The benefits of back pain
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Background. Chronic lower back pain (CLBP), without definable cause, is a symptom commonly presented to GPs, accounting for a significant proportion of their workload; it is also a common reason for sickness absence, and thus of national economic importance.

Objectives. This qualitative study aims to explore how sufferers of CLBP describe their pain and its impact on their lives, and how their problem is dealt with in the consultation with their family doctor.

Method. Semi-structured interviews were carried out with a sample of attenders at a back pain clinic set up in general practice. Transcription and analysis was carried out using a grounded-theory approach.

Results. Sufferers of CLBP describe withdrawal from normal social obligations, including work. They view their GP as being unable to help and, because of this, the doctor becomes a resource through which their social and economic inactivity can be legitimated.

Conclusions. Presenting with CLBP permits the patient a good deal of power over the GP: it is difficult for the GP to challenge the patient’s ideas without damaging the relationship. GPs are forced to collude with the patient’s definition of ill-health, which may not be in the best interests of the patient or society.

Keywords. Chronic lower back pain, sick role, psychosocial variables.

Introduction

Chronic lower back pain (CLBP)—when pain is localized to the lumbar spine, or referred to the leg—is commonly presented in general practice. Lifetime prevalence of lower back pain has been estimated at 60%, and it has been estimated that up to 80% of the population will present these symptoms in general practice at some point. It has been suggested that there is little difference in prevalence between men and women, but that a disproportionately higher burden of such pain is borne by socio-economically disadvantaged groups in society.

CLBP presents the GP with a significant management problem, once sinister signs and symptoms have been excluded. It is well established that pain is often experienced in the absence of an identifiable organic pathology, that both the severity of experienced pain, and the level of disability as a consequence of this, may be difficult to relate to the severity of organic pathology where it can be identified; and that there are complex relationships between the experience of pain and psychological and sociological variables. Similarly, there is now much evidence to suggest the co-occurrence of CLBP with depression or anxiety.

We can predict the dilemmas that the GP faces as follows:

- how to manage expressed pain;
- how to identify psychosocial variables that relate to functional somatization;
- how to respond to the patient’s demands for further investigation and treatments that will ameliorate experienced pain;
- how to manage the patient’s gradual disillusionment with the failure of medical investigations and treatments;
- how to respond to the patient’s definition of pain as the consequence of physiological degeneration.

In the face of these dilemmas it is not surprising that much of the clinical management and treatment of long-term disabling chronic lower back pain is often ineffective, and that sufferers become increasingly pessimistic about the possibility of recovery. Sufferers themselves face a set of dilemmas about how...
best to respond to the apparent failure of clinical investigations to demonstrate 'what is wrong' and the extent to which health professionals appear to be confused in the face of their symptoms. In addition, the patient also has to make sense of, and respond to, suggestions that the 'real' pain and disability that he or she experiences is not of organic origin and reflects underlying psychological problems.3

Given the foregoing, it makes little sense to view CLBP as a localized clinical problem. Instead, its presentation and continued experience needs to be understood in a wider social context, in which the ways in which the two sets of participants in a consultation conceive of each other play a key role. This paper takes such an approach, reporting on a qualitative study which attempts to examine the ways in which sufferers of CLBP and GPs conceptualize the 'problem' of managing each other. This paper explores the descriptions of back pain by expert patients and the definitions that sufferers apply to the activities of GPs. A hypothesis is explored that suggests that back pain acts as a resource for a patient and discusses the implications this has for the consultation.

Method

The study was set in a large inner-city general practice (12 500 patients), in central Manchester. The area is characterized by high levels of socio-economic deprivation and unemployment, poor housing stock and crime. The area is also characterized by a significant degree of ethnic diversity.

