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Making sense of chronic illness using Emotional Freedom Techniques (EFT): An existential view of illness

Abstract

Objective: This article explores chronic disease patients' personal symbolic meanings of their diseases, as emergent from their experience of Emotional Freedom Techniques (EFT) therapy. The present study is part of a larger study that explored chronic disease patients' and EFT practitioners' experiences of using EFT to support chronic disease healthcare.

Design: Eight chronic disease patients who had received EFT were interviewed for this study. Semi-structured interviews were conducted via face-to-face, or via telephone, or the online videoconferencing platform, Zoom. Interviews were transcribed verbatim and data was analysed using Interpretative Phenomenological Analysis methodology.

Results: Three themes emerged, namely 'illness as an embodiment of unresolved emotional issues', 'illness as body's call for time-out and attention', and 'illness as a boundary from other people'.

Conclusion: EFT offers promise as a suitable therapeutic approach to help chronic disease patients make sense of their life stories and lived experiences, and consequently, symbolic meanings of diseases. The exploration of illness symbology and meaning-making may offer therapeutic value to patients, from both an existential and a health behaviors perspective.

Key words: Emotional Freedom Techniques (EFT); chronic disease; Interpretative Phenomenological Analysis (IPA); symbolic disease; illness construction

Background

For most of the 20th century, health and illness were viewed from a biomedical perspective, which is based on a separation of the mind and the body. According to the biomedical model, the mind and the body are separate entities unique to each other (Descartes, 1952). According to Mehta (2011, p. 202), the mind is an “immaterial, but thinking substance”, whereas the body is a “material, but unthinking substance”. Ryle (1949) suggested that the body is subject to mechanical laws and the events happening to and inside the body are viewed as events happening in a person’s physical world. The events happening in, and to, the mind are considered to be part of a person’s mental world (Ryle, 1949). The biomedical model, based on a dualistic view of the mind and the body, sees humans as biological organisms, and disease as a departure from biological norms (Mehta, 2011; Boyd, 2000). Boyd (2000, p. 9) contended that “there is an objectivity about disease which doctors are able to see, touch, measure, smell.”

According to the biomedical model, deviations from the biological norm are often a result of a chemical or physical occurrence and can be corrected using a physical or chemical substance. From a biomedical view, health is understood primarily as the absence of disease (Mehta, 2011). The biomedical model has what appears to be a linear view of disease, whereby diseases have a specific (usually single) biological cause, and a specific biomedical treatment. However, other perspectives on health have emerged since the advent of the biomedical model. In the 1970s, George Engel suggested that disease must be viewed from a systems-thinking approach. Psychological and social aspects of an illness must be considered, in addition to the biomedical dimension (Engel, 1977). Engel’s view came to be known as the ‘biopsychosocial model’ of health. Since the advent of the biopsychosocial model of health, our understanding of illness has widened, as is evident in current literature on the various risk factors of chronic disease.

Chronic diseases are often prolonged, cannot usually be spontaneously resolved or completely cured (AIHW, 2012). These illnesses are complex and multifaceted in both causality and impact, with the ability to cause premature death or long-term functional impairment or disability. Chronic illnesses pose physical, emotional and economic burden on people, families, and economies across the world. The Australian Institute of Health and Welfare (AIHW) has developed a conceptual framework outlining the various determinants of health and risk factors, which may either increase the probability of a person developing a chronic illness, or hamper the management of existing chronic conditions. This framework of chronic illness risk factors has been illustrated in Figure 1. According to this framework, a person's individual physical and psychological framework coupled with a variety of determinants such as health behaviors, socio-economic and cultural influences, as well as biomedical factors can influence development and progression of chronic diseases

Insert Figure 1 here

Congruent with a more holistic biopsychosocial view of health, and an understanding that people's individual physical, social, and psychological makeup can influence disease, new perspectives have emerged which call for a more existential person-focused approach to healthcare. A seminal work within this paradigm belongs to one of the pioneers of psychosomatic medicine, Georg Groddeck (1977, p. 32-33), who states:

I had become convinced that the distinction between body and mind is only verbal and not essential, that body and mind are one unit [. . .] In other words, from the first I rejected a separation of bodily and mental illnesses, tried to treat the individual patient.

Works by other contemporary theorists have added to the discussion on a person-focused view of health. For example, while traditional biomedicine has been concerned with the cause and cure of diseases, contemporary theorists such as Wilberg (2011) present an existential view of disease which aims to understand the *meaning*, rather than the *cause* of a disease and its symptoms. Wilberg's (2011) existential perspective on disease is rooted in: 1) phenomenology, in that it is concerned with patients' lived experiences of illness; and 2) hermeneutics, in that it views the human body as a "living biological language" (Wilberg, 2011, p. 308). This living biological language has often been referred to as the "lived body" in phenomenological literature, i.e. the body that is *felt* by a person from within (Willberg, 2011). Unlike the "clinical body" which can be objectively examined by medical professionals, the lived body is a subjective embodiment and expression of a person's internal state of being or consciousness.

In the discourse of the lived body, symptoms are seen as "messengers" of the patient's story or subjective lived experience (Wilberg, 2011, p. 208). Wilberg (2011) posits that somatic states of disease and physical symptoms not only impact a person's psychological state (as has already been established by Western medicine to an extent), but are also expressions or embodiments of a person's psychological state or consciousness. Wilberg (2011) suggests that the occurrence of a specific disease at a specific *time* in a person's life represents or holds a particular meaning in the broader existential framework of the person's lived world, and is not simply a case of biological misfortune.

Compatible with Wilberg's (2011) standpoint, Broom (2002) also advocates for a unified "personhood" view of health, based on the premise that a patient's subjective reality has a crucial role in the development and maintenance of disease, and in recovery from it. Broom (2002) discusses the phenomenon of "somatic metaphor" which becomes evident when:

a physical disease - in its pathology, the organ(s) involved, and/or its body location - appears to be “saying” the same thing, expressing the same meaning, as the patient's subjective “story,” conveyed in verbal language or in the pattern of important and meaningful events in the life of the patient (p. 16).

Physical diseases, which may be viewed as somatic metaphors of patients’ meanings and subjective stories, are referred to as “symbolic diseases” (Broom, Booth & Schubert 2012). Broom et al. (2012) recommend a clinical approach, which involves the clinician working with the client to explore the client’s personal meanings, life experiences, and stories in an attempt to understand the symbology of disease.

Psychotherapy interventions may assist patients to make sense of their lived experiences, and the symbolic meanings of their diseases. A contemporary psychotherapeutic tool, called Emotional Freedom Techniques (EFT), also known as “Tapping,” may be used to help patients understand their subjective meanings and illness symbology, and co-construct new meanings to facilitate healing.

