. These interviews will **not** be audio-recorded or transcribed.)

In addition, you will be asked to complete a brief questionnaire related to how you are feeling at the end of every individual Shared Reading and Cognitive Behavioural Therapy session.

### *Shared Reading and Cognitive Behavioural Therapy Sessions*

There will be a Shared Reading groups (of 24 weeks) and a Cognitive Behavioural Therapy groups (of 6 weeks) over the course of the study. You will be allocated to one of the following groups or combinations of groups: (i) a Shared Reading group only; (ii) a Cognitive Behavioural Group followed by a Shared Reading group. You will be asked to complete a questionnaire with the researcher at the end of each three-month period.

### Shared Reading

The reading group will be informal and small (no more than 12 people) and will meet once a week for two hours at Broadgreen Hospital, University of Liverpool, to read short stories, novels and poetry together aloud, with regular breaks in the reading for discussion of what is being read. The group will be led by a trained project worker from The Reader Organisation, who will choose the reading material guided by the group members' interests and tastes. No previous experience or expertise is necessary and there will be no pressure on participants to read aloud themselves or to discuss the books if they do not wish to do so. The focus is on relaxation and enjoyment and you will be able to contribute as much or as little as you like.

### Cognitive Behavioural Therapy

The specific aims of Cognitive Behavioural Therapy include helping people with chronic pain to: recognize negative thoughts and feelings; understand the problems with negative thoughts and feelings; challenge negative thoughts and behaviours;

develop positive ways of acting through techniques such as relaxation, pacing and goal setting. Cognitive-behavioural therapy encourages people to be active participants in their health care, becoming knowledgeable about chronic pain and its impact and ultimately taking control of the pain rather than letting pain control them.

### *Audio-video recording of the Shared Reading and Cognitive Behavioural Therapy Sessions*

The Shared Reading and Cognitive Behavioural Therapy sessions will be audio-video recorded. These recordings will only be watched/listened to by members of the research team and a transcriber working for the University, and your name will not appear in the written transcription or in any reports or articles. We may include verbatim quotations from the sessions in reports, the research summary and articles, but your name will not be mentioned in any part of the written material.

### *Interviews*

When the reading group sessions are completed, you will be invited to take part in an interview in which the researcher will ask you questions about your experience of the reading group. The researcher will invite you to view selections from the video-recordings of the group sessions in which you have participated as a reminder of the experience. You do not have to take part in both parts of the research, and you can take part in the reading groups and not take part in the interviews if you wish. The interviews will take place at Broadgreen Hospital.

These video-assisted interviews will be audio-recorded, and the audio-recordings will be destroyed as soon as they have been professionally transcribed. (This will usually happen within a month of the interview taking place.) The recordings are confidential to the project, and will only be listened to by members of the research team and a transcriber working for the University, and your name will not appear in the written transcription or in any reports or articles. We may include verbatim quotations from the sessions in reports, the research summary and articles, but your name will not be mentioned in any part of the written material.

### **Are there any disadvantages or risks if I take part?**

Though there are no specific risks or harms associated with taking part in this research, the content of the literature in Shared Reading or the personal experience touched on in Cognitive Behavioural Therapy can sometimes cause emotional distress. Likewise, the questionnaire completed with the researcher, and the video-assisted interviews, might cover potentially distressing personal issues. In the focus groups and in the interviews, you will not have to discuss issues about which you feel uncomfortable. In the event that you become distressed, you will be free to terminate the interview with the researcher, or to leave the room during a Shared Reading or Cognitive Behavioural Therapy session and speak with the group leader or health practitioner once the session is over.

### **What are the benefits of taking part?**

Observed and reported outcomes for participants in Shared Reading have included: being ‘taken out of the themselves’ through the stimulation of the book or poem; feeling ‘good’, ‘better’, ‘more positive about things’ after taking part in the group; valuing an opportunity and space to reflect on life experience, through memories or emotions evoked by the story or poem, in a supportive atmosphere; improved powers of concentration; a sense of common purpose and of a shared ‘journey’; increased confidence and self-esteem; valued regular social contact and decreased sense of isolation.

