

Experiences of living with chronic back pain: the physical disabilities

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Abstract

Experiences of living with chronic back pain: loss and limitation in daily life

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Purpose: Back related functional limitations are largely assessed using lists of activities, each scored on a yes/no basis and the scores then summed. This provides little information about how chronic back pain (CBP) patients live with their condition. This study describes the consequences of living day-to-day with CBP and documents the 'insider' accounts of its impact on daily life.

Method: Unstructured interviews, using the 'Framework' approach with topic guide, were recorded and transcribed verbatim. Subjects were sampled for age, sex, ethnicity and occupation from new referrals with back pain to a rheumatology outpatient clinic. Eleven subjects (5M; 6F) were interviewed either in English (N=9) or their preferred language (N=2). Interviews were read in depth twice to identify the topics. Data were extracted in phrases and sentences using thematic content analysis.

Results: Four themes emerged: sleep/rest, mobility, independence and leisure. All subjects reported issues about sleep and rest, nine about mobility, seven about independence and six on leisure. Most descriptions concerned loss and limitation in daily life. Strategies for coping with sleep disruption and physical limitations were described.

Conclusions: Subjects provided graphic 'in depth' descriptions of experiences living with CBP every day; expressed regret at the loss of capabilities and distress at the functional consequences of those losses. Facilitating 'adjustment' to 'loss' may be more helpful than inferring the potential for a life free of pain as a result of therapeutic endeavours.

INTRODUCTION

Back related functional limitations are largely assessed using indices or lists of activities, each scored on a yes/no basis and the scores then summed. This approach provides little information about how chronic back pain (CBP) patients live with their condition. Although the value of functional status has been advocated, these types of measures are not widely used [1]. A better understanding of chronic back pain sufferers' experience of living with pain and insight into their motivations, needs and strategic approaches to coping on a day-to-day basis are needed. They provide health professionals with a better understanding of the patients' frame of reference. This enables health professionals to give better advice to patients if they are willing to operate from the 'inside world' as experienced by the pain sufferer.

Consequently the 'insider view' is increasingly used to provide this understanding. Recognition of the importance of documenting 'patient's voices' in narrative-based medicine is one aspect of evidence that contributes to better clinical practice [2]. Previous studies have explored patients' experiences of being 'caught up in the system' [3] and their transition from being well to being 'pain-afflicted' [4]. These accounts have also explored the ways individuals conceptualise and describe the quality and intensity of their pain and found that these bore little resemblance to commonly used assessment tools [5]. Such tools also fail to consider the experience and meaning of illness from the individual's viewpoint [6]. Similar accounts on the impact of chronic back pain on physical activity have not been published, although others have investigated functional activity items within standard questionnaires [7,8],

or used an existing functional index [9,10]. However, physical activity and return to normal life is widely recommended as beneficial for those with back pain [11].

The relationship between pain and pain behaviour to disability has been explored [9]. This study has also suggested that the functional correlates of low back pain can be simply and reliably measured. However the limitations caused by back pain in everyday life may or may not be fully accounted for in the formal assessments of activities of daily living (ADL). The insider perspective of chronic back pain is important to gain understanding about which functional activities are of most value to the individual. Without this insight, it cannot be understood how individuals perceive their disabilities and how their pain has influenced their ability to perform everyday activities.

Current advice to individuals with acute back pain is to maintain usual activities if possible [12]. If it is the responsibility of health professionals to assist their patients in maintaining or returning to their usual activities, then better awareness of the nature of those responsibilities is called for. The relevance of pain to function has been alluded to in a study of elderly people [9] but must be relevant to all age groups with limited activities due to pain. Commonly used functional assessment tools for those with back pain do not discriminate between those who report pain-related activities, those who exhibit pain behaviour, and those who decline to perform an activity for fear that such activities will increase their symptoms. Although Weiner et al [9] have called for observational studies, the insider account, which brings the individual's value judgement to bear on the information, may be more helpful.