Emotional Freedom Techniques (EFT)

Emotional Freedom Techniques (EFT) is a therapeutic modality which combines Chinese acupressure with Western psychotherapeutic approaches. The application process of EFT has been documented by Craig and Fowlie (1995) and by Church (2013). In a typical round of EFT, a subject first consciously invokes, or is psychologically exposed to a specific emotional trigger, such as a distressing memory, negative emotion (e.g. anger, fear), object of phobia etc. The subject then self-reports an initial perceived distress rating, also known as the “subjective unit of distress” (SUD) score on a scale of 0 to 10, where a score of 0 indicates no distress, and a score of 10 indicates high distress. Subsequently, the subject gently taps on certain acupoints on the face and upper body with his/her fingertips, while focusing on the distressing emotional trigger, and concurrently voices statements of self-acceptance, e.g. “Even though, I am feeling

this anger, I accept myself.” The process is repeated, until the SUD score is significantly reduced. Other cognitive strategies and wording may be employed by practitioners and users to supplement the above process (Craig and Fowlie 1995; Church 2013).

Several studies and review articles have been published in peer reviewed psychology and medical journals examining the efficacy of EFT therapy for various mental and physical health conditions (Feinstein, 2018). Meta-analyses of clinical trials indicate large effect sizes in EFT treatments for anxiety (Clond, 2016), depression (Nelms & Castel, 2016), and PTSD symptoms (Sebastian & Nelms, 2016). Studies investigating the effects of EFT on physical chronic health problems such as tension headaches (Bougea, Spandideas, Alexopoulos, Thomaidis, Chrousos, & Darviri, 2013), obesity (Stapleton, Sheldon & Porter, 2012a), traumatic brain injury (Church & Palmer-Hoffman, 2014), chronic pain (Ortner, Palmer-Hoffman & Clond, 2014), and psoriasis (Hodge & Jurgens, 2011) have also been published.

There are various proposed hypotheses in relation to the mechanism of action in EFT. For example, EFT may have potential effects on the body’s physiological systems that regulate stress, emotional intensity, and associated neural transmission frequencies (Diepold & Goldstein, 2008). Additionally, EFT treatment appears to decrease activity in the amygdala, leading to calming of the fight, flight, freeze threat response to emotional triggers (Stapleton, Sheldon & Porter, 2012b). Furthermore, the aspect of self-acceptance statements in the EFT process may also be instrumental in reducing suffering, similar to other interventions such as Cognitive Behavioral Therapy (CBT) and Mindfulness which rely on the premise that acceptance of, rather than resistance to, a particular condition reduces suffering (Brattberg, 2008).

Study Aim

The present study forms part of a larger PhD research project that explored EFT practitioners' and chronic disease patients' lived experiences of using EFT to support chronic disease healthcare. Part of the broader study's outcomes relating to EFT practitioners' experiences of using EFT to support chronic disease healthcare have been published in (Reference withheld for blind peer review). Another emergent theme from the larger study related to the application of EFT to help patients make sense of their life stories and lived experiences, and construction of disease symbology. The present study explores chronic disease patients' personal symbolic meanings of their diseases, as emergent from their experience of using EFT therapy. This article presents the meanings ascribed by the study's participants to their illnesses through their EFT therapy experience. The focus of the present article is therefore on the emergent meanings themselves, rather than the process of EFT therapy. Further information on the process of EFT therapy may be found in (Reference withheld for blind peer review).

Kleinman (1988) delineates a distinction between the terms "illness" and "disease". Kleinman (1988) describes "disease" as "an alteration in the biologic structure or functioning" (p. 5), and "illness" as the "innately human experience of symptoms and suffering" (p. 3). Given the current research is concerned with patients' personal experiences and meaning-making of their health conditions, we have adopted the term "illness" in our exploration of the individuals' unique human experiences of their symptoms, suffering, and circumstances.

Using EFT to make sense of illness experience

The current study focused specifically on the use of EFT for making sense of the illness experience. Indeed, other traditional and talk therapies such as CBT, or psychodynamic therapy may be used in a similar vein. However, some argue that the unique combination of somatic engagement with the physical body, while focusing on the emotional triggers renders EFT as a

brief intervention, where often spontaneous or rapid results are reported by users (Feinstein, 2018). While the acupoint stimulation is considered to be a salient feature of the EFT therapy, with often concise usage of wording, users report cognitive shifts through the process, with generation of new insights and reframing of experiences occurring through the EFT therapeutic process. The sense-making may not arise from lengthy verbiage between the client and therapist, but instead through a cognitive shift within the client as a result of the Tapping process. Feinstein (2019) conducted a qualitative analysis of EFT session scripts as a preliminary step towards understanding the role of language in the EFT therapeutic process. Feinstein (2019, p. 14) concluded that:

My sense is that acupoint tapping can be effectively applied in the service of any theoretical perspective—psychodynamic, behavioral, cognitive, humanistic, spiritual, or in the more integrative fashion that is increasingly being utilized within the field (Stricker, 2010). Regardless of the clinician’s orientation, however, and in ways that are not yet fully understood, the tapping seems to increase the neurological impact of words formulated to enhance healing, growth, and well-being. Indeed, as emphasized earlier, Energy Psychology protocols were significantly more effective than otherwise identical protocols (using the same wording and adjunct procedures) but without the acupoint tapping (Church et al., 2018).

The exact mechanism of action in EFT is not yet clear, with a range of plausible explanations such as reduction of stress hormones and other physiological markers (Church, Yount & Brooks, 2012; Bach, Groesbeck, Stapleton, Sims, Blickheuser & Church, 2019), changes in microRNA expression (Yount, Church, Rachlin, Blickheuser & Cardonna, 2019) currently being investigated. However, as suggested by Feinstein (2019) in the quote above, the EFT modality offers a unique synergy between acupoint stimulation and use of cognitive tools and techniques, e.g. fostering of self-acceptance, reframing of problems etc. that could be resulting in a therapeutic meaning-making experience for users.

Methods

Theoretical Approach

A qualitative research orientation was deemed appropriate for the present study, because qualitative data offers a useful means of exploring research questions pertaining to human experiences and meaning-making (Guest, Namey & Mitchell 2013). A constructivist epistemological position (different from a *constructionist*) was assumed for this study. A constructivist view posits that people receive knowledge through their senses, and/or communication, and interpret and actively construct their reality based on their experiences, and interactions with their environment (Von Glasersfeld, 1995). According to constructivism, "knowledge does not reflect an objective, ontological reality but exclusively an ordering and organization of a world constituted by our experience." (Von Glasersfeld, 1984, p. 24)

Von Glasersfeld (1989) suggests that cognition is adaptive, i.e. it helps people organize their experiential world reality, rather than discover an absolute truth, or objective reality. Constructivism further suggests that the meanings created by people are continually tested against previous knowledge and either reinforced or modified in line with new experiences (Schwandt 2007). Von Glasersfeld (1995, p. 7) proposes the concept of "viability", wherein the focus is not on an absolute truth that accurately matches an objective reality, rather, "concepts, models, theories, and so on, are viable if they prove adequate in the contexts in which they were created." Psychotherapeutic approaches, (in this case, EFT), often aim to help patients and their therapists collaborate to make sense of patients' lived experiences through an interpretative process, and co-construct positive or more productive meanings about seemingly difficult experiences or circumstances.