Cognitive Behavioural Therapy may enable participants to develop skills and strategies that they can use to manage specific problems that they are currently facing, as well as to cope better with long-term and future stresses and difficulties. The group may also provide participants with a sense of support and community.

### **What happens when the research study stops?**

After we have collected the data for the research, we will spend some time analysing it, and then we will prepare a written summary of the findings that will be made available to all the participants. Audio tape or CD versions will be made available if preferred. This summary will include details of how to access a copy of the short report of this study that will be available online, or as a hard copy on request.

If you are keen to continue attending a reading group once the six-month study is completed, the project worker leading the group will advise you on Shared Reading groups in the local area which you might attend.

### **Will my taking part in the study be kept confidential?**

Yes, all the information about your participation in this study will be kept confidential. The details are included below. Please note one exception however. The researcher has a duty to report any disclosure by participants that suggests a risk of harm to themselves or to others.

### **What will happen if I don’t want to carry on with the study?**

If you decide that you want to withdraw from the study, then depending on what you wish to happen, your data can be withdrawn from our analysis, or you can have your contribution so far included.

### **What if there is a problem?**

Should you have a concern about any aspect of your involvement with this research project, you should ask to speak with the researchers who will do their best to answer your questions and address any concerns in the first instance: Grace Farrington (gracef@liverpool.ac.uk); Dr Josie Billington, (0151) 794 2734; jbilling@liv.ac.uk). If you remain unhappy, and wish to complain formally, you can do this through the

University of Liverpool Complaints Procedure. Details can be obtained from the researcher or from the University of Liverpool: (0151) 794 2000.

### **Will my taking part in this study be kept confidential?**

Yes, your taking part in the study will be kept confidential to the project. All data will be anonymised, and stored securely at the University of Liverpool for seven years, and then destroyed. The anonymised data will be seen only by members of the research team, and will not be used for a further study. Your name will not be used in any published material resulting from the study, including reports. These procedures are compliant with the Data Protection Act (1998).

### **What will happen to the results of the research study?**

The results of this research study will be summarised and sent in either a written form, or as a CD or tape, to all of the participants in the research. A further brief report of the findings will be made available to participants, and also to key stakeholders at Royal Liverpool Hospital, The Reader Organisation, University of Liverpool, and to other people interested in reading and health. We also hope to publish the findings in a peer-reviewed publication, and to present at relevant conferences. You will not be identified in any report or publication.

### **Who is organising and funding this research?**

This exploratory piece of research is being funded by the British Academy.

### **Who has reviewed the study?**

This study was given a favourable ethical opinion by [NRES Committee Northwest].

### **Contact details**

If you have any questions or concerns about this study, please contact either Josie Billington on 0151 794 2734 or at Centre for Research into Reading, Literature and Society (CRILS), 213 Whelan Building, University of Liverpool, Liverpool L69 3GB. [jbilling@liv.ac.uk](mailto:jbilling@liv.ac.uk)

**You will be given a copy of this Information Sheet and a signed consent form to keep.**

**Thank you for considering taking part in this research project**

**7.2. Appendix 2: Participant Consent Form.****Consent Form – Reading Groups****Comparing Get into Reading and Cognitive Behavioural Therapy for  
Chronic Pain****Royal Liverpool/Broadgreen Hospital and University of Liverpool****Researcher: Grace Farrington, University of Liverpool**

Please initial box

1. I confirm that I have read and understood the information sheet dated for the above study (Version 2, 20/05/14). I have had the opportunity to consider the information and to ask questions, and I have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that the researcher will ask me: (a) to complete a series of questionnaires relating to my physical and mental health and well-being; (b) to answer questions about my time in the Shared Reading and/or Cognitive Behavioural Therapy group.

4. I agree to the Researcher audio recording the Shared Reading and/or Cognitive Behavioural Therapy group.

5. I agree to the researcher video-recording the Shared Reading and/or Cognitive Behavioural Therapy group.

6. I understand that the recording of the group discussions will be

transcribed, and quotes from the discussion may be reproduced verbatim in a written summary, and/or a report, and/or a published journal article, but my name will not be included.

