Complementary and Alternative Therapy for Low Back Pain

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Complementary and Alternative Therapy for Low Back Pain

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This thesis for honors recognition has been approved for the Department of Nursing.

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Abstract

Low back pain is the second most common reason people seek medical care in industrial countries (Quinn, 2006). A significant number of people have been turning to complementary and alternative therapy to treat their low back pain, making low back pain sufferers among the most frequent users of complementary and alternative therapies (Quinn, 2006). This study, using a phenomenological method, is an exploration of the lived experience of three people who have used complementary and/or alternative therapy to treat low back pain. Qualitative phenomenological methodology was utilized to explore the lived experience of three individuals with low back pain. Giorgi’s analysis was used to generate themes (Russell, 1999). The themes of this study are changing temperament, seeking pain relief, limiting activities, fearing further injury and adjusting roles. These findings may help health care providers understand the experience of individuals with low back pain and the journey of seeking pain relief through treatment with complementary and alternative therapies. These results, although they describe a large-scale problem, are applicable to this study.
Chapter I

Background

Low back pain is the second most common reason people seek medical care in industrial countries (Quinn, 2006). In America, it is estimated 80% of the population will experience back pain at some point in their lives (Harvard Health Letter, 2007) and 30% of Americans experience chronic back pain every year (Hoffman, 2007). Given the significance of the problem, it is important to find an effective way to prevent and manage low back pain. Due to the cost, complications, and side effects of traditional treatment, alternative therapies are being more commonly used either alone or in conjunction with other therapies. Methods such as chiropractics and osteopathy, acupuncture, and massage have been shown to be effective in relieving back pain and are less invasive (Quinn, 2006). Psychological treatment is also becoming a popular alternative treatment of low back pain (Hoffman, 2007). The purpose of this thesis is to explore the experience of living with back pain and complementary and alternative modalities.

Description of Low Back Pain

All low back pain is categorized as either nonspecific low back pain, back pain that could be connected to radiculopathy or spinal stenosis, or as back pain potentially associated with another specific spinal cause (The Clinician Review, 2007).

With low back pain, psychosocial factors are important to assess (“New LBP Guidelines Encourage Conservative Approach, Spinal Manipulation,” 2007). Poor job satisfaction, monotony, performing uninteresting tasks, and psychological stress are
related to low back pain (Yip, 2001). There is a relationship between poor social support and low back pain; it is important for nurses to consider this connection when treating such patients (Yip, 2001). Furthermore, according to Yip (2001), psychosocial factors affected the gastrointestinal system leading to recurrent and persistent low back pain. Smoking was also associated with experiencing low back pain (Yip, 2001).

Risk Factors and High Risk Groups

Due to the vast number of ways in which back damage and pain can occur, there are numerous risk factors. According to Woolf (2003):

The occurrence of low back pain is associated with age, physical fitness, smoking, excess body weight, and strength of back and abdominal muscles. Psychological factors associated with occurrence of back pain are anxiety, depression, emotional instability, and pain behavior (e.g. (exaggerated) outward display of pain, guarding). . . Psychosocial aspects of health and work in combination with economic aspects seem to have more impact on work loss than physical aspects of disability and physical requirements of the job. (p. 652)

Ironically, nursing as an occupational group has the highest incidence of low back injury (Yip, 2004). Other occupational groups that perform work such as lifting, bending, twisting, pulling, and pushing are also at a high risk for low back injury (Woolf, 2003). Psychological workplace variables also play a role in low back pain. Components such as job dissatisfaction put people at a higher risk for low back pain (Woolf, 2003). Men and
women are at equal risk for back pain; however, people between the ages of 30 and 50 have a higher occurrence of back pain (Porth, 2007). Above all, the biggest risk factor for having future low back pain is a history of low back pain (Nguyen, 2007).

Impact on the client

Low back pain is an exceptionally disabling condition due to the involvement of physical, psychological, financial, and social factors. Furthermore, cognitive, emotional, biological, and behavioral symptoms lead to pain, distress, and disability. Significant disability leads to work truancy and its subsequent decline in productivity and negative economic impact (Hoffman, 2007). However, people with back pain do not only experience financial difficulty due to inability to work. In addition, they pay 60% more for health care than those without low back pain, 30% of which directly comes from physical therapy or special treatments (Pinto, 2007).

Along with not being able to perform their work, there are many other areas in which people with low back pain are unable to function normally. People have difficulty fulfilling domestic responsibilities and are forced to give up their normal social, sporting, and recreational activities. Although the severity of impact low back pain on people’s normal lives may vary, it is certain that their level of pain impacts their life in some way (May, 2007). With all of these factors it is no wonder that depression and chronic low back pain go hand in hand (Chou, 2007).

Impact on the family

People experiencing low back pain are not the only ones who are affected. Family members of those suffering are affected as well. Members of the household must go
through lifestyle changes, such as the financial impact and role changes. Significant others may suddenly be responsible for tasks the person with low back pain can no longer manage, as well as caring for their loved one during their long rehabilitation (Ignatacicius, 2006).

