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Southampton Education School

A Biographical Study of Men with Chronic Low Back Pain

by

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ABSTRACT

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A BIOGRAPHICAL STUDY OF MEN WITH CHRONIC LOW BACK PAIN

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Low back pain is a common condition that will affect 80% of the population at some point in their lives. For the majority of people the pain and associated disability will be resolved and they will resume normal activities. For a small proportion of this group however, the condition will remain unresolved with associated long-term pain and disability; this is termed chronic low back pain (CLBP). The costs associated with CLBP are high both physically and emotionally for the individual, and in terms of the economic burden placed on society pertaining to healthcare costs and lost productivity.

CLBP is a multifaceted condition. Whilst a biopsychosocial model of care, as opposed to the traditional biomedical model, is advocated as the best approach for its management it has been suggested that the impact on the self-concept and identity of individuals with this condition has not been fully explored or addressed.

This study employed a biographical approach with the aim of understanding the impact on the lives and identities of men living with CLBP. Five men were recruited and in-depth interviews were undertaken which were audio-recorded, transcribed verbatim and analysed thematically.

The identity of all the participants in the study had been affected by CLBP. Clear themes emerged that included feeling defined by their CLBP, experiencing feelings of frustration and anger, the inability to retain their masculine role, the impact on fatherhood, public and private identities, physicality and feeling a liability or burden to others. The support received from significant others was also highlighted. The participants detailed how exercise and education were major aspects in the management of their condition whilst resilience and the use of humour were also very apparent in their narratives as mechanisms to enable them to cope with CLBP.

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DECLARATION OF AUTHORSHIP

I, Julian Mark Pearce

declare that the thesis entitled

A Biographical Study of Men with Chronic Low Back Pain

and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
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- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- none of this work has been published before submission.

Signed: ………………………………………………………………………..

Date:………………………………………………………………………….

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Definitions and Abbreviations

CLBP	chronic low back pain
LBP	low back pain
VAS	visual analogue scale

1. Introduction

1.1 Overview

> *At the beginning of the 21st century the international epidemic of back pain and disability continues to exact a huge toll in terms of suffering and costs.*
>
> (Schoene, 2004: ix)

While this study will detail epidemiology, aetiology and the economic burden of back pain, its primary focus is understanding the reality of living with back pain for the men in this study by exploring their narratives. It is hoped that through hearing the participants' stories an insight will be provided into how back pain has impacted on their lives and ultimately to gain an understanding of how back pain can be more effectively managed, allowing lives to be lived to their optimum. The research utilises a biographical approach and is specifically focused on the impact of back pain on the identity of the participants.

Back pain is very common condition; half the UK adult population report back pain lasting more than 24 hours at some time during the year (Palmer *et al.*, 2000). It is estimated that four out of every five adults will experience back pain at some point during their lives (Palmer *et al.*, 2000). The total costs associated with back pain are estimated to correspond to between 1% and 2% of a country's gross national product (GDP) (Norlund and Waddell, 2000).

My reasons for undertaking this study are both professional and personal. Professionally as a physiotherapist having worked both clinically and latterly in training student physiotherapists, I am acutely aware of the immensity of the problem of back pain and heartened to see the rejection of the purely physical perspective and the recognition of the holistic picture culminating in the biopsychosocial approach to its management (Waddell, 1987; Kendall *et al.*, 1997; Kendall *et al.*, 2009). I question however if all the necessary psychosocial issues to manage these patients optimally have been identified and agree with Osborn and Smith (2006: 220) when they suggest that:

> *…a contradiction between the painful body and the preferred self could represent an important obstacle to therapeutic rehabilitation if not acknowledged or resolved.*

As such, the intention of this study is to understand more about the self-concept and identity of individuals with chronic low back pain (CLBP) in order to more effectively help these individuals in the future. To that end the aim of this biographical study is to explore the narratives of men living with CLBP in order to elucidate the impact of long term back pain on their individual lives and identities. The study aims to illustrate how their stories can be employed as vehicles to enable a better understanding of their lives. In doing so the study aims to illustrate different ways of being that veer from the norm but are nonetheless legitimate so that men living with back pain can more effectively manage their lives. It is hoped that more general insights about the effects of living with CLBP will be illuminated so that others, including professionals treating men with CLBP, listen to their stories and regard these individuals holistically rather than as a set of symptoms.

From a personal perspective, in my time as a practising physiotherapist, I have often felt both ill-equipped and as if I have little to help those with CLBP. I hope that the findings of this study may go someway towards providing clinicians of the future with a greater understanding of psychosocial factors affecting individuals and hence the wherewithal to offer more effective management strategies.

1.2 Structure of thesis

Chapter 2 Literature Review provides a broad overview of CLBP (pain, disability, management) and introduces key sociological theory: symbolic interactionism, self-concept, identity and masculinity. It details the rationale for the study and introduces the key research completed to date in this field.

Chapter 3 – Methodology and Method outlines the biographical approach and highlights fundamental aspects of this methodology. It details the process of data collection and interpretation highlighting ethical considerations.

Chapter 4 – Findings: Participant's Stories offers a short biography of each participant with the intention of letting their story be told in context without detailed analysis or interpretation that is intent on drawing out common themes and can obscure pertinent personal detail.

Chapter 5 – Discussion undertakes what was intentionally avoided in the previous chapter namely presenting the common themes evident from the analysis of each narrative and interpreting them in the light of previous research.

Chapter 6 – Conclusion summarises the findings and addresses the aim of the research. Recommendations for practice and future research are provided and the limitations of this study are acknowledged. Additionally personal reflections on the whole process are presented.

2. Literature Review

2.1 Introduction

This biographical study aims to gain an understanding of the impact on the lives and identities of men who have been living with chronic low back pain (CLBP). It will explore how living with back pain over a period of many years has affected the lives of the participants by examining their narratives. A biographical approach is adopted in this study in order to understand the lived experience of others (Roberts, 2002). This is particularly pertinent to the research presented here as it is difficult to measure pain or disability and the effect it can have on an individual is entirely subjective (McCaffery and Beebe, 1989). This chapter will draw particularly on the literature in health and sociology, using it to contextualise CLBP from historical, medical and socio-cultural perspectives. In doing so the chapter will consider pain and disability, with particular emphasis on low back pain and how chronic low back pain is defined. How people with CLBP have been dealt with by the medical profession is explored to provide some background to a typical patient journey, as well as how illness has been, and is now, perceived medically and socio-culturally. Theoretical aspects of identity and the self are considered, in particular symbolic interactionism and Goffman's (1959) notion of dramaturgy, and they are used to critique the literature about masculinity, pain and chronic illness in men.

2.2 Pain and Disability

While the central focus of this research is the impact of CLBP on male identity, the term low back pain in reality, encompasses both pain and disability (Waddell, 2004) that in turn can affect a person's identity (Osborn and Smith, 2006). The link between the pain and disability seems obvious; pain leads to disability and ultimately this impacts on quality of life. This widely held concept of pain and disability suggests both a linear and a proportional relationship; pain leads to disability and a given quantity of pain leads to proportional disability. Neither reflects reality; some people with severe pain present with minimal disability and simple backache can result in permanent disability (Waddell, 2004). The management of pain and disability and the interventions offered vary; this will be considered further as part of the patient journey.

Pain is a symptom; not a disease or a diagnosis. Disability essentially means that activity is restricted. Neither can be measured objectively, clinicians are reliant on what the patient self-reports. Waddell (2004) suggests that our failure to distinguish between pain and disability is a major reason for our difficulty in effectively managing LBP. The purpose of this study is not to differentiate between pain and disability but rather to understand through their narratives how one or both may or may not have impacted on the participants' identity, and as a result offer some insights into better management of CLBP.

Many health care professions still hold *a very mechanistic view of pain as* [simply] *a signal of tissue damage*; you put your hand in the fire (tissue is damaged) you have a sensation of pain (Waddell, 2004: 28). The key problem with this view is why do people with the same injury report different levels of pain and disability? This problem is exacerbated when considering chronic rather than acute pain.

Loeser (1980) proposed a new way of looking at pain in four stages – nociception, pain, suffering and pain behaviour. Nociception is the detection of tissue damage resulting in stimulation of nerve fibres carrying information to the central nervous system (CNS). Pain is initially the perception of noxious stimuli at the spinal cord (reflex arc) which secondly is registered as pain when that information has been transmitted to the brain via the spinal cord. Suffering is the negative, affective (unpleasant emotional) response produced in the higher centres of the brain by pain or other emotional situations (anxiety/grief/depression). Finally pain behaviour consists of any output (all behaviours) which are commonly understood to suggest the existence of a tissue damaging stimulus (recognised as being indicative of the perception of pain) e.g. limping, grimacing, moaning, taking medicines, unable to work.

What Loeser (1982) accomplished in this work was the formal recognition of an emotional component in understanding pain. His 'emotional response' and the corresponding 'pain behaviour' are very individualistic. This is particularly pertinent for this research as it legitimises the individuality evident in the wide spectrum of potential 'pain behaviour'. Waddell (2004) while recognising the benefits of Loeser's (1982) categories also sees that the use of the word 'pain' as in both nociceptive pain and pain behaviour is confusing because it does not differentiate between the discrete stimuli and the broad clinical syndrome.

Merskey's (1979: 250) seminal definition of pain neatly captures both the sensory and emotional aspects of pain:

> *An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.*

The concept of mere *potential tissue damage* resulting in an *unpleasant emotional experience* is hard to understand with reference to the purely mechanistic biomedical approach to pain perception (Merskey, 1979: 250; Waddell, 2004). Waddell's (2004: 32) holistic interpretation within a biopsychosocial perspective is more comprehendible:

> *The sensation of pain, emotions, and pain behavior are all integral parts of the pain experience.*

This succinct précis recognises and therefore legitimises the previously questionable psychosocial aspects associated with the *pain experience* (Waddell, 2004). The crucial point however, for this research is the notion of 'unpleasant' – pain, emotions and pain behaviour; all are negative concepts and as such have the potential to negatively impact on identity. A person's ability to retain their previous identity will be compromised in the face of all the components (physical and psychosocial) of the *pain experience* (Waddell, 2004: 32). Osborn and Smith (2006: 216) effectively capture this concept when they state that:

> *The embodied unpleasantness of chronic pain involves an assault upon and defence of a preferred or desirable self.*

While the presence of pain can be recognised by others through accepted pain behaviours, it is the loss of functional ability and the resultant disability that is often most closely associated with a person who is in pain affecting how they are viewed by others and hence their identity (Holloway *et al.*, 2007; Bernardes and Lima, 2010). Disability can be defined as restricted activity (Waddell, 2004). The World Health Organisation (WHO) (2011) defines disability as:

> *An umbrella term for impairments, activity limitations and participation restrictions.*

The WHO suggest that activity limitation (WHO, 2000) is evident when a person is unable to execute or achieve an activity without difficulty.

As previously highlighted there is not a constant, proportional relationship between pain and disability, both are subjective measures and clinical disparities are common. It is this lack of a correlated relationship that ultimately explains how back pain and disability have impacted on society recently.

> *Despite popular belief, there never was an epidemic of back pain. Back pain has always been a common bodily symptom, but it is no more common today than it has always been. Rather, the evidence is of an epidemic of disability associated with ordinary backache.*
>
> (Waddell, 2004: 87)

2.3 Low Back Pain (LBP) and Defining Chronic Low Back Pain (CLBP)

In the literature low back pain (LBP) is the customary term utilised to describe pain in the 'small of the back' or lumbar region; chronic low back pain (CLBP) is differentiated from low back pain (LBP) by the duration of the pain. While this study will predominantly focus on CLBP, in reviewing the literature the term LBP is employed, as this is commonly used.

The low back is commonly defined as the area between the bottom of the rib cage (12th rib) and the buttock creases (gluteal folds). Some people with LBP will complain of pain in their legs (sciatica) which may be present in addition to or without LBP.

Low back pain is a common condition that will affect most people at some point during their lives. For the majority of people the pain and associated disability is resolved and they return to normal activities. A small proportion will, however, develop long term pain and disability, which if present for over a year would suggest that they are unlikely to return to normal activities (Savigny *et al.*, 2009).

Until relatively recently the mechanism that culminated in the perception of any type of pain was simplistic and linear - stimulus (injury) was directly related to response (pain) as first proposed by Epicurus (342-270 BC) (Horn and Munafo, 1997). Horn and Munafo (1997: 2) state that traditionally pain theory:

> *has proposed that the activation of specific pain receptors and transmitters, as a result of injury, [are] projected to an isolated pain centre, via a spinal pain pathway.*

In 1965 Melzack and Wall proposed a new concept that pain could be modulated or 'gated' at the spinal cord thus affecting the pain signals sent to the higher centres and hence the perception of pain (pain gate theory). The gate could be opened or closed by ascending sensory input or descending signals from the brain that would be influenced by cognitive or emotive domains such as stress and fear. The linearity of pain perception was rejected and psychological influences were recognised in the perception of pain thus allowing a more widely accepted definition of pain that now recognises both the sensory and emotional elements of pain (Merskey, 1979).

2.3.1 Aetiology of LBP

LBP is initiated by a physical problem which is normally mechanical in nature i.e. symptoms are exacerbated by movement. This is true for the non-specific or benign LBP where a specific cause (e.g. a prolapsed intervertebral disc or a spinal tumour) has been ruled out through diagnostic triage.

Pain can arise from any innervated (receives a nerve supply) structure these include:

- vertebrae
- intervertebral discs
- dura and nerve root sleeves
- facet joint capsules
- ligament and fascia
- muscle

Waddell (2004: 159) states that:

> *For more than 100 years, orthodox medicine, orthopedics, and biomechanics have searched for a structural cause for back pain.*

The search has been essentially unsuccessful with Nachemson, Waddell and Norlund (2000) suggesting that it is very difficult to identify a single cause for back pain, in about 85% of people with back pain no clear pathology can be established. This lack of a clear pathology and subsequent diagnosis has led to varying negative classifications (malingering, skiving etc) where it is thought that symptoms are fabricated or exaggerated for secondary gain (Waddell, 2004; Holloway *et al.*, 2007). This type of 'labelling' has the potential to be extremely destructive to the self and identity of those so categorised.

2.3.2 Classification of LBP

This study aimed to recruit men with chronic low back pain (CLBP); chronicity being determined by the duration of pain. Conventionally LBP has been classified according to its duration (Savigny *et al.*, 2009); with Spitzer and Leblanc (1987) suggesting the following criteria:

- less than 6 weeks – Acute
- 6-12 weeks – Sub-acute
- longer than 12 weeks – Chronic

Waddell (2004) in considering alternative classifications used in the past (acute is the same duration [six weeks] and chronic anything more than 6 months) suggested that it was too late to start thinking about the back pain as chronic after 6 months and proposed 6 weeks as a better alternative. Whilst this time frame provides a simple classification, it fails to reflect reality where people's pain varies, resolves and often returns (Waddell, 2004; Savigny *et al.*, 2009). Recent guidelines specifically seek to address the persistent, episodic or recurrent LBP that has lasted longer than 6 weeks but less than 12 months which it classifies as persistent and non-specific LBP (Savigny *et al.*, 2009). Savigny *et al.* (2009) therefore suggest a slight alteration to the classification of LBP; acute low back pain remains, as previously stated, of a six week or less duration but CLBP is categorised as severe, disabling pain that has lasted for more than 12 months. It is hoped that appropriate management in the early stages will reduce the number of people with LBP progressing to chronic status (Savigny *et al.*, 2009).

2.3.3 Epidemiology

Estimates for the prevalence of LBP vary considerably and do not distinguish between LBP of differing durations however, Walker (2000) suggests that at:

- any point in time (point prevalence) up to 33% of the population will have LBP
- Over a 1 year period (1 year prevalence) 65% of the population will have LBP
- At some point in their lives (lifetime prevalence) 84% of the population will have LBP

Savigny *et al.* (2009) suggest that LBP affects approximately one third of the UK adult population annually, with 2.6 million people seeking advice from their GP each year while 11 million people in the UK will have experienced back pain for at least one week in the last month (Arthritis Research Campaign, 2002).