Recommended outcome measures for low back pain include the Oswestry and the Roland questionnaires [13]. The Oswestry questionnaire includes a question about the influence of the pain on the 'social life' [14], but this lacks any helpful description of the nature of the limitations, whilst the Roland contains no broad social activities item [15]. Two other questionnaires, not included in the recommendations contain items about social activities including hobbies and sports [16] and the Dallas Questionnaire included an item on social life where the respondent could rate how much the pain interferes with activities such as games, going out etc [17]. This is surprising, given that the importance of individual's participation in valued activities such as leisure is recognised [18]. By relinquishing social participation, feelings of loss about perceived quality of life and emotional distress [18] will not be appraised.

The impact of pain and its associated disabilities are thought to be influenced by sleep [19], and the value of an unbroken night's rest is important for pain management [19-21]. Sleep is also seen to be an important outcome measure in pain research [21, 22]. However, little is known about the patient's experience of disturbed sleep and how and why they attribute the cause of the sleep loss to their back pain.

Mobility disability is addressed in most commonly used back pain assessments. The Aberdeen has 'walking' as a response category for two items [16], the Dallas incorporates mobility items directly [17], while the Roland has the widest range of mobility items [15].

The purpose of this study was to explore and describe the physical consequences of living day-to-day with CBP and to document the 'insider' accounts of how the pain impacts on daily activities.

METHODS:

Sixteen subjects were approached. They were identified from the referral letter as new patients. They had been referred to a rheumatology outpatient clinic and the referral letter suggested that low back pain was the primary problem. The subjects were purposively sampled for age, sex, ethnicity and occupation and 12 agreed to be interviewed and to have their interview tape-recorded. However, one interview could not be recorded due to equipment failure. Interviews were unstructured using the 'framework approach' and followed a topic guide [23,24].

Subjects were interviewed in English (n=9) or their preferred language (n=2) prior to attending their outpatient clinic appointment. Interviews took place in the subjects' homes by prior arrangement. Each interview lasted between 45-90 minutes. One interviewer was fluent in appropriate Indian languages and subjects were given a choice of language preference for the interview. All interviews were tape-recorded and all subjects provided informed consent.

Recordings were transcribed verbatim and read in depth twice to identify the topics or concepts. The 2 non-English interviews were translated from the tape recordings by one researcher with appropriate linguistic skill and the translations later checked independently by another researcher fluent in the languages used.

Data were extracted in the form of words and phrases using thematic content analysis. The themes of interest related to physical disabilities. An independent researcher, who was not involved in the interviews, reviewed the data and confirmed or contended the analysis. Any disagreements were discussed with reference to the topic guide used in the interview to identify the topic that triggered the response.

When the subjects attended their outpatient clinic appointment, further data were collected as described previously [5]. The data relevant to this report are total duration of pain, duration of the current episode of pain, the Roland and Morris back pain disability questionnaire [15], the Modified Zung score [25] and the subject's self reported ethnicity [26]. These data, together with the demographic profile of these patients are given in Table 1.

[Insert Table 1 about here]

A standard medical history and musculo-skeletal examination was performed on all subjects in the rheumatology clinic. They were investigated with blood tests and radiology in accordance with clinical need. Detailed diagnoses of this group have been reported previously [5] and are summarised in Table 2.

[Insert Table 2 about here]

The study was formally approved by the Local Research Ethics Committee.

Analysis

The process described by Ritchie and Spencer [24] for the analysis of contextual qualitative data was applied [23,27,28]. This method tends to be more structured than would be the norm for much other qualitative research and the analytical process tends to be more explicit and strongly informed by a priori reasoning [29]. Each transcript was read in detail twice and on each occasion data consisting of the subject's words were extracted for the issues under investigation, i.e. the physical consequences of living day-to-day with CBP. Subsequent primary analysis of the extracted data indicated the range and pattern of the accounts given by subjects when addressing issues within these themes. Further analysis grouped descriptions according to type and formulated categories.

Subjects

The sample consisted of eleven patients (5 male, 6 female) who agreed to be interviewed and tape-recorded. Their mean age was 49.3 (sd 15.2, range 27-79) years; men 51.2 (sd 4.3, range 45-57) and women 47.7 (sd 21.0, range 27-79) years. The mean total duration of spinal pain was 10.4 (sd 8.7, range 0.5-29) years; men 11.2 (sd 3.0, range 8-14) and women 9.7 (sd 12.0, 0.5-29) years. The mean episode duration of pain was 16.8 (sd 27.5, range 1-96) months; men 24.0 (sd 40.4, range 1-96) and women 10.8 (sd 10.3, range 3-24) months.