In 1996 a back pain clinic was set up in the practice, funded by Regional ‘waiting list initiative’ monies, aimed at reducing referrals to secondary sector services. The clinic was staffed by an osteopath and an acupuncturist, and patients were referred by GPs for assessment and treatment (up to a maximum of six sessions) if they fulfilled the following criteria:

- aged 18–65 years;
- back pain experienced for more than 6 weeks in the previous year;
- no sinister symptoms;
- previously investigated as clinically necessary;
- no demonstrable organic pathology.

Over a period of 12 months, 86 patients were referred for assessment; three were inappropriately referred and two reported that they had been referred without their agreement. Forty-one completed assessment and treatment. Importantly, the rate of attendance was poor: some 21 did not attend their first appointment, and 19 subsequently failed to attend for second or subsequent appointments.

The present paper arises out of an audit evaluation of the clinic for which local ethics committee approval was obtained. All persons referred to the clinic were invited to complete a structured evaluation questionnaire, and those in a subgroup of 20 were asked to participate in a semi-structured, face-to-face interview which focused on their experience of CLBP and of treatment to date, and their expectations of the treatment offered by the clinic. Interviews were tape-recorded and transcribed, with the subjects' permission, and transcripts were analysed using a conventional qualitative method.6

The study group was diverse: consisting of nine males and 11 females aged between 21 and 56 years. It also reflected the ethnic diversity of the area; self-reported ethnicity was as follows: eight white British, five Afro-Caribbean, six from Pakistan or Bangladesh, and one Middle Eastern.

Results

CLBP demands withdrawal from normal social obligations

Subjects provided a relatively uniform account of the aetiology and trajectory of their pain. Its onset was often mysterious, suddenly disrupting normal activities:

‘‘The pain came suddenly, like a bolt from the blue.'’ (33-year-old South-Asian male)

Such pain is immediately debilitating; it leads to the patient systematically withdrawing from normal social and economic activities. But what was striking about subjects' accounts of their pain was that it was defined in terms of passive acceptance of inevitable degeneration. This was frequently seen in terms of inherited abnormality:

‘‘I was bound to get it, like my mother. I knew I’d get it—it's hereditary—well the specialist said it was arthritis of the spine; Dr T [the GP] says its spondylosis; I think it's hereditary.’’ (47-year-old white British female)

Such pessimism was a common feature of subjects' descriptions of the onset and trajectory of their disorder. Central to this is the notion that the process of degeneration involved is a permanent feature of their lives, and that it leads to isolation. This involves the collapse of everyday responsibilities and obligations. Subjects reported that they were no longer able to meet the expectations of their families:

‘‘My mother, I couldn’t really go to nurse her when she needed help, or help her in hospital.’’ (42-year-old South-Asian male)

‘‘There was a bereavement in my parents’ house and [in our culture] most people sit on the floor, but I was lying down on cushions—it seemed very rude. (46-year-old South-Asian male)
The consequence of this was a high degree of dependence on others—either within the family or, amongst nearly all of the subjects in this study, on state benefits.

“...I ended up going home to my mum and dad ‘cos I needed help, my back was just stuck. I wasn’t able to go out to pubs or clubs with my friends, I was always saying: ‘Sorry I can’t go out because of my back’.” (21-year-old white British male)

“I would like to start some kind of work, but I cannot because I have no qualifications and I have got a physical disability.” (42-year-old South-Asian male)

Analyses of interview transcripts suggested that these subjects have a well-defined back pain ‘career’: their stories attest to the central organizing function that CLBP plays in their lives. Such accounts are often well-rehearsed and have considerable practical utility for them in their dealings with others. The kind of degenerative model that they deploy is well documented in a range of studies carried out over the past 20 years; its practical utility lies in the extent to which it acts as a resource to explain their disability and to legitimize their pessimism about the potential for recovery. When asked if he saw such a possibility, one subject responded thus:

“No, I think I will carry on with the pain, carry on with being careful, that’s how my life will go.”

(43-year-old Middle-Eastern male)

Some subjects were candid about the extent to which they subsequently deployed this intractable and disabling pain as a social resource, which explained their withdrawal from everyday activities—and especially from formal and informal work—to family, friends and the Department of Social Security. As we have already observed, most of the subjects in this study were on short-term sick benefits or long-term incapacity benefit.

