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Original article

The impact of chronic low back pain is partly related to loss of social role: A qualitative study



Florian Bailly^{a,b}, Violaine Foltz^{a,b}, Sylvie Rozenberg^{a,b}, Bruno Fautrel^{a,b}, Laure Gossec^{a,*,b}

^a Service de rhumatologie, hôpital Pitié-Salpêtrière, AP-HP, 47-83, boulevard de l'Hôpital, 75013 Paris, France

^b Institut Pierre-Louis d'épidémiologie et de santé publique, UPMC université Paris 06, Sorbonne universités, 75013 Paris, France

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ABSTRACT

Objectives: Chronic low back pain (LBP) has an important impact on quality of life, through pain and functional incapacity, but also psychosocial distress. The social participation consequences of LBP have been less explored. The objective was to better understand experiences of patients living with chronic LBP, with a focus on impact on relationships with family, friends and work colleagues.

Methods: Monocentric qualitative study in a tertiary-referral centre in Paris, France. Participants had chronic mechanical LBP. Semi-structured interviews were conducted during 4 focus groups discussions focusing on living with LBP. Verbatim was categorized and coded using thematic content analysis.

Results: Twenty-five persons (11 men, 14 women) participated; ages ranged 25–81 years. Participants often reported a negative self-perception in social interactions, with shame and frustration regarding their difficulties to perform activities of daily living. They often felt misunderstood and unsupported, partly due to the absence of visible signs of the condition. Participants suffered from the negative collective image attached to LBP (“benign/psychological disease”). LBP resulted in some patients in a significant loss of social identity with perceived impossibility to perform one's social role at home and at work. In contrast, family and friends were sometimes a support and helped in pain management.

Conclusion: A systematic assessment of social role is needed in LBP care.

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1. Introduction

Chronic low back pain (LBP) is a common condition, which has an important impact on quality of life [1], resulting in important costs to society. As defined by the World Health Organisation, this condition is accepted as a biopsychosocial phenomenon in which anatomical injury interplays with other factors [2]. Beyond pain and disability, psychological and social aspects have a significant impact on living with chronic LBP [3–12]. Mental aspects of chronic LBP are related to psychological distress, in particular anxiety and depression [3–7]. Patients develop different active or passive, positive or negative, coping strategies to deal with the pain and functional limitations [8,9,11–13]. Relationships with others may also play an important role in LBP [4,14]. Psychosocial factors in both private life (e.g., low emotional support) and in the workplace (low workplace social support, low job satisfaction) are risk factors for chronic back pain [15]. “Lack of a support person to talk to about

problems” and “poor relationships with peers or supervisors” are “yellow flags” identifying patients at risk of chronic LBP [16].

The impact of relationships with family and friends on living with chronic LBP was briefly explored only in a few qualitative studies [5,17–21]: Participants reported in one study being a burden to their families with increasing misunderstanding as time went on with no diagnosis or formal explanation [5]. The other studies did not explore in depth the role of social participation in LBP [17–21]. On the other hand, relationships with health professionals have been well evaluated: individualized care, clear explanations, reassurance, discussing psychosocial issues and future options enhances positive relationships [22–24]. In fact, it appears that patients with LBP who have greater social participation may have also a better physical health status [25]. Psychosocial and relationship aspects are important not only to better understand LBP but also can be an element to guide its management [2]. The management of LBP needs to take into account the physical aspects of the disease, but also in this context, social interactions, which can be targeted by specific rehabilitation programs. Identifying experiences of patients living with chronic LBP and their perception of relationships with others, both in the private sphere or at work, can

* Corresponding author.

E-mail address: laure.gossec@psl.aphp.fr (L. Gossec).

be useful to develop effective methods of reintegrating chronic LBP patients in the work place [2].

Most of the research on the psychosocial aspects of chronic LBP was performed using instrument-based questionnaires, surveys, or epidemiological data sets. Qualitative research methods involve the systematic collection, organization and interpretation of textual material derived from talk or observation, and are more relevant than quantitative studies for further in-depth understanding of LBP patient experiences [26]. This study aimed to better understand experiences in relation with participation, and social difficulties of patients living with chronic LBP, with a focus on impact on relationships with family, friends and work colleagues.

2. Material and methods

A qualitative study based on the focus group interview method [27] and with an epistemological outlook was conducted. The results are presented according to the framework of the consolidated criteria for reporting qualitative research (COREQ) [28]. The present study was reviewed and approved by the research ethics board of the Pitié-Salpêtrière Hospital, and patients provided written informed consent.

2.1. Recruitment and participants

Outpatients from a public university hospital and two private practices in Paris, France were invited to participate in focus groups interviews if they had sub-acute or chronic nonspecific low back pain, and were fluent in French; but in fact all patients included had chronic LBP. The only exclusion criterion was recent back surgery (less than 3 months). Particular attention was paid to the selection so as to obtain a wide spectrum across demographics (particularly age and educational level). A minimum of five participants in each group was required to ensure response diversity, and a maximum of ten participants to facilitate discussion in the focus group process.

2.2. Focus groups design

An interviewer guide was developed to conduct the semi-structured interview, which consisted of general and specific questions, supplemented by probes. Focus group methods are particularly adapted for broad topics like living with LBP. This form of qualitative research was preferred to individual interviews in order to stimulate exchanges, to provide a more comfortable setting for discussion while lessening respondents' anxiety and to stimulate interactions among group participants. The focus groups were moderated by a rheumatologist (LG) and lasted 90 to 120 min; a second physician (FB) took additional notes that contributed to the data analysis. Before beginning the session, demographic characteristics were collected from the participants. The lead interviewer posed questions to the group as a whole, although individual involvement and participant interaction were encouraged. Participants were asked to describe their behaviour, beliefs and mind-sets regarding LBP and its impact. First, the general impact of LBP was discussed, then some specific aspects related to social life participation (including family life, friendships and work interactions)

Table 1
Characteristics of participants in focus groups.

	Total sample n = 25	Focus group 1 n = 7	Focus group 2 n = 6	Focus group 3 n = 7	Focus group 4 n = 5
Age, years, median (range)	51 (25–81)	49 (42–59)	54.5 (32–81)	46 (29–56)	60 (34–66)
Gender, male, n (%)	11 (44)	3 (43)	2 (33)	5 (71)	1 (20)
Low back pain duration, years, median (range)	10 (1–35)	2 (1–35)	7 (2–20)	15 (4–25)	10 (2–25)
Pain intensity visual analog scale (0–10), median (range)	4 (0–8)	4 (0–7)	4 (0–8)	3 (0–4)	6 (0–7)

were addressed. The general introductory question about relationships was “How do you manage relationships with others with your chronic LBP?” Relations with health professionals and therapeutics of LBP (medications, spine injections, back school. . .) were not discussed. In the middle of the session, the facilitator summarized the main topics and opinions of the participants, and invited them to develop others aspects or other opinions about LBP.

2.3. Number of subjects

The guiding principle in determining sample size in qualitative research is theoretical saturation which is reached when ongoing data collection no longer yields new information and insights. [29]. This was the case in the present study.

2.4. Data analysis

The sessions were recorded and subsequently transcribed. The focus group transcriptions were analysed by two researchers (FB and LG), using directed and summative qualitative thematic content analysis methods [30] Five steps were followed:

- transcripts were read to gain a contextualized impression of the discussion, and preliminary themes chosen;
- units of meaning were identified and coded;
- similar codes were condensed in categories;
- Descriptions were then summarized to establish concepts;
- Descriptions and concepts were reviewed by the other co-authors, experts in LBP.

Furthermore, one of the patients participating checked the final concepts for face validity. Due to anonymised data analysis, it was not possible to link a comment to a specific participant. The qualitative findings are presented as descriptive summaries and illustrated by quotes from the transcripts.

3. Results

3.1. Participants

The sample consisted of 25 participants, 11 men and 14 women (Table 1). Patients participated in one of 4 focus groups with 5 to 9 participants per focus group age, sex, pain intensity, duration of pain, occupation, duration of work disability, family status. They ranged in age from 25 to 81 years, with a median age of 50 years. Disease duration ranged from 1 to 35 years, with a median duration of 10 years. Median visual analog scale for pain was 4 out of 10 (range, 0–8). Eighty percent had radicular pain associated with back pain (in case of presence of radicular pain, the back pain was predominant), 5 participants (20%) were on sick leave while 16 (64%) were in the workplace, 2 were retired, 1 was unemployed and 1 was work disabled. Sixteen participants (64%) had benefited from intensive back rehabilitation [31].

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