The mean Roland score was 11.7 (sd 5.6, range 1-19) and the mean Modified Zung was 25 (sd 10.1, range 10-44).

RESULTS

Four themes emerged from the analysis: sleep/rest, mobility, independence and leisure activities.

Sleep and Rest (table 3)

Lack of sleep and disrupted sleep because of back pain were issues of concern for nearly all interviewees. Subjects 2,3,7 specifically recounted being woken up by the pain. Pain associated with lying in a particular position was identified by Subjects 5 and 7. Two subjects (10 and 11), however, found resting or lying down relieved their pain.

In addition to Subject 8, who revealed a strategy for coping with pain at night, i.e. getting up, taking medication and a hot drink, two other subjects described their pain coping behaviours.

'I am sound asleep in my room, exhausted. Probably from 9, 11 o'clock the pain really starts and wakes me up. I will twist, turn and curl myself - no, no, no. I have to get up. To get up and walk and walk and walk.... If it is night time I've walked up

and down the stairs, yes, and make a cup of tea.... I have to get up and walk 20, 25 minutes, half an hour, then the pain - then it will gradually disappear. (Subject 2)

'And naturally you have to get up.... sit down or sleep on the floor.... sometimes I sleep on the floor, and you can't sleep' (Subject 4)

Mobility (table 4)

Mobility issues featured strongly in the interviews as areas where back pain limited ability and strategies for self-management activities (Table 4). Specific limitations reported were ceasing running (Subjects 1 and 3), unable to stand (Subjects 9 and 11) and difficulty with stair climbing (Subject 4). One subject (2) revealed how he became housebound, and two subjects (1 and 8) expressed fears that prevented them from engaging in mobility activities. Two subjects (3 and 8, both with referred pain in their legs [5]) identify causes for their walking problems as being 'limping' and 'leg gives way'.

Independence (table 5)

Information volunteered by subjects about being independent was generally of individual importance. Most talked generally about limitations to activities, but some specified which activities had caused concern. Being independent or having to rely on others for activities such as going to the toilet (Subject 1), bathing (Subject 8), putting on stockings (Subject 8), cooking (Subjects 8 and 11) and getting up in the morning (Subject 3) were all specifically mentioned. The value of independence was

expressed by Subjects 1, 4, and 8, with some frustration at their limitations. Some subjects retained elements of independence in some activities (Subject 1 - shopping; Subject 7 - cooking and the 'school run').

Leisure (table 6)

Six subjects, only, talked about leisure activities and their back pain experience. It appeared that the ability to carry out the activity had either been reduced or the activity had been given up. The main leisure activities mentioned were gardening and travelling. Giving up or reducing engagement in these activities was evident. It was noted that five subjects did not describe any leisure activities during their interviews.

The results demonstrate that those with chronic spinal pain experience fairly extensive sleep disruption and mobility limitations. In addition, their condition has consequences for independence and curtails leisure activities. These subjects provided rich accounts of their physical state through the narrative and revealed problems that were not evident by the standardised assessment tool used (Roland & Morris Questionnaire).

This is clearly illustrated by subject 5 who scored 'one' on the Roland (Table 1) but reported poor sleep (Table 3), walking problems (Table 4), limited activities (Table 5) and did not report any leisure. He also scored 27 on the Modified Zung questionnaire, suggesting that the sleep disturbance reflected his underlying mood rather than the physical cause of the pain.

Discussion

The ‘insider’s accounts’ of the effects of LBP on their lives provides insights beyond that gained from item responses in standardised assessments, and the importance of subjective accounts of pain has been discussed [5]. The amount of distress caused to patients by being unable to do what they want to is enormous and probably contributes to the degree of depression noted previously in a large cohort of patients from north-west London [30]. These narratives clearly demonstrate the extent of emotional distress consequent to the back pain and disability that cannot be gained from standardised assessments alone. They argue for the incorporation of biopsychosocial dimensions being assessed in everyday clinical practice in order to provide a holistic approach to spinal pain. Management of LBP disability remains a major clinical challenge requiring a refocusing of treatment to a ‘client-centred’ rather than ‘pain-centred’ approach, thus shifting the emphasis to an ‘enablement’ model of care. As Main and Spanswick (page 17) have discussed, ‘modern pain management requires consideration not only of the perception of pain but of the reaction to it (whether behaviourally, cognitively or emotionally)’ [31].