Interpretative Phenomenological Analysis

One of the many qualitative research paradigms is the approach of phenomenology. Phenomenology refers to the study of structures of experience, or consciousness (Crotty, 1998; Smith, Flowers & Larkin 2009). The approach of phenomenology has evolved through the work of numerous philosophers and thinkers, including the philosopher Martin Heidegger (Crotty, 1998). Heidegger proposed the concept of interpretative phenomenology which posits that humans are embedded in the context of their lifeworld (e.g. comprising objects, language, and relationships); therefore, humans' experiences are subjective, and dependent on their own perspectives (Crotty, 1998; Smith et al., 2009). Over the last few decades, phenomenological theorists have applied a "worldly" approach to the study of lived experience, one that aims to understand people's perspectival involvement with their meaningful, lived worlds.

Interpretative Phenomenological Analysis (IPA) is a contemporary research methodology which was developed to study people's unique subjective experiences using an interpretative approach (Smith et al., 2009). IPA aims to explore participants' lived experience, meanings, and perceptions. IPA has its origins in theories which posit that humans do not passively consume information about an objective reality, rather, they actively interpret and endeavor to understand their experiential world by formulating their own meanings and organizing their biographical stories in a form that makes sense to them (Brocki & Wearden, 2006). IPA was commensurate with firstly a constructivist epistemological position, and secondly, the study's aim to explore chronic disease patients' lived experiences, and their meaning-making.

IPA is underpinned by three theoretical pillars: phenomenology, hermeneutics and idiography (Smith et al., 2009). IPA is concerned with the study of lived experience (phenomenology). IPA also involves a double-hermeneutic or interpretative component, whereby the participant first interprets his/her own meaning-making and experience in the

telling, and the researcher then interprets the participant's account of his/her experience and meaning-making. Finally, IPA is also idiographic, i.e. it is concerned with the detailed explication of unique or individual cases, which means that only a small sample size is necessary, even appropriate (Smith, 2010).

Sampling and Recruitment

In alignment with the idiographic nature of IPA, purposive sampling of a small well-defined homogenous group of participants for whom the research question is relevant, is required (Smith & Osborn, 2008). Purposive sampling involves selecting participants with certain pre-decided characteristics, such that, in light of adequate context, a reasonably sound perspective on a given topic can be developed (Brocki & Wearden, 2006). This article was part of an overarching study, which was approved by the [Ethics Committee name withheld for blind peer review]. Participants were recruited through EFT interest groups, namely, Association for the Advancement of Meridian Energy Techniques (AAMET), EFT Universe, Association for Comprehensive Energy Psychology (ACEP) and EFT Australian Practitioners Inc. (EFTAP). Inclusion criteria were that participants had to be physical chronic disease patients aged over 18 years who had used EFT as part of their healthcare regimes. People with cognitive impairments, intellectual disabilities, or mental illnesses, pregnant women, and patients under palliative care were excluded from this study due to ethics requirements.

Given that EFT is a relatively contemporary tool, placing geographic and/or socio-demographic criteria such as location and gender, or restricting the type of chronic diseases under consideration, would potentially significantly reduce the number of eligible participants, making recruitment challenging. Despite the socio-demographic diversity, the sample for the present study is homogenous in terms of participants' suffering from physical chronic diseases who had used a specific therapeutic tool (EFT) to support their healthcare. Respondents to

advertisements were screened by asking questions via email or telephone, about their health conditions, and their use of EFT, as part of purposive sampling.

Given IPA's idiographic focus, sample sizes are often small (Smith, 2010). Sample sizes may be as small as five or six participants (Smith et al., 2009). Eight chronic disease patients (all female), located across Australia (three), UK (three), Canada (one), and USA (one) were interviewed for this study. There was no intention to exclude other genders from the study. However, only women responded to the advertisement calling for research participants. Since the predominance of females in the sample was a matter of chance rather than an intended outcome, a feminist methodological basis for the study was not explored or considered - although it might be useful for explorations in further studies. Further discussion on the implications of the all-female study sample is provided in the limitations section at the end of the article.

The chronic illnesses within the emergent study sample included Mast Cell Activation Disorder, Chronic Fatigue Syndrome (CFS), Fibromyalgia, Chronic Migraines, Crohn's Disease, and Arthritis. Given that EFT is a contemporary therapeutic intervention and its emerging evidence base is relatively new, the researchers decided to not restrict the kind of chronic illnesses under consideration in order to enable broad data generation within the context of generic patient healthcare, rather than disease-specific care. As such, inclusion criteria were not placed on the type of chronic diseases under consideration for the larger research study. However, the majority of patients who expressed interest in participating in this study had conditions with somewhat uncertain aetiology (e.g. CFS, Fibromyalgia, Crohn's Disease). This may be due to people with these conditions being more willing to trying alternative or contemporary therapies such as EFT, in the face of a less prescriptive or specific biomedical treatment pathway. A further discussion of the aforementioned study design aspect

has been provided in the limitations section later in this article. Participants' names were changed to preserve confidentiality. Participant information is provided in Table 1.

Insert Table-1 here

Data Collection

Semi-structured interviews, a commonly used data collection tool in IPA studies (Smith & Eatough, 2007), were used in the present research. Semi-structured interviews serve as intentional conversations that allow researchers to elicit targeted detailed information from participants (Smith et al., 2009; Liamputtong & Ezzy, 2009). Because most participants were based interstate or overseas, interviews were also considered to be the most viable form of data collection. The participants were interviewed via telephone or Zoom (a video-conferencing platform) and the interviews lasted between 60 – 120 minutes. Interviews were recorded using a smartphone application (in the case of telephone interviews) or directly through the video-conferencing platform's in-built recording functionality (Zoom).

Interview questions or prompts were mostly left open-ended so that participants could freely and descriptively share their experiences (Liamputtong & Ezzy, 2009). Participants were asked questions about their experiences of illness (e.g. when it started, symptoms, impacts on quality of life), experiences of using EFT, personal meanings of disease, personal notions of recovery, and general perceptions about EFT as a technique. For example:

- Can you please tell me a bit about your problem or illness?
- How were you introduced to EFT and why did you decide to try it?
- Can you elaborate on your experience of using EFT to support your chronic disease healthcare?
- What sort of emotional issues did you address in your EFT sessions?

Further questions emerged as the interviews progressed as per the semi-structured interview approach (Smith & Eatough, 2007). Subsequently, the interviews were transcribed verbatim, including non-verbal responses such as laughter, long pauses/hesitation, and other emotional reactions as these can assist in the interpretative process (Smith et al., 2009).

Data Analysis

The IPA data analysis process as described by Smith et al. (2009) was employed for this study.