7. I agree to the Researcher audio recording an interview with me.

8. I understand that the recording of the interview will be transcribed and quotes from the interview may be reproduced verbatim in a written summary, and/or a report, and/or a published journal article, but my name will not be included.

9. I understand that data collected from the study may be looked at by regulatory authorities or by persons from the Trust where it is relevant to my taking part in this study. I give permission for these individuals to have access to this data.

10. I agree to take part in the above study.

-----

Name of participant

-----

Date

-----

Signature

-----

Name of person

-----

Date

-----

Signature

taking consent.

### 7.3. Appendix 3. Measures Booklet

## Chronic Pain, Shared Reading and CBT Study

### Assessment Forms

#### Instructions

Please read the instructions carefully at the top of each section.

The forms will require you to think how you have been feeling over different periods of the last few weeks. If you would like to add any further comments about your problems, you are welcome to include these at the back of the questionnaire.

#### Tips for filling in the questions

- This questionnaire may seem rather a lot of work.
  - When answering the questions it is best to put down the first answer that comes to mind. Do not spend too long thinking about any question.
  - You may find it easier to just complete one part at a time and come back later to the next part. There is no problem in completing it this way.
- 
- Be careful to answer **ALL** of the questions, as we will not be able to gain a complete picture of how you are recovering, unless all the sections are complete.

Thank you very much for your co-operation.

**Part A: GHQ-12**

**Instructions:** We should like to know if you have had any health complaints and how your health has been in general, over the last few weeks.

Please answer ALL the questions simply by **circling** the answer, which you think most nearly, applies to you. Remember that we want to know about present and recent complaints, not those you had in the past.

It is important that you try to answer ALL the questions.

Have you recently. . .

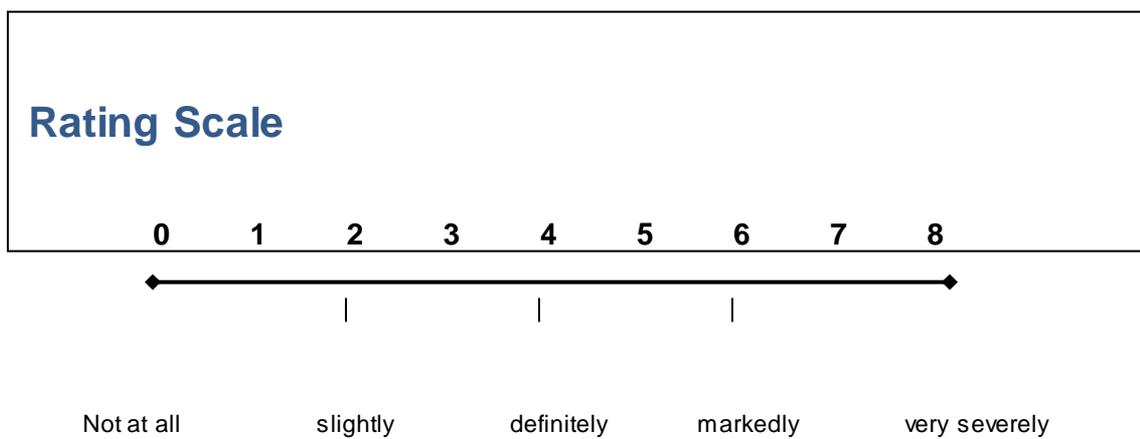
1	been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2	lost much sleep over worry?	Not At all	No more than usual	Rather more than usual	Much more than usual
3	felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4	felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less than usual
5	felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual



6	felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7	been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8	been able to face up to your problems?	More so than usual	Same as usual	Less so than usual	Much less than usual
9	been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10	been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11	been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12	been feeling reasonably happy, all things considered?	More so than usual	Same as usual	Less so than usual	Much less than usual

**Part B: WAS**

People's problems sometime affect their ability to do certain things in their daily lives. Using the scale below, please indicate in the relevant boxes how your problems affect your ability to function in any area. There is a space left to add another valued activity that you may find that you are having particular difficulty with eg reading, driving the car etc.



