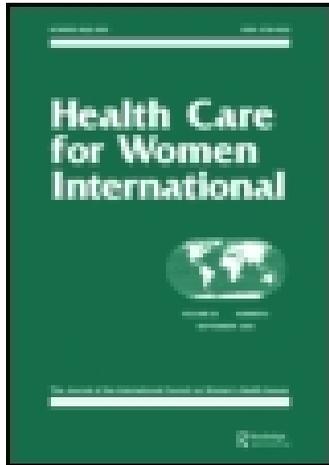


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The Experience of Low Back Pain in Iranian Women: A Focus Group Study

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Chronic low back pain (CLBP) often proves resistant to treatment because there are different biological, psychological, and social factors that can affect its treatment. In this study, we explored Iranian women's beliefs regarding the cause of their LBP. Findings are based on four focus groups (N = 24 participants) with LBP patients. Participants articulated their causation beliefs (Explanatory Models) about low back pain through three themes: idioms of distress: stress in women's lives; lack of knowledge resulted in high-risk behaviors; and organic/biomedical. Given the difficulty regarding diagnosis and treatment of CLBP, understanding patients' health beliefs, causation beliefs, and experiences are warranted.

Chronic low back pain (CLBP) is a complex phenomenon warranting prevention and a sophisticated treatment response. Although there is increasing research evidence supporting an interdisciplinary model of care that addresses biopsychosocial factors, little is known about women's experiences of CLBP. Furthermore, qualitative understanding of CLBP from a cross-cultural perspective is extremely limited. In this study, we explored the causation beliefs held by 24 Iranian women living with CLBP. The lead author conducted four focus groups at the Rheumatology Research Center (RRC), Tehran University of Medical Sciences (TUMS; Iran), with the intent of discovering how the women explained or accounted for their CLBP. Understanding these causation beliefs has implications for the prevention

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and treatment of this condition. While modest in its breadth and depth, the findings from this qualitative study are relevant to not only Iranian women, but also to women who are living with CLBP.

Unrelieved or inadequately managed pain causes suffering, alters lives, and frustrates health care providers and patients. Pain, particularly in its chronic forms, challenges the biomedical model since it obscures the traditional borders between mind and body, objective and subjective, real and unreal, physical and psychosocial (Borkan, Reis, Hermoni, & Biderman, 1995). Among the different types of pain, CLBP is the most common of the musculoskeletal disorders presented in general medical practice, but its clinical management presents significant challenges to care providers.

A tension arises when diagnostics do not reveal pathology. Symptoms associated with CLBP become suspect without clinical evidence. Nonspecific CLBP may not exist as a disease defined through the medical model of organic pathology, but rather as a symptom located within a biopsychosocial model of illness behavior (Chew-Graham & May, 1999). People frequently perceive physical symptoms that cannot be linked to a physical disease. This tendency is known as somatization and it is found among individuals with psychosocial distress who articulate this distress through physical symptomatology (Keyes & Ryff, 2003). For example, in many parts of Chinese society, the experience of depression is expressed physically rather than psychologically. Depressed Chinese people may not report feeling sad, but rather they express discomfort, feelings of inner pressure, and symptoms of pain, dizziness, and fatigue. These culturally coded symptoms may confound diagnosis among Chinese immigrants in the United States (Kleinman, 2004). In certain cases, such understanding may help predict both a willingness to follow a prescribed course of treatment and effective treatment outcomes (Borkan et al., 1995).

Thus, the development of CLBP and its disability may be dependent on many psychosocial factors, and, in this way, CLBP necessitates that health care providers consider both physical as well as psychosocial components of pain management (Parish, 2002). A recent randomized clinical trial in Norway confirmed the multidimensional aspects of CLBP and reinforced the need to consider biological, psychological, and social factors in the treatment of chronic pain (Dysvic, Natvig, Eikeland, & Brattberg, 2005). Awareness of patients' explanatory models or patients' understanding of disease and the manner in which they interpret their illness offers insight into these multidimensional causative factors. Kleinman (1980) describes explanatory models as cultural conceptions of illness and the requisite treatments held by patients and practitioners. Patients living with CLBP hold explanatory beliefs about their pain including its genesis and effective treatment.