Overall, the data analysis process encompassed:

1. Revisiting the data: reviewing interview notes, listening to an interview recording, and reading of an interview transcript.
2. Initial note-taking to capture points of interest: a non-exhaustive and iterative exercise which involved making detailed comments and notes on the data and engaging with the data both broadly and in-depth. Comments were made on the similarities and differences, extensions and inconsistencies in the participants' accounts.
3. Synthesizing preliminary themes by reviewing exploratory notes: reviewing exploratory notes developed in the above step, then rearranging and restructuring the data into smaller manageable pieces and subsequently, "themes".
4. Grouping and organizing emerging themes to structure data: compiling themes based on their similarities, differences and contextual settings. This step was defined by the scope of the research question. Themes were clustered together under categories, also known as "super-ordinate themes." Super-ordinate and their constituent sub-themes represent a hierarchical or relational structure between the emergent themes.
5. Reviewing the next case: upon completion of the above steps for a given piece of data, moving to the subsequent piece of data (e.g. another participant's interview transcript) and repeating steps 1 – 4. As per IPA's idiographic focus, each case was reviewed such

that new themes could emerge in the current analysis. When reviewing each new case, the researchers see the new dataset in its fullness and code new themes, without particular regard for any themes that may have already been generated in the previous cases. This process endeavors to minimise the influence of previous analyses on the current analysis.

6. Looking for patterns across cases: identifying connections between the various cases and their themes. Consequently, restructuring and renaming the themes to ensure consistency in the terminology of the super and sub themes.

Brocki and Wearden (2006) highlight the importance of employing reflexive procedures in IPA. To enhance rigor in the execution of research, consideration of personal known and emergent conceptions, and emotional responses to the data is important (Smith et al., 2009). Therefore, reflexive note-taking was undertaken throughout the research process. The first author's responses to the data, both emotional and analytical, were also extensively discussed with the co-authors throughout the research process, from designing the research scope and methodology, data collection, to data analysis, and writing up of outcomes.

Results

During the interviews, participants talked about their personal symbolic meanings of their illnesses, as emergent from their experience of EFT therapy. Three major themes emerged regarding participants' symbology of their illnesses, namely, "illness as an embodiment of unresolved emotional issues," "illness as the body's call for time-out and attention," and "illness as a boundary from other people." This section unpacks these themes.

Illness as an Embodiment of Unresolved Emotional Issues

Participants described illness as an embodiment of unresolved emotional issues. Participants perceived an array of emotional challenges involving past traumas, limiting beliefs, and habits as being contributors to their illness experience. Fleur, for example, who had suffered from Chronic Fatigue Syndrome, elaborated on her understanding of the connection between her emotional issues and physical illness:

I think what became apparent when I found EFT was that I was doing all this stuff for my health ... I was eating really well, and doing all the things I am meant to be doing ... I had just started to meditate as well ... but I was not really getting far. When I found EFT, I realized that it could be underlying things that were keeping me unwell ... So, it made me... start to really look at you know, what I had been through in my life, and how I could resolve those traumatic events and ... those habits and programs I was running, and my beliefs and things like that. And it made me realize ... that it was all that really that had made me unwell, and it was all that, that was going to help me get well. (Fleur, CFS)

Fleur's account points to a search for the "missing piece of the puzzle" involving her healthcare, because making healthy life choices did not yield their expected benefits. Addressing emotional issues such as past traumas and negative beliefs through her use of EFT seemed to fill this gap for Fleur. Fleur also alludes to a sense of latency of the unresolved emotional issues, something that one may not necessarily be consciously aware of on a day-to-day basis. EFT then became a trigger for helping her to understand those unresolved issues from her past and subsequent healing.

Similarly, Kayley, who had also experienced CFS, described her understanding of the connection between her emotional and physical health. However, unlike Fleur who had not previously considered the role played by her emotional issues in her illness until she came across EFT, Kayley admitted to having perhaps an "inner knowing" about the impact of her emotions on her physical health:

I knew deep inside that I was ill because of emotional stuff, because I had never been happy and okay in my life ... And [if] I could ... look at as much of the subconscious stuff and manage to bring up and heal it, that my body would know what to do. That the body is meant to be healthy ... There is something in the way of it being healthy, but really the body will go back to full health if it is given the chance. (Kayley, CFS)

Kayley's account also adds to the previous discussion of the latency or buried nature of unresolved emotional issues, as described by Fleur. It appears that while Kayley perceived that her emotional state had contributed to her illness, she would need a therapeutic process (EFT, in this case) to bring their specific details to the fore and try and address them. Also noteworthy from Kayley's quote is an apparent personification or anthropomorphisation of the physical body, as if the body has a mind or conscious intelligence of its own and ability to undertake conscious action, illustrated by "my body would know what to do." Interestingly, she also seems to describe healthfulness as the body's default state, hampered perhaps through deviations, such as negative emotion or trauma.

Participants also described their physical bodily problems as being embodiments or manifestations of unresolved emotional issues. For example, Rhea, who had suffered from arthritis, recounted an experience of pain relief achieved through addressing of emotional issues:

My husband passed away almost 20 years ago. My children were really young at that time. So, there was really no time to stop and feel grief. And realizing that it was all those emotions that had been locked up... The lower back pain was crucial, and that was gone in like one major session that we did... The pain was gone. It was like literally gone [laughs]. It was emotions ... and attachment ... that I was holding in the back. Overnight when it cleared, I was like, "oh my God!" you know, "it's just gone!" And here I was, clinging on to stuff that I didn't even know. (Rhea, arthritis)

Rhea's account has an evident sense of disbelief at the speed with which her back pain dissipated after this particular EFT session in which she addressed her emotions surrounding

her husband's death when she was a young mother. There is a sense of "magic cure" of Rhea's back pain, once the emotional issues were addressed. The other noteworthy component of this account is Rhea's explanation of the apparent somatization of her unresolved emotional issues to back pain. Her expression "emotions had been locked up" describes emotions as being tangible, almost physically palpable entities with the ability to lodge and dislodge themselves in the physical body. This metaphorical entrapment of emotions in the physical body is also congruent with the notion of the latency of emotional issues that was discussed previously, wherein Rhea described not recognizing the emotions and attachments she had been "holding in the back."

In further explaining her experience, Rhea also said:

The pain was just something that the body was trying to tell me about [laughs]. (Rhea, arthritis)

This quote adds to the evolution of the discussion on the anthropomorphisation of the physical body, whereby the pain is viewed as a linguistic tool for the body, a messenger perhaps, for the body's needs. This notion of illness as part of the body's language, is explored further in the following theme.