Subjects

Although purposefully sampled and small in number, a comparison of these 11 subjects with a larger cohort from the same service indicates that they were not dissimilar on mean age, Roland and Modified Zung [30]. The mean total duration of pain was also similar, but the episode duration of pain was noticeably less for the six women (11 months compared to 34 months). Eight of the 11 subjects were from South

Asia, reflecting the strong Asian population within north west London, particularly as seen by this rheumatology service [30,32]. It is therefore our view that these patients are fairly representative of patients attending this service. There is no reason to assume that these patients differ in any major way from other large city populations with a similar ethnic mix.

Edwards et al [33] have highlighted that ethnic differences may have an important influence ‘on how pain is appraised and responded to emotionally and behaviourally’ (p.135). Some of the responses from our subjects may reflect their ethnicity and cultural background. It has been found in our clinic that those from South Asia report CBP significantly differently to their non-Asian counterparts [34] and complete questionnaires differently [35].

Although other qualitative research has been carried out in samples of patients with low back pain [3,36,37], it is unusual that the narrative data is linked to clinical data and diagnoses. In this respect these findings provide a more complete picture of the individual’s pain experience and behaviour than usually reported.

Sleep

Nine of the 11 subjects noted difficulties sleeping and 2 also noted the benefits of resting or lying down. The genesis of poor sleep may be complex, embracing insomnia, anxiety [38], depression [38], and post-traumatic stress disorder [39] in addition to nociceptive pain relating to painful posture or movements. Our subjects

clearly related their disturbed sleep to pain. It has long been understood that gaining a good night's rest is important in the management of chronic pain [20,40,41].

These findings agree with those of McCracken and Iverson [20] who reported that pain played a smaller role in the prediction of daily functioning than sleep disturbance. They argued that it was the disturbed sleep that led to the distress and impaired functioning [20]. In addition, Affleck et al [19] in a study of women with fibromyalgia, reported that more pain was reported by poor sleepers and that a night of disrupted sleep was followed by a significantly more painful day. The same may be true for people with CBP, although specific temporal relationships between pain perception and sleep disturbance require further research. Sleep may also be disturbed by systemic symptoms e.g. nocturia, which was noted in 7% of a cohort of patients with neck pain [32].

Other research has attempted to investigate sleep disturbance using diaries and activity monitoring of patients with chronic musculoskeletal pain. Findings indicated that disturbed sleep was most strongly associated with pain severity according to subjects diary records, but not according to the objective measures used [42]. It remains unclear whether more pain causes disturbed sleep or disturbed sleep leads to worse pain experience resulting in poorer function. Our insider accounts provide a picture of a spiral of disturbed sleep patterns and worsening function during the day. The relationship of some patients' pain to posture and turning in sleep is clearly evident in some accounts in table 3.

These findings have important implications for management. Now that long-acting analgesics are available (e.g. Dihydrocodeine or Codeine with Ibuprofen), they should be considered for those who describe pain related to posture or turning over in bed. Long-acting non-steroidal anti-inflammatory drugs may perform this function but some would argue that prolonged use may have few benefits in chronic pain [43] and may have greater risks of side-effects than for pure analgesics [44,45], particularly if patients are elderly [11,46,47 (page 268), 48] or if antidepressants are being used concomitantly [46,47]. For those individuals whose sleep disturbance may reflect depression, at least in part, tricyclic antidepressant medication may be particularly helpful in view of their sedative and pain-modulating properties [48]. Some individuals may find non-pharmacological therapies helpful, e.g. relaxation, music, praying (or going downstairs for a drink (subject 8)).

An unbroken night's sleep and return to usual activities are common outcome measures in CBP rehabilitation. However, the Roland contains only one item that asks if the subject 'sleeps less well' [15], but does not address issues such as rolling over in bed and lying down to ease the pain. The Oswestry and Aberdeen both attempt to quantify the amount of sleep disturbance [14,16], however the Aberdeen only asks about the worst night of the preceding fortnight [16]. The Dallas also attempts to quantify sleep disturbance using a visual analogue scale [17] and the Brief Pain Inventory (BPI) attempts a similar quantification using a rating scale [49]. These standardised tools have a role to play in indicating a global picture of how the patient is affected by their pain. However the significance of sleep disturbance to their daily life is lost and therefore this information is difficult for clinicians to use routinely in a client-centred approach to management.