Researchers have come to understand that questions about knowledge and beliefs regarding LBP are appropriately explored through qualitative

methods such as interviews and focus group discussions. At the present time, however, little is known about patients' subjective experiences and beliefs regarding LBP. Most researchers have investigated CLBP through instrument-based questionnaires, surveys, or epidemiological data sets rather than entering into the experiential world of these patients. In contrast, and through the use of focus group discussions, we explored the causation beliefs of Iranian women who suffered from CLBP.

METHOD

Four focus groups, each composed of six women diagnosed with CLBP, were conducted at the RRC of TUMS in Iran. Each focus group met for 1.5 to 2.0 hours. Potential participants were invited from known CLBP patients as identified by their physicians. Convenience purposeful sampling was used and inclusion criteria were based on predetermined characteristics: female, age >18, suffering from LBP for more than 90 days, and fluent in Farsi. Exclusion criteria included the presence of any surgery on the vertebra column or mental illness.

The Ethics Committee of Tehran University of Medical Sciences approved the study. Participants ($N = 24$) read and then signed the informed consent forms. The focus group discussions were taped recorded and then transcribed verbatim in Farsi. Subsequently the transcripts were translated into English by the lead author. The focus groups transcripts underwent basic content analysis; that is, data were open coded by the researchers. Similar codes were grouped into categories; the categories were then aggregated into three themes.

Trustworthiness, and in particular credibility, were addressed by the following: a sample size offering a rich data set; the same moderator for all focus group discussions; and collaborative data analysis. To conduct the focus group, a moderator's guideline, which consisted of general and specific questions supplemented by probes, was used. These questions were formulated based on the literature and in consultation with specialists who were involved in treating LBP patients. The moderator managed each session and an assistant took notes that contributed to the data analysis.

Before beginning the session, demographic characteristics were collected from the participants. The session commenced with an introduction and general outline of the interview questions. Each woman then was requested to present her story of back pain in approximately 5 minutes. The lead author posed questions to the group as a whole, although individual involvement and participant interaction were encouraged. In this article, we focus on participants' causative beliefs regarding their CLBP.

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- I - Idioms of Distress: Stress in women's lives
- The body speaks of pain in the women's lives.
- II - Lack of Knowledge Resulted in High Risk Back Behaviors
- Health Professionals
 - Parents
- III - Organic/ Biomedical
- Genetic
 - Aging
 - Pregnancy

FIGURE 1 Causation beliefs.

FINDINGS

A total of 24 women took part in this study. They ranged in age from 18 to 70 years, with an average age of 42.9. The participants came from different socioeconomic backgrounds. All of the participants were married except one individual. One participant was a smoker, and two of the women were engaged in exercises on a regular basis. Few women ($N = 4$) had a college education, whereas the levels of education of most participants were diploma or high school, with five participants having less than high school education. In terms of ethnicity, all of the participants were Iranian and spoke Farsi fluently. Just over half of the women ($N = 13$) stated that they suffered from mild back pain. There were no substantive differences in the emergent categories or themes in terms of educational experience or between older and younger participants.

CAUSATION BELIEFS

The participants spoke about the nature and causes of their CLBP within the context of their lives. The themes explaining the genesis of the CLBP follow: *idioms of distress: stress in women's lives; lack of knowledge resulted in high-risk behaviors; and organic/biomedical*. See Figure 1.

Idioms of Distress: Stress in Women's Lives

The majority of the women voiced that their lives were difficult and they faced many struggles. Psychological and emotional pain thusly was embodied and served as a cry for help in light of stressful situations in their lives. For example, the women frequently stated that they were burdened

with housework without any support from their husbands or children. They believed that the burden of hard work without support caused stress for them and subsequently made their pain more severe. Their back pain gave voice to these difficulties; their back pain was expressed as idioms of distress:

I have to do all of the housework, by myself, so that doing this much work is outside of my ability and causes me more stress. In this situation besides being tired physically, I do not have any peace of mind and then my back pain becomes more severe. At this time my back says to me, "You have to be rested."

Another participant added,

When I have too much work to do, I even forget to take my pills. You know, we forget ourselves and pay attention to our family all the time.