Illness as the Body's Call for Time-out and Attention

Participants' accounts further illustrated the notion of illness as a messenger for the body. Many of the participants discussed long-standing behavioral patterns of "pushing themselves" to the point of exhaustion and a physical state vulnerable to illness. They suggested that unresolved emotional issues and limiting beliefs from the past may have contributed to the maintenance of these unhelpful behavioral patterns and consequent ill health, for example:

Both my parents were war veterans... there was alcoholism in the family, lots of violence. So, I learnt ... that I need to be independent. And I have to look after myself. Don't complain you know, when you are sick. You have to find your own way, don't tell people... And, don't give yourself that much

attention. Just keep going. Just keep going, keep working ... Be [a] good girl ... Be the good girl. Be the good girl, the good girl ... And, rather than relaxing and taking it easy, telling people I am sick, and I can't come to work, when I started feeling the symptoms that day... I was like "no you are going to work" ... You know it was the physical exhaustion ... It was the body asking, like the body sending me signals. It calls you to attention. It just stops you [chuckles] ... [the body says] "just stop and give me and attention." (Candace, Fibromyalgia and Migraines)

Candace perceives a clear role played by the difficult family environment experienced in her early life, in inculcating emotional and behavioral patterns of overdoing and pushing her body beyond its limit. As Candace is recounting her past experiences, she seems to have no trouble presenting a number of different examples of beliefs and ideas, illustrating the extent to which she attributes her early life experiences to have contributed to unsustainable behavioral and emotional patterns. Furthermore, the repetition of the phrase "be the good girl" is also to be noted, demonstrating a poignant cultural narrative. This phrase also has resonance with the archetype of the responsible and "does as she is told" female who meets her commitments without complaining, often at the expense of self. Furthermore, Candace's quote also adds to the exploration of the anthropomorphized body, whereby she views her illness as the body's messenger, an expression of the body's need to be cared for, and attended to. There is also a notion of an impasse between the learned cultural behaviors of "being the good girl" and pushing herself, and her body's ability to continue performing and living up to those expectations; ultimately leading to a breakdown of the status quo, in her case, through an illness experience.

Similar to Candace, Alicia also described a tendency to push herself to exhaustion:

The other expectation which ... has been really big in terms of my healing journey was the need to push on. This whole you know... other people are depending on me. I have just got to... push through it ... Pushing through the tiredness, thinking if I get it done, I can relax... The way I was brought up was just "suck it up." And so, a very large part of my current journey, and to a certain extent, my work in EFT

has been, not doing that, and working out, what I refer to as "hell yeah, I want to do that." Like, "really, why am I doing this?" ... So picking my battles... simplifying my life, and ... doing what really matters to me. (Alicia, Mast Cell Activation Disorder and CFS)

Alicia's account illustrates her journey from constantly over-doing and pushing herself to now pacing herself. Alicia's patterns of overworking in the present for a prospective reward, such as a potential future opportunity for relaxation, and the fear of disappointing or letting other people down, suggest a general precedence of responsibility over wellbeing. Alicia also presents a significant cultural narrative that enduring distress without complaining (as illustrated by the vernacular "suck it up") may be considered the more morally correct or virtuous way of being in the world. Alicia used EFT to address these unhealthful patterns and bring about greater self-awareness to assist her decision-making regarding her day-to-day choices and workloads. Consciously and actively questioning her own motives for doing things, and doing less seems to have been beneficial for Alicia. The growth from pushing herself because other people were seemingly depending on her, to now doing "what really matters" to her personally also demonstrates an enhancement of her own sense of self-worth and improved capacity for self-care.

CFS patient, Daisy, also described her long-standing behavioral patterns of over-doing beyond her physical capacity:

I was a very driven person, so I fitted that classic thing of just not stopping, always wanting to do. I used to compete, show jumping and different kind of things when I was a teenager. That was really [laughs] tiring and exhausting... at least two days every week where I was competing... I was also a music journalist in my teens and my twenties... Work was really full on and then you would always be leaving work to go to an album launch or a gig that went on really late at night. So, again that was more, [laughs] more exhausting myself ... So I suppose it's all a perfect recipe for gaining CFS ... I didn't really know [laughs] that I was meant to pace myself or I wasn't meant to push myself, that that was a really bad idea (Daisy, CFS)

Daisy introduces another dimension to this theme, i.e. over-achievement and exhausting oneself in the pursuit of goals. Daisy engaged in a wide range of activities which could otherwise be enjoyable, life-enhancing, or rewarding. However, the way Daisy partook in these activities at the expense of her personal wellbeing, trying to fit in a large number of activities in her daily schedule, made them exhausting. There appears to have been a lack of mindful self-awareness with respect to the impact of these activities on her health and wellbeing at the time. While Daisy may have initially started pursuing these goals and hobbies with the view to bring some form of life-enhancement, when they became health-detering, she seems to have continued pursuing them for the sake of pursuing goals, rather than for the personal satisfaction or fulfilment that these activities may otherwise have brought. Daisy's use of the expression "perfect recipe for gaining CFS" is also noteworthy, and reflects her current understanding that her lifestyle was unsustainable at the time. Her use of the expression "perfect recipe" suggests the almost inevitability of an illness setting in, given her exhausting lifestyle. Daisy also laughs almost self-deprecatingly, recounting her former lack of understanding around the need for self-care, something that is very obvious to her in the present day. This reflection illustrates a substantial change in Daisy's current perspective on life, and in her behavioral patterns.

Illness as a Boundary from Other People

This next theme illustrates participants' view of illness as serving a "boundary" from other people. This theme, 'illness as a boundary from other people', is somewhat interlinked with the previous theme, 'illness as the body's call for time-out and attention', wherein the illness is viewed as a messenger for the body. This theme represents a continuation of the previously described notion of the anthropomorphized body which has an ability to think and call the person towards more self-care and attention. While similar in that regard, the current theme is

distinct in its focus on illness providing a sense of buffer or space from other people. The previous theme, on the other hand, illustrated implications of beliefs, behaviors and emotional patterns relating more to the self. The current theme, however, contextualizes the illness experience in participants' ways of dealing with and relating to the people in their lives. For example, participants described their tendencies to over-empathize with other people, or "over-help" others to a point that their own needs were compromised. For example:

My mum was a very big helper. She was always helping other people, and giving up her own things for other people. And she expected me to do the same. And any time I couldn't or I didn't want to, then she basically told me I was being selfish. There was no room for me to have needs basically. I was meant to be giving, giving to everybody... So I guess I had to make myself worse off than everybody else in order to be looked after and given the space that I needed to not have to help people anymore because I couldn't.... I wasn't allowed to have needs, to have boundaries. So, that was my boundary. I had a reason why I couldn't give to people... that was the only way my body knew to deal with, with not being able to cope with my life any more. (Kayley, CFS)

Kayley's account illustrates the disempowering impacts of familial obligations and expectations on her wellbeing. Her experiences resonate with the cultural notion that there is virtue in selflessly serving others at the expense of self, and looking after oneself equates with being selfish. Kayley's quote also suggests a lack of personal agency, a sense of needing "permission" perhaps, from other people (e.g. her mother) to look after herself; particularly illustrated by her expression, "I wasn't allowed to have needs." Kayley alludes to her illness as giving her almost a socially acceptable reason as to why she could not continue to serve others, and instead needed support from other people. Her account also has resonance with the concept of anthropomorphisation of the body that has been previously discussed, whereby the illness is viewed as a messenger of the body. Here, Kayley alludes to her illness almost as the body's coping mechanism, as a way for legitimizing her body's needs for personal boundaries and self-care.