One year on from their first episode of LBP, 62% still have pain and 16% of those initially unable to work remain not capable of returning to work (Hestbaek *et al.*, 2003).

2.3.4 Economic Burden

The economic burden of LBP is significant; the most up to date studies available are for 1998 but the UK retail price index increased by 28.8% in the ten years to 2008 (Savigny *et al.*, 2009). This increase needs to be taken into consideration when interpreting these figures.

Health costs in 1998 for back pain were £1.632 billion, of which £565 million was for private (non NHS) provision (Maniadakis and Gray, 2000). The indirect costs due to lost production were between £3,440 million and £9,090 million depending on the approach used to interpret the data (Maniadakis and Gray, 2000).

The associated cost, therefore, of treating a condition in which in 85% of cases there is no clear diagnosable pathology is exorbitant (Nachemson *et al.*, 2000). There is clearly a need to understand LBP more fully and specifically the relationship between pain and disability (Waddell, 2004).

2.4 Patient Journey

Traditionally the management of LBP has utilised a biomedical model of health care that has a specific focus on disease (Waddell, 2004). Waddell (2004) summarises the approach in Figure 1.

Pain = Tissue Injury

Tissue Damage → Impairment → Disability → Incapacity for Work

Figure 1 Waddell’s summary of the biomedical approach to LBP

The premise being that if the pain can be cured, the disability will resolve. While this model appears to work well in clear-cut pathologies, it has not worked for back pain and may have in fact exacerbated the problems associated with this condition (Waddell, 2004). The biomedical model does not take into account the psychological or socially debilitating factors of LBP. However, Waddell's (1987) paper entitled 'A new clinical model for the treatment of low-back pain', advocated a holistic, biopsychosocial approach. This approach takes into account a range of factors and is discussed in more detail later in the chapter.

The onset of LBP is routinely self managed often with 'over the counter' medication and avoidance of exacerbating activities including work. At the end of the self-certification period, if not before, should the individual be unable to return to work they will consult their GP. Their consultation should involve diagnostic triage (see section 2.4.1 Management of Patients with Low Back Pain) which may require them to be referred to a specialist for their opinion and possible intervention. The majority of people, in addition to their sickness certification, will receive advice and prescription medication. They may also be referred for Physiotherapy, Osteopathy or Chiropractic management which could be offered through the NHS or privately. These options along with a variety of others (acupuncture, massage, etc) can be accessed directly by the public without seeing their GP but will have to be financed by the individual or through insurance. While 90% of people with acute LBP will recover in six weeks up to 7% will develop chronic LBP (Nachemson *et al.*, 2000). These patients with CLBP will account for approx 80% of the health and social care costs associated with the management of LBP (Nachemson *et al.*, 2000) which was in excess of £1·6 billion for the NHS in 1998 (Maniadakis and Gray, 2000). It is the ongoing management of those with CLBP that clearly has the major financial impact. Access to services, for these people, like pain management, ongoing rehabilitation (Physiotherapy, Osteopathy and Chiropractic) vary considerably according to locality. The Telegraph (30 May 2012) reports on the *postcode lottery of care* in terms of the variation in the amount of money spent on *physiotherapy, drugs, and pain management clinics* for those with *arthritis and other joint problems* (Adams, 2012: 1). The article is based on a report published by the Arthritis and Musculoskeletal Alliance which audited progress in the implementation of the Musculoskeletal Services Framework (Department of Health, 2006) in England (Arthriris and Musculoskeletal Alliance, 2012). The disparity reported across different regions was stark:

> *There is a greater than thirteen fold variation in the amount of money being spent by commissioners on patients with musculoskeletal conditions, which cannot be attributed solely to differing local needs.*
>
> (Arthriris and Musculoskeletal Alliance, 2012: 6)

The lack of appropriate services locally will inevitably lead to many people managing their condition through prescription medication and therefore not having an opportunity to access the biopsychosocial approach (see section 2.4.2 Psychosocial Factors in Low Back Pain) (Waddell, 1987; Clinical Standards Advisory Group, 1994; Waddell *et al.*, 1996; Kendall *et al.*, 1997; Waddell *et al.*, 1999; Kendall *et al.*, 2009). It is hoped that this research will illuminate pertinent aspects of the participants' own journeys which could, in all likelihood, include turning-points or specific events, which are a fundamental component of the biographical approach, (see section 3.3.3 Epiphanies) such as changes to the management of their CLBP that can provide a greater understanding of their lives (Denzin, 1989; Erben, 1998). It would be extremely useful to understand how effectively participants have been managed both physically and psychologically over the duration of their CLBP, and if and how, this has affected their identity.

2.4.1 Management of Patients with Low Back Pain

In (1994) the Clinical Standards Advisory Group (CSAG) suggested how services should be organised to effectively manage back pain in the NHS. Key recommendations were for diagnostic triage and psychological assessment alongside the more usual pain control, manipulation, exercise, functional restoration and vocational rehabilitation. The concept of 'Red Flags' was also endorsed which, alongside diagnostic triage screened for serious spinal pathology (Clinical Standards Advisory Group, 1994). 'Red Flags' consist of a list of symptoms that were indicative of specific pathology rather than simple mechanical (pain occurring with activity) backache e.g. unexplained weight loss, non-mechanical pain or saddle anaesthesia (Clinical Standards Advisory Group, 1994). Diagnostic triage allowed the clinician undertaking an assessment (GP, Physiotherapist, Chiropractor, Consultant etc) with reference to 'Red Flags' to allocate patients into one of three groups:

- Simple backache – the patient is well but has mechanical pain
- Nerve root problem – severe or progressive motor weakness
- Possibly serious spinal pathology (Red Flags).

Depending on their allocation to a particular group the patient could be treated or referred to a more appropriate clinician. These concepts were endorsed and further developed by the Royal College of General Practitioner's guidelines (RCGP) (Waddell *et al.*, 1996) and subsequently updated (Waddell *et al.*, 1999) to include an evidence base for any advocated management approaches.

2.4.2 Psychosocial Factors in Low Back Pain

LBP has been described as a 20th century medical disaster (Waddell, 2004: 1). Independent, expert advice based on sound research was required to guide clinicians in their management of patients presenting with LBP. The guidelines, as detailed in the previous section (Clinical Standards Advisory Group, 1994; Waddell *et al.*, 1996; Waddell *et al.*, 1999) promoted a holistic approach to patient care; in addition to physical manifestations they advocated that psychosocial issues also needed to be considered. Guidelines have been updated and new ones continue to be written (Savigny *et al.*, 2009) suggesting that they continue to be useful and that research into the management of LBP is evolving. It is hoped that this research will provide some understanding of how well this holistic, biopsychosocial approach to the management of LBP is being implemented into clinical practice (Waddell, 1987).

In his seminal work Waddell (1987) proposed a new model for the treatment of low back pain; this is a biopyschosocial approach:

> *We must approach low-back disability as an illness rather than low-back pain as a purely physical disease. We must distinguish pain from disability.*
>
> (Waddell, 1987: 632)

This model attempted to formally address aspects of back pain other than just physical symptoms. Additionally the RCGP (Waddell *et al.*, 1996) like the CSAG (Clinical Standards Advisory Group, 1994) recommend that during assessment psychosocial factors be considered, specifically addressing attitudes and beliefs about back pain, psychological distress and depressive symptoms, illness behaviour, family and work issues. The subsequent RCGP edition of their Low Back Pain Evidence Review (Waddell *et al.*, 1999) continues to support this approach in the hope of decreasing the chances of chronicity.

The key work on screening, assessing and managing the psychosocial aspects of back pain was published by Kendall, Linton & Main in 1997. The authors (Kendall *et al.*, 1997: 1) continuing with the flag theme – 'Red Flags' were indicative of physical risk factors (potential serious spinal pathology) - introduced the concept of 'Yellow Flags' which they defined as:

> *...psychosocial factors that are likely to increase the risk of an individual with low back pain developing prolonged pain and disability causing work loss and associated loss of quality of life.*

'Yellow Flags' are therefore psychosocial risk factors. Kendall *et al.* (1997) suggest that the risk factors for long term work disability caused by low back pain, having received considerable attention over the previous five years, are well known and understood. The majority of risk factors are psychosocial. This concurs neatly with Waddell's (2004) epidemic of disability associated with back pain, rather than an epidemic of back pain itself.

Kendall *et al*. (1997) suggest that the assessment of psychosocial 'Yellow Flags' should consider the following seven categories:

- Attitudes and beliefs about back pain - belief that pain is harmful or disabling
- Behaviours - use of extended rest/reduced activity
- Compensation - lack of financial incentive to return to work
- Diagnosis and treatment - health professional sanctioning disability
- Emotions - fear of increased pain with activity or work.
- Family - over-protective partner/spouse
- Work - history of manual work/frequent job changes/stress at work/job dissatisfaction

The work of Kendall *et al*. (1997) clearly demonstrates the impact of psychosocial factors on long term work disability. The seven categories detailed above are therefore likely to affect the individual's sense of self and identity (Charmaz, 1994). The 'Yellow Flags' concept has recently been further developed with an increased focus on the action required to avoid unfavourable outcomes rather than just predicting the potential for long term pain and disability (Kendall *et al.*, 2009). 'Blue Flags' consider the workplace and the relationship between work and health; the reduced ability to work and prolonged absence from work (Kendall *et al.*, 2009). While 'Black Flags' focus on the context in which people function (societal or workplace) and consider how other people, systems and policies and can potentially block positive actions and initiatives from healthcare providers and the workplace (Kendall *et al.*, 2009).

While 'Yellow Flags' cover a plethora of psychosocial issues, identity is perhaps an overarching psychosocial factor that has, to date, received scant specific attention or recognition in the research into low back pain. This study therefore hopes to specifically consider the identity of men with CLBP by asking them to tell their story.

2.5 Illness Narratives

The types of illness stories that are told are important for this study because they provide an intimate and detailed insight into the realities of living with CLBP. According to Smith and Sparkes (2008: 18):

> *People are born into a culture that has a ready stock of narratives from which they draw upon, appropriate, adapt, apply and perform in their everyday social interaction.*

The narratives detailed below represent reality and how an individual manages and copes with their illness. Some of the potential identities associated with a specific illness narrative are more acceptable to society than others and this can affect how an individual chooses to present their illness to others.

Frank (1995) suggests that sick people tell essentially three types of stories or narratives. Frank (1995: 76) recognises the risk of creating a *general unifying view* that force individual stories to fit a specific type. Frank (1995: 76) however, justifies his decision on the grounds that it will allow closer attention to the stories ill people tell and *aid listening* which is *difficult because illness stories mix and weave narrative threads*. Proposing some general types of narrative will help to sort out those threads (Frank, 1995).

2.5.1 Restitution Narrative (Frank, 1995)

This is the most common narrative especially for those who are recently ill but not for the chronically ill. The basic concept is:

> *"Yesterday I was healthy, today I am sick but tomorrow I'll be healthy again…as good as new".*

(Frank, 1995: 77)

The restitution narrative is the story we all want to hear, tell and hope will be our experience when we are ill. Essentially it is a learnt story that is socially acceptable and we are conditioned to believe this is the way illness should be told. It is entirely congruent with Parsons' (1951) sick role concept in which illness duration is limited and recovery is certain. The reality that people do get better and those that don't continue to hope they will, give credence to this approach. The ill patient will want the predictability of their former body restored; they want to be cured, so their preferred story will be restitution. The restitution will occur by either surgery or medication and therefore the restitution occurs not through the patient's personal efforts but because of the expertise of others. There are limitations to this approach, the restitution narrative does not work when the patient has a chronic condition, is dying or cannot afford (financially) the commodity required for cure The concept of changing physical capabilities, as a result of chronic illness, that require renegotiation of social obligations and personal identity doesn't fit with Parsons' (1951) sick role theory. The ultimate limitation, however, is mortality; as the patient approaches death how can a restitution narrative be viable? While the limitations of the restitution narrative appear obvious Smith and Sparkes' (2004) and Sparkes *et al*.(2011) found that conversely even among those with severe, permanent disability the majority of participants chose to tell a restitution narrative; their hope of restitution was paramount.

The restitution narrative supports the modernist premise that for every suffering there is a remedy; if this is not the case it draws modernity into question (Frank, 1995). Modernity views the body as an autonomous entity (an "it" to be cured) that can be separated from the self, which is awaiting restitution and as such is closely aligned to the biomedical model discussed earlier. The body is 'deconstructed' into various discrete parts, any of which can be fixed. Heroism can be seen in both doctors and patients, the heroism is both complementary and unequal – the doctor's work is active, the patient's passive; the patient will therefore be perceived inferior as an individual (Frank, 1995) . It is possible that both this dated hierarchical view of the doctor-patient relationship and a more up-to-date, holistic, patient-empowered approach will be evident in the data gathered for this study.

2.5.2 Chaos Narrative (Frank, 1995)

Chaos is the opposite of restitution; in this narrative the patient and his/her life will not get any better. Chaos stories lack order, there is no logical progression, they are told as the patient experiences life, without sequence or discernable causality; this makes the stories difficult to 'hear'. This is further complicated by the alternation of silence and “and then” repetitions. Chaos stories produce anxiety just as restitution stories are reassuring. While restitution stories tell us how we can overcome suffering, chaos highlights how easily any of us can succumb to a pessimistic alternative. There is immediacy in chaos, you are not able to gain distance and reflect back on the experience, you are unable to put it into words – the body is incarcerated in its present, frustrated needs. The patient is swept along, without any control; culminating in the potential for major consequences to their previous identity. It seems reasonable to consider that the participants in this study may well tell chaos narratives with their experiences of LBP progressing to chronic status while potentially being exacerbated by a confusing plethora of diagnoses and treatments.

Chaos stories are an anathema to modernity – the basic concepts of remedy, progress and professionalism have failed, instead vulnerability, futility and impotence are clearly evident. Modernity is fundamentally about ‘fixing’. Therefore doctors and patients struggle to accept the chaos narrative because it undermines the norm of restitution in exemplifying what medically is too complex to ‘fix’. This can be distressing for the patient as it goes against socially and medically accepted norms and therefore the patient is denied any purchase on their past or present identity in the maelstrom of their chaotic experiences.

2.5.3 Quest Narrative (Frank, 1995)

In the quest narrative illness is accepted and used. The patient sees themselves as on a journey or quest – something is to be gained through the experience. The patient telling the quest story has a clear story to tell; the teller of the chaos narrative is unable to articulate a story due to their suffering while in the restitution narrative the ‘real player’ or agent is either the doctor or the medication. The tellers of quest stories are searching for an alternative explanation for being ill – they are looking for purpose and meaning in their lives as a result of their illness. They seek to share this purpose or meaning with others – to inspire others.

Modernism promoted the doctor to hero status; heroism was not achieved through the perseverance of the patient but by the doctor actively accomplishing a task successfully (Frank, 1995). Hearing the quest story and acknowledging the chaos story both call for a shift in the hero status of the doctor from that of actively accomplishing to those individuals who are persevering through suffering (Frank, 1995). Perseverance is a trait that is likely to be evident in the participants in this study as they cope not only with CLBP but also with the impact this has on their identity.

2.6 The Sick Role

Parsons (1951) proposed the concept of a “sick role” in which he outlined the responsibilities and duties of both physician and patient. Parsons’ theory is founded on the healthy, fully functioning adult as being the standard or normal (Charmaz, 1999) and suggests that illness results in deviance. The sick role allowed institutionalised social control over that deviance and therefore disruption was controlled primarily by the doctor/physician (Charmaz, 1999). The idea that the inability to assume normality standards equals ‘deviance’ raises major equality issues and the suggestion that those who have a disability require paternalistic management seems at odds with how people with disabilities are perceived in the UK today particularly in regard to the recent Equality Act (UK Government, 2010). The context and time in which Parsons was writing should be remembered, as should our potentially emotive interpretation of the word ‘deviance’ which is defined as *diverging from usual or accepted standards* with a caveat however of *especially in social or sexual behaviour* (Oxford Dictionaries, 2012). In the past these concepts were probably more accepted – society invested power in the doctor to manage sickness (deviance) which unquestionably they had the power to do (Parsons, 1951). Deviants could be ‘fixed’ and returned to fully functioning members of society (Parsons, 1951). This concept is however flawed as evidenced by those with any chronic or deteriorating condition including CLBP.