**Impact on society**

Due to the major disabling nature of low back pain, it causes considerable costs to society. It is estimated that low back injury and pain has a total cost of over $37.5 billion dollars per year in the United States. Of that, $3.1 billion dollars (Steenstra, 2006) are from people missing an estimated 149 million days of work per year due to low back injury (Nguyen, 2007).

In 2005 there were a reported 4.2 million nonfatal occupational injuries, 42% being sprains and strains. Of those sprains and strains, 63% involved the spine. Workers' compensation systems cover 127 million U.S. workers, all of whom have more office visits, hospital admissions, treating physicians, diagnostic referrals, therapeutic procedures, and longer duration of care compared with patients covered by other forms of insurance. This large number of procedures is a major factor in the estimated yearly cost of job related injuries and deaths: $128 billion to $155 billion dollars (Nguyen, 2007).

**Ethical decisions**

The most invasive treatment for low back problems is surgery. Surgery is usually done for pinched nerves, bone spurs, or degenerative diseases. Using surgery as a treatment for low back pain, although it is fairly low risk, is very controversial. The controversy is related to people recovering without surgery (Harvard Health Letter,
2007). According to the Harvard Health Letter (2007), such a randomized clinical study reported in the November 2006 issue of the *Journal of the American Medical Association* found no statistical difference between patients who had surgery and those who did not.

Medications such as non-steroidal anti-inflammatory drugs have been shown to have mild, principally short-term benefits for people with low back pain, with relatively low cost and low gastrointestinal and renovascular risks. Opioids, on the other hand, have substantial risks, such as addiction, although they are effective in treating pain that is not helped with non-steroidal anti-inflammatory medications. Muscle relaxants are another option for short-term relief of acute low back pain; however, they have central nervous system side effects. Medication therapy is not recommended for an extended time unless the person is having continued success in relieving his or her pain without adverse effects (Chou, 2007).

The American College of Physicians and the American Pain Society recommend clinicians should look at nonpharmacologic therapy for patients who do not improve on their own. Spinal manipulation is recommended for acute low back pain, while exercise, acupuncture, massage, spinal manipulation, yoga, cognitive-behavioral therapy and progressive relaxation are suggested for chronic or sub-acute low back pain (Chou, 2007). Positioning, exercise, heat and ice therapy, and diet therapy are other nonpharmacologic treatments that have been proven effective (Ignatavicius, 2006).
Chapter II

Review of Literature

This is a review of literature on the pathophysiology of low back pain, the evaluation of low back pain, and treatments. Evaluation techniques reviewed include diagnostic and outcome measurements. Treatments discussed include exercise, medications, multiple types of acupuncture, yoga, and psychological therapies.

Pathophysiology

Back pain can occur for many reasons, including problems with the vertebral column, the spinal nerve roots, muscles and ligamentous structures of the back, or from degenerative changes or disease processes. Weak muscles, heavy lifting, twisting, bodily vibration, spinal compression, obesity, pregnancy, or cancer can damage the back and lead to pain. However, pain can come about in persons without these mechanisms (Porth, 2007).

When tissue damage does occur, it is sensed by nociceptors, or pain receptors, in cells. The nociceptors in turn send a message to the spinal cord through either A* fibers or unmyelinated C fibers depending if the pain is sharp and discriminated or continuous respectively. The spinal cord then transmits the sharp pain impulse through the fast neospinothalamic path, and continuous pain through the slower-conducting, circuitous paleospinothalamic tract. Both pathways lead to the brain’s thalamus. From the thalamus the signal goes to the somatosensory cortex where it is interpreted, to the limbic system where emotional pain is experienced and the brain stem centers where the autonomic nervous system forms its responses (Porth, 2007).
Pain is very complex due to its subjective nature and the fact that it differs from person to person. Pain is described as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage” (Ignatavicius, 200, p. 63). Specifically, low back pain is, as Woolf (2003) defined it, “pain localized below the line of the twelfth rib and above the inferior gluteal folds, with or without leg pain” (p. 652). Back pain is typically supported as acute if it lasts less than six weeks, sub-acute if it lasts anywhere from six weeks to three months and considered chronic if it lasts more than three months (Woolf, 2003). Recurrent episodes are very common and can lead to acute back pain becoming chronic. According to Nguyen (2007), “after an episode of nonspecific low back pain, 20 to 44 percent of patients have a recurrence within one year, and up to 85 percent have a recurrence during their lifetime” (p. 1497).

**Diagnosis and Testing Recommendations**

When evaluating a patient with low back pain, it is necessary to obtain a thorough physical exam and history, including the psychosocial dimension (Chou, 2007). According to Chou (2007) patients should then be classified in one of three general categories including “non-specific low back pain, back pain associated with radiculopathy or spinal stenosis, or back pain potentially associated with another specific spinal cause” (¶ 2).