Fibromyalgia patient Candace, also described her lack of self-care, and tendency to put other people before herself:

I was running around, taking care of everyone else ... Mothers sometimes do that. And ... if I think back long time, [I had the belief that] family is first. You know, and I am like a second ... that's my biggest lesson, actually ... That I am equal with my family. (Candace, Fibromyalgia and migraines)

Candace's quote suggests that the propensity to always put other people first may sometimes stem from cultural and social expectations of certain roles or archetypes. Her account portrays the cultural narrative of the hard-working, giving mother and selfless female figure who serves her family righteously without regard for self. Candace states that such a behavioral pattern fueled by the cultural expectations of mothers led her to 'burn out' Candace's quotes such as "I am second," and "family is first" are particularly noteworthy and demonstrative of a traditional social narrative, whereby despite serving her family selflessly, the mother occupies a somewhat lower position or rung in the family's hierarchy of importance. Candace eventually journeys from this apparent conditioning, towards a sense of greater self-worth and ascription of "equal importance" to herself.

Participants described various ways in which their illnesses provided a buffer or barrier from other people. For example, the previous two accounts presented participants' tendencies to "over-give" to others, often at the expense of self. In addition, participants also expressed proclivities towards over-empathizing with other people's suffering, to the point that it impacted their own wellbeing. For example, Hannah recounted:

I get pain because I'm an empath; I feel other people's pain ... 85% of what I feel physically in my body is not mine ... I have a "secondary gain," I think it's called. If the Crohn's goes, I will have no excuse to hide ... I am always looking for a safe place to hide. Always. I sit at the back of rooms; I don't go to movies very much unless I really like the movie. I stay away from crowds ... I would say no to social events. It would have given me the excuse to "oh, I'm just too tired," "I'm just too sick," "I can't go," "I can't do." (Hannah, Crohn's Disease)

Hannah describes a somatization of her perception of other people's pain in her own body. Her quote also alludes to a somewhat involuntary nature of her empathy, and her perception of a strong external locus of control in relation to her wellbeing. Her repeated use of the term "hide," and coping mechanisms such as staying away from crowds, not going to the cinema, sitting at the back of rooms, and declining social invitations are also to be noted. These poignantly illustrate the difficulty associated with her heightened empathy for other people's suffering, to the point that the distinction between her own and other people's distress becomes blurred. The strong external locus of control also means that "hiding from people" becomes a key coping mechanism for her sensitive temperament. Additionally, Hannah introduces the paradoxical concept of "secondary gain," a perceived benefit from having an illness. Hannah describes her illness almost as offering a refuge from other people; as providing a reasonable justification for not engaging in social interactions and activities that she did not wish to partake in.

Another participant, Fleur described her exploration of secondary gains as part of her EFT therapeutic process:

One of the other things that was a big shift for me was I started looking into secondary gains ... When I started to get unwell, I realized that I didn't have to attend things I didn't want to. I didn't have to do things I didn't want to. I didn't have to see people I didn't want to. And it came quite that side of it, that illness [was] quite convenient. Because I had never been good at saying no. I never had barriers. I just used to run around trying to help everyone all the time, despite what was going on with me. So, that side of the illness made me a little bit selfish, but in a way that I should have been being anyway for myself... So, when I started working on those through Tapping, again there were big shifts there as well. I felt that energetically, physically, mentally everything. (Fleur, CFS)

Fleur's quote presents an interesting narrative, whereby saying "no" is viewed as a bad or selfish thing. Paradoxically, Fleur uses the term "convenient" to describe her debilitating illness, implying that it perhaps seemed easier to have an illness experience, than "selfishly" saying "no" to other people. There is a sense that the illness might have even provided

permission from the self to withdraw from other people and social demands. Fleur's quotes also echoes the previous discussion, whereby the illness provided the participants a way of legitimizing self-care or putting their own needs over others. Fleur admits to feeling significant benefits from addressing these secondary gains through the EFT (Tapping) process, illustrated by the quote "big shifts." For some participants, e.g. Fleur, becoming "more selfish" is seen almost as a symptom of personal growth and empowerment. A greater sense of this apparent selfishness is suggestive of greater self-agency and internal locus of control.

Discussion

Frank (1995, p. 6) argues that the experience of illness begins when "ill people recognize that more is involved in their experiences than the medical story can tell." The current article explored chronic disease patients' meaning-making of their illnesses in their broader existential frameworks. Common themes that emerged explored patients' accounts of their illnesses as "somatic metaphors" of their life stories, emotional or behavioral patterns, and subjective life experiences. In phenomenological literature, as described by theorists such as Edmund Husserl, Merleau-Ponty, and Heidegger, there is a conceptualization of the "lived body" (Toombs 1988). The lived body, as the name implies, represents the bodily experience as it is lived from within by the person. The body is not an object situated in a world, instead, it is the person's view of the world (Toombs 1988; Wilberg 2011).

Kleinman (1988) proposes that a disease can be more holistically understood as a manifestation of social or psychological trauma that is expressed via cultural narratives, and/or metaphors. As such, a clinician must not only appreciate the patient's physical body and symptoms as objects to be treated, but also as a subjective embodiment, or harbinger of the patient's biography, life experiences, and social interactions (Kleinman 1988). Kleinman

(1988) also argues for the importance of giving patients the opportunity to recount and re-present their stories in their own words.

This article presented three themes emergent from chronic disease patient accounts, namely, “illness as an embodiment of unresolved emotional issues,” “illness as body’s call for time-out and attention,” and “illness as a boundary from other people.” Participants often portrayed a personified view of their physical bodies, as if the body has its own conscious intelligence, and an ability to undertake conscious subjective action. Participants often referred to their illnesses as being harbingers of their bodies’ messages about their needs.

Participants described their perceptions of their illnesses as embodiments of unresolved emotional issues. Wilberg (2014) argues that every mental, emotional, or psychological state is also a bodily state. A mental state is not merely an entity contained within a person’s mind or brain, but is also experienced or expressed in the body, and vice versa. Consequently, Wilberg (2014) argues that aspects of illness should not be classified into mental and physical components. Instead, an illness is best viewed from a personhood approach, as postulated by the lived body conceptualization.