Parsons (1951) suggests that there are four key elements (expectations and obligations) pertinent to the sick role:

- Exemption from normal responsibilities without punishment. The exemption needs to be legitimised and the physician may act as both a *court of appeal as well as a direct legitimatizing agent* (Parsons, 1951: 436). Legitimisation cannot only be regarded as a right but is also an obligation where people are told that they are not well enough to be at work and need to go home to bed. Parsons suggests that this has a moral connotation and that legitimisation has a social function to protect against malingering. However, the legitimising role of the physician as proposed is problematic, requiring the ability to differentiate between true malingering and chronicity, which could mean never returning to work. Were the legitimising decision inaccurate someone with a chronic condition (CLBP) could be labelled as a malingerer with major psychological consequences to their identity (Waddell, 2004; Holloway *et al.*, 2007).
- The sick person is exempted from responsibility for being ill, he can’t help it. He cannot be expected to get well by an act of will, this is not influenced by his

attitude; rather his condition must be treated. This is significantly at odds with the biopsychosocial approach advocated by Waddell (2004) and the ‘Yellow Flags‘ concept which suggests that attitudes and beliefs about back pain and other psychosocial aspects are risk factors for chronicity, for example when simple back pain is not resolved and becomes chronic (Kendall *et al.*, 1997).

- Being ill is an undesirable state and therefore there is an obligation to want to get well. The resumption of the patient’s position in society, their role identity (Stryker, 1980 in Stets, 2007) and the independence associated with masculinity (Connell, 1987 in Gerschick and Miller, 1995; Lack *et al.*, 2011) all support the state of undesirably and the longing for restitution.
- There is an obligation *to seek technically competent help* i.e. a physician *and to cooperate with him in the process of trying to get well* (compliance with medical advice) (Parsons, 1951: 437 ; Charmaz, 1999). This obligation is dependant on the previous one in that the undesirability of the current state and the wish for restitution are prerequisites to seeking help and compliance with the advice proffered.

The responsibility of the physician is to *do everything possible to forward the complete, early and painless recovery of his patients* (Parsons, 1951: 450). Parson’s (1951) sick role reflects the biomedical model of health with its compartmentalising approach. The focus or specific ‘compartment’ was the *physical aspects of disease* [which] *has led to neglect of the psychologic and social aspects of illness* (Waddell, 1987: 637). This neglect suggests that the psychological and sociological aspects linked to recovery would not be considered, instead just the physical symptoms are the focus for treatment. This narrow, one-dimensional approach of the biomedical model has continued until recently, which Waddell (2004) suggests has been central to our ineffective management of LBP. Interestingly despite Parsons’ (1951: 431) predominant focus he acknowledged the failures inherent in reductionism and in an early nod to biopsychosocial recognised the individual as comprising of a *biological system…*[with] *personal and social adjustments*. The holistic approach of the biopsychosocial model favoured today (Waddell, 1987; Clinical Standards Advisory Group, 1994; Waddell *et al.*, 1996; Kendall *et al.*, 1997; Waddell *et al.*, 1999; Waddell, 2004; Kendall *et al.*, 2009) would have been lacking in the past (and this may still be the case) (Charmaz, 1999) therefore patient management would have been compromised and the chances of chronicity increased (Savigny *et al.*, 2009).

Charmaz (1999: 213) suggests that the sick role is based on a model of acute illness:

> *…people become sick – suddenly – seek help, become legitimate patients, relinquish usual responsibilities, follow medical advice, and then, voilà, recover.*

The transience of the sick role is endorsed by the work of Frank (1995) which he categorises and refines as the 'restitution plot' - *I was well, became unwell but will soon become well again* [author's words].

According to Charmaz and Olesen (1997: 455) the sick role is essentially based upon *unquestioned professional authority, rapid professional intervention, patient compliance, and a timely recovery*. If the patient complies with 'medical orders' recovery will occur – they will be well again and able to resume their normal roles and identities. Unfortunately this theory fails to account for those who do not recover; those with chronic conditions and long term disability like the participants in this study with CLBP. This perspective of illness fails to address what happens to these 'deviants', how they are managed and how they are viewed by others and themselves which will inevitably affect both their self-concept and identity (Cooley, 1902; Charmaz, 1999; Baumeister, 2011).

In Charmaz's (1999) opinion the sick role based on this model of acute illness still dominates our health care system but it is increasingly challenged in its failure to account for chronic illness and disability where basic care, control of symptoms and slowing the rate of deterioration prevail rather than cure. The management of chronic illness, as opposed to simple, acute illness is evolving. The hierarchical doctor-patient relationship so evident in Parsons' (1951) sick role, has changed to a partnership where options are discussed and decisions regarding health care are negotiated (Charmaz, 1999). Patients therefore become empowered and in doing so take responsibility or ownership for their health and illness (Charmaz, 1999). The patient with a chronic illness, unless it is all consuming is unlikely to occupy the sick role for much of the time. They are much more likely to identify themselves with their ordinary role of worker, carer, partner or parent than with that of being sick (Charmaz, 1999).

It could be suggested that for many patients a major epiphany (Denzin, 1989; Erben, 1998) occurs not at the initial diagnosis but rather on realisation that the *timely recovery* inherent in Parsons' (1951) model of acute illness is unlikely (Charmaz and Olesen, 1997: 455). When *timely recovery* does not happen it is likely that the patient starts to reflect on how they see themselves and how they think others will see them (Cooley, 1902; Mead, 1934 in Wallace and Wolf, 1995).

Pain is invisible, the signs and symptoms of pain can be seen and interpreted however but the existence of pain cannot be objectively confirmed or the intensity independently quantified. People may have been nominally allocated a ‘sick role’ but the root cause, however genuine, is latent from others; the presence of pain cannot be independently confirmed and therefore its legitimacy remains questionable. Charmaz (1999) suggests that while patients with chronic pain may initially enjoy legitimacy due to their physical symptoms, their moral status rapidly diminishes. When their actual physical symptoms are queried and a diagnosis of malingering is suggested they may find that not only is the legitimacy of their symptoms revoked but treatment too (Charmaz, 1999). A plethora of terms are available to describe the patient whose pain is not seen as arising from a physical cause. Malingering with its negative identity connotations, characterised by the exaggeration of symptoms with the hope of financial gain, is not considered a medical condition (Samuel and Mittenberg, 2005). Somatisation Disorder (previously know as hysteria) - a psychiatric disorder where a patient complains of physical symptoms but there is no identifiable cause - is however, formally recognised as a medical condition (MedlinePlus, 2012). While both conditions appear very similar, the resulting impact of a misdiagnosis is considerable. The integration of the biopsychosocial approach (which advocates considering more than just the physical symptoms) to the management of pain deems that the presence and quantity of pain to be whatever the patient reports (McCaffery and Beebe, 1989). The basic premise being, how can an individual question the presence, quantity or impact of the pain perceived by another or determine whether it is of a physical or psychological origin? This draws into question the supreme role of the doctor as advocated by Parsons (1951) and ultimately alters the whole sick role concept.

2.7 Identity and Our Sense of Self

Human beings are conscious, cognate and reflexive beings; they have the capacity to think about themselves - the capability for self-referent thought (Brown, 1998). Reflexive consciousness is an important part of self–awareness; this allows an individual to collect an, *extensive store of information about themselves* this can be termed their self-concept (Johnson *et al.*, 2002; Baumeister, 2011: 49). Reflexivity, as a component of self–awareness, allows humans to think about themselves and as such:

> *…the self is implicated in two ways. I am the one doing the seeing, and the thing I am seeing is ME.*

(Brown, 1998: 2)

It was James (1890) who first differentiated the duality between the ‘I-self’ as the aspect of the self that is actively doing (thinking, perceiving, seeing, organising and interpreting) and the ‘Me-self’’ as the *object of our attention* (Brown, 1998: 2). The ‘I-self’ is the active agent that organises and interprets one’s experiences over time and is responsible for the construction of the ‘Me-self’. The ‘Me-self’ focuses on who people think they are, what they are like; these are termed self-referent thoughts and are often referred to as self-concept (Brown, 1998). The way people feel about themselves (self-referent feelings) are captured by the term self-esteem (Brown, 1998).

This research is concerned with the impact of CLBP on the participants’ identity. Identity is inextricably connected to an individual’s self-concept and self-esteem. Therefore these are important theoretical considerations in the research presented here, as it seeks to discover how CLBP has affected the participants’ self-evaluation and self–concept and therefore their identity.

From a sociological perspective Charmaz (1999: 209) suggests that the self refers to:

> *All those qualities, attributes, values and sentiments, including feelings of moral worth, that a person assumes to be his or her own.*

The purpose of this study is to explore how the impact of living with CLBP affects the lives and identities of the men. With this in mind, an exploration of how men with CLBP think they are perceived by others, how they see themselves and feel about their own persona, and how that differs from those without CLBP is necessary. Brown (1998) explains that how we feel about ourselves (self-esteem) and how we see ourselves (self-image/self-concept) is influenced by our views of who we think we could, should and ought to be and this can be explained in four hypothetical selves:

- The attainable self
- The ideal self
- The ought self
- The undesired self

The attainable self represents the type of person we want to be; a self that is achievable. James (1890 in Brown, 1998) suggests that the closer our present self is to our attainable self the better we feel about ourselves. The impact of CLBP and the resultant disabilities on the participants in the study are likely to mean that their present self is far removed from their attainable self resulting in associated negative feelings.

The ideal self is an idealised, unattainable self. Most people do not confuse the ideal and attainable self however, when this occurs they may be seen as delusional.

The ought self details what we feel we should be; the identity we should assume and be able to live up to. This will be influenced by a variety of factors such as, role models, social class, gender identity, masculinity etc. People's perceptions of who they are now (current self) and their inability to live up to the 'ought self' (the discrepancy between the two) make them prone to feelings of guilt and anxiety (Higgins, 1987 in Brown, 1998). The inability to live up to an appropriate benchmark because of CLBP makes the concept of the 'ought self' particularly pertinent to this research.

Finally the undesired self represents what people are afraid of becoming. Levels of happiness are dependant on the degree of distance between our present self and the undesired self. The impact of CLBP could result in the possibility of assuming an undesired self thus removing any distance between present and undesired self and therefore creating unhappiness and emotional insecurity.

In developing their concept of differing selves Markus and Nurius (1986) proposed the idea of 'real' and 'possible selves'. The 'real' self corresponds to the ought self with the 'possible' selves being attainable, ideal or undesired. They suggest that this *type of self-knowledge pertains to how individuals think about their potential and about their future* (Markus and Nurius, 1986: 954). Possible selves represent who we could become and who we are afraid of becoming. As such the idea of possible selves can function either as incentives e.g. who we do/don't want to become or *as an evaluative or interpretive context for the current view of self* (Markus and Nurius, 1986: 955).

It seems reasonable to hypothesise that that those recruited to this study may, as a result of their CLBP, have experienced the discrepancy between who they perceive themselves to be (current self) and their attainable (possible) self or may indeed have become the undesired self with the potential ramifications to their self-esteem (Higgins 1987 in Brown, 1998; Markus and Nurius, 1986).

The initial development of the self and identity and its subsequent adaptation can be considered through the concept of Symbolic Interactionism.

2.7.1 Symbolic Interactionism.

The concept of symbolic interactionism is based upon an individual's interaction with their social world: the thoughts and emotions that result from this interaction form their perceptions of that world and of themselves, and subsequently determine their behaviour (Wallace and Wolf, 1995). Interaction with others impacts not only on social but also personal identity and the ongoing 'moulding' of the self-concept. Identity is driven by an individual's interaction with others and their internal evaluation and interpretation of these interactions.

While Blumer is the person who actually coined the term 'Symbolic Interactionism' he appears to have been significantly influenced by other key American sociologists, including Cooley and Mead. Cooley (1902) through his concept of the 'looking-glass self' focused on the importance of others in the formulation of the self. This idea is based upon the premise of imagining how we look to another person or:

> *…the self you understand as a result of information reflected back at you in the judgement of others with whom you interact.*

(Wallace and Wolf, 1995: 187)

Cooley (1902: 184) suggested there are three stages to the process:

> *…the imagination of your appearance to the other person;*
>
> *the imagination of his judgement of that appearance;*
>
> *and some sort of self feeling, such as pride or mortification [as a result of your interpretation]*

Mead rejected the functionalists' view of the individual as a passive recipient of social and psychological forces (values, norms, roles and status) to which they are exposed (Wallace and Wolf, 1995); rather he suggested that by actively engaging in their environment and interpreting and evaluating their interaction with others, they create their own social reality and sense of self over their life course (Kaufman, 1986). The process is therefore one of self-interaction, interpretation leading to particular types of behaviour. The crucial component in this process is reflexivity; personal reflection and evaluation allowing the individual to see themselves from the perspective of others - Cooley's (1902) looking-glass self - and thus form a conception of themselves, a self-concept (Cooley, 1902).

Blumer, as a student of Mead, developed Mead's concepts into a more logical and systematic approach arguing for a stimulus-interpretation-response sequence of events, so that the response to a given behaviour from another is preceded by interpretation and analysis (Wallace and Wolf, 1995). 'Others' critical to the development the self can be divided in to two specific categories (Cooley, 1902). The 'significant others' are the specific people (e.g. parent, teacher, doctor, spouse) whose opinion matters to the individual. The interpretation of 'significant others'' reaction can therefore enhance or diminish an individual's self-concept. Likewise the generalised 'other' represented by specific groups (family, work colleagues, rugby team) that feature in peoples lives are also important in the development of an individual's self-concept e.g. life and soul of the party, good sportsman etc. Further the generalised other can be extrapolated to include society at large and how individuals are expected to behave in particular situations and thus develop and assume socially accepted roles. Both these 'others' affects how an individual perceives themselves and the role they play. An individual's self-concept will inevitably reflect and internalise the inherent structure and roles evident in society (Stets, 2007). Role-identities are therefore assumed (university student, husband, father) along with corresponding appropriate behaviour as a result of the interaction of the individual and 'others'. Stryker (1980 in Stets, 2007) developed this concept arguing that individuals become committed to a role-identity, they then act in a manner appropriate to their conception of that identity, focusing on maintaining and protecting it because having internalised it, their self-esteem is based on their performance in that role.

This study will consider how the self has developed after the onset of CLBP and whether new role identities have been established. The concept of how individuals present themselves to others and the roles they assume are specifically addressed by dramaturgy (Goffman, 1959).

2.7.2 Dramaturgy

Dramaturgy was developed by Goffman (1959) who used the approach of symbolic interactionism to examine the interaction between two or more people in the social setting. He looked at how individuals present themselves to others. The use of theatrical metaphors (actors, stage, and audience) were employed to allow detailed observation and analysis of social interaction; everyone is simultaneously an actor to others (audience) and part of an audience to other (actors). The theatrical context is further developed by locating the actors with reference to the stage (Wallace and Wolf, 1995: 222, 223). The front of stage represents anything witnessed by the audience;

the actor's specific intent being to influence that audience, while the back of stage region is hidden from the audience, the actor is not trying to influence anyone, they can just be themselves.