Mobility

Of the nine subjects who reported mobility issues, seven specifically mentioned walking and two standing. Thus only two subjects did not mention difficulties in mobility. Mobility problems appear to be an issue causing concern to these CBP subjects, but are not specifically mentioned in Deyo's recommended outcomes [13] although walking tests have been used in studies of low back pain patients [50].

The Roland had items on 'walking more slowly', 'standing for short periods' and 'walking short distances' 'because of pain in my back' [15]. These items would only identify the difficulties reported by subjects 4 (walks 'a little bit') and 8 ('the more I walk the worse it gets'). The Oswestry questionnaire has one section with six items on walking 'distance' and another section for standing [14] which may address the issues raised by subjects 4, 8, 9, 11; but not those of e.g. subject 2. The BPI has one item on walking ability that asks the patient to self-rate if the pain interferes on a scale of 0-10 [49]. However this provides no information about how and why mobility is limited.

Two subjects (9 & 11) commented on difficulties during standing, which is not itemised on the Roland questionnaire. Experience in a back pain clinic suggests that standing still is a greater problem for many with low back pain than either sitting or walking. If clinicians routinely document the ability of their patients to sit, stand and walk, not only do they have a simple functional assessment, but also statements that define abilities (or disabilities) that can be valuable if called to advise on disability benefits or work potential.

The Dallas questionnaire asks about standing tolerance and walking restriction [17]. However, it has been reported that the slower walking velocity of low back pain patients is caused by a decrease in step length [51,52]. In addition, both these studies identified asymmetrical gait pattern (or limping) as significant in the performance of walking in chronic low back pain patients. There is some evidence that these gait abnormalities are due to dysfunction of reflex pathways [53]. Neither the Dallas, Oswestry, BPI nor the Roland questionnaires ask about limping or asymmetrical walking. It is noteworthy that one subject in this study reports limping and explains what he means (subject 3) and another that the leg gave way (subject 8).

These subjects appear to report walking problems that are not just physical but also have a psychological influence. They report being *scared* (subject 1), being unable to *go anywhere* (subject 2), the roads being dangerous (subject 8) and 'I can't walk' (subjects 3,5), even though neither of these subjects were dependent on a wheelchair. This is consistent with previous reports on the influence of pain-related fear and beliefs on walking performance [51]. These fears may contribute to the inability of the primary care team to manage this pain satisfactorily and the need for referral to secondary care.

Independence (Table 4)

The subjects reporting independence issues illustrate two domains of independence. Firstly those activities that may be characterised as 'activities of daily living' such as '*getting my stockings on and off*' (subject 8) and secondly those that reflect social

integration e.g. *'running 'to and fro' from school'* (subject 7). All the commonly used assessment tools include items relating to these two aspects of independence [14,16,17,54], except for the Roland which only addresses activities of daily living [15]. The importance of dependency on others is incorporated in all the above questionnaires except the Aberdeen [16]. In this study four subjects reported reliance on others to complete everyday tasks (subjects 1,3,4, and 8) and two commented specifically on how they would rather do things for themselves (subjects 1 and 4).

The subjects also indicated the emotional consequences of loss of independence. One-third reported feelings of helplessness as a result of their limitations (subjects 1,4,5,and 11) e.g. *'helpless like a vegetable'* (subject 1). The emotional consequences of pain are more often being addressed [15,17,54], although neither the Oswestry [14] or the Aberdeen [16] questionnaires do so. Such feelings of helplessness may contribute towards the fear of disability or re-injury that, in turn, may give rise to a poor prognosis and / or depression [55]. Others report the link of emotional state, disability and chronic back pain in those seeking compensation or who are compensation recipients, even after settlement [56].