The second emergent theme explores patients’ notion of illness as the body’s call to attention and a trigger for time-out. Participants discussed their behavioral patterns of pushing themselves too much, over-doing, over-achieving, having to be independent, and not expecting social support. Ware (1993) presents research involving interviews with 50 chronic fatigue syndrome patients, to understand and identify themes in the participants’ life histories and illness experiences. A common theme emergent from the study was around high personal standards for performance, difficulty saying “no” to people, over-helping others, over-giving etc. Participants used terms such as “workaholics,” “perfectionists,” and people who “would go all out,” or “push themselves to do more.” The participants claimed to give so much to others that they had very little resources left for themselves. Saltzman (1991) has described this

notion as a “cult of busyness,” an “exhausting lifestyle,” that involves “over-doing, overworking, over trying to please everybody, and just over-everything.” Ware (1993, p. 72) also denotes this to be a “health-hazardous cultural morality.”

Several cultural narratives presented in the current study include the “good girl,” and “the selfless feminine figure,” and “the hardworking mother.” Participants discussed their longstanding behavioral patterns of compromising their own needs for other people arising from patterns learnt in childhood, or exhibited as a result of unconsciously following societal expectations of certain roles. Chanfrault-Duchet (1991) describes this as a conflict between the self and the society. Simmons (2009) presents the notion of the “curse of the good girl,” as a psychological glass ceiling, and a set of unsaid rules that the good girl must follow, e.g. not getting mad, not crossing the line, not having opinions, and so on. Simmons (2009) argues that being unconditionally selfless, giving, or kind is an impossible pursuit, one that only renders females who aim to express this goodness, as perpetually self-critical due to not achieving these unachievable standards. Walkerdine (1985, p. 231) also notes that the construction of the good girl narrative includes being “nice, kind and helpful”. Similarly, Roseneil (1996, p. 100) attests, even within the twenty-first century, women are still expected to be first and foremost “domestic creatures” and nurturing wives and mothers. Women who do not nurture, Roseneil (1996, p. 100) argues, are “castigated as selfish and unnatural”.

The final theme presented in this article was around “illness as a boundary from other people.” Participants discussed their perception of heightened empathy to other people’s suffering, and perceived somatization of others’ suffering as pain or discomfort in their own bodies. There are two contesting viewpoints of empathy in phenomenological literature (Zahavi 2014). The first view suggests that empathy allows for a direct perceptual experience of another’s experience. The second view suggests that empathy is a person’s self-mediated, cognitive, indirect understanding of another’s experience. The participants’ accounts suggest

that some participants appeared to feel that they were having direct experiences of other people's pain, including some participants perceiving their empathetic experiences to be involuntary. Indeed, if they viewed their empathy as their own constructions of other people's pain, they might not feel so disempowered and lacking control.

“Secondary gains” is a concept that first emerged in psychoanalytic literature (Fishbain, Rosomoff, Cutler & Rosomoff, 1995). Fishbain et al. (1995) suggest that secondary gains can have direct correlation with illness behaviour. Davidhizar (1994) also indicates that secondary gains may contribute to patients' wanting to continue to “remain in the sick role.” The study's participants, however, present secondary gains as notions or meanings constructed as part of the EFT therapeutic process. Participants talked about their perceptions of secondary gains in that, their illnesses provided them what they thought were “legitimate” reasons to justify their lack of social interactions, inability to engage in employment, inadequacy to help people at the expense of self. Disease was perceived by the participants, as offering a “refuge” or “space” from a variety of burdens, including but not limited to social demands, stressful job or life situations, and pressures to assist or other people at the expense of self.

Traditional talk therapists typically work with the conscious mind, deriving inferences and guiding clients in the therapeutic process by observing and altering thoughts and behaviors (Soon, Brass, Heinze & Haynes, 2008). Some researchers argue that the therapeutic process of EFT through its combination of somatic engagement with cognitive tools may be providing greater access into the unconscious mind more readily than talk therapies (Simek, 2020; Craig, Bach, Groesbeck & Benor, 2009; Feinstein, 2018).

Implications for Practice

Emotional components and metaphorical patterning in the generation and maintenance of physical illness were described by eight of the eight study participants. They also attributed improvements in their physical condition to having addressed such influences. These findings suggest that assessing the psychosocial and existential aspects of an illness as a routine part of medical diagnostic procedures would be valuable, and that provisions for working with these influences when identified should be made available. The eight cases reviewed here, as well as several clinical trials (Bach et al., 2019; Bougea et al., 2013; Church et al., 2014; Church & Palmer-Hoffman, 2014; Hodge & Hurgens, 2011; Ortner et al., 2014; Stapleton et al., 2012a), show EFT to be valuable in identifying and resolving psychological and existential aspects of physical healing.

The themes emergent from this study allude to the view of illnesses serving a “purpose” in the patients’ life-worlds. The anthropomorphisation of illness and the ‘body’ by the patients through notions such as the body using illness as a means to get the patient’s attention, imploring a period of rest, or a break from constantly helping others at the expense of personal well-being, points to the patients’ recognition of their previous unproductive health behaviors. It appears from the patients’ accounts that upon making sense of their illness experiences, they were able to gain new insights about their previous unhealthy thought and behaviour patterns and consequently inculcate more healthful patterns. It thus appears that illness constructions and meaning-making of illness experiences may offer therapeutic value to patients, not only in an existential sense, but also as a means of prompting recognition of current and past unhealthy thought and behaviour patterns, and development of new healthful behaviors.

The concept of secondary gains, indeed a paradox, as discussed by the participants also offers noteworthy implications for healthcare practice. The illness experience, otherwise a difficult, often debilitating experience is suggested to offer a benefit, a refuge perhaps from

demanding people, responsibilities or life circumstances. Practitioners may therefore, assist patients look into their personal secondary gains. For example, practitioners may facilitate an exploration of the underlying feelings of low self-worth or social conditioning that may be leading patients to repeatedly “over-help, over-do, or over-achieve” at the expense of their personal wellbeing. Reviewing belief and emotional patterns that trigger or perpetuate behaviors detrimental to health may thus offer therapeutic value to patients.

Limitations of study

The IPA methodology requires a participant sample to be homogenous. Most IPA studies incorporate homogeneity of participants’ socio-demographic characteristics. In the current study, participants varied in age groups, and geographical locations, albeit all participants were based in developed countries. The homogeneity of the sample in the current study mainly arises from the participants’ use of EFT to support their physical chronic disease healthcare. As participants were located in different countries, and countries vary in their public health care systems and arrangements for their citizens, this could influence the experiences of the study’s participants.

Since only women responded to the advertisement calling for research participants, other genders’ experiences could not be explored. This might form the basis for a future research project. Out of the people expressing interest, those who met the inclusion criteria were shortlisted for the study. There was no intention to exclude other genders from the study, but it was a logistical or matter of chance in the study. Nevertheless, because the predominance of females in the sample was not an intended outcome, a feminist methodological basis for the study was not explored or considered - although it might be useful for explorations in further studies. It should also be noted that for the larger EFT study, however, one male EFT practitioner participant and one non-binary gender practitioner participant had been included.