It is not recommended that diagnostic testing and imaging be used regularly for patients with non-specific low back pain. However, patients who have a history and physical exam indicating an underlying neurologic problem should be diagnosed with tests and imaging. Patients with radiculopathy or spinal stenosis should be diagnosed
using magnetic resonance imaging, and computed tomography if they are surgical or epidural steroid injection candidates (Chou, 2007). As with any other issue in which patients are seeking health care, they should be provided with evidence-based information as to their treatment(s) options and the expected course (Chou, 2007).

Measuring patient outcome is another important aspect of testing. Patient outcome testing determines the effectiveness and efficiency of the treatment. Familiarity and consistency with outcome measures and their use for the patient with low back pain are essential for clinicians in order to provide the best possible care (Resnik, 2005).

Instrument/Scale Validity and Reliability

The Health-related Quality of Life (HRQL) questionnaires measure many different aspects of health including an individual’s physical, psychological, emotional, and social well being (Resnik, 2005). Due to the comprehensive effect of low back pain on an individual, HRQL questionnaires are important to holistically treat patients. The HRQL questionnaires are subcategorized into generic, condition specific, or patient specific. While generic questionnaires are useful in a large, diverse population, condition specific evaluations may be more specific and have a less complex score interpretation (Resnik, 2005). Patient-specific questionnaires are considered especially useful in evaluating specific changes in an individual with low back pain because they “assess what is most important to each individual patient,” according to Resnik (2005, p.16).

Generic. The SF-36 is a common generic HRQL used for the evaluation of low back pain. The two different components it contains, physical and mental, measure general health, physical functioning, role functioning, bodily pain, mental health,
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emotional functioning, vitality, and social functioning. The SF-36 is a self-administered questionnaire. A major benefit of using the SF-36 is that it is available in 12 different languages and it has standardized scoring. This ability to use the questionnaire for people who speak different languages and still have a standardized score lends itself to easy comparison between groups (Resnik, 2005).

**Condition Specific.** The Roland-Morris Disability Questionnaire is an HRQL questionnaire commonly used to evaluate persons with low back pain. Individuals fill out the Roland-Morris Disability Questionnaire before and after treatment to assess their self-reported functional status. Adapted from a generalized health questionnaire, the Roland-Morris Disability Questionnaire assesses a person’s perceived limitation in performing 24 activities of daily living due to back pain within the “past few days”. The questionnaire score is calculated by adding the number of “yes” answers. The scale ranges from no to severe disability, or zero to 24 respectively. One problem with the Roland-Morris Disability Questionnaire is the use of different external criteria, from global perceived effect of change to rating pain intensity (Kuijer, 2005). Kuijer (2005) found notable differences in responsiveness when using different external criteria with the same group.

The Oswestry Low Back Pain Disability Questionnaire has been shown to be reliable and valid for evaluating individuals with low back pain. It is a self-administered questionnaire that includes ten sections concerning a person’s activities of daily living and pain. Each section is scored from 0-5, and total score of the sections multiplied by two to determine the patient’s perceived degree of disability. Some problems with the
Oswestry Low Back Pain Disability Questionnaire include the number of responses left blank or not answered completely (Resnik, 2005).

Patient Specific. For patient specific evaluation, the patient chooses up to five main activities that he or she has difficulty performing due to low back pain. The patient provides a baseline evaluation of how well he or she can do the activity: zero indicating he or she cannot do it at all and ten indicating he or she can do it fully. The individual’s progress is then measured after a specified amount of time by re-evaluating how well he or she can perform the same activities (Resnik, 2005).

Treatment

All guidelines for the treatment of low back pain include the clinician giving advice. Along with exercise, advice is the most common treatment for low back pain in a general practice setting (Pengel, 2007). In order to look at the effects that exercise and advice have on pain and function in low back pain, Pengel (2007) performed a factorial randomized, placebo-controlled trial. The study included 259 patients from seven hospitals and clinics in Australia and New Zealand. The outcomes were measured with a 0-10 pain scale, a Patient-Specific Functional Scale, an 11-point global perceived effect scale, a Roland-Morris Disability Questionnaire, the number of health care contacts, and the Depression Anxiety Stress Scales-21. Pengel (2007) reported:

In participants with sub acute low back pain, physiotherapist-directed exercise and advice were each slightly more effective than placebo at 6 weeks. The effect was greatest when the interventions were combined. At 12 months, the only effect that persisted was a small effect on participant-reported function. (p. 787)
Medication

Medications are another one of the most frequently prescribed treatments for low back pain (Chou, 2007). Chou (2007) reviewed pertinent articles taken from Medline and the Cochrane Database of Systemic Reviews to assess the effects of medications on low back pain sufferers. An analogue pain scale, the Roland-Disability Questionnaire, and the Oswestry Disability Index were used to evaluate effectiveness. The results showed that NSAIDs, acetaminophen, muscle relaxants, and tricyclic antidepressants had good short-term effectiveness. However, Chou (2007) noted that “evidence is insufficient to identify one medication as offering a clear overall net advantage because of complex tradeoffs between benefits and harms” (p. 505).