Goffman, by highlighting the back of stage region, allows an understanding to be gained of the hidden work required in order to give the successful front of stage performance (Wallace and Wolf, 1995). There could be however dissonance and associated emotional cost for the 'actor' if the front of stage performance is far removed from the back stage identity. The concept of an individual controlling their behaviour through evoking or suppressing certain emotions to conform to a specific identity is termed emotional labour (Hochschild, 1983). There are inevitable consequences:

> *Individuals obliged continually to enact a narrow range of prescribed emotions are likely to experience emotional dissonance. This reflects the internal conflict generated between genuinely felt emotions and those required to be displayed. This can result in emotional exhaustion and burnout.*
>
> (Huy, 1999: 310)

It is recognised that the participants in this study may feel the need to give a 'front of stage' performance in everyday life and specifically perhaps during their interview; it is hoped however, that something of the true 'back of stage' realities will be attained. In an attempt to see beyond the 'front of stage' performance this research will consider role-identities (Stryker, 1980 in Stets, 2007) and try to understand if the ability to actively select and retain a specific identity is maintained in disability or whether the ability to self determine that specific identity and the corresponding social structure associated with it is affected and becomes more passive (Charmaz, 1995b; Holloway *et al.*, 2007; Bernardes and Lima, 2010). The active selection of role identity through socialisation allows choice, possibly subconsciously, about role identity; interaction with the 'lads from the rugby club' will fashion, broadly speaking, a real masculine identity (Stets, 2007). There is choice about who you interact with and the 'masculinity' of the environment; the ability to continue to interact in the chosen environment could be altered by CLBP and the alternative may not fit comfortably with previously held role identities. The concept of identity and in particular masculine role identity needs to be considered.

2.7.3 Identity

Identity is the differentiation of one's self-concept from that of others across time as a result of various meanings conferred on oneself both by oneself and by others and society (Baumeister, 2011). According to Charmaz (1994: 269) identities:

> *define, locate, characterize, categorize and differentiate self from others…Personal identities define a sense of location, differentiation, continuity and direction by and in relation to the self.*

Identity essentially defines who you are (Charmaz, 1994). It provides you with *meaning, unity and purpose* (McAdams, 1997: 6) and differentiates an individual's self-concept from that of others. Hewitt (1989 in Charmaz, 1994) considers the notion of social identity (which may be compromised for the participants in this study) and suggests that it comprises of a combination of the social, relational and collective selves. Social identity is based upon cultural meanings and community memberships, which are conferred upon the person by others. Social identity is bestowed by the society in which an individual functions because they 'live' in an appropriate, recognised manner. Social identity is altered when the 'appropriate, recognised manner' is interrupted e.g. the working husband and father is unable to work because of back pain, the mother works full-time and the father walks the children to school using a walking stick.

2.7.4 Identity/Self-Concept and Pain

Ostrander's (2008) study looked at men with violently acquired spinal cord injury and supports the concept of an interrupted social identity. He suggests that these men, in a similar way to those who, either by injury or illness, become disabled (potentially like the participants in this research), often then struggle with redefining both their identity (personal) and role in society (social identity). Erikson (1963) considers that identity comprises both a consistent self and the on-going sharing of that self with others. Throughout life personal identity needs to be constantly reconciled with the identity (social) assigned by others (Erikson, 1963). Therefore the men in this study will have to have had to consider redefining their identities (personal and social) post their development of CLBP. From a symbolic interactionist perspective, it is our interaction with others that gives us meaning and identity. It is the successful amalgamation of the personal and social identities that allow a person to feel contented with who they are (Erikson, 1963). This continual 'moulding' means that an individual's personal identity opinions are consistently being evaluated by others (social identity) and usually adapted accordingly, leading, hopefully to a positive psychological sense of selfhood or being. It must be recognised however, that if a person's personal identity opinions are challenged or negatively reinforced through social identity this will not provide a psychological sense of well-being.

Once these identities are internalised they become part of the self-concept (Charmaz, 1994). Osborn and Smith (2006) and Brown (1998) suggest that terms like self-concept, sense of self and identity are used interchangeably but essentially refer to a stable yet dynamic compilation of fundamental beliefs and opinions that allow a person to define themselves personally and publicly. The shaping of the identity can be traumatic, capturing and characterising the very essence of who we are (Erikson, 1963). We may not like aspects of our identity, this may be particularly evident in the social identity that is conferred on us by society (Hewitt, 1989 in Charmaz, 1994). Likewise questioning the validity of an identity because of life changes can be traumatic; for example the loss of valued attributes, such as physical abilities and prowess, social roles and personal pursuits as a result of CLBP can lead to an eroding of identity (Charmaz, 1994). It is likely that the participants in this study may well have faced the erosion of their identity after developing CLBP.

More recently the issues of identity and the self in relation to CLBP have been considered (Werner *et al.*, 2004; Sparkes *et al.*, 2005; Osborn and Smith, 2006). Osborn & Smith (2006: 216) discuss the concept of *living with a body separate from the self* when they consider the personal experience of people with CLBP and the impact on their self-concept. They argue that:

> *the embodied unpleasantness of chronic pain involves an assault upon and a defence of a preferred or desirable self.*

Osborn & Smith's (2006: 217) paper focuses on one emergent theme from a larger overall study – the participant's experience of CLBP *in relation to their self-concept and physical body*. The relationship was somewhat contradictory; the degree to which CLBP impacted on the participant's self-concept because of pain and or dysfunction in a specific body part was detailed but *placed outside of the* [preferred] *self* and categorised as, *not me*, while the normally functioning body parts *were taken for granted and given little attention* (Osborn and Smith, 2006: 219). The relationship between the self-concept and painful bodies was *defined more by alienation and exclusion* rather than *integration, accommodation or acceptance* (Osborn and Smith, 2006: 220). Their findings show that all participants in their study located *what was* *painful* outside of their *preferred self* (Osborn and Smith, 2006: 219). Acceptance of CLBP and integrating that into a valued self-concept could be an important component in the successful management of, and care for, these individuals (Osborn and Smith, 2006).

Whilst Osborn & Smith (2006) consider the separation of selves in those with CLBP, Sparkes, Bately and Brown (2005: 131) explore an embedded aspect of identity, that of masculinity. They broadly consider bodybuilding in their study - *the muscled self and its aftermath* and specifically the case study of *an elite, black, male bodybuilder* - Jessenka. According to Klein (1995 cited Sparkes *et al.*, 2005) the motivations for bodybuilding appear to be primarily focused on conforming to a hegemonic form of masculinity; the more insignificant a person feels internally, the more they strive to give an external appearance of significance.

Jessenka was small, black and no good at sport – the opposite of his father and brothers; as such he was ridiculed and bullied. Through a chance encounter he started bodybuilding and ultimately became a British champion. He was sought after, courted and developed a new identity – issues of race and ethnicity disappeared. That all changed when he, as a result of a car accident, developed chronic back pain. Unable to train and compete because of back pain he lost his muscle bulk, his identity and ultimately reverted to his previous identity becoming small and black again; *he is now just another black man on the streets having to deal with the racist stereotypes imposed on him* (Sparkes *et al.*, 2005: 152). Leder (1990: 76) captured the negative influence and impact of pain:

> *The disruption and constriction of one's habitual world thus correlates with a new relation to one's body. In pain, the body or certain parts of the body emerges as an 'alien presence'.*

This concurs closely to Osborn and Smith's (2006: 220) findings that the relationship for their participants between their self-concept and painful bodies was characterised by *alienation and exclusion*. The *'alien presence'* is disruptive and cannot be controlled (Leder, 1990: 76). The masculinity conferred through performance cannot be sustained in the face of disability (Connell, 1995). Jessenka was unable to find a new self-concept, the body his previous identity was based on was *just fading away…becoming a source of embarrassment to him and a reminder of his inadequacies* (Sparkes *et al.*, 2005: 149). He was ashamed of his body that was *metamorphosing back to whence it came*, it seems reasonable to suggest that he was fearful of resuming his previous self-concept, that of the undesired self associated with his pre-bodybuilding body (Sparkes *et al.*, 2005: 149).

Jessenka's identity was bound up with physical appearance but when pain is not clearly manifested physically, identity can be similarly challenged. Werner *et al.'s* (2004) study considers women with Fibromyalgia (chronic muscular pain) which can be seen as lacking an organic cause (psychosomatic). The women were seen as striving for *credibility* in the eyes of the researchers, for their pain to be seen as *real and somatic rather than imagined or psychological* having met with *scepticism and mistrust* by doctors, family and friends (Werner et al., 2004: 1035, 1042). The women tried to distance themselves from the preconceptions of negativity (whining and complaining) generally associated with women who have this condition (with its connotations of hysteria). While the women emphasised their physical and emotional strength there remained a hint of shame in their accounts and although not overtly detailed, stigmatisation regarding the legitimacy of their condition from health service personnel and in everyday life was clearly impacting on their self-concept.

The findings of Werner *et al*. (2004) are echoed in the work of Holloway, Sofaer-Bennett and Walker (2007: 1458) who specifically considered stigmatisation of people with chronic back pain, suggesting this can result in:

> *…self doubt and challenges to personal identity, leading to feelings of disempowerment and shame.*

All the participants in their study clearly detailed how they had been stigmatised which Goffman (1963) describes as a discrediting trait. Holloway *et al.'s* (2007) study identified stigma in four categories:

- Healthcare system: patients seeking help for their chronic back pain sought legitimisation of their pain through the biomedical explanations while health care professionals *faced with a lack of congruity between pain behaviours and medical findings* suggested psychological causes (Holloway et al., 2007: 1458). Stigma is therefore assigned to the health professional for failure to diagnose and treat and to the patient for their failure to provide a diagnosable condition or respond to treatment;
- Work: being 'off sick' with a bad back through negative media coverage is viewed as a scam to live off social security with the ultimate aim of 'secondary gain';

- Significant others: the lack of a formal diagnosis combined with the invisibility of back pain aroused suspicions among family and friends that the pain wasn't real (it's legitimacy was questioned);
- Everyday life: the fact that the pain is not visible means that people become stigmatised, labelled as 'benefit cheats'. Visible injury like a broken leg in plaster is seen as authentic and legitimate but the invisibility of chronic back pain means the condition is discredited ultimately leading to feelings of shame.

Bernardes & Lima (2010) developed the concept of stigma further with their specific consideration of stereotypes in gender identity. Having detailed the valued characteristics of men (*endurance, dominance, independence and instrumentality*) and women (*affectionate, expressive, dependent, concerned with others' needs and an object of desire*) they surveyed the opinion of both laypeople and nurses (health professionals) with regard to how they perceived a person with CLBP (Bernardes and Lima, 2010:194). Both the nurses and the laypeople perceived a man with CLBP as having less masculinity and more feminine-related traits than a typical man, similarly the women with CLBP were seen as having less femininity and more masculine-related traits than a typical woman. Interestingly their findings also suggested that *the man and woman with CLBP were more similar to each other than the typical man/woman* (Bernardes and Lima, 2010: 194). The findings of this study provide further evidence of why men with CLBP will risk their health and even their own lives to protect their male identity (Bernardes and Lima, 2010; Holloway *et al.*, 2007; Charmaz, 1995b).

Charmaz (1995a: 657) concurs with the findings of the previous studies, recognising that chronic illness *threatens the integrity of self…[and] with impairment intrudes upon a person's daily life and undermines self and identity*. People aspire to achieve various goals in life of which particular facets of identity could be one. Identity goals can be defined *as preferred identities that people assume, desire, hope, or plan for* and how with changes in functional ability (potentially as a result of CLBP), identity goals are revised and modified (Charmaz, 1995a: 659). Ultimately a balance needs to be found between the needs and limitations of the body and the construction of an appropriate identity (Charmaz, 1995a). The adoption of this process suggests that these people have progressed to being able to 'care' for and reside in their altered body but not be entirely defined by it (Charmaz, 1995a). The participants in this study therefore may well have undergone changes to both their personal and social identities because of the CLBP.

2.8 Masculine Identity, Pain and Disability

For many men the concepts of identity and masculinity are synonymous – 'you can't be a real man without adhering to the basic ideals of masculinity; there is only one male identity – masculinity'. Brannon (1976 in Sabo and Gordon, 1995: 6) identified four major components of the American male role:

- No Sissy Stuff: the need to be different from women
- The Big Wheel: the need to be superior to others
- The Sturdy Oak: the need to be independent and self-reliant
- Give 'Em Hell: the need to be more powerful than others, through violence if necessary

These four characteristics neatly sum up the all American hero John Wayne as portrayed in myriad screen appearances. Interestingly while this reference is over 30 years old the components it highlights still seem pertinent today. Lack *et al.* (2011: 103) concur suggesting that in Western culture the dominant discourse of hegemonic masculinity is *tough, independent, physically competent, mentally strong and aggressive*. Sabo & Gordon (1995) continue to develop this idea further suggesting that many of the expectations and characteristics associated with masculinity in the contemporary gender order like ambition, aggressiveness, self discipline and competitiveness are inextricably linked to male obsession with power over others by imposing their definition of reality. This power concept is very evident in the concept of the gender order (and indeed patriarchy) which is based on two structural aspects both of which are hierarchical; women are dominated by men and inter-male dominance (the minority dominate the majority). Sabo & Gordon (1995: 2) *contend that gender influences…the ways men perceive and use their bodies, and men's psychological adjustments to illness itself*. The male obsession with power and dominance over others is reflected in how they see and utilise their bodies, disability changes that perception which may require significant psychological modification and adaptation to the self-concept and identity.

At the beginning of the 1960s the biomedical model of disease/illness was starting to be questioned as the variation evident between the health of men and women could not be adequately accounted for by using this approach alone (Sabo and Gordon, 1995). This brought about the development of a more holistic socio-cultural model of health and with this came a greater understanding of the role gender plays in attitudes towards health and illness. The gender issue was however dominated by feminist scholars so there was little specific attention to men's health until the late 1970s (Sabo and Gordon, 1995). Two of the four components of the 'male role' as highlighted earlier (Brannon 1976 in Sabo and Gordon, 1995) are specifically addressed by Sabo and Gordon (1995). The 'Give 'Em Hell approach' tends to suggest a hard living, risk taking, a 'live for the moment' approach which if linked to alcohol, drugs and fast cars/motorbikes has an unquestionable correlation with male death rates (Sabo and Gordon, 1995). While the 'Sturdy Oak' characteristic (dependable and self-reliant) suggests that a man will tend to deny symptoms and internalise feeling and emotions thereby limiting any overt expression of feelings and thus any support (Sabo and Gordon, 1995). Either of these stereotypical masculine identities would be hard to maintain with CLBP. Living the fast life is hard to equate with someone who has chronic pain however, the pain-dulling effect of alcohol/drugs may allow this for a while. It is easier to reconcile the man with CLBP who has internalised feelings and emotions but the lack of expression and therefore support available will ultimately have consequences on his well being.

Parsons and Bales (1953 in Gordon, 1995) detailed the distinction between male instrumental, technical roles and female expressive, supportive roles. Using this categorisation it is interesting to note that a man disabled through CLBP is more likely to be able to retain the perceived feminine expressive and supportive roles rather than the instrumental and technical male roles (this concurs with the findings of Bernardes and Lima (2010). This would suggest that the identity of a previous masculine self (Stryker's role-identities) could be impacted and potentially seen as downgraded, and therefore could negatively affect an individual's self-concept and future identity (Stryker, 1980 in Stets, 2007). In developing this further Harrison, Chin and Figarrotto (1992 in Gordon, 1995: 249) suggest that the socially prescribed male role is one that:

> *…requires men to be noncommunicative, competitive and nongiving, and inexpressive, and to evaluate life success in terms of external achievements rather than personal and interpersonal fulfilment.*

The dominating male role (as described above) is essentially based on stereotyping and an unrealistic view of masculinity. This suggests that men who are unable to meet this standard may develop feelings of inadequacy which may lead to both physical and psychological problems (Gordon, 1995) as they are unable to live up to the 'ought self' (Higgins 1987 in Brown, 1998) or their chosen role-identity (Stryker, 1980 in Stets, 2007).

Connell (1987 in Gerschick and Miller, 1995: 185) suggest that modern masculinity honours men who are *strong, courageous, aggressive, independent and self reliant*. Whereas people with disabilities, according to Murphy (1990 in Gerschick and Miller, 1995: 185), *are perceived to be, and are treated as, weak, pitiful, passive, and dependant*. The impact of disability (CLBP) for men is therefore likely to be far-reaching and with its resulting stigmatisation, perceived masculinity is likely to be affected (Bernardes and Lima, 2010). Murphy (1990 in Gerschick and Miller, 1995: 185) suggests that *men with physical disabilities experience "embattled identities" because of the conflicting expectations placed upon them as men and as people with disabilities*. They feel their identity is under attack because of differing expectations associated with being male and disabled – you assume an identity for one or the other but not both (Bernardes and Lima, 2010).