On another note, an all-female participant sample for this article, can also be seen to increase the homogeneity of the sample. Additionally, some researchers suggest that women are more likely to be impacted by long-term chronic illness which can affect their quality of life (e.g. Abdelaziz 2007). This study took various different chronic health conditions under consideration. Given that chronic diseases vary so widely in their causes, symptoms, and treatments, the findings of this study may be interpreted in the context of generalized patient well-being only, and not disease-specific healthcare.

We also note that this article reported results associated with an investigation of eight (8) research participants. This sample size may be considered to be small in case of quantitative, or even qualitative research studies that are conducted from a realist epistemological perspective. However, for the current study which adopted an idiographic lens and interpretative phenomenological analysis methodology, smaller sample sizes are considered common, even recommended practice to allow for detailed investigation of individual cases (Smith et al., 2009). Nonetheless, there is value in conduct of further research studies with similar epistemological paradigms with larger sample sizes to further investigate the commonalities and distinctions in the illness metaphor patterning in larger participant populations.

Conclusion

This study explored chronic disease patients' personal symbolic meanings of their illnesses as emergent from their experience of EFT therapy. Three major themes emerged in relation to patients' meanings of their illnesses, namely "illness as an embodiment of unresolved emotional issues," "illness as body's call for time-out and attention," and "illness as a boundary from other people." An illness may be phenomenologically viewed as serving a purpose in the broader existential framework of a person's lived world. EFT offers promise as a suitable

therapeutic approach to help chronic disease patients make sense of their life stories and lived experiences, and consequently, symbolic meanings of illnesses. The exploration of illness symbology and meaning-making may offer therapeutic value to patients, from both an existential and a health behaviors perspective.

Conflicts of Interest

The authors declare no conflicts of interest.

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Table 1: Participant Information

| Participant pseudonym | Age | Country of Residence | Gender | Health condition | Overview of EFT utilisation |
|------------------------------|------------|-----------------------------|---------------|--|---|
| Alicia | 53 | Australia | Female | Mast Cell Activation Disorder and Chronic Fatigue Syndrome | Self-administered, With practitioner (primarily online therapy) |
| Candace | 56 | Australia | Female | Fibromyalgia and migraines | Primarily self-administered |
| Cassandra | 65 | USA | Female | Chronic Fatigue Syndrome and Fibromyalgia | Self-administered, With practitioner |
| Daisy | 46 | England | Female | Chronic Fatigue Syndrome | Self-administered, With practitioner |

| Participant pseudonym | Age | Country of Residence | Gender | Health condition | Overview of EFT utilisation |
|------------------------------|------------|-----------------------------|---------------|--------------------------|---|
| Faith | 36 | Scotland | Female | Chronic Fatigue Syndrome | Self-administered, With practitioner |
| Hannah | 57 | Canada | Female | Crohn's Disease | Primarily self-administered |
| Kayley | 23 | England | Female | Chronic Fatigue Syndrome | Self-administered, With practitioner (primarily online therapy) |
| Rhea | 55 | Australia | Female | Arthritis | Self-administered, With practitioner |

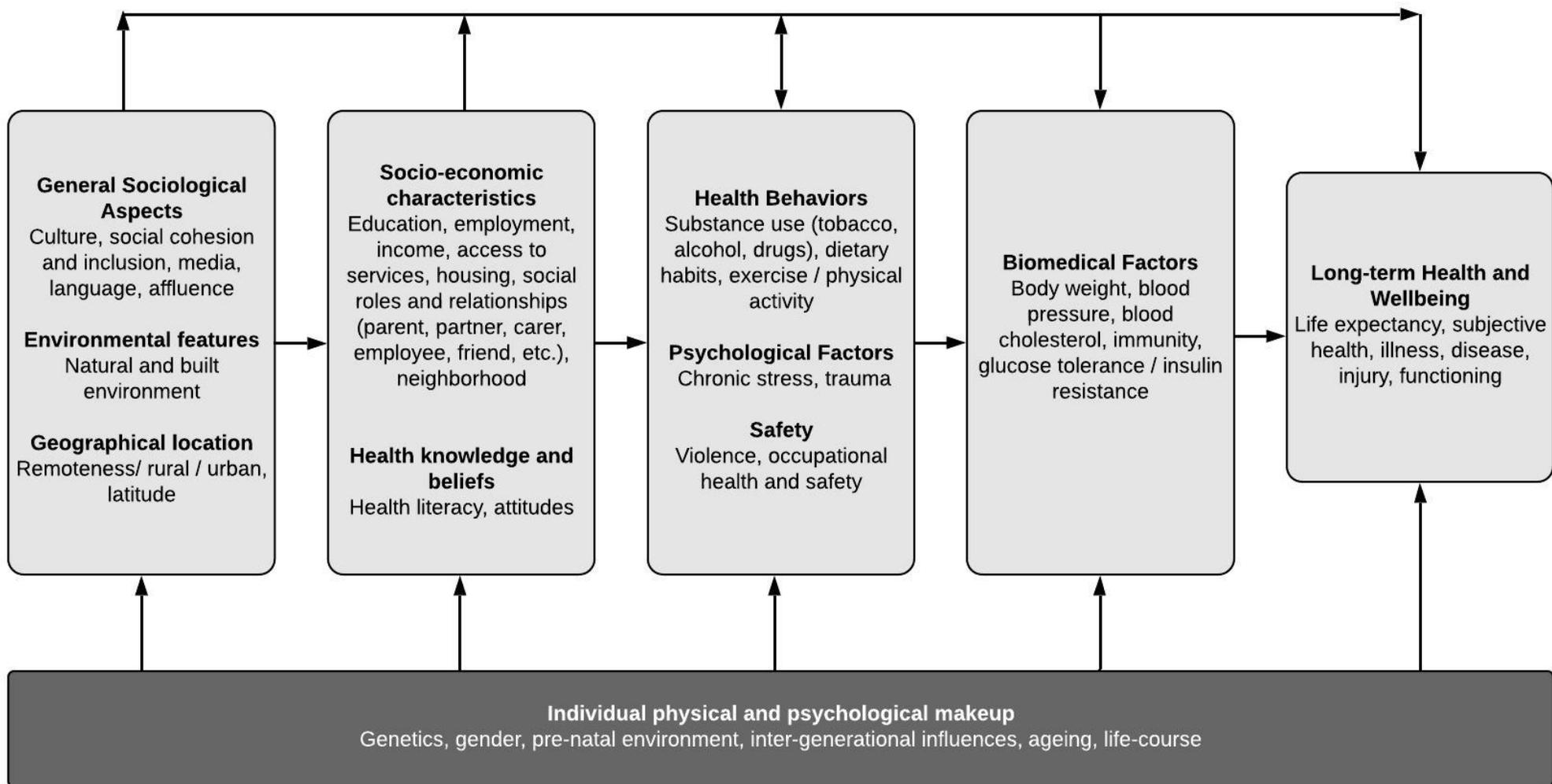


Figure 1: Conceptual Framework for Determinants of Health and Chronic Illness Risk Factors (adapted from AIHW, 2012; Figure 1.1; p. 4)