Leisure

The subjects mainly reported cessation, or reduction, in their leisure activities. For those who engaged in fairly active pursuits, such as golf (Subject 1), or badminton (Subject 2), stopping may lead to reduced overall activity and physical deconditioning. Although returning to normal activities including leisure pursuits is regarded as a positive outcome for recovery from LBP [57], only the Aberdeen questionnaire

contains an item to assess how leisure activity is affected by pain [16]. The Dallas Questionnaire does, however, include a question on ‘social life’ which is illustrated with ‘dancing’ and ‘games’ [17]. More recently, the BPI has been recommended for use in pain research and has an item on ‘enjoyment of life’ [49].

It has been suggested that people with CBP need all their physical capacity to complete essential and necessary everyday tasks, and so have little residual physical capacity to engage in additional or optional leisure activities [58]. These authors also suggested that fear of movement may cause CBP sufferers to avoid activities requiring physical effort [55]. However, our subjects did not report any engagement in more sedentary leisure and hobby activities and it was noticed that five did not mention leisure activities at all. They may have given them up completely as they had been coping with their back pain for several years. Therefore, it could be suggested that their lack of leisure pursuits could consist of both physical and psychological barriers. In addition, the reduction or cessation of leisure activities may also reduce opportunities for social interactions and may lead to social isolation.

Conclusion

The picture portrayed by these subjects is of chronic spinal pain as a disability preventing them from leading the lives they want to lead. In relating their experiences of living with spinal pain, subjects expressed regret at the loss of their physical capabilities and distress at the functional consequences of those losses. Pain and rehabilitation professionals may find it helpful to consider a more disability-orientated approach in helping to overcome both the physical and the psychological components

of spinal pain. Facilitating 'adjustment' to 'loss' may be more helpful than inferring the potential for a life free of pain as a result of therapeutic endeavours.

Subjects were particularly concerned by the impact of their pain on their sleep, mobility and personal independence. In addition, the pain curtailed their leisure activities and hence may contribute to social isolation.

In order to address fully the management of CBP, health professionals need to look beyond standardised assessment tools and utilise the patients' experiences as additional evidence contributing to better clinical practice.

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Table 1 Demographic data of eleven patients with chronic back pain.

| Patient | Age/ Sex | Marital Status | Occupational Class | Current or last Occupation | Ethnicity | Duration Total (years) | Duration Episode (months) | Roland | Mod Zung | QTF class |
|---------|-------------|-------------------|-----------------------|-------------------------------|-----------|------------------------------|---------------------------------|--------|-------------|------------------------------|
| 1 | 45M | Married | 2 | Shopkeeper ¹ | Indian | 8 | 96 | 15 | 24 | 6 |
| 2 | 50M | Married | 2 | Nurse ² | Mauritian | 14 | 1 | 15 | 23 | 1 |
| 3 | 57M | Married | 3M | Engineer ¹ | Sikh | 12 | 12 | 15 | 10 | 3 |
| 4 | 52M | Married | Self-employed | ³ | Indian | 8 | 5 | 12 | 13 | 1 |
| 5 | 52M | Married | 3N | Accountant ⁴ | Indian | 14 | 6 | 1 | 27 | 2 |
| 6 | 60F | Married | Housewife | ⁵ | Indian | 29 | 3 | 11 | 24 | 3 |
| 7 | 28F | Married | 3M | Bakery Assistant ⁵ | Indian | 6 | 24 | 7 | 19 | 1 |
| 8 | 79F | Married | Retired 5 | School Cleaner ⁴ | English | 20 | 5 | 17 | 31 | 3 |
| 9 | 27F | Single | 3N | Sales Assistant ³ | Irish | 2 | 24 | 19 | 35 | Neck pain dominan t |
| 10 | 35F | Married | 4 | Bakery Packer ⁶ | Indian | 0.5 | 6 | 13 | 44 | 1 |
| 11 | 57F | Married | 3N | Secretary ⁵ | French | 0.7 | 3 | 4 | No data | 2 |

Key: ¹ Unemployed; ² Sick Leave; ³ Unable to Work; ⁴ Retired; ⁵ Housewife; ⁶ Employee