Charmaz (1995b) elaborates on the concept of embattled identities suggesting that valued personal attributes, physical capabilities, social position and hobbies/interests provide self-definition and confer positive identity both social and personal. Their loss leads to an identity predicament as inabilities become overt and hard decisions have to be made about what now constitutes personal identity. This is because according to (Charmaz, 1995b) a masculine identity evolves over a lifetime from exposure to and participation in the accepted gender order and is never really considered by those whose identity remains unchanged. Chronic illness impacts on identities never previously considered that maintain a man's place not only in the gender order but additionally in male dominance hierarchies. Because chronic illness changes a man's abilities in relation to work, sport, hobbies/pastimes and sexual activities it inevitably impacts on status in male hierarchies, modifies power balance in relations with women and makes him start to question his masculinity. Essentially chronic illness can downgrade a man's status in the gender order and marginalise his masculinity.

2.8.1 Masculinity, Private & Public Identity

As illness progresses it may become increasingly difficult to preserve valued masculine identities built upon sexual performance, being the bread-winner and providing financial stability (Brannon 1976 in Sabo and Gordon, 1995). These identity concerns are furthered when the wife/partner needs to seek employment or increase working hours to maintain financial stability and hence places more strain on an already strained relationship. This perceived *loss of control outside the home leads to efforts to preserve self by exerting more control within it* (Charmaz, 1994: 280). The inability to retain the valued public identity and the ensuing frustration can be analysed from a dramaturgy perspective, the front of stage performance is affected with an associated emotional cost that is likely only to be evident in the back of stage persona (Goffman, 1959; Hochschild, 1983; Huy, 1999).

Charmaz (1994) details the differences often evident between the public and private identity. For some men the need to portray a present identity that is continuous with their previously identity is important and the impact of chronic illness is played down for example adopting the 'Sturdy Oak' characteristic (Brannon 1976 in Sabo and Gordon, 1995). For others, the cost of maintaining that identity (the emotional labour) is huge and in some cases life threatening but they must keep the identity credible at all costs (Hochschild, 1983; Huy, 1999; Bernardes and Lima, 2010). Conversely some men make the most of their illness in their private identity becoming increasingly dependent and self-pitying. Such identities can become so focused and developed that they place huge demands upon a partner and ultimately impact on the whole household (Charmaz, 1994).

Generally men try to minimise the impact of illness on working and socialising and will go to elaborate lengths to maintain their public identities (Charmaz, 1994). By carefully controlling the working day, specifically the amount and type of work undertaken, allows men to preserve their work identity and therefore their masculinity. The inability to retain control of their identity in the workplace or other social environments seems often to result in withdrawal and potential social isolation (Bernardes and Lima, 2010). Some men, often through considerable effort and at significant 'cost', are able to prevent illness and disability from impacting on their identity, they are extremely resourceful, going to great lengths to retain vital involvement in key roles thus minimising any changes to identity (Charmaz, 1994). While this to many men is of paramount importance it comes at a 'cost' to them because:

> *Traditional assumptions of male identity, including an active, problem-solving stance, emphasis on personal power and autonomy, and bravery in the face of danger form a two-edged sword for men in chronic illness. On the one hand, these assumptions encourage men to take risks, to be active, and to try to recover which certainly can prompt recreating a valued life after serious episodes of illness and therefore, bolster self-esteem. On the other hand, these assumptions narrow the range of credible male behaviours for those who subscribe to them. Hence, they foster rigidity in stance and set the conditions for slipping into depression. Men's assumed difference between masculine*

> *identity and the "lesser" identities of women and children shrink as they lose ordinary "masculinizing practices".*

(Charmaz, 1994: 283)

Reconstruction of a positive identity or sinking into depression seems to be affected by whether a man sees he has future possibilities. Charmaz's (1994) findings indicate that men primarily founded their preferred identities in action (Sabo and Gordon, 1995; Lack *et al.*, 2011). If they could not see a valued realm of action and no way to preserve their valued self, the chances of slipping into depression increased (Charmaz, 1994). The stigma associated with the loss of valued identities - gradually becoming less visible ('invisible') together with others questioning the legitimacy of CLBP may lead to feelings of decreased self-worth, shame and depression (Holloway et al., 2007).

Having established the impact that chronic illness has on issues of identity and masculinity the next section will consider how society views the person who is chronically sick.

2.8.2 Spinal Cord Injury – Application of the Theory to Practice

Smith & Sparkes (2004) used Frank's (1995) illness narrative classification and the use of metaphors in their study which looked at a group of men who had sustained a spinal cord injury through playing rugby union football. Their study considered the narratives told by men with permanent, acquired disability, albeit overt, visible disability; as such it was deemed relevant to this research.

The participants who told restitution narratives often used war or sporting metaphors the most common being *a fight to make a comeback* (Smith and Sparkes, 2004: 616). The concept of being able and willing to fight is inherent in western hegemonic masculinity, as previously discussed (Lack *et al.*, 2011). Smith & Sparkes (2004) suggest that the fight metaphor is clearly linked to their association with rugby and how closely this is aligned to their desire to *restore the self and the expectation to return to one's former life* (Smith and Sparkes, 2004: 617). It is suggested that the use of narrative and certain metaphors may be counterproductive and limiting when it comes to reconstructing a new body-self, where fighting an enemy objectifies and externalises disability from the self. This concept is evident in the work by Osborn and Smith (2006: 216) who discuss the body being *separate from the self* and Sparkes *et al.* (2005: 148) who describe how the body can be seen as an *alien presence…foreign to the self*. The use of such metaphors present other problems, for while they may be crucial in heroic forms of masculine identity in order to gain acceptance for themselves and others, they also highlight, in their interaction with others, the participants' incompleteness. As such, the identities behind these facades begin to suffer while the definition of a successful recovery or an acceptable new identity remains narrow. Charmaz's (1994) paper entitled, *Identity dilemmas of chronically ill men* (see section 2.8.3 Chronic illness in men) develops this concept considerably detailing the lengths to which a man will go to protect his identity

Only one participant in Smith and Sparkes (2004) study was categorised as having a chaos narrative where, according to Frank (1995), the person imagines life never getting any better. The participant's world was understood as *occupying an empty present and the future is a foregone conclusion* (Smith and Sparkes, 2004: 619). Metaphors used included *choking, solid darkness*, disconnection from life in this world and *being set apart from other bodies* (Smith and Sparkes, 2004: 619-620). In this situation the participant sees that their identity has clearly been decimated and they are unable to live up to the 'ought self' (Higgins, 1987 in Brown, 1998). However this is no longer the issue rather it is being able to just retain the previous self which seems to be now impossible thus leading to a deepening depression.

Two participants were seen as having quest stories; *they accept impairment and disability and seek to use it…something is to be gained from the experience*, an opportunity even though difficult (Smith and Sparkes, 2004: 621). Journey metaphors were frequently used, the most common *involved the image of being reborn*, an opportunity to re-make themselves and not be constrained by an inability to *accept bodily contingency as part of the fundamental contingency of life* (Smith and Sparkes, 2004: 621, 622). This also allows an opportunity to consider future identities by recognising they will *inhabit different bodies throughout their lives*, which is a crucial part of a developing self (Smith and Sparkes, 2004: 624). A maturing, evolving process has been underway in these individuals, the body previously viewed as being *separate from the self* (Osborn and Smith, 2006: 216) or as an *alien presence…foreign to the self* (Sparkes *et al.*, 2005: 148) is now seen in a different light. A more communicative identity emerges that wants to help others interpret their own disability experiences on their journey; to help allow the reconstruction of *alternative identities, notions of self and form of embodiment* (Smith and Sparkes, 2004: 624).

2.8.3 Chronic Illness in Men

Charmaz's (1994) study looked at chronically ill men and initially details how they come to terms with the fact that death could occur and how identity issues were managed. Uncertainty was also debated, how it was accommodated and how in the light of this uncertainty men viewed their conditions. This study was also regarded as pertinent as it specifically considered similar issues to the current research.

Charmaz (1994) suggested four major ways in which men viewed their condition as an:

- enemy
- ally
- intrusive presence and
- opportunity.

She suggested that a man was not limited to one view; during the illness the man may view his condition in different ways. Charmaz (1994) suggests that defining illness as either an enemy or an ally explicitly creates personifications. Concurring with Smith and Sparkes' (2004) study, Charmaz (1994) suggests that viewing illness as an enemy both objectifies and externalises it and thus distances it from both the personal and social identity. The enemy personifications corresponds with Frank's (1995) restitution narrative and the fighting metaphors used in Smith and Sparkes' (2004) study. Viewing illness as an ally however, emphasises subjectivity and identification thus allowing integration with both personal and social identities. A correlation is evident with Frank's (1995) quest narrative both with the view of illness as an ally and an opportunity.

Visible disabilities can result in social identification that impacts on self-definition and thereby become an intrusive presence. Charmaz (1994) suggests that visible disability becomes a master identity because it defines every other identity. While the CLBP of the participants in this study may or may not be visible though the associated disability, its impact, in terms of the participant's self-concept (their feelings of *moral worth* (Charmaz, 1999: 209)) and identity (how the self-concept differs from others depending on the meaning conferred on oneself not only by oneself but importantly by others, their social identity (Baumeister, 2011; Hewitt, 1989 in Charmaz, 1994)), is likely to be significant. Attempts may be made to alter an assigned social identity or to prevent the allocation of an unwanted identity through a 'front of stage' performance (Goffman, 1959).

Charmaz (1994: 278) found that men devoted much effort to preserving the self, this involved *maintaining essential qualities, attributes and identities of the past self that fundamentally shape self-concept*. The men's goal was to retain who they were and how they related to others in the past. This became problematic however when *all valued social and personal identities remain in an irretrievable past* (Charmaz, 1994: 279). Identities that were conferred through their working ethos or sporting prowess were irretrievable (Charmaz, 1994). They have sustained an *assault* on the *preferred self* (Osborn and Smith, 2006), the body is perceived as an *alien presence* (Sparkes *et al.*, 2005) and they have no option but to assume an undesired self (Brown, 1998). Their inability to measure up to their valued self from the past results in preoccupation with it and furthers their identity quandary:

> *The distance increases between a man's past self, by now reconstructed in memory in an idealized form, and present identities, as valued former identities collapse and new ones are viewed as negative.*
>
> (Charmaz, 1994: 280)

While the perception of self-concept and identity will be affected by illness it will also be influenced by more usual criteria like age and social class. Charmaz (1994) found that middle aged and younger men took years to resolve the identity issues brought about by illness. Older working class men were more resigned to their situations and built their lives around illness. Middle class men sought meaning through illness and the opportunity for a positive new identity because as Frank (1991 in Charmaz, 1994: 1) suggests illness is:

> *…an opportunity, though a dangerous one…Illness takes away parts of your life but in doing so it gives you the opportunity to choose the life you will lead, as opposed to living out the one you have simply accumulated over the years.*

This inherent opportunity, despite the negative aspects, offers the chance of a 'new beginning'. Charmaz (1994) develops this suggesting that if illness can be seen as an ally it may be possible to perceive it as an opportunity for reflection, re-evaluation and change, concurring again with Frank's (1995) quest narrative. The variation in the ability to resolve identity issues brought on through illness is noteworthy and it could be suggested that it is based on the perception of the length of life remaining and the possibilities available in the outstanding time. It would also seem reasonable to suggest that financial security and education would be influential. It does however, seem somewhat strange that the overall concept of male identity can differ so considerably based on issues of age and social class. This is explored to some extent in the narratives of the men in this study.

2.9 Summary

This chapter has defined the specific issues that will be considered in this study and has detailed pertinent theory and research. The following chapter will provide a rationale for the biographical methodology employed, detail specific aspects of this approach and explain the specific method utilised.

3. Methodology and Method

3.1 Introduction

With the purpose of eliciting the voices of men with chronic low back pain (CLBP), research located within the interpretive paradigm was undertaken. A biographical approach was adopted to bring together the life stories of men with CLBP and more specifically to investigate if their pain had impacted on their male identity. Charmaz (1995a: 657) recognises that chronic illness *threatens the integrity of self…*[and] *with impairment intrudes upon a person's daily life and undermines self and identity*. This research focused on whether CLBP would have a similar impact upon the men in this study.

This study adopted a biographical approach because a major strength of biographical research is the ability to study the self; how the self is constructed from the life experiences of the individual. Roberts' (2002: 1) definition of biographical research succinctly justifies its utilisation in this research as it:

> *seeks to understand the changing experiences and outlooks of individuals in their daily lives, what they see as important, and how to provide interpretations of the accounts they give of their past, present and future.*

Narrative is a defining aspect of the biographical approach; according to Erben (1998: 13) *human identity is narrational*. Individual lives are lived through time and are, as such, understood through narrative (Ricoeur, 1980; Erben, 1998). Individual lives are comprehended through *narratives by which time is experienced* and through this process identity is acquired (Erben, 1998: 13). Narrative allows varied individual experiences to be drawn together and analysed in the light of the social context thus the evolution of an identity can be considered (Erben, 1998).

Goodley and Tregaskis (2006) suggest that narrative is appropriate for studies that look at disability and impairment. Their proposal that impairment and disability is a social phenomenon that is *storied, negotiated and constructed in different ways* would suggest that the narratives of disabled people, who experience impairment (and disability) in both a personal and social construct, may be particularly insightful regarding their identity (Goodley and Tregaskis, 2006: 644). It would therefore appear to be wholly appropriate for considering the identity of the participants with CLBP in this study. Smith and Sparkes (2008: 19) concur suggesting that *bodily experience is deeply embedded in narrative…the body is a storyteller, and it is partly through the tales it tells that we may interpret, give meaning to and understand bodies* (and therefore ourselves). Finlay (2004: 474) agrees suggesting that narratives, once interpreted and contextualised, *offer rich, valuable and powerful insights* into others' lives. It is hoped that by using a biographical, narrational approach insights will be provided about the identity of the men with CLBP in this study. Furthermore, gaining an understanding of specific individuals and their lives will illuminate issues pertinent to a wider population.

3.2 Aim of the Research

The aim of this biographical study was to explore the narratives of men living with CLBP in order to elucidate the impact of long term back pain on their individual lives and identities. The study aimed to illustrate how their stories could be employed as vehicles to enable them to have a better understanding of their lives and in doing so illustrate different ways of being that veer from the norm but are nonetheless legitimate. Furthermore these narratives may also help other men living with long term back pain to understand their own stories so that they can more effectively manage their lives. It is hoped that more general insights about the effects of living with CLBP will be illuminated so that others, including professionals treating men with CLBP, listen to their stories and regard these individuals holistically rather than as a set of symptoms.

Specifically this research aims to consider if CLBP impacts on the identities of men. If so how their identities are altered as a result of CLBP and therefore how their lives may be better understood so that more appropriate management of their condition may be possible. According to Osborn & Smith (2006: 220) the:

> *…contradiction between the painful body and the preferred self could represent an important obstacle to therapeutic rehabilitation if not acknowledged or resolved.*

The invisibility of pain may lead to it being discredited; disbelieved by the lay public and labelled by health professionals as being of a psychological origin with the resulting stigma and the potential for feelings of inadequacy and shame (Holloway *et al.*, 2007). It is therefore suggested that there is a need to address issues of personal and gender identity in the management of those with chronic back pain (Holloway *et al.*, 2007; Bernardes and Lima, 2010).

This research seeks to provide a greater understanding of how identity and self-concept are compromised by examining the narratives of men with CLBP. It is hoped that any pertinent findings will influence the future development of appropriate therapeutic approaches in order for CLBP to be more effectively managed and men better able to understand their bodies and thus live a more fulfilled life.

This chapter will now give an overview and a rationale for the biographical methodology utilised for this research. This will be followed by a description of the investigation method, ethical considerations will be discussed and an explanation of the data analysis procedures will be provided.