	Activity	Rating (0-8)
1	<b>Work</b> (if you are not employed, rate it imagining how your work would be affected)	
2	Manage my home	
3	Socialise with other people	

4	Enjoy doing things alone	
5	<b>Form and maintain close relationships with other people</b> ( <i>including the people you live with</i> )	
6	<b>Reading</b>  -----	
7	<b>Personal valued daily activity?</b>  <i>Please specify the activity below</i>  -----	

If there are any other areas of your life that have been specifically affected by your problems that you would like to tell us about, please use this space below.

*Additional Information*

**Part C: Ryff Scales**

The following set of questions deals with how you feel about yourself and your life.

**Please remember that there are no right or wrong answers.**

**PERSONAL GROWTH**

**Response Scale:** strongly disagree (1), moderately disagree (2), slightly disagree (3), slightly agree (4), moderately agree (5), strongly agree (6).

	<b>Question</b>	<b>Response (1-6)</b>
1	I am not interested in activities that will expand my horizons.	
2	In general, I feel that I continue to learn more about myself as time goes by.	
3	I am the kind of person who likes to give new things a try.	
4	I don't want to try new ways of doing things--my life is fine the way it is.	
5	I think it is important to have new experiences that challenge how you think about yourself and the world.	
6	When I think about it, I haven't really improved much as a person over the years.	



7	In my view, people of every age are able to continue growing and developing.	
8	With time, I have gained a lot of insight about life that has made me a stronger, more capable person.	
9	I have the sense that I have developed a lot as a person over time.	
10	I do not enjoy being in new situations that require me to change my old familiar ways of doing things.	
11	For me, life has been a continuous process of learning, changing, and growth.	
12	I enjoy seeing how my views have changed and matured over the years.	
13	I gave up trying to make big improvements or changes in my life a long time ago.	
14	There is truth to the saying you can't teach an old dog new tricks.	

## PURPOSE IN LIFE

**Response Scale:** strongly disagree (1), moderately disagree (2), slightly disagree (3), slightly agree (4), moderately agree (5), strongly agree (6).

	Question	Response (1-6)
1	I feel good when I think of what I've done in the past and what I hope to do in the future.	
2	I live life one day at a time and don't really think about the future.	
3	I tend to focus on the present, because the future nearly always brings me problems.	
4	I have a sense of direction and purpose in life.	
5	My daily activities often seem trivial and unimportant to me.	
6	I don't have a good sense of what it is I'm trying to accomplish in life.	
7	I used to set goals for myself, but that now seems like a waste of time.	
8	I enjoy making plans for the future and working to make them a reality.	
9	I am an active person in carrying out the plans I set for myself.	



10	Some people wander aimlessly through life, but I am not one of them.	
11	I sometimes feel as if I've done all there is to do in life.	
12	My aims in life have been more a source of satisfaction than frustration to me.	
13	I find it satisfying to think about what I have accomplished in life.	
14	In the final analysis, I'm not so sure that my life adds up to much.	

**Part D: Dalgard Questionnaire**

**Response scale:** 1=strongly disagree, 2= disagree 3=disagree as much as agree, 4=agree, 5=strongly agree

	Question	Response (1-5)
1	There is really no way I can solve some of the problems I have	
2	Sometimes I feel that I'm pushed around in life	
3	I have little control over the things that happen to me	
4	I often feel helpless in dealing with the problems of life	
5	There is little I can do to change many of the important things in my life	

**Part E: Short Warwick-Edinburgh Scale**

**Response scale:** 1=none of the time; 2=rarely; 3= some of the time; 4=often;  
5=all of the time.

Items:

	Question	Response (1-5)
1	I've been feeling optimistic about the future	
2	I've been feeling useful	



3	I've been feeling relaxed	
4	I've been dealing with problems well	
5	I've been thinking clearly	
6	I've been feeling close to other people	
7	I've been able to make up my own mind about things	

Thank you very much for taking the time to complete all of the questions.