“I mention it to people that I have this pain so that people can give me a bit of sympathy, perhaps, and give me allowances.” (43-year-old South-Asian male)

Subjects’ accounts of their experience of CLBP and their responses to it sit comfortably with much existing work around fear-avoidance models of pain: intractable pain incites fear that activity will exacerbate it, while inactivity further weakens the subject and makes discomfort more likely when the patient is mobilized. But a fear-avoidance model is, of itself, insufficient to explain the behaviour of subjects in this study. The role of the GP is vital, as will be discussed below.

Subjects recognized that their GP was unable to help, but viewed the doctor as a resource through which their social and economic inactivity could be legitimated. Subjects in this study had uniformly low expectations that medical intervention would alleviate their symptoms and permit a return to ‘normal’ life. They were caught in a cycle of degeneration and disillusionment. They were divided, however, over the question of whether their GP wished to help, but were unable to meet their needs; or whether the GP was also caught in a cycle of disillusionment and pessimism. The willingness of GPs to help was always placed in counterpoint to their inability to practically do so, however:

“I was seeing my doctor quite a lot and complaining and telling her of the pains and that, and it got to a certain stage when I was there most of the time, or I would just go in and pick up a bottle of painkillers. But then I started to get pains in my legs and it was very bad—and I did get to know her [the doctor] very well, but at the end of the day it didn’t get anything done. It was just someone else to talk to apart from my mum and dad, so I’d be happy after I’d seen the doctor, ‘cos I could have a chat with her. She knew that whatever she told me was not enough, I wanted something else, but at the same time she was trying to help me.”

(21-year-old white British male)

In this context, the doctor’s inability to act was well understood to lead them also to feelings of pessimism and disillusionment:

“I think, as a doctor, I’d feel helpless if, with something like back pain, not being able to offer much beyond pain relief.” (27-year-old white British female)

Similarly:

“If there’s something he could have done about the pain, the first time I came, he would have done it.” (49-year-old Afro-Caribbean female)

Other subjects imputed a general disillusionment to GPs.

“He must think, ‘oh no, not another one with back pain’. I mean, they do, don’t they?” (27-year-old white British female)

The role of the doctor here is not to offer a resolution for the pain, for subjects have no confidence that this can be achieved. But there is a degree to which their pessimism about the future trajectory of their pain appears to depend on the doctor being equally pessimistic. When this seems to the patient to be the case, then their own inactivity and withdrawal from normative expectations about conduct is completely legitimate.
Subjects recognize the relationship between psychosocial variables and pain
All subjects in this study recognized that there was a connection between psychological state and the experience of pain: but equally, they were concerned to emphasize that they were ‘not like the others’ and that their experience of pain was real. In this context, some respondents actively connected the experience of pain with psychological distress:

“. . . the effect the pain has on my life—it’s completely changed it. I feel a burden [tearful], they’ve tried to give me tablets for depression, but I don’t want them. I’d rather cope . . . sometimes when I’m on my own I cry buckets, then I tell myself to stop feeling sorry for myself.” (47-year-old white British female)

Similarly:

“. . . it just comes, mind you, when I have a lot of stress it comes. I think it comes at me more . . . it makes me upset and stressed, it makes me very low. I can be very low with it . . . I have cried you know, when I am on my own.” (56-year-old white British female)

Of course, the precise nature of the relationship between psychological distress and CLBP is difficult to establish. There is no doubt that the experience of pain and disability is distressing, and subjects in this study were doubly disadvantaged by the urban environment in which they live, and their own lack of economic resources. We cannot know, in these cases, whether psychological distress preceded and was manifested in CLBP or whether CLBP itself led to psychological distress. However, each subject described an experience of CLBP which fits in well with the association between chronic pain and depression that is affirmed by other studies. What seems to be at stake here is the degree to which it was important for them to be seen as ‘genuine’ cases in a social environment where the doctor may appear to doubt the ‘reality’ of the pain, but also where state sickness benefits are not an unusual means of obtaining additional income, especially where families have been affected by long-term unemployment.