3.3 Overview and Rationale of the Biographical Approach

A qualitative approach was deemed most appropriate for this study because the central tenet of the biographical approach is to gain an understanding of the life experiences of an individual (Denzin, 1989; Erben, 1998; Roberts, 2002). The approach had previously been brought into question, Goodson and Sikes (2001:14) detail how:

> *Under modernism, life history languished because it persistently failed the 'objectivity tests'; numbers were not collected and statistical aggregation produced and, since studies were not judged to be representative or exemplary, contributions to theory remained parsimonious.*

However, more recently there has been a well-documented turn to biographical methods in social sciences (Chamberlayne *et al.*, 2000). This recognition has elevated people's stories (narrative) to data that can stand on their own as pure description of experience or be analysed for psychological, sociological, cultural and political relevance and therefore deeper meaning (Chamberlayne *et al.*, 2000). This legitimises the biographical approach by recognising both the type of data that can be produced and its far-reaching application and relevance. Goodson & Sikes (2001) argue that there is a clear polarisation between differing methodologies and their appropriateness for collecting specific types of data. They suggest that if you want to determine *how*, *why*, *what's it like* and *what does it mean to you* then a life history (biographical) approach should be considered. Using this method for answering questions of *who*, *where*, *how many* and *what kind* they suggest is not appropriate (Goodson and Sikes, 2001: 22).

The purpose of biographical research is, through analysis, to gain an understanding of the life experience of an individual (Denzin, 1989; Erben, 1998). Erben (1998) develops this by suggesting that biographical research has both general and specific purposes. The general purpose he argues is to provide greater insight into the *nature and meaning of individual lives or groups of lives* while the specific analyses, *a particular life or lives for some designated reason* (Erben, 1998: 4). The general purpose of this research is to consider the biographies of men with CLBP to gain a greater insight into their lives and how this has affected their identity. The specific purpose seeks to consider how people living with CLBP are treated and what the significant issues are for them.

Four fundamental components of the biographical approach will be considered: narrative and identity, time, epiphanies and context.

3.3.1 Narrative and Identity

The purpose of this study is to explore how men with CLBP consider their identity. The qualitative approach utilised means that each participant is asked to tell his story; a story about how he sees himself, about how he thinks others see him, essentially providing an insight into who he thinks he is. This section details how people are able to describe their life and who they are.

Narrative or story telling fundamentally consists of a *symbolized account* of human actions with a temporal dimension (Sarbin, 1986: 3). Bruner (1987) suggests that the only real way to describe ‘lived time’ is through narrative because people report the happenings in their life through telling stories. Narrative is a fundamental aspect of human life and therefore central to our understanding of human conduct – we are, according to MacIntyre (1985: 216) *essentially a story-telling animal*. Ricoeur (1980) proposes that the accounts people give of their lives could be termed *plots* – an individual’s story is composed of events that have occurred in their life; recognisable patterns of events – plots – are bound together to form the story that usually details *human predicaments and attempted resolutions* (Sarbin, 1986: 3). McAdams (1997: 12) uses the term *personal myth* in a very similar way which he defines as:

> *a special kind of story that each of us naturally constructs to bring together the different parts of ourselves and our lives into a purposeful and convincing whole*

He continues explaining how:

> *A personal myth delineates an identity, illuminating the values of an individual life.*

(McAdams, 1997: 34)

Our lives are storied , *we think, perceive, imagine and make moral choices according to narrative structures* (Sarbin, 1986: 8; Smith and Sparkes, 2008). We all have a *stock of stories* through which we understand society (MacIntyre, 1985: 216) and which we *draw upon, appropriate, adapt and perform* [in our] *everyday social interaction* (Smith and Sparkes, 2008: 18). It is therefore, through narrative that we understand our lives and are able to make sense of them (Taylor, 1989); it allows us to *constitute and construct our realities and modes of being* (Smith and Sparkes, 2008: 18). Through telling stories about our lives we ultimately fashion a narrative identity (Smith and Sparkes, 2008). The portrayed self-concept is fashioned according to the life events selected (this suggests that some events are rejected) to provide an appropriate (in eyes of the individual) narrative of themselves. The narrative and the subsequent identity is therefore a construct of the individual through a process that while learnt is essentially subconscious. McAdams (1997: 28) explains that:

> *…many scholars have suggested that the human mind is first and foremost a vehicle for story telling. We are born with a narrating mind, they argue.*

By exploring personal narrative we are able to understand the evolution of an identity, what events, relationships and interactions have occurred to inform the narrative and therefore, the identity (Smith and Sparkes, 2008). The centrality of narrative to humans, the fact that we use it to bestow meaning on our lives and ultimately to shape our identity, suggests that interpreting narratives is appropriate for this research which is about the life stories of men with CLBP and how this has affected their identity (Taylor, 1989; Smith and Sparkes, 2008). As MacIntyre (1985: 212) says:

> *It is because we all live out narratives in our lives and because we understand our own lives in terms of the narratives that we live out, that the form of narrative is appropriate for understanding the actions of others. Stories are lived before they are told*

Hardy (1968 in Erben, 1998: 15) develops this theme to an all-encompassing level, the breadth of which is succinctly captured in the following:

> *We dream in narrative, day-dream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticise, construct, gossip, learn and love by narrative.*

It is hoped that in hearing the narratives of the men with CLBP in this study, an understanding of their lives and their identity will be achieved.

3.3.2 Time

According to Ricoeur (1980) time as the ultimate referent of human existence can only be understood through narrative. That life experiences are storied (narrated) seems to be inseparably linked to the fact that we understand events as occurring in a time continuum e.g. this happened first, then that but at the same time, etc (Ricoeur, 1980; Mc Adams, 1997). Ricoeur (1980) in his work on time and narrative explains how we understand time in terms of stories (narrative) - an action leads to an event with a subsequent counteraction: the events are organised by time. Narrative, identity and time then appear to be inextricably linked.

Narrative therefore is a defining component of biographical research because it recognises that *lives are lived through time and are made intelligible by being composed of narratives* (Erben, 1998: 12-13). Some other approaches to research have segmented lives to such a degree that all concepts of time/chronology have been lost (MacIntyre, 1985). Bruner (1987) concurs with Ricoeur (1980) arguing that we are able to articulate the temporal dimension of our lives most effectively through narrative. Time is obligatory to understanding lives:

> *For biographical research, time and its passage must be seen as the inescapable feature of human life…In short, human identity is narrational, lives being composed of narratives by which time is experienced.*
>
> (Erben, 1998: 13)

This is of particular importance to this research as the chronicity (defined by duration) of the low back pain is central to the life experience of the individual. The life experience prior to the development of CLBP, the progression of the condition and the epiphanies experienced need to be understood through time.

3.3.3 Epiphanies

In trying to understand the specific life experiences of an individual, meaning may often be attributed to a momentous event such as the death of a loved one or in the case of this research the occurrence of a back injury. The impact of these momentous events or turning-points on an individual and their life course can be far-reaching; understanding and analysing them may therefore provide significant insight into the life being studied. Biographical research is undertaken through *the studied use and collection of personal-life documents, stories, accounts and narratives which describe turning-point moments in individuals' lives* (Denzin, 1989: 13). Turning-point moments or epiphanies are, according to Denzin (1989: 70) *interactional moments and experiences which leave marks on people's lives*. Erben (1998) utilises the term *specific events* which, while closely related to the concept of epiphany, need not be interactional or momentous. Erben's (1998) perspective is however clearly evident in the definitions Patton (2002: 451) provides for Denzin's (1989) epiphany categories. The major epiphany will *touch every fabric of a person's life…their effects are immediate and long term*. The cumulative epiphany represents *reaction to events that have been going on for a long period of time*. The minor or illuminative epiphany considers events that are *symbolically representative of major problematic moments in a relationship*. Finally the relived epiphany represents *episodes whose effects are immediate but their meanings are only given later, in retrospection, and in the reliving of events*. The breadth encompassed in the above classification would suggest that all types of epiphany are likely to be represented in the findings of this study. The realisation, for a participant, that they will not be 'cured' of their CLBP or the need to find worth in a new identity may be something that is achieved through the immediacy of a major epiphany or gradually, through reflection over a period of years as in a relived epiphany (Patton, 2002).

3.3.4 Context

The issues of both epiphany (Denzin, 1989) and specific events (Erben, 1998) have previously been discussed and Erben (1998) is resolute in his grounding of these occurrences in local, cultural and societal context and chronology. As with any other study the relevance of context to the participants of this study is of supreme importance. Without this type of fundamental information the researcher will be unable to make sense of a life or arrive at a true understanding of the self that is being analysed. The significance of any decision cannot be fully appreciated unless it is placed in context (Erben 1998). A lack of context will significantly alter the interpretation and diminish the depth and richness of the data produced. The narrative of a participant therefore offers the opportunity to see the individual as more than just a, *collection of symptoms and problems* it is possible to see something of their *life, struggles and relationships* (Finlay, 2004: 475). This was seen as fundamentally important to this research and interestingly mirrors the approach being advocated for the ongoing management of people with LBP (Kendall *et al.*, 1997; Kendall *et al.*, 2009).

A major strength therefore of the biographical method for this research is the opportunity to study a life history, albeit for a designated duration, and be able to probe and understand why the epiphany/specific events occurred. This involves understanding a broader perspective of the person's life; indeed Erben (1989) clearly established the need to consider the life changing events in terms of family and other significant persons, wider society and the changing attributes of the self-concept, in the chronological context of important public issues. These issues would include changing approaches to managing back pain, perceived importance of psychosocial issues in LBP, shift of responsibility and power (including financial) to primary care and changes to the benefits system. Comprehension of the participants' evolving identities in this research will inevitably require consideration of this 'broader perspective'. Attainment of which will allow the decisions and thought processes of the participants to be viewed holistically in a socio-historical context thus providing a detailed insight into their perspective and how these issues may have affected their identity.

3.4 Plan of Investigation

3.4.1 Participants

Participants were recruited from the local branch of BackCare (a national organisation (charity) with local branches whose remit is to significantly reduce the burden of back pain) and through a local private physiotherapist.

Every male member and recent members of the local BackCare branch received a recruitment pack which contained a letter, a participant information sheet, an acceptance slip and a stamped addressed envelope (see Appendix 1). Where possible these packs were distributed by the chairman during meetings or posted if necessary.

Individual patients who met the inclusion criteria were approached by the private physiotherapist; if they were willing to be involved they were sent a recruitment pack.

3.4.2 Inclusion Criteria

This research broadly aims to consider the biographies of men with CLBP and specifically to understand if and how CLBP impacts on their male identity. The inclusion criteria therefore are:

- Male
- Ongoing history of chronic low back pain

3.4.3 Pilot Study

A pilot study was undertaken, with two men who were friends of the researcher and had CLBP, with the specific purpose of determining if the interview schedule was appropriate and then adapting it, if necessary. The first pilot interview resulted in a major review of the schedule – some questions were seen as irrelevant and it was felt that there was a need to use more open questions to allow the participant to tell their story more fluently. Additionally there was a clear requirement for the researcher to stop talking and to listen to the participant. Having made the alterations the second pilot interview was deemed successful in all respects and no further revisions were required.

3.4.4 Ethical Considerations

Going back over a life story that specifically focuses on pain and the impact that that pain has on a person's life and identity could cause some distress to the participant. To manage this eventuality details of BackCare's helpline which can be accessed either via telephone or email were kept 'to hand' during the participant interviews. Additionally, if it was considered appropriate, participants could be directed to their GP. The necessary risk assessment procedures were complied with fully.

The researcher using a narrative approach is faced with an ethical dilemma because of the duality of their role in forging the required *intimate relationship* with the participant and yet fulfilling academic requirements regarding the reporting of research findings (Chase, 2005; Goodwin, 2006; Josselson, 2007: 538). The relationship between participant and researcher both before (at recruitment stage) and during an in-depth interview is one where it is hoped to foster trust and intimacy which then, in turn, demands dignity, privacy and confidentiality. This responsibility can often be at odds with *the scholarly obligation to accuracy, authenticity, and interpretation* (Josselson, 2007: 538) in the written word. During this research issues of anonymity and confidentiality were adhered to, fortunately however, this did not appear to compromise the author's scholarly obligation or relationship with the participants as detailed above and below.

The narrative aspect of biographical research is ethically complex because it is, in essence, a *relational endeavor* (Josselson, 2007: 537) where participants are asked to share aspects of real life so the researcher and their audience can learn about, and have a better understanding of that life. The researcher will undoubtedly influence the findings of the interview through their own self-concept and their perceived power; it must therefore be remembered that *a narrative is a joint production of narrator and listener* (Chase, 2005: 657). There is consequently a need to clearly position the researcher within the research process and to recognise what they 'bring' (in terms of bias) to the process (Riessman, 2006). Reissman (2006: 186) details how:

> *…events are selected, organized, connected and evaluated as meaningful for a particular audience...[they] do not speak for themselves…they require interpretation.*

In the past the researcher was deemed as coming to the study without any preconceptions but:

> *now different biographical experience and ways of seeing are not merely recognized but embraced as part of a negotiated interactive relation between researcher and researched which continues – and should be reflected on – during the research.*

(Roberts, 2002: 158)

Reflexivity also described as a 'confessional', should therefore be undertaken to position the researcher in the findings and to further recognise that the self of the researcher *with its fantasies, biases and horizons of understanding, is the primary tool of inquiry* (Maso, 2003; Pope and Mays, 2006; Josselson, 2007: 545). The researcher *is a central figure who actively constructs the collection, selection and interpretation of data* (Finley, 2003). Reflexivity determines which aspects of the findings are attributable to the participant, which to the researcher and what are, *co-constructed* (Finlay, 2004: 479) *from the interaction between them* (Josselson, 2007: 545).

While the thrust of narrative research is what can be learned from the participant, inevitably the issues of how the participant relates to the interviewer (age, gender, class, race) need to be considered (Miller and Glassner, 2011). The power in the relationship is often seen to lie with the researcher because of their supposed expertise (Riessman, 1993; Roberts, 2002; Josselson, 2007). This perceived attribution of power places a significant ethical responsibility on the researcher to *listen empathetically but not judgementally*, to recognise the impact of sharing personal and sensitive aspects of the participant's life and to avoid asking questions that while they may be illuminating are ethically inappropriate (Josselson, 2007: 546).

With this in mind it was necessary to position myself within the research. I recognise that I would be perceived as coming from a white, middle class background, having been educated to an above average standard and having a professional background. I was cognisant of the fact that this could impact on the relationship I was able to establish with the participants. As such I endeavoured to do my utmost to limit any bias and tried to be aware of any socio-cultural influence which may have affected my relationship with the participants.

The concepts of validity, reliability and generalisability form the accepted standards in quantitative research (Finley, 2006). Broadly speaking these concepts are rejected in qualitative research as *the integrity of the research process and the quality of the end product would seem to require evaluation criteria of quite a different order* (Finley, 2006: 320). In order to formalise rigour within the qualitative paradigm Lincoln and Guba (1985) proposed four criteria against which studies can be evaluated – credibility, transferability, dependability and confirmability. Collectively these can be captured by the term trustworthiness - in terms of *being able to demonstrate both rigour (process) and relevance (end product)* (Finley, 2006: 320). These criteria are termed parallel or foundational because according to Guba and Lincoln (1989) they parallel the rigour criteria evident in the positivist approach but, according to Sparkes and Smith (2009: 492), were proposed following a *strong critique of positivism*. While criteria are potentially applicable for specific genres of qualitative research strict adherence to these quality standards may constrain much research in the interpretive paradigm so that ultimately it may become worthless (Sparkes and Smith, 2009). Guba and Lincoln (1989) soon recognised that in constructivist inquiry, considering method was only one factor in evaluating the quality of research and that other issues like outcome, product and negotiation criteria were equally significant. The breadth of research utilising an interpretive paradigm requires breadth in terms of interpretation, it is not possible to mandate what must be done in all qualitative approaches (Sparkes and Smith, 2009). Smith and Deemer (2000: 894) suggest that:

> *criteria should not be thought of in abstraction, but as a list of features that we think, or more or less agree at any given time or place, characterise good versus bad inquiry.*

Sparkes and Smith (2009: 495) concur with Smith and Deemer (2000) in their suggestion that seeing criteria as *characterizing traits or values that influence our judgements,* [will allow] *constant reinterpretation as times and conditions change.* Smith and Hodkinson (2005: 922) concur suggesting that:

> *As we approach judgement in any given case, we have in mind a list of characteristics that we use to judge the quality of the production. This is not a well-defined and precisely specified list; to the contrary, this list of characteristics is always open-ended, in part unarticulated, and always subject to constant interpretation and reinterpretation.*

The criteria used to judge research in this paradigm change depending on context and the purposes (Sparkes and Smith, 2009). These criteria are not used in an absolutist manner rather as pointers to instigate consideration and reflection. Criteria used will be derived from looking at the work of others using a particular approach and familiarising oneself with the discussions on how this type of approach is judged (Sparkes and Smith, 2009).