Advice, exercise, and medication are effective for short-term low back pain. With low back pain, however, pain and disability typically become chronic and reoccurrence of back pain is common. Therefore, it is important to find effective treatment for low back pain that lasts longer than three to six months and for back pain that is reoccurring.

Nurses who encounter patients with low back pain should be aware of effective treatments beyond advice, exercise, and medications in order to thoroughly treat and educate individuals (Pengel, 2007). According to Chou (2007), “for patients who do not improve with self-care options, clinicians should consider the addition of nonpharmacological therapy with proven benefits” (¶ 8).

Complementary and Alternative Therapies

An increased demand and public awareness of complementary and alternative treatments has brought about more accurate scientific clinical studies that evaluate the
different therapies for safety and efficacy. One such study by Secor (2004) demonstrated that “practical data collection systems could be implemented in a CAM clinic utilizing several treatment modalities” (p. 506). The prospective study found that quantitative outcome measurement instruments can be utilized in outpatient clinics and also re-emphasized the effectiveness of chiropractic, naturopathic, and acupuncture therapies in treating low back pain and improving quality of life (Secor, 2004).

**Acupuncture**

Witt (2006) demonstrated the effectiveness of acupuncture in treating low back pain in a study that used a randomized controlled trial plus a nonrandomized cohort. The study found that acupuncture, in addition to routine care, improved the symptoms and quality of life in people suffering from low back pain compared to routine care alone. The improvements seen during the trial’s three months of treatment continued for at least the three months following treatment. Formal qualifications of the physicians performing the acupuncture were found to not be a factor in the treatment outcome, whereas younger age, severe complaints of pain, and more than ten years of education were all outcome predictors. In addition to examining the effectiveness of acupuncture, Witt (2006) evaluated the cost. The study found that although acupuncture was more expensive than routine treatment, it was shown to be more cost effective. These findings connote acupuncture is effective in treatment and cost for patients with low back pain.

**Electroacupuncture**

The application of electrical stimulation through acupuncture needles has actually been proven to be more effective in treating chronic low back pain and improving range
of motion at the spine than regular needle acupuncture. Electrical heat acupuncture, during which acupuncture needles are heated, has also been shown to be more effective than traditional acupuncture in improving lumbar flexion and pain reduction immediately after treatment for low back pain (Tsui, 2004). A double-blind, randomized, controlled trial study done by Tsui (2004) compared electroacupuncture to electrical heat acupuncture. The study had all three groups (electroacupuncture, electrical heat acupuncture, and control) perform exercises at home, and all three had improvements in pain. In addition, those who were treated with electrical heat acupuncture had significantly less pain at two weeks, and those treated with electroacupuncture had significantly improved straight leg raise and Roland Morris Disability Questionnaire scores (Tsui, 2004). This improvement in pain and straight leg raises suggests that patients should use electroacupuncture and/or electrical heat acupuncture in addition to exercise to treat low back pain.

Yoga

Yoga is a popular exercise suggested for low back pain that has been proven effective. A randomized, controlled trial done by Sherman (2005) compared the effects of viniyoga with conventional exercise classes and with a self-care book. The study results, although not statistically significant, showed that the yoga group consistently reported better outcomes than the exercise group. The effectiveness of yoga is thought to be superior in treating low back pain compared to conventional exercise due to the focus not only on strengthening muscles and increasing flexibility, but also increasing body awareness and how people position and move themselves. Additionally, yoga works on
relaxing tense muscles, and relieving mental stress (Sherman, 2005). This study suggests that viniyoga is safe and effective in treating not only the physical aspect of low back pain but the mental aspect as well.

**Massage**

Individuals experiencing low back pain frequently choose massage therapy as a complementary and alternative modality. A cross-factorial comparative study done by Melancon and Miller (2005) compared the difference in perceived low back pain relief in those who use massage for treatment to those who use traditional therapy. The study found that there was a significant linear decline on the whole in mean pain ratings on the Oswestry Disability Index. The traditional therapy group had a slightly lower mean pain rating of 0.83 than the 0.93 mean pain score of the massage group. Although the study found traditional therapy to be to some extent more favorable for relieving back pain, the study suggested there are benefits of massage that outweigh the decreased relief of back pain. These benefits included lower cost, fewer adverse effects and more control over health care choices since massage is self-referred (Melancon, 2005).

**Psychological**

A meta-analysis of randomized controlled trials done by Hoffman (2007) showed the importance of including the psychological aspects of low back pain. The study found that using psychological interventions for chronic low back pain were efficient when it came to reported pain, pain-related interference, depression, disability and health-related quality of life among individuals with chronic low back pain. This information proposes a holistic approach is necessary in treating chronic low back pain (Hoffman, 2007).
Coping. The way in which women cope with stress may result in lowered pain tolerance and psychosomatic low back pain symptoms. A case-controlled study of 182 women in Hong Kong found that those with a lot of housework or work-related stress, those who are caregivers for a relative or friend, and those who report having ordinary-to-bad relationships with the people they live with have an increased incidence of low back pain (Yip, 2001).