And finally another woman observed,

If we get sick some day, they expect us to do for them as the same we did before.

In the next excerpts, the participants made the linkage between their emotions (anger) and their impact on their back pain. In essence, back pain became a proxy indicator of emotional upset. It was akin to an "emotions barometer":

When I am angry . . . I feel very severe pain in my lower back. I am the same person with the same disease, but I feel worse when something bothers me mentally.

Another participant confirmed this emotion–back pain connection and revealed the following:

Yes, I know this. It is like me. The severity of low back pain varies on different days.

Social pressure was mentioned by several women as a source of stress and accounted for their LBP. Participants observed that self-sacrifice, and putting the needs of others first, caused them stress:

I am a very social individual, so that I sacrifice myself for others. If I am supposed to have a guest for next week, I will be in a stressful position throughout the week, because I do want everything to be okay—as high quality and quantity as possible.

We live for others [our family], not for ourselves. We consider all of their needs and don't get any feedback from them.

Lack of Knowledge Resulted in High-Risk Back Behaviors

From the women's perspectives, lack of knowledge about their backs resulted in high-risk inquiry behaviors. Moreover, they voiced this knowledge deficit as an important factor in relation to the genesis of their back pain. The women observed that they had engaged in their work and daily activities with unhealthy postures. They readily acknowledged that they previously had not done any strength supportive exercise because the women were unaware of body mechanics. The participants did not know the structure and function of their backs and they could not articulate the advantages of special exercises for back pain. They believed their parents and health professionals could have been more helpful in exploring back pain prevention. Furthermore, they suggested that physician care providers and parents were remiss regarding this lack of education:

Throughout all of my life, I have done heavy work without complying with healthy behaviors. I did not do the strength exercise; of course I did not know what that was or how can I reduce my pain or get rid of it. Right now I know something about healthy preventive behaviors, but, before—nothing.

If we know about these things, we comply with them. The health providers and physicians should have educated us regarding this.

The structure and function of vertebra were discussed in the focus groups. None of the participants had any knowledge of their vertebra, even though they knew their physicians had diagnosed them as having LBP. Participants suggested that their physicians were too busy to teach them about their backs:

The physicians are too busy to consult their patients, let alone to educate us about the structure and function of the vertebra column.

The health care providers should educate the patients regarding low back pain prevention approaches, but they do not, or I don't know, maybe they have not enough time.

Organic/Biomedical

A few participants described the causes of CLBP in purely biological or mechanical terms. They also suggested that LBP was a natural consequence of aging and the wear and tear on their backs:

My low back pain is due to aging, and there is not any cure for it.

Another participant spoke of overuse, misuse, or bad back habits during the course of her life. When she was younger she believed that such activities were the symbol of youth and strength. In this regard the participant noted of following:

I thought I would be young and strong forever and I could do heavy work by the end of my life, but now I know that I cannot do the work as I did 40 years ago.

Only one participant stated that her LBP was caused by genetic reasons. She added that a congenital or genetic defect predisposed her to back pain:

It is obvious to me that there is a genetic predisposition to low back pain in my body system, so there is not any definite cure for it.

Some women believed that pregnancy and childbirth were the causative factors for their LBP:

My back pain started when I gave birth to my last child. I had subsequent pregnancies without recommended intervals, and I believe it is the main factor of my back pain.

DISCUSSION

From an explanatory model approach, it is very important to understand the viewpoints of participants (Bhui & Bhugar, 2002). Health care providers who gain specific knowledge about the values and beliefs of patients can maximize therapeutic intervention by advocating for patients in diverse health care settings (Purnell & Paulanka, 1998).

Anthropologist Arthur Kleinman suggested that by exploring explanatory models of illness we can better understand illness and disease within the context of patients' lives. Research has shown, however, that often there are important differences between the explanatory models of professionals and those of people experiencing an illness (Chew-Grahamans & May, 1999). The match or mismatch between providers' and women's explanatory models regarding CLBP is poorly understood. Research in this area is much needed, as patients who hold different accounts of their back pain compared with their care providers may be at risk for deterioration of their condition.