With regard to this research and the narrative approach utilised Lieblich *et al* (1998: 171) recognise that the interpretive paradigm:

> *asserts that narrative materials - like reality itself - can be read, understood and analysed in extremely diverse ways and that reaching alternative narrative accounts is by no means an indication of inadequate scholarship but a manifestation of the wealth of such material and the range of sensitivities of different readers.*

Nevertheless, Lieblich *et al* (1998: 173) have suggested some broad, characterising traits that can be employed to evaluate narrative research and that may be useful in evaluating this research. These characteristics are:

- *Width: the comprehensiveness of evidence. This dimension refers to the quality of the interview or the observations as well as the proposed interpretation or analysis. Numerous quotations in reporting narrative studies, as well as suggestions of alternative explanations, should be provided for the reader's judgement of the evidence and its interpretation.*

- *Coherence: The way different parts of the interpretation create a complete and meaningful picture. Coherence can be evaluated both internally, in terms of how the parts fit together, and externally, namely, against existing theories and previous research.*

- *Insightfulness: The sense of innovation or originality in the presentation of the story and its analysis. Close to this criterion is the question of whether reading the analysis of the life story of an "other" has resulted in greater comprehension and insight regarding the reader's own life.*

- *Parsimony: The ability to provide an analysis based on a small number of concepts, and elegance or aesthetic appeal (which relate to the literary merits of written or oral presentations of the story and its analysis).*

While consent was attained to interview the participants (see Appendix 2), is this really ‘informed’ in regard to interpretation and the attribution of meaning in the published document? To manage this concern but also to determine the veracity and trustworthiness of the research, transcripts of interviews or even final write-ups may be given to participants and their opinions on the accuracy of the documents sought – this is known as member checking (Lincoln and Guba, 1985) or respondent validation (Pope and Mays, 2006). Lincoln and Guba (1985) regarded member checking as the most appropriate way of establishing credibility (Pope and Mays, 2006). While this is laudable, it is also problematic. Following an interview a participant is likely to reflect on that event and this may impact on how they feel now, compared to how they felt at the time of the interview (Josselson, 2007). They may not recognise their contribution or the findings may not reflect their opinion but it should be remembered that:

> *While the task of the researcher in the data-gathering phase is to clarify and explore the personal meanings of the participant’s experience, the task in the report phase is to analyse the conceptual implications of these meanings to the academy.*

(Josselson, 2007: 549)

The researcher has a duty therefore to analyse and interpret multiple interviews and to construct representative themes as truthfully and honestly as possible (Denzin and Lincoln, 2005). These themes are potentially incongruent with a single individual’s opinion. As every interview will have *multiple truths* and all selves have numerous voices, the final write-up will be the *construction of the interpreter* (Josselson, 2007: 551)

Rather than asking the participants to check the transcripts for accuracy with all the inherent issues detailed, the researcher did their utmost to ensure that participants had ample opportunities to clarify and explore the meaning of what they had said so further checks were considered unnecessary. As an additional check for reliability however, another biographical researcher was asked to check a coded transcript to determine if they agreed with the researcher's coding process (see Appendix 3). The researcher also adhered to Mays and Pope's (2006: 88) overarching requirements for a *clear exposition of methods, of data collection and analysis*.

The veracity of the research in Josselson's (2007) opinion lies in both the researcher's authority and their clear enunciation that the write-up is their honest interpretation of the interviews undertaken (Erben, 1998; Riessman, 1993). While detailing that:

> *The inherent ethics of narrative research lies in the resolute honesty of the researcher's reflexivity, which states clearly the biases, aims, and positioning of the knower and the circumstances under which the knowledge was created, with the researcher taking full responsibility for what is written. From this point of view, the report is not ''about'' the participants but ''about'' the researcher's meaning making.*
>
> (Josselson, 2007: 549)

Prior to gathering any data ethical permission was obtained from both the School of Education and the University of Southampton (see Appendix 4 - RGO Ref 7696).

3.4.5 Data Collection

Prior to initiating data collection each participant was asked to sign a consent form (see Appendix 2). An in-depth interview that was audio-recorded was undertaken at a convenient location for each participant. In-depth interviews *provide a meaningful opportunity to study and theorize about the social world* (Miller and Glassner, 2011: 131). Miller and Glassner (2011: 131) argue that not only do interviews allow information to be gathered about the specific subject under investigation *including the contexts and situations in which it emerges* but also they provide *insights into the cultural frames people use to make sense of these experiences and their social worlds.*

The interview schedule having been honed through the pilot study was used as a broad guide for each interview (see Appendix 5). It was hoped that sufficient information would be obtained through a single interview.

Chase (2005) suggests that in in-depth, narrative interviews there is a need to move away for the interviewer-interviewee relationship to one of narrator and listener, to re-evaluate how interview questions and answers are perceived. Trying to exert a controlling influence and maintain a preconceived structure to the interview will produce frustration when the interviewee veers away from the interviewer's perceived requirements. There is a need to recognise that interviewees answer posed questions, while narrators have *stories to tell and voices of their own* (Chase, 2005: 660). Biographical researchers therefore need to remember that:

> *…stories that people tell constitute the empirical material that interviewers need if they are to understand how people create meaning out of events in their lives.*
>
> (Chase, 2005: 660)

In order to make that shift from interviewee to narrator Chase (2005) details the need to frame the interview as a whole with a broad question about whatever story the narrator has to tell in relation to the current subject. The crucial issue is that the 'broad question' needs to be pertinent and understood within the narrator's social and cultural context. There is a need therefore, for preparation to fully understand the context in which the narrator is operating in order for the 'broad question' to stimulate the narrator to tell their story (Chase, 2005). The pilot study allowed the listener to practise the concept of asking broad, pertinent and appropriate questions of the narrator, additionally it was useful for the 'listener' to become accustomed to hearing the stories of participants with CLBP.

In addition the participants were asked to provide a quantitative measure of pain. It was hoped that this would prove a useful adjunct and assist in the interpretation of the narrative. The interview utilised an adapted Visual Analogue Scale (VAS) to gauge the severity of the pain reported by the participants over the duration of their CLBP. Huskisson (1974) borrowed the original idea from psychologists who used it to measure personality (Huskisson, 1996). A VAS consists of a 10cm horizontal line; the ends of the line represent the extremes of what is being measured (Huskisson, 1996). The usual extremes of pain are stated as 0 = no pain while 10 = worst pain imaginable. The individual is asked to mark on the line the point (distance along the line) that represents their pain; the distance from the end point can then be measured with a ruler to provide a pain score. The VAS is a well-respected and widely used scale to measure pain, it is considered sensitive, easy to understand and thought to provide an accurate representation of pain intensity (Sriwatanakul *et al.*, 1982; Huskisson, 1996). The use of the VAS in this study aimed to quantify the mean pain experienced by the participants over the duration of their CLBP. The participants were asked to score their pain verbally between 0 and 10, where 0 = no pain while 10 = worst pain imaginable.

3.4.6 Data Analysis

Riessman (2006) suggests that the thematic approach is useful when looking for themes common to a number of cases and the events they report. As this was considered likely in this research a thematic approach was used to analyse the data collected from the participant interviews. Audio tapes of the interviews undertaken were initially fully transcribed verbatim; the transcripts were then read and re-read in depth prior to being coded to determine common themes/patterns.

The data was analysed in accordance with the six phases of thematic analysis suggested by Braun and Clarke (2006). The first phase is familiarisation with the data which involved reading and re-reading the transcripted data capturing initial ideas, looking for *patterns of meaning and issues of potential interest* (Braun and Clarke, 2006: 86). Overall, the emphasis was on what was said rather than how it was said – on the *told* rather than the *telling* (Reissman, 2006: 186). Secondly the initial ideas that emerged allowed codes to be formulated which represented a specific area that seemed consistently evident or particularly important in the transcripts e.g. ‘anger’, ‘supportive wives’ etc. Each transcript was then examined systematically and data relevant to the specific codes was collated. The coded data was organised and allocated into specific themes, which were reviewed prior to naming and defining each theme. Finally specific, highly pertinent and appropriate quotes were selected to illustrate the themes detailed in the discussion chapter. The centrality and influence of the researcher is significant and it should be remembered that they will select and organise the transcripts and ultimately, through their interpretation, construct the findings (Riessman, 2006).

3.5 Chapter Summary

This chapter has provided an overview and a rationale for the use of a biographical methodology. It has detailed the plan of the investigation and specifically addressed ethical issues pertinent to this methodology. The next chapter will provide an overview of the stories of the participants who took part in this research and the subsequent chapter will discuss these narratives with reference to the themes that emerged from the data.

4. Findings: Participants' Stories

4.1 Introduction

This chapter will provide a short biography of each participant together with some interpretation to allow the richness of their story to be heard in context rather than an examination of the overall themes that have emerged as a result of further analysis; these will be discussed in detail in the next chapter. A complete biography of each participant is not provided but the aspects of the lives lived and the impact of living with CLBP that are pertinent to this thesis are presented. While there may be particular common themes running through each story the narratives (interpreted by the author) are unique and illustrate the individual circumstances of each participant with reference to time, as well as historical and cultural context. Epiphanies or turning points in their lives (Denzin, 1989; Erben, 1998), as highlighted by the participants, will be considered.

4.2 Living with Back Pain: Cyril's Story

Cyril is seventy two years old, married with three children and five grandchildren. He has been a member of BackCare (previously known as The Back Pain Association) for thirty years and as the chair of the local branch, I had sought his permission to contact members to participate in this study. He was most helpful in distributing recruitment letters and completed one himself.

Cyril described himself as a very fit and active young man who qualified as a physical training instructor while in the army and where he also attained his NCOs Cadre and his Lifesaving Bronze Medallion. He enjoyed weightlifting - winning his division at the Southern Counties Weight Lifting Championships in 1956 – and returned to this sport after completing National Service (he was bench-pressing and squat-lifting 330lbs).

Cyril developed back pain when he was 26-28 years of age while turning some:

> *…great big universal beams instead of waiting and doing it by crane…I was laid up for several weeks and in those days it was just pain killers and rest.*

Cyril's pain was initiated by a specific event and could be attributed to his impatience or perhaps to management productivity demands. This was a major turning point in

Cyril's life that has continued to affect him and as a result his identity as a physically strong and able person, and as a husband and father has been altered. Cyril has had chronic low back pain (CLBP) for about 45 years. Averaging that pain out over the 45 years, Cyril would score his pain as between 5 and 6 using a Visual Analogue Scale (VAS) (see Chapter 3 – Methodology and Method).

Cyril's employment history was varied; he was a bricklayer and drayman, prior to completing his National Service in Cyprus during the EOKA emergency (Cypriot independence). He subsequently worked predominantly in heavy engineering and shipbuilding. For the last few years of his working life Cyril worked in a post room for a government agency and finally as a cemetery gatekeeper for the city council. The majority of Cyril's employment, as a welder, would be categorised as skilled manual work; he classifies himself as, *working class*. The primary jobs, heavy engineering and shipbuilding - involving exacting physical activity - were characterised by a pattern of being intensely busy (converting cruise ships like the Canberra and QE2 for use in the Falklands Crisis) to periods of inactivity as a result of repeated redundancy. These periods of financial hardship are set against a backdrop of regular episodes of back pain also necessitating time off work that he could ill afford. Cyril explained how this impacted on him and his family:

> *…when my back's been really bad and* [I've been laid] *up for weeks and weeks on end…that meant time off work and also it meant financial stringency.*

This was because many firms, at that time, did not provide sick pay so employees were reliant on 'Sickness Benefit' payments to provide some income through their National Insurance contributions (administered by Ministry of Pensions and National Insurance which subsequently became the Department of Health and Social Security). This 'benefit' would not equate to their usual wage and is likely to have put sick workers – especially the long term sick - under financial pressure. Cyril therefore joined the Wiltshire Working Men's Friendly Society as his father and grandfather had done. They made up the short fall in the usual wage after receiving Sickness Benefit. According to Cyril this system worked well until, *Maggie changed it*. Having come to power in 1979 Thatcher instigated the taxing of Friendly Society benefits over a certain threshold. Additionally under the Thatcher government weekly tax rebates were stopped, *you got to wait until the end of the financial year to get your tax rebate*. So for Cyril and others there was, *hardship…sometimes I was six weeks, eight weeks laid up* *with my back*. Additionally he pointed out that having lost your job in a recession you were unlikely to gain employment within 6 months:

> *…that was another thing Maggie done, she stopped the dole money or unemployment benefit from a year down to six months and when there's a recession on, six months is nothing.*

Eventually in 1980 it was decided that he should have a Laminectomy (bone is removed from the vertebrae to take pressure off the nerves) which in 1980 was a major operation and necessitated six months off work. Fortunately at this time Cyril was working for a ship building firm who did provide sick pay. Therefore for Cyril and his family that was one less thing to worry about. Neither the operation nor a previous serious car accident in 1970 (which caused ongoing neck problems) - the other men travelling with Cyril never went back to work - stopped Cyril returning to work.

Cyril describes how living with back pain has affected his life:

> *When you've got it you get very depressed, there is a worry about money, you get short tempered…it seems to go on and on and on for weeks sometimes when it was really bad…it's blighted your lifestyle really because it restricts you.*

The relentlessness of the pain was compounded by Cyril's inability to work; the effect that this has had on both him and his family is evident. His frustration resulted in depression and anger, he wanted to work and provide for his family instead he was unable to work and had the resulting financial worries. As well as the physical restrictions there were also, *constraints because of the money situation, if you've got a young family…you've got a mortgage and all the outgoings*. Fortunately Cyril had the Friendly Society to help him. Later he returns again to the unrelenting impact of CLBP on his life:

> *…it wears you down mentally and you, you think "Oh hells bells how, how long's this gonna go on for" and you do get very short tempered and you can't sleep properly.*

He discusses how when applying for jobs, being honest and disclosing that he did get back pain was a dilemma because, even though it is discriminatory, he knew it may prevent him from obtaining employment as Cyril says:

> *…it's probably going to preclude you* [being considered for the position]*…it does blight your life.*

The question of dishonesty with employers would have been another point of stress for Cyril who was already anxious about the financial insecurity he and his family had to cope with, and this may also have led him to question his self-concept. In Cyril's opinion this is compounded as, *ageism creeps in*, because in his view getting older makes securing employment very difficult. Cyril reflected further on the loss of his self-concept when he described how losing his job was a, *big thing*, and how he felt, *bloody useless*. He goes on to discuss how he:

> *…can always remember sitting at the kitchen* [table] *almost bursting into tears because it gets very depressing. You think you're, what am I you know; men probably define themselves, sometimes by their, their, their occupation. I know it's wrong probably because it's not who you are but we do tend to do that, I think, because without a job who are you?*

There were clearly major conflicts for Cyril's sense of self; tensions between honesty and needing a job, getting older but needing to secure employment. He felt worthless, back pain had impacted on his employability and as such deprived him of his identity. His inability to assume an appropriate identity impacted psychologically (Gordon, 1995) as he was unable to live up to his 'ought self' (Higgins 1987 in Brown, 1998).