Posture. Yip (2001) reported that nurses and other health professionals can empower women to improve their work and home environment by teaching them effective, healthy ways to handle stress and providing them emotional support. Also, by identifying caregivers who may be experiencing stress and supporting them through education and available resources, nurses can potentially prevent or help lessen low back pain. In addition Yip (2001) states that nurses need to be aware of a person’s daily posture when assessing an individual with low back pain. Posture is important to address when creating an individualized care plan and in preventing reoccurrence of low back pain.
Chapter III
Methodology

Design

A significant number of people have been turning to complementary and alternative therapy to treat their low back pain, making low back pain sufferers among the most frequent users of complementary and alternative therapies (Quinn, 2006). While treating individuals with low back pain, it is important for health care providers to not only understand the effects of the illness for which they are treating the person, but also the experience of the treatment being used. By understanding what low back pain sufferers are experiencing while they are going through treatment with complementary and alternative therapies, health care providers will be more able to treat patients holistically and be as therapeutic as possible. To gain insight into the lived experience of using complementary and alternative therapies to treat low back pain, a phenomenological method will be used for this study.

Phenomenology. Phenomenological research looks to understand the meaning of life experiences. Understanding in phenomenology is gained by studying the way individuals view themselves, others, and everything else that touches their lives (Russell, 1999). In researching individual experiences, phenomenology “uncovers the meaning in everyday human experience and brings the meaning of being human to the reader through language” (Russell, 1999, p. 224).

Bracketing and open-ended questions. In order to avoid research biases in phenomenology, bracketing and open-ended questions will be used. Bracketing is the
identification of former knowledge, ideas, and beliefs regarding the phenomenon being studied. By performing a self-assessment, the researcher attempts to acknowledge any biases, separate them out, and maintain an impartial study. Using open-ended questions during unstructured interviews also ensures the data collected is complete and not influenced by the researcher (Russell, 1999). The primary interview question will be “Tell me about your back pain and your use of alternative and complementary therapies.”

Sample

This is an exploration of the lived experience of three people who have used complementary and/or alternative therapy to treat their low back pain and are willing to share their individual experiences. To participate in this study, the participants must have or have had low back pain and must use or have used complementary and/or alternative therapies as treatment for that pain. Two women and one man all English-speaking volunteers age 18 years and older were recruited through word of mouth and flyers posted on the Carroll College campus and the natural health food store.

Confidentiality

All interviews will be performed at a mutually agreed-upon location once consent forms are completed (see Appendix A), and no data was collected until the research project has Institutional Review Board approval. No names or identifying characteristics of the interviewees was collected. Pseudonyms were used for tape recordings. Data will be kept in a locked file and destroyed after five years (Russell, 1999). The researcher has completed the National Cancer Institute’s training for protection of human subjects.
Data Collection

Data for the study will be collected through an in-depth interview with the individual. Interviews will be audiotaped and then transcribed into documents for data analysis.

Analysis

Data for the study will be analyzed after lengthy interviews are conducted to gain a full description of the lived experience. The method of analysis for this study will be Giorgi’s method (Russell, 1999), which includes the following steps:

1. Read the entire disclosure of the lived experience straight through to obtain a sense of the whole.

2. Reread the disclosure to discover the essence of the lived experience under study. Look for each time a transition in meaning occurs. Abstract these meaning units or themes.

3. Examine meaning units for redundancies, clarification, or elaboration. Related meaning units to each other and to a sense of the whole.

4. Reflect on the meaning units, and extrapolate the essence of the experience for each participant. Transform each meaning unit into the language of science when relevant.

5. Formulate a consistent description of the meaning structures of the lived experience for all participants. (p. 230).
Chapter IV

Results

The purpose of this study was to gain understanding of the lived experience of three individuals who have used alternative therapies for low back pain. By exploring the personal accounts of people who have lived with low back pain and used alternative therapy during treatment, nurses can gain insight into the experience, and therefore be more understanding of those in similar situations. Qualitative phenomenological was the methodology utilized for this research study. Giorgi’s Method for data analysis was used to code the data and identify common themes from the transcribed interviews. Throughout data analysis five major themes became evident. These themes included the following: changing temperament, seeking pain relief, limiting activities, fearing further injury and adjusting roles. Each of these themes will be presented with quotes from participants to support each theme.

Changing Temperament

The theme changing temperament had two subthemes (a) pain, and (b) effects of medications. Each of these subthemes had a profound effect on the participant’s mood and temperament.