Table 2 Clinical diagnoses of eleven patients with chronic back pain

| Patient | Diagnosis |
|----------------|---|
| 1 | Left L5 root compression by prolapsed L4/5 disc confirmed by CT scan and at surgery. |
| 2 | Mechanical low back and neck pain associated with radiological C5/6 narrowing and generalised anterior degenerative change. |
| 3 | Mechanical low back pain associated with radiological borderline compression of L5 root (on MRI) , bulging lumbar discs on CT scan, and a degenerative scoliosis associated with disc narrowing L 2/3 and L 4/5, and with sensory loss right L5 distribution. |
| 4 | Mechanical low back pain associated with radiological osteophytes at L3/4. |
| 5 | Mechanical low back pain associated with radiological scoliosis and bulging disc (CT scan), tenderness at L4/5 and physiotherapeutic L5/S1 facet joint dysfunction. Co-morbidities: Coronary artery by-pass graft 1986, hypercholesterolemia. |
| 6 | Mechanical low back pain clinically arising from L5/S1 segment but no abnormality on CT scan. Co-morbidities: Osteoarthritis of the knees. |
| 7 | Mechanical low back pain associated with radiological disc narrowing at L4/5 (? old Scheuermann's disease) |
| 8 | Mechanical low back pain associated with radiological disc degeneration L 2/3/4/5/S1 with variable facet joint degeneration related to degenerative scoliosis convex to the right at T12/L1. Osteoporotic collapse of two thoracic vertebrae. Disc narrowing with degenerative change at C5/6/7. Osteoarthritis of the right hip, with hip replacement on left. Co-morbidities: congestive cardiac failure, asthma, hypothyroidism. |
| 9 | Road traffic accident with acceleration / deceleration injuries to cervical and lumbar spine. MRI showed mild thecal indentation C5/6 and C6/7. Post-traumatic stress disorder. Neck pain dominant - from road traffic accident. |
| 10 | Mechanical low back pain associated with spinal and peripheral joint hypermobility and obesity. |
| 11 | Mechanical low back pain associated with radiological spondylolisthesis secondary to disc space narrowing and severe facet joint osteoarthritis at L4/5 confirmed on CT scan. |

(From: Subjective pain experience of subjects with chronic back pain.

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Table 3 Sleep and Rest issues in chronic back pain

| Subject No: | |
|--------------------|--|
| 1 | ‘...every morning I wake up and I have these pains in my back’ |
| 2 | ‘I get this pain especially when I'm resting. When I go to sleep.... really relaxing, an hour or two asleep, the pain starts.’ |
| 3 | ‘I may not have sleep at night.’ |
| 4 | ‘Sometimes at night it gives me a pain, it wakes me up.... it wakes me up. I can't sleep.’ |
| 5 | ‘I feel pain, you know, when I sleep.... When I sit, it's not that hurtful, but when I go to bed, yes it hurt.’ ‘If I sleep on this side, yes I hurt. When I try to move, yes I do have sharp pain.... I'm confined to one side, and more or less one place.’ |
| 6 | ‘When I'm sleeping at night, it can hurt....’ ‘And now at night I was sleeping and when I sleep, it slowly burns and then it gets better.’ ‘....sitting down I find hard. Sometimes it hurts a lot, sometimes there's nothing.’ |
| 7 | ‘So the problem is that I just can't sleep.’ ‘At night I just can't sleep flat on my back at all. Only if I lie sideways can I sleep. I know immediately if I've gone onto my back, it wakes me up.’ ‘Even if you're tired, if your lower back starts hurting it just wakes you up automatic.’ ‘....when I'm sitting as well I have to put something behind me, a cushion or something. You have to sit straight.... otherwise you just can't sit.’ |
| 8 | ‘If it gets too bad in the night I get up and take two of those[drug] or what ever you pronounce it, and a cup-a-soup and after a while I can go back to sleep again. But some nights I can't.’ |
| 9 | ‘.... and when the shooting pain occurs you can't sleep.’ |
| 10 | ‘If I'm taking rest then it's better, but I can't.’ |
| 11 | ‘I cannot carry on, er, er, I have to lay down.’ |