The current state of knowledge suggests that CLBP must be viewed as a complex phenomenon that incorporates physical, psychosocial, and behavioral factors. Consequently, a biopsychosocial treatment model is necessary for the development and implementation of LBP management interventions (Asenlof, 2005). Previous studies reveal that there are many

psychosocial factors that can be offered by patients as causes or contributors to CLBP (Borkan et al., 1995; Keyes & Ryff, 2003; Parish, 2002) and the best approach to understanding them is to have the client or patient state them (Bhui & Bhugar, 2002). Although this suggestion sounds simple, it is not without challenges. Seeking an understanding of psychosocial causative factors may require health care providers to look beyond the body and the boundaries of the biomedical model. Furthermore, such factors may require a multidisciplinary approach to the treatment of CLBP (Chew-Graham & May, 1999). While highly effective, this approach to the treatment of CLBP is complex and costly (Guzman et al., 2001; Hulst, Vollenbroke-Hutten, & Ijzerman, 2005).

In this study, we explored the women's experiences to gain insight into their beliefs regarding the cause of their CLBP. These cross-cultural findings confirm that LBP is a much more complex phenomenon than the current biomedical conceptualization (Borkan et al., 1995). The majority of participants in this study identified stress in their lives as the source of their back pain. In essence, their back pain served as a proxy for the pain in their lives. In the literature, researchers note that disease-oriented approaches to conditions such as LBP tend to medicalize stress and obscure both its historical and psychosocial context, and this kind of stress is considered physical more so than psychosocial (Davis & Joakimsen, 1997). The Iranian women identified that whenever they experienced social pressures they felt worse without any accompanying pathology. Iranian women are very much affected by their relationships with others, and most of the time they consider others first rather than themselves. This is the culturally based principle of "selflessness" (Lipson & Hafizi, 1998). As Bagheri (1992) observed, Iranian women are, in general, concerned with respectability and a good appearance of their homes. Participants voiced that keeping up such appearances and managing their households were stressful activities. Of interest, such household-based stress was confirmed as an independent predictor of LBP among Chinese middle-aged women (Yip, Ho, & Chan, 2004). Like their Chinese counterparts, the Iranian women would benefit from a restructuring of household work such that stress is decreased and the women concurrently are empowered to manage their household affairs.

More than half of the participants voiced lack of knowledge about their backs, which in turn resulted in high-risk back behaviors. The effects of education regarding the prevention of back injuries or decreasing LBP have been demonstrated by other researchers (Heymans, Van Tulder, Esmail, Bombradier, & Koes, 2005; Tavafian & Eftekhari, 2005). Participants in this study observed that their parents and health professionals were remiss in providing basic information about their backs, the prevention of back injuries, and knowledge about LBP. Tavafian and colleagues (2005), in a qualitative study, concluded that a lack of knowledge contributed to noncompliance regarding healthy back behaviors, both in terms of

prevention and the treatment of LBP. Fortunately, the Iranian women in this study were aware of these knowledge deficits and their needs and also many of them requested further information. Iranian researchers, health care providers, health education specialists, and particularly health policymakers who are involved in Iranian woman's health, are strongly urged to consider the health education needs of women and the availability of prevention programs in the health system.

CONCLUSION

Although modest in scope, this qualitative study revealed that beyond physical injury or degenerative processes, the majority of the Iranian women participants identified their CLBP as a consequence of stress, of meeting cultural and social expectations regarding selflessness, and of the ongoing management of their households. The lack of social support within their lives contributed to their stress and consequently their back pain. Although not without challenges, care providers whether in Iran or elsewhere would be wise to explore patients' causation beliefs and take actions, as appropriate.

Recent research and best practice standards reveal that a multidisciplinary approach is needed in the treatment of CLBP (Guzman et al., 2001). Despite numerous studies in this regard and strong evidence-based literature supporting the benefits of the multidisciplinary approach in treating LBP, there is limited experience regarding this treatment approach in Iran. The traditional physician–patient treatment model is the norm.

Finally, several of the women identified the need for preventive programming and additional information regarding CLBP. These needs have been identified in other studies (Symonds, Burtone, Tillotson, & Main, 1995; Tavafian et al., 2005).

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