**7.4. Appendix 4. 12-hour Daily Pain Record**
**Daily Record (week no.....)**

Date  w/c 18/05/15	Time <i>(every 12 hours)</i>  AM PM	Pain rating <b>(0-10)</b>  AM PM	Optional information			
			How are you feeling? <i>(Please write 2 words. You can use the list overleaf if you like).</i>  AM PM	Medication <i>(usual or any changes?)</i>	Side effects <i>(usual or any changes?)</i>	What influenced your pain today?
Tuesday	<del> </del>	<del> </del>	<del> </del>			
Wednesd ay						
Thursday						
Friday						
Saturday						
Sunday						
Monday						
Tuesday	<del> </del>	<del> </del>	<del> </del>	<del> </del>	<del> </del>	

If you forget and miss a recording, don't worry just leave that line blank and complete the diary at the next time point.

### 7.5. Appendix 5. Positive and Negative Effect Scale (PANAS).

#### PANAS

This scale consists of a number of words that describe different feelings and emotions.

Read each item and then list the number from the scale below next to each word.

Indicate to what extent you feel this way right now, that is, at the present moment.

1	2	3	4	5
Very Slightly	A Little	Moderately	Quite a Bit	Extremely
or Not at All				

\_\_\_\_\_ 1. Interested \_\_\_\_\_ 11. Irritable

\_\_\_\_\_ 2. Distressed \_\_\_\_\_ 12. Alert

\_\_\_\_\_ 3. Excited \_\_\_\_\_ 13. Ashamed

\_\_\_\_\_ 4. Upset \_\_\_\_\_ 14. Inspired

\_\_\_\_\_ 5. Strong \_\_\_\_\_ 15. Nervous

\_\_\_\_\_ 6. Guilty  
Determined

\_\_\_\_\_ 16.

\_\_\_\_\_ 7. Scared

\_\_\_\_\_ 17. Attentive

\_\_\_\_\_ 8. Hostile

\_\_\_\_\_ 18. Jittery

\_\_\_\_\_ 9. Enthusiastic

\_\_\_\_\_ 19. Active

\_\_\_\_\_ 10. Proud

\_\_\_\_\_ 20. Afraid

Write down two words or phrases about your experience of the reading group today

.....

.....

## 7.6. Appendix 6. Record of Reading Material in Shared Reading Sessions.

### Chronic Pain Shared Reading Group: List of texts used

Session 1	Charles Dickens, <i>A Christmas Carol</i>
Session 2	<i>A Christmas Carol</i>
Session 3	<i>A Christmas Carol</i> Thomas Hardy, 'The Oxen'
Session 4	Elizabeth Bowen, 'The Visitor'
Session 5	David Guterson, 'Arcturus' Phillip Booth, 'First Lesson'
Session 6	David Guterson, 'Wood Grouse on a High Promontory Overlooking Canada' Rilke, 'Evening' Emily Dickenson, 'Tell all the truth'
Session 7	Elizabeth Taylor, 'Flesh' Brian Patten, 'One Another's Light'
Session 8	Edith Wharton, <i>The House of Mirth</i> David Harsent, 'The Player'
Session 9	George Saunders, 'The Falls' Mark Doty, 'Golden Retrievals'
Session 10	Doris Lessing, 'Sunrise On The Veldt' Laurie Sheck, 'Mysteriously Standing'
Session 11	Tobias Wolff, 'The Liar'
Session 12	Dan Jacobson, 'The Little Pet' Fleur Adcock, 'For a Five Year Old'
Session 13	Edith Wharton, 'Mrs Manstey's View' Norman Nicholson, 'The Pot Geranium'
Session 14	Joyce Carol Oates, 'Where is Here?' Anne Bronte, 'Domestic Peace'

Session 15	Carol Shields, 'Mirrors' Elizabeth Jennings, 'Resemblances'
Session 16	John Steinbeck <i>Of Mice and Men</i> Edward Thomas, 'For these'
Session 17	<i>Of Mice and Men</i>
Session 18	<i>Of Mice and Men</i> e.e. cummings 'A man who had fallen among thieves'
Session 19	<i>Of Mice and Men</i> W. B. Yeats, 'The Lake Isle of Innisfree'
Session 20	<i>Of Mice and Men</i> Edwin Muir, 'Dream and Thing'
Session 21	<i>Of Mice and Men</i> Christina Rossetti, 'Shut Out'
Session 22	<i>Of Mice and Men</i> Robert Burns, 'To a Mouse'