Pain. All of the participants expressed a negative impact that living with low back pain had on their mood. The change in emotional disposition was mainly attributed to being in pain. Pain caused individuals to be cranky, mad, angry and even depressed. One individual stated, “I can see how I have less sympathy, or less compassion, like, I don’t know how to say it, my temperament is uh, strained . . . I have a shorter fuse, I’m less tolerant and I’m just uncomfortable, I think like being in that chronic pain situation, or
just being in pain for several days. After awhile it just starts effecting, decreasing your patients and I don’t like how it makes me feel sick.” As this participant discussed, experiencing pain disrupts not only one’s disposition towards others, but also towards oneself.

**Effects of medication.** Another factor participants reported contributing to the change in mood was the side effects of medications. Taking the prescribed medications for low back pain caused these individuals to feel high, sedated, and uncomfortable. As one participant recalled, “you get tired of taking pills, they make you rummy, you can’t drive, you can’t operate with machinery that you get hurt with, so you’re kind of a buzz case, not very much fun to anyone around ya, your family.” Later in the interview he also added, “I’m not very frisky with 8 pills ya know!” Another participant described a time when she was on pain medication saying, “I spent the next 3 days like in bed, like comatose!” Anti-inflammatories also had negative side effects. As one individual said, “They had me on a prednisone taper and I had lots of side effects from that like my head felt like it was going to blow up.” The negative side effects of medications led to negative temperaments.

**Seeking Pain Relief**

The participants that were interviewed have gone to great lengths to find relief for their low back pain. All three of them had used at least six different modalities including traditional medical model treatments and alternative therapies. While the medical management included medications and surgeries, the alternative therapies attempted by these individuals were numerous. Ice and heat therapy, chiropractics, TENS units, massage, stretching and exercise, cranial sacral work, reflexology and positive
affirmations were all discussed as therapies utilized to seek relief of low back pain. As
one interviewee stated, “anything to get relief.” He added later in the interview, “I hate
pain! I used to think oh be tough and I’m tough ya know, I can take it and I’ll tell ya
between the colon cancer and the gallbladder thing, I’m tired of pain. . . I’ve been there, I
don’t want that.” Another participant, when discussing her treatment, stated, “I decided to
do something about it because it was hurting so bad.” The low back pain experienced was
to these participants intolerable and it drove them to seek pain relief through many
different routes namely alternative and complementary modalities.

Limiting Activities

The participants of the study noticed that their normal activities were limited due
to the low back pain they experienced. This theme was closely linked to temperament.
Living with low back pain altered the participants’ mood due to the limitations of
activity. One participant who has been unable to perform her typical exercise regimen
due to her back pain acknowledged, “Running was kind of my release, so I’ve been kind
of crabby lately.” Further into the interview she elaborated saying, “It’s super frustrating
and some days I cuss up a storm and I wish I could go back to normal! ‘Cause I’m not
use to being held back by something as tedious as like a low back injury.” Another
participant described how her pain effected performing daily tasks saying, “I did have a
horse business for like a year and it really bothered me and then also I think I’ve noticed
it when I ride my horses and I notice it when I’m lifting hay bales and that kind of thing.
It flares up when I clean the house.” She also recalled back pain affecting travel stating
that, “I remember going to Disneyworld and so it was bothering me that whole week, and
that decreased my activity.” Low back pain even limited the way one person normally
interacted with his family. He admitted, “You reach the point where you can’t do anything, ya know, we have grandkids and I don’t want to play with them, I don’t feel like playing with them.” All participants’ daily activities were in some way altered due to their low back pain.

Fearing Further Injury

In analyzing the data, a fear of further injury was quite evident. Fearing further injury lead to the patients being continuously conscious of their activities. As one individual acknowledged, “I think the worst thing for me, the pain is bad enough, but ya know I can handle the pain, ya know, I can take care of it, but I think it’s the fear of permanent damage . . . Each time it happens I feel like, oh my god I could be damaging those nerves even more every time and I think that that scares me. So for me that would be the worst part of it, not the pain but the possible long term effects.” Long term damage was a prominent fear in the individuals of this study.

Due to the fear of further injury one interviewee said, “I have to be really careful to not do things that set me back cause then it just starts all over again.” Similar guarding due to fear of further damage was recognized in the other individuals when they stated, “Every time I go to work I feel like I’m taking that risk of injuring myself permanently. . . I’ve got to concentrate on using like proper form and using my legs more for things than my lower back.” Additionally, “I’m kind of babying it and taking care of it as much as I can, so I can get back to running.” Fear of further injury also affected the treatment one individual used for her low back pain. She stated, “I don’t want to have surgery cause I’ve seen people who’ve not done well and have had permanent damage.” Fear of long term damage led this individual to choose more alternative and complementary therapies.
Adjusting Roles

The experience of living with low back pain led to a role change in each participant and a subsequent adjustment to that role change. One participant stated, "It makes me feel, like old. It does, it makes me feel like not as healthy, not as young. So I think you start to get an image of yourself as sick, or not as being as young and flexible and able to do the things that you would like to do...I don’t want to take on that sick role." To adjust this individual said, "I think as I get older now I hesitate to take on clinical jobs, and I really think about that...and that made me think I would like to have other type of activities like teaching and being a nurse practitioner." For this individual, the role adjustments were both in how she viewed herself and what career paths she chose.