Table 4 Mobility: Limitations and Strategies

| Subject No: | |
|-------------|---|
| 1 | ‘I can't run.... I'd go on a nice little run, but I dare not because I'm scared now, you know I'm very scared that I could do some injury to myself... The only thing I do is just, er, do walking you know, as much as I possibly can. As soon as I start feeling tired I just take a bus’ |
| 2 | ‘....sometimes 2 or 3 weeks I become, what is the word? Recluse, you know. I shut up probably. I'm not saying for 2, 3 weeks but probably for 5, 6 days I would not be able to go anywhere, even just for a walk or something. Then I gradually go out.’ |
| 3 | ‘Sometimes I limp.’ ‘I stopped going early in the morning for long runs, short runs. But I may go for a walk.... and sometimes I can't walk even.’ ‘Because of the pain I have some weakness that has come in my leg. I can't lift very high and I feel I have strain on my thigh.’ |
| 4 | ‘....it was very bad.... I couldn't climb the stairs even.’ ‘I walk a little bit on the roads.’ |
| 5 | ‘You see it is painful here, see when I walk. I couldn't walk, you know....’ ‘My walking problem, you see, it's painful.’ ‘Now I can't do because I can't, I can't walk.’ |
| 6 | ‘I still do go for a walk every day though.... Every day I go for a walk. Even before my leg started hurting, I used to walk.’ |
| 8 | ‘I can't walk out in the road because my back starts aching and my leg give way.... I won't go in the road, it's too dangerous now.’ ‘The more I walk the worse it gets. It's peculiar. Once I've walked I'm absolutely finished to keep on.’ |
| 9 | ‘I stand for, say, 10 minutes - pain.’ ‘I'm driving, but driving is very painful.’ |
| 11 | ‘....er, gets a bit painful to stand up..... And I feel the pain. I cannot carry on being on my feet.’ |

Table 5 Independence Issues

| Subject No: | |
|-------------|---|
| 1 | <p>‘At one time I couldn't move to eat’ ‘Going to the toilet in the morning was a bit difficult... I went to the toilet myself, I wouldn't let anybody do anything for me on that side.’ ‘I still do some shopping for my wife.’ ‘I don't like to be spoon fed or mothered. I'd rather take care of myself.’ ‘...you feel helpless, like a vegetable because you cannot move.’</p> |
| 3 | <p>‘What movement would you expect? And I have to shout to my wife to come and assist me.’</p> |
| 3 | <p>‘Sometimes, the pain can be severe, very severe. Can't get up in the morning.’</p> |
| 4 | <p>‘I want to do this sort of thing, or I want to do that and that. I cannot do it.’ ‘...now and then you are waiting for somebody else to do the things for you.’ ‘...healthwise, independent is very important. It is very important.’</p> |
| 5 | <p>‘It's very difficult, it's sometimes limit you, how you say, activities.’</p> |
| 7 | <p>‘There's always something or another that needs doing in the house - the cooking. You can keep yourself busy with all that. And when school's on there's the running to and fro from school.’</p> |
| 8 | <p>‘I've not been able to bath unless this lady comes down and helps me...’ ‘I had a job getting my stockings on and off.’ ‘I've found out how to sit and iron now.’ ‘By the time I've gone and got some washing to put in and sort out and that, and I've got myself something to eat then I will be in pain.’ ‘One of our church members - she came and cooked me dinner and everything for me, you know.’</p> |
| 11 | <p>‘...at times is very painful because if I do cook for up to half and hour in the kitchen, I have to lay down, to put my legs up.... Yes, it give a bit of relief, yes.’ ‘I have to shorten hefty, heavy work and try to make it easy on my back and to lay down in order to recuperate in between to be able to carry on.’ ‘You cannot do as much work as you would like to. It handicaps you, really, it does. It's really handicapping.’</p> |

Table 6 **Leisure Activities**

| Subject No: | |
|--------------------|--|
| 1 | ‘I would go in the garden and do a bit of this and a bit of that now and then, you know, but now I just don't bother.’ ‘I used to go and play golf.... to relax and things like that.’ ‘I used to be a very keen DIY person. I was going to build a cupboard this summer and do a bit of painting, but unfortunately all on the back burner at the moment....’ |
| 2 | ‘I was quite active, used to play badminton quite a lot... I used to go regularly at least once a week. I have not played badminton for about nearly six months now.’ |
| 4 | ‘I don't want to travel, or, any long distance anything. I don't, I can't travel. Can't sit constantly.’ |
| 6 | ‘I was doing the gardening here yesterday. I was doing some work, and there was nothing.’ |
| 8 | ‘I won't travel by transport.’ |
| 11 | ‘....if I am doing the gardening so, I've got to stop to lay down for 20 minutes. Then I go back to it, and then arrgh!’ |