Cyril also feels he is different to the person he was before he had back pain, he like Don (see later), details how it makes him wary of things that could exacerbate his pain, people were constantly reminding him to, *mind your back*. Cyril expresses how people presume that having a bad back is, *swinging the lead*, - malingering - this attitude has caused him at times to become, *short tempered – sometimes I've really flown off the handle*. Cyril clearly portrays the mismatch that is present between his internal sense of self and how others perceive him, and he wants to reject that negative public identity (Charmaz, 1994) which is derived from his perception of others' opinions of him (Cooley, 1902). Prior to back pain he spoke about how you feel, *you're invincible…strong and probably…err a bit arrogant*. Not waiting or considering it necessary to use the crane suggests that Cyril's feeling of invincibility fuelled by his sense of masculinity and possibly the naivety of youth may have played a part in his initial injury (Sabo and Gordon, 1995).

Cyril explained how from a working perspective some, *people are very, very ignorant,* of how pain restricts your lifestyle, because of their lack of understanding and working, *in a macho type environment,* which lacks compassion, ringing in sick and taking time off work is difficult because this is perceived as making excuses and needing special treatment. Cyril added that taking time off added to his concerns about his employability and long term future; explaining how you were concerned about if your job would still be there when you were better or if redundancies came up would, *you be one of the first ones out?* He recognises that while many would, *decry the unions* [as] *there were a lot of strikes…back in the seventies*, he would much, *prefer to work with a firm that had the unions in there because of the protection you've got*. Cyril's anxiety about financial insecurity and being unable to provide for his family, as he believed he should, were exacerbated by his concerns about being employable.

Cyril described how (because of back problems, being out of work or unable to do a job) he felt a, *liability,* to his family and he recognised that, *it must have an effect on married life*. He explained about the stress and strain that it put on his relationship over a period of time because, as he sees it, the, *main breadwinner,* is off work, with the resultant financial worries and the inevitable short temperedness that ensues. I get the impression that Cyril's family struggled financially; eventually Cyril's wife became a child minder and additionally they let out a room in their home long-term to help with the household budget. Cyril explained how this affected him, and how it threatened his traditional masculine identity:

> *You feel bloody useless…it's an old fashioned attitude probably that in my generation, you were the one who, you were the breadwinner and your wife, you know, was* [the one who] *brought up the family.*

Cyril also explained about the amount of money he had paid out privately for acupuncture and manipulation to try and gain some relief which, when combined with a lack of sick pay has, *been a big worry*.

Interestingly, Cyril later returns to the issue of being short tempered and suggests this is felt acutely at particular points in his life, for example, *especially when you've got young children around*. Cyril explained how his back pain impinged on his relationship with his children – he could not do the things he wanted to do with them like swimming and playing rounders – and how they responded to this situation compounded his feelings of inadequacy, as a husband and father. He reflects on their observations:

> *Oh we can't do that because Dad's back's bad, he's up in bed with his bad back; he can't do anything.*

His children's comments on how they perceived him added to Cyril's belief that he was defined by his CLBP. This inability to interact with his children as he would have wished was clearly frustrating for Cyril and appears to have impacted on his identity as a father.

However, back pain doesn't appear to have affected hobbies and pastimes; Cyril did not appear to have had much spare time because of taking on any overtime available during evenings and weekends along with building a large extension on a previous house, and until recently undertaking all his own decorating. Cyril was advised to swim to help with his back pain and as he has always loved swimming that was no hardship, swimming 5 days a week did help and subsequently the hydrotherapy accessed through BackCare for the last 30 years has helped to ameliorate the pain. Swimming and hydrotherapy have clearly had a significant impact on Cyril physically and mentally as evident when he states, *one of the best things is definitely the hydrotherapy*.

He described himself as, *working class…not very academic 'cos I left school at 15* [with] *no qualifications,* and importantly as a family man who clearly worked hard to support his family and became worried when he was unable to do so because of back pain or redundancy. His inability to work at times because of either pain or unemployment appears to have affected his masculine identity, *you feel bloody useless…without a job who are you?* He was unable to comply with the independent and self-reliant expectations that are inherent in the traditional view of masculinity (Brannon 1976 in Sabo and Gordon, 1995). Cyril always had a mortgage to pay and children to feed and clothe; financial insecurity meant he was not always able to fulfil the traditional masculine role of family provider that he regards as an important aspect of his identity. This has led to Cyril repeatedly questioning his sense of self over his life span whilst living with CLBP. Cyril is however immensely grateful to his wife and family for the support they have given him through these trying times. He values the support that he has received and appreciates how difficult it would have been to cope financially, physically and psychologically without them, *it must be hard if you are on your own and you've got nobody else to back you up* (Charmaz, 1994).

Cyril acknowledges that CLBP has, *blighted*, his life and recognises that inevitably having back pain to that extent will define you in some people's eyes. This is apparent because people not only ask the usual, *how are you keeping,* they also enquire specifically, *how's your back?* This is a clear recognition of the extent to which his back pain has impacted on his life as people inevitably enquire specifically about its current condition. The concern and interest expressed however, means that Cyril is never allowed to forget the fact that he has a bad back, it is his public identity, he is labelled as a man with a bad back.

Cyril's resilience is evident throughout his story; when he was off work because of his CLBP his consultant suggested he swim everyday. At first he:

> *…could just about manage a length* (of a small pool) *'cos my back was so bad but gradually it got better and better.*

Cyril swam everyday Monday to Friday, he needed to get better and he was prepared to do whatever was needed. He was made redundant in the week of his 54th birthday, in the middle of a recession and again his resilience and determination is evident as he went to:

> *…Romsey Job centre, Winchester Job Centre, Southampton Job Centre, Eastleigh Job Centre as well as applying in the papers for any jobs that seemed to be relevant.*

He was out of work 6 months and discusses how the rejections 'knocked him back' but eventually his persistence paid off and he got a job. Retiring early or just staying on the dole were not options for Cyril; he needed a job not only for financial reasons but to maintain his sense of self and identity – his dignity demanded it.

Cyril's back pain is now thankfully improved; recently medication prescribed for his neck pain appears to have been very beneficial for his back pain too. His financial situation is now secure through receiving compensation for hearing loss and an inheritance, *we are financially better off than ever*. He no longer has the financial worries, *it's a big relief that you haven't got to worry about a job and also what sort of occupation* [will you be able to cope with, you don't need to ask yourself] *can I do this?* Importantly he no longer feels a liability to his family. The lack of financial concerns and no longer having to act in the traditional male role of breadwinner has given Cyril an improved sense of self.

Since retirement Cyril has embraced many interests including singing, painting and joining the University of the Third Age; which indicates that he is still active and wishes to be part of a community however, the activities are less physical than they might have been if he didn't have CLBP. He and his wife enjoy gardening and visiting National Trust houses and Hillier's Gardens at Romsey.

We met at his home (his choice) and during the interview he provided a richness and depth to our discussion; his memory for dates and facts was superb. I found myself asking questions that were not specifically related to the research purely because his conversation was so engaging.

4.3 Living with Back Pain: Harry's Story

Harry asked if it was appropriate for his wife to join us for the interview, this proved very useful as she was able to help with specific details and offered another perspective to Harry's story.

Harry is seventy seven years old, married for fifty four years, with four children and ten grandchildren. Harry's working life has revolved around transport, initially working for British Rail for seventeen years in York before moving to Teesside and joining South Durham Steel and Iron Company as head of the transport department in the steel works. Harry's work would be categorised at managerial/administrative and he would be deemed as lower middle class. Harry was made redundant thirteen years later, *one of the victims*, of the downturn in steel industry in the late 1970s. He was then unemployed for a year before securing a job for a high street retailer as manager of their re-supply depot in Winchester. He left this post after six months as he didn't like the job and became a financial advisor until he retired in 1997. Alongside his regular employment Harry was in the Territorial Army for thirty five years as a movement control officer advising fighting units on supply issues. Harry enjoys reading, watching television and sport, having spent so long in York he remains a very keen supporter of York City Football Club. As a boy Harry was Head Chorister at Chichester Cathedral and has continued to sing throughout his life; he still enjoys listening to singing. When he was younger he played hockey and squash and continued to play even after he developed back pain. Harry and his family spent holidays caravanning and walking, Harry was reasonably fit and active, according to his wife:

> *he didn't let it* [CLBP] *rule his life…he wasn't always thinking "Oh my back", whereas now he is, because it is there with him all the time.*

This change may well be the result of deterioration in his back and/or co-morbidities making his pain less transient. It could also be due to the normal aging process; Harry is getting older and understandably doing less and his decreasing activity may be having a detrimental effect on his CLBP.

A very specific event, attempting to lift a piano in his mid to late twenties, initiated Harry's back pain he, *slipped a disc and in those days it wasn't a thing which the National Health Service seemed very interested in*. Consequently Harry didn't approach the NHS with regard to his back pain for several years. His back, has been a weakness ever since and Harry initially spent a lot of time resting on the floor and was treated by a bonesetter (a practitioner who is not formally qualified that offers manipulation for back pain). Until the last ten years Harry's pain wasn't constant, at its worst he rated it as a 7 or 8 but on average 3-5 on the VAS (see Chapter 3 – Methodology and Method). Even though the onset of back pain was caused by a single occurrence, this does not appear to have created a turning point for Harry that has caused him to alter his life; his attitude has been, *you get on with it*. Over the last 10 years Harry has developed arthritis and this has increased his back pain to an 8 and at times, at its worse, 10 on the VAS. In the last couple of years Harry has had severe episodes of sciatica in both legs at separate times. For a period of time he completely lost the strength in his left leg causing the leg to unexpectedly collapse under him resulting in him falling. Despite his doctor's advice to the contrary, Harry attended his granddaughter's wedding in Mauritius and while there, went on a boat trip to see the dolphins; his and his wife's description of him trying to board a boat, from the soft, sandy beach, while using a walking stick resulted in us all having a good laugh. He still lifts heavy weights on a regular basis and his wife worries that following his heart bypass he might die, Harry's attitude is, *if it's my time to go…well that's it isn't it*. CLBP has not stopped Harry working, playing sport or fulfilling his Territorial Army commitments. Harry's gritty determination and humour in the face of adversity, is evident in his, *you get on with it*, attitude, he doesn't give up, and this resilience is clearly an integral part of his self-concept.

Harry doesn't feel that the back pain has changed him at all, as previously stated, he wasn't going to let back pain dictate his life - his identity was unaffected. There may however, be a distinction between Harry's assertion that he remains unchanged and his determination to carry on as normal and thus retain his customary public identity. Even when it first began his wife stated that, *Oh it didn't bother us at all, it was just a damned nuisance*, and Harry agreed. Harry never had a day off work because of his back pain and feels that it hasn't impacted on his family life, he recognises that now he would be unable to carry a sleeping grandchild into the house from the car but was able to do that with his own children. Harry's ability to fulfil his role as a father allowed him to retain a positive self-concept in this aspect of his life. This is very different to Cyril who was unable to fully fulfil his paternal role and this continues to be a disappointment to him. Cyril didn't want to take time off work either but perhaps the fact that his pain and disability seemingly impacted more on his life than Harry's and the manual nature of his job, compared to Harry's more sedentary role, forced the issue. While Harry's role would have given him more choice about taking time off work his determination to carry on may have resulted in him never having any time off.

Neither has back pain prevented Harry playing Squash, Hockey or undertaking his TA role. While Harry still holds with, *at no time in my life has my back told me what to do,* because things have worsened in the last 5 years his wife suggests that the increased pain has stopped him socialising. So self-concept and identity are now possibly threatened by the worsening pain – very similar to Cyril but with different trajectories over the life course. Harry questions if this is because of his back or just the fact that he is getting older and he, *can't be bothered sort of thing*. He had a quintuple bypass in 2002 and describes himself as, *more of a miserable old bugger than I used to be…I've got a short fuse*. Harry's reported misery could potentially be associated with his CLBP. Having the quintuple bypass in 2002 seems to have been a turning point for Harry and in conjunction with ageing has contributed to an alteration in outlook and self-perception. Interestingly that time scale also fits with the deterioration in his back pain and Harry admits that the pain may have had a, *detrimental effect,* on his attitude to life now. As a consequence it may have negatively affected his self-concept but he is unable to distinguish between the effects of the bypass, CLBP and aging. He hasn't got the patience anymore, he, *just can't be bothered*. He doesn't want to go out even in the car. Harry's wife reported that Harry said:

> *To be honest…I am quite happy to sit in this chair and watch television and have your company and that's, that's it.*

While Harry recognises this, he doesn't believe this change in him can be solely attributed to his back pain. This suggests that Harry is becoming more introverted and unlike previously he isn't *getting on with it* anymore. It would appear that this is not solely an attitude issue as Harry's wife explained he is physically unable to walk the dog as she says, *you can't literally, can't do that now can you?* Harry used to do all his own internal decoration and while he tries to undertake little DIY jobs he is so much slower and this together with his exacting standards means that he, *doesn't even attempt to do it now*. While Harry sees himself as, *getting idle, lazy whatever you like…umm can't be bothered*, he still chooses to attend exercise sessions in the hydrotherapy pool as a member of the local BackCare group because he wants to improve his back, which it does and he would attend additional sessions were they available.

I conducted the interview at Harry's house. Harry clearly valued the presence of his wife and deferred to her when he was unable to remember specific details. This is significant and indicative of the fact that he is willing to take a less active role in his own life. Harry was very open, honest and frank detailing, with the help of his wife, some very personal aspects of his life. He recognised how hard his wife has worked over the years, taking care of four children and how she was always very supportive of him. Both Harry and his wife were well-spoken and from his employment history I would have judged that they should have been financially comfortable. They have however, had some, *terrible, terrible financial problems* that caused Harry to break down in front of their GP, who then seems to have labelled Harry as being depressed.

My impression was that Harry's back pain up until the last 10 years was not as life changing as some of the other participants – Harry's wife described it as, *more of a niggle than a chronic thing*. Harry concurred saying, *that's a better description*. Harry's, *life has got to be lived…get on with it,* attitude was refreshing. I was struck by the positive attitudes of both Harry and his wife; the laughter engendered by their account of the boat trip in Mauritius was delightful. This is particularly pertinent because this occurred earlier this year when Harry's back pain was likely to have been severe and he had significantly reduced function in his left leg. Overall I feel Harry's wife captured it well:

> *He's good you see Harry is; he doesn't let it get him down.*

Harry's self-concept and sense of identity doesn't appear to have been threatened by his CLBP until more recently, he has been able to do all the things he wanted to do throughout his life. His self-perception has remained intact and he has had the long-term support of his wife to enable him to achieve this.

4.4 Living with Back Pain: Don's Story

Don is forty six years old, married with 5 children. He is a chartered surveyor, which would been seen as a middle class occupation and while it would have required visiting building sites the actual work would not have been physically demanding. His current role, which he has held for ten years, is sedentary; he is no longer actively involved in visiting building sites or physically surveying buildings which he says, *is a bit of a sadness* to him. He is aware that the lack of physical activity in his current role (he spends a lot of time sitting), *compounds his problem*. He also recognises that his CLBP may well prevent him returning to a physically active surveying job.

Don's back pain began very specifically when he was 24 years old but, unlike Cyril and Harry, for no apparent or obvious reason. Averaging his pain across the 22 years he has had CLBP, Don would score it as 3 on the VAS (see Chapter 3 – Methodology and Method). Don enjoys sport, he continues to play cricket (despite the fact that this can exacerbate his back pain), watches rugby on TV - actively engaging in shouting at the TV and he would like to resume archery. These are all very masculine behaviours and activities.

At times Don feels defined by his back pain – he is no longer known by friends and colleagues as just, *Don, but Don with the bad back*! Don explained how there are people around him who love him (including some friends) but they:

> *…make some sort of compensatory adjustment because I've got a bad back and that doesn't quite feel the same as being loved because you haven't got a bad back.*

Don details how he struggles with the concept of calling his back problem an injury because:

> *…it's not a visible injury…its not like a cut…*[you] *can't see it.*

The lack of visible evidence raises concerns for Don, he wants to have his CLBP legitimised and quash any suggestion of malingering or fraudulent behaviour. Additionally his non-visible, non-legitimised condition brings on feelings of impotence:

> *Got a