Another participant discussed her role change and how she has to adjust saying, "I can’t just go out and do like all the sports and activities that I really love to do, so...my sports cause that’s probably my favorite thing to do and it’s really frustrating cause I was in such good shape and now I’m getting out of shape cause I can’t run. But more so just frustrating. And I find it hard to sit in desks for like a really, really long period of time, like by the end of my management class it hurts really bad cause we sit there for 3 hours in hard chairs and I just kinda try and move around, but sometimes it really helps just to lay flat afterwards." She continued, "It’s hard for me too because we have to lift patients while we’re at the hospital for nursing clinical and so I have to be really careful now.”

This participant’s role as an athlete and as a student needed to be adjusted due to her low back pain.
The third participant had yet a different way in which his own roles needed to be adjusted. When discussing how low back pain affected him he said, “I have chores to do around here that I can’t get to! Gotta bring somebody in, so there ya know you feel you’re being, god they’re castrating me, ya know. You do, ya know, your masculinity starts to dwindle because you can’t do anything.” All of this study’s participants conveyed that living with low back pain led them to have to adjust to different roles in their work, recreation and relationships.

The study results give insight to the experiences faced by the three individuals interviewed. Through these research results, one can arrive at a better understanding of the actual experiences those living with low back pain and using alternative therapy face. When attempting to care for those who have low back pain and are using alternative therapies to treat it, nurses must examine each individual’s experience in order to provide a plan of care that is effective to each different case. Examining the way in which those with low back pain view their condition and the impact it has on their life can give nurses much insight and provide more holistic, successful treatment.
Chapter V
Discussion

The participants’ experience of living with low back pain and using complementary and alternative therapies for treatment were described by the following themes: changing temperament, seeking pain relief, limiting activities, fearing further injury and adjusting roles. These themes that were discovered will be further elaborated on and the nursing implications considered. Additionally, the limitations of this study and future recommendations will be discussed.

Changing Temperament

The participants’ account of living with low back pain was marked by a change in their temperament. The individuals that participated in the study attributed that change to the pain they experienced and the side effects of medications they took to relieve that pain. A study by Shröder et al. (2007) supported this finding of pain directly influencing mood. According to Shröder et al. (2007) chronic conditions, including pain, frequently influence emotions and control cognitions. Shröder et al. (2007) defined control cognitions as, “the individual’s perception that they have power over their behavior or the achievement of outcomes” (p. 280). Although the participants may not have recognized a lack of control as the reason for their change in temperament, uncontrolled pain and adverse effects of medications are things the person believed he or she could not control.

As nurses treating patients with chronic low back pain it is important to understand the individual’s temperament may be altered and negative emotions or moods that occur are due to their low back pain. Nurses need to take into consideration the effects negative moods and temperament may impact the patient’s relationships as well
and ensure family and significant others are educated about the influence pain has. It is also important to support the individual’s independence and perception of control. Educating patients about their treatment options, including alternative and complementary therapies, and allowing them to choose their modalities is one suggestion for increasing a person’s feelings of control. Other ways in which nurses can nurture a patient’s control cognitions is by getting them involved in the treatments and having them perform as many activities of daily living as they can independently.

Seeking Pain Relief

Participants’ in this study all reported going to great lengths in seeking relief of their back pain. A study by McCracken, Vowles & Gauntlett-Gilbert (2007) found a connection between relief seeking behaviors and a decreased recovery. It was found that, “carrying on with activity, while acknowledging that pain is present, were associated with better physical, psychosocial, and emotional functioning over time. Attempting to control pain or seek support or help, on the other hand, was associated with relatively worse functioning over time” (McCracken, 2007, p. 346). This evidence suggests that the individuals interviewed for this study could, by attempting so rigorously to rid themselves of pain and the incidents that come with it, be in turn causing themselves more pain. McCracken, Vowles & Gauntlett-Gilbert (2007) suggested to treat pain “not as something to be altered, avoided, or controlled, but rather as something that can occur in experience without interfering with function” (p. 348). For individuals being treated for chronic low back pain, nurses can help increase functioning by assessing and addressing the patient’s beliefs about their pain. Allowing the patient to discuss his or her
feelings about the pain helps the person acknowledge pain is present and recognize it as something that cannot be avoided but can be ameliorated.