Discussion
CLBP involves both sufferer and doctor in negotiating conflicting roles
So far, we have indicated that the experience of CLBP in this study group is characterized by a highly pessimistic explanatory model in which both sufferer and doctor are assumed to be powerless in the face of an intractable degenerative disorder. This is a compelling explanation for the poor level of attendance at the back pain clinic from which subjects were drawn, but it does not explain their relatively frequent consultations with GPs at the health centre.

One way to understand the frequency of consultation amongst these patients is to see their encounter with the doctor not as a clinical event, which might lead to a palliation or cure of their pain, but rather as performing an important social function. In the early 1950s the American sociologist, Talcott Parsons, observed that in Western societies being sick could be understood not simply as a pathological event, but as a kind of deviance from social norms organized around health. Conduct in relation to sickness, he argued, ultimately depended on the extent to which others were prepared to concede to the sick person an attributed identity or role that permitted them to depart from everyday obligations and expectations, about their individual behaviour and in relation to their contribution to group activities and tasks.

Parsons’ explanatory model, founded in ideas about roles—the ways in which we all organize activities according to learned models of talk and behaviour that ‘fit’ with those displayed by other members of the society to which we belong—has subsequently been much criticized. Nevertheless, it remains a useful way to conceptualize aspects of the social relationships between those who are ill and their peers. In most instances, assuming the ‘sick role’ means that individuals are conceded the right of temporary withdrawal from their normative activities by their peers at home and at work. At the same time, however, it is normally expected that they will seek appropriate care and the resolution of their symptoms. This acts to give legitimacy to their withdrawal from their everyday activities.

Subjects in this study were faced with a key problem. The cause of their pain was either unidentified (and unidentifiable), or the focus of disagreement between health professionals. At the same time, they continuously experienced pain and disability that was undoubtedly ‘real’ to them, and which made it impossible for them to live out ‘normal’ productive lives. Medical legitimation of this was a functional requirement of their circumstances: their self-identity, re-organized family relationships and state benefits depended on it. They had a great deal invested in it. In this context, it is not surprising that they were highly resistant to treatment strategies, which in the clinic were organized around mobilization and lifestyle changes, or through alternative treatments such as acupuncture, and which suggested that their recovery was a matter of psychological adjustment. Health beliefs organized around a simple model of mechanical degeneration and medical confusion leading to psychological distress enabled them to stay ‘locked in’ to the sick role. In turn, being sick had ‘added value’ in that it enabled them to avoid some of the stigma that is attached to unemployment and to psychological distress. At each stage of their career
Conclusion: some implications for GPs

It is clear that GPs find it difficult to resolve the kinds of problems that we have described above. GP training emphasizes that the consultation is a point of negotiation between patient and doctor, and building and maintaining a 'good' doctor–patient relationship is attributed paramount importance in GPs' own accounts of their work. Presenting with CLBP actually permits the patient a good deal of power over the GP: negotiation between doctor and patient enables the patient to make explicit their ideas about cause, and their expectations of treatment. It is difficult for the doctor to resist these, in part because the relationship between GP and patient is continuous. While other health professionals—to whom the GP may refer the patient—can place limits on treatment regimens or at the outset indicate that their treatment is not appropriate, the GP cannot. It is to the GP that the patient will always return, with CLBP and, more importantly, with other symptoms as they arise. An unsympathetic response to CLBP may mean that the patient is subsequently reluctant to attend if more sinister or serious symptoms appear. It is therefore in the doctor's interests to maintain the status quo and not to challenge the patient’s attribution of cause or effect in CLBP. The effect of this is that the GP is forced to collude with a definition of ill-health, and of appropriate responses to this, that may not be in the long-term 'best interest' of the patient.

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References