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Original Article

'Talking a different language': a qualitative study of chronic low back pain patients' interpretation of the language used by student osteopaths

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A R T I C L E I N F O

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A B S T R A C T

Background: A growing body of research evidence has identified psychosocial factors to be important in the management of low back pain (LBP). Evidence suggests that healthcare professionals have a considerable influence on patients' attitudes and beliefs. Few studies have investigated how patients experiencing LBP interpret the language used by their osteopath during their consultation and the impact of language on their attitudes and beliefs of their LBP.
Objectives: To explore and describe how patients with acute or chronic LBP interpret the language used by student osteopaths when explaining their diagnosis, and the impact their interpretation has on their attitudes and beliefs of their LBP.
Method: Semi-structured qualitative interviews were conducted with a purposive sample of nine patients experiencing LBP who had recently attended an osteopathic teaching clinic in the UK. Interviews were transcribed verbatim and elements of grounded theory were used as a framework for data analysis.
Results: Participants expressed a range of interpretations in response to the language used when discussing their LBP. The use of medical words, metaphors and analogies, reassurance and the patient-practitioner relationship were identified as factors influencing the level to which participants engaged, taking an active role in their care.
Conclusions: The language used by student osteopaths' influences patient beliefs about LBP in a variety of ways. The current study furthers understanding of how language contributes to these beliefs, identifying ways through which communication can contribute to improved healthcare through enhancing patient engagement.

Implications for practice

- The language used by student osteopaths influences patients' LBP attitudes and beliefs in a variety of ways.
- The language used to explain and describe LBP to patients can influence the level to which they engage and take part in their own care and management.
- Educators working closely with students should not promote models and theories of osteopathy which emphasise physical and pathbiomechanical explanations/descriptions of LBP.
- Biomedically orientated descriptions may engender fear and disengagement in patients, and construct unhelpful beliefs and negative attitudes towards their LBP.

1. Introduction

Rudyard Kipling's famous quote "Words are, of course, the most powerful drug used by mankind" [1] p. 237) illustrates how the spoken word can have a strong impact on individuals' feeling and self-perception. Neuroimaging research shows that pain-related words can influence the central nervous system, contributing to the perceived threat associated with the experience of pain [2]. Language is essential to communication and a crucial part of creating meaning of the individual lived-experiences of the internal world (the body) and outside (social) world [3]. The same word can

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mean different things to different people, and this meaning is co-constructed through social interaction [4] and is dependent upon the interpreter's values and beliefs [5].

Effective language and communication is considered an important part of osteopathic clinical practice. In the UK, Australia and New Zealand, current osteopathic practice standards emphasise the requirement for practitioners to communicate effectively in order to provide safe and effective care [6–8]. Verbal communication is more than just an exchange of words, it helps to build trust and confidence and therefore plays a fundamental role in developing and maintaining a therapeutic relationship [9]. Furthermore, evidence suggests that effective communication (e.g. reassuring and validating communication) has a positive effect on patients' emotions relating to their musculoskeletal pain [10,11]. A review of practitioner-patient communication by Street Jr. et al. [9] identified an association between communication and health outcomes, and identified two pathways through which this occurs: A direct pathway - influencing emotions such as hope, reassurance, fear and anxiety, or indirectly through gaining patient understanding and trust in treatment aims [9]. It concluded that a deeper understanding of the specific aspects within communication is needed to see how and why this occurs [9].

In the UK, the National Institute for Health and Care Excellence (NICE) estimates that low back pain (LBP) affects about one third of the adult population each year [12], and is estimated to cost an annual £12.3 billion [13]. However, the burden of chronic LBP extends deeper than medical costs alone. Evidence indicates that chronic LBP (CLBP) negatively impacts upon self-image [14,15], psychological health, personal relationships, and CLBP is associated with higher levels of depression and anxiety [16]. Psychosocial factors are well recognised as important predictors for both the initial onset of LBP and chronicity [17,18]. For people experiencing CLBP, attitudes and beliefs can present barriers to recovery as well as influence pain perception and response to treatment [18]. Although the experiences, attitudes and beliefs of individuals experiencing CLBP have received some attention in the context of osteopathy [15,19], there has been little primary research exploring what influences the beliefs of LBP patients receiving osteopathic care. A cross-sectional survey from New Zealand suggests that negative views about the back and back pain are prevalent amongst LBP patients, and are associated with reduced confidence in movement of the back [20]. Low expectations of recovery, depression and avoidance of movement, or activities that might cause pain or injury, have all been associated with poorer outcomes [21]. Qualitative research has offered an insight into the nature and context of individual LBP patients' views. For instance, a qualitative study by Darlow et al. [22] identified that information from healthcare professionals was often interpreted by patients with LBP (acute and chronic) as meaning that the back is vulnerable and requires protection. This resulted in some participants experiencing feelings of anxiety, avoidance of activities and frustration when their pain continued [22]. A review of qualitative research investigating the role of healthcare practitioners in helping people suffering from CLBP, suggests that gaining an understanding of the individuals' pain experience is imperative for practitioners when adopting person-centred approach [15]. Communication has been perceived by patients as the most important factor in their care [23,24]. Individuals consulting practitioners appreciate clear explanations of their LBP as well as self-management, treatment aims and reassurance [23]. Such information should be delivered in a way that is individual to their needs [25]. Theories of health behaviour suggest that what patients think and believe about their LBP effects their behaviour [26]. Therefore, how patients interpret the explanation regarding their diagnosis may play an important role in the amount of control an individual perceives they have in managing their LBP.

Healthcare professionals have been found to have a strong influence upon the attitudes and beliefs of people with LBP, with information and advice having lasting effects upon patients' beliefs [22,27]. Similar findings were demonstrated in a qualitative study by Stenberg et al. [28] where healthcare professionals seemed to influence the views and beliefs towards physical activity of Swedish men and women, who were experiencing neck and back pain. Explanations given by healthcare practitioners appeared to reinforce pain beliefs relating to physical activity enhancing fears of damage or, motivating participants to engage in exercise [28]. However, further research is needed to explore the transferability of these qualitative studies to an osteopathy context in the UK and elsewhere.

Exploring how patients interpret information has proved to be valuable in other healthcare professions. For example, a qualitative study conducted in two Rheumatology outpatient clinics in the UK, identified that patients did not always interpret reassurance in the way that medical doctors had intended. Participants' interpretation of the doctor's words were constructed in accordance to their own views and experiences [29]. It appears that people experiencing LBP often misinterpret commonly used medical terms. For example, a study by Barker et al. [30] demonstrated that patients' perception of the meaning of ‘medical words’ were often different to the intended meaning of the healthcare professional. The study included a wide range of practitioners involved in the management of patients with LBP; however osteopathy was not well represented.

The aim of this study was to explore how patients with LBP interpret the language used by student osteopaths when explaining their LBP diagnosis and what influence this interpretation might have on patient attitudes and beliefs about LBP.

2. Methods

The methods are reported according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) [31].

2.1. Study design

The study adopted an interpretive qualitative research design, using constructivist grounded theory as a framework for data collection, analysis and conceptualisation [32]. An interpretive approach to grounded theory [33] sought to construct new and contextual knowledge surrounding patients' subjective experiences and interpretations of the explanation provided to them about their LBP.

2.2. Participants

Nine participants took part in the research. All participants were recruited from a purposive sample of patients currently being treated for LBP at the British School of Osteopathy (BSO) General Clinic. Purposive sampling was used to enable a range of experiences to be explored [34]. Table 1 presents a summary of participants' characteristics.

2.3. Recruitment of participants

Participants were recruited through posters displayed within the BSO clinic. Patients who expressed an interest were screened via email or telephone to ensure they met the inclusion criteria (Table 2). A participant information sheet was emailed or given directly to the participant. A two week cooling off period between recruitment and interview was observed in order to provide