**Limiting Activities**

Changes brought about by the low back pain and the traditional treatments used limited the participants’ activities such as exercise, recreation, and chores. In a cross-sectional study of people suffering from chronic idiopathic axonal polyneuropathy (CIAP), Shröder et al. (2007) found that self-reported activity limitations explained inconsistency in depressed temperament. The study also reported that activity limitation accounted for variances in control cognitions. In a different cross-sectional study of people who had experienced a stroke, Shröder et al. (2007) found that similar to individuals with CIAP, when stroke victims could not perform what they considered their usual activities there was a higher incidence of negative emotions such as anxiety and depression and lower control cognitions. The participants in this study were found to have similar responses to their activity limitations. Although none of the participants reported anxiety or depression, the inability to perform what was considered normal activities led to descriptions of feeling crabby, frustrated, and bothered. While treating people suffering from low back pain activities should only be limited when absolutely necessary. Providing extra time and support for individuals while in performing their activities of daily living will decrease their sense of limitation and thus decrease the negative emotions associated with activity limitation. Nurses seeing individuals suffering from low back pain should continually assess the patient’s psychosocial dimension. Forming a therapeutic relationship and encouraging the verbalization of feelings can help
the nurse and patient recognize negative emotions and depression so they can be addressed.

Fearing Further Injury

A common theme found in the participants’ testimonies was the fear of further injury. Kvist, Ek, Sporstedt, and Good (2005) found in a study of athletes that underwent anterior cruciate ligament reconstruction that individuals who chose to not return to participating in their pre-injury sport had a higher level of fear of re-injury than those who chose to return. The study also found that increased fear of re-injury was correlated with a low perception of knee-related quality of life (Kvist, 2005). The study by Kvist, Ek, Sporstedt, & Good (2005) supported the findings of this study, where individual’s fear of further injury led to them choosing not to return to pre-injury activities. The participants in this study related the limitation of pre-back pain activities with a lower perception of quality of life. For nurses, encouraging people with low back pain to examine and express their own emotions and fears is important for treatment. If nurses address the fears individuals may have about further injury, it is more likely for these individuals to overcome their fear and return to their pre-injury quality of life.

Adjusting Roles

This study found that all participants had a role adjustment subsequent to their low back pain. Asghari and Nicholas (1999) reviewed literature on the role of personality dimensions in adjustment during chronic pain. Their examination found the personality dimension of neuroticism, in which people have a greater propensity for experiencing negative, anxious, or moody emotions, greatly impacted a person’s coping ability. Individuals with a greater neurotic personality dimension had more unhelpful pain-related
beliefs, such as that their pain was mysterious, and weakly understood, not limited or fixable, and had a higher degree of self-blame (Asaghar, 1999). This study did not take into account the personality traits of those interviewed, however, research suggests it is a factor in how one adjusts to chronic pain. Research suggests that an individual’s personality should be assessed to foresee how they will be able to cope with role adjustments. Performing such assessments and encouraging the patient to find effective coping mechanisms and treatment modalities is an important nursing role. Nurses should assess the strengths and weaknesses of each patient’s personality and help him or her form helpful coping mechanisms, and thus, a more successful adaptation to role adjustment.

Limitations and Recommendations

The study was limited to three participants living in Helena, Montana. Thus it was limited in the sample. Two women and one man were interviewed, giving an unequal representation of the male perspective. The age range of participants represented a wide range, individuals in their twenties, forties and seventies. However, the economic and socio-cultural backgrounds of all three individuals were similar.

Future studies need to be conducted involving more people, from different geographical areas and backgrounds in order to investigate differences and common themes across gender, socio-cultural, and economic subgroups. In addition, in depth studies examining and comparing the lived experience of specific alternative and complementary therapies could lead to improved understanding and patient care.
Conclusion

The purpose of this study was to explore the experience of living with back pain and complementary and alternative modalities. This phenomenological study, of three Montana residents, found five common themes. The themes of this study were changing temperament, seeking pain relief, limiting activities, fearing further injury and adjusting roles. Nurses will gain from this thesis an understanding of the lived experience of low back pain and using alternative and complementary treatments.
Appendix A

Carroll College

Consent to Participate in Back Pain Study

**Title:** Alternative and Complementary Therapy for Low Back Pain

I have been invited by Casey Hursh, a Carroll College nursing student to participant in a voluntary research study. The purpose of this study is to gain understanding of alternative and complementary therapy for low back pain.

If I choose to participate in this study, my participation will consist of an audio tape recorded interview with Casey Hursh lasting about 60 minutes. In this interview, I will be asked to discuss my experiences, feelings, and recovery from low back pain. There is a chance that this interview will make me recall painful situations related to the low back pain, therapy and recovery. I may refuse to answer any questions and stop the interview if I become uncomfortable. I realize that I may withdraw from this study at any time. Confidentiality will be maintained throughout the study, and at no time will my name or identifying characteristics be used. My audio taped interview will be labeled with a pseudonym. I am aware that this research will be used to advance the understanding of alternative and complementary therapy for low back pain. There may be presentations and publications associated with this study. There are no costs involved with participation in this study. I am aware that if I have any questions I can call Casey Hursh at 503-545-7838 or Dr. Joni Walton at 447-5490 or email at jwalton@carroll.edu.

I agree to participate in this study:

Name

Date

Researcher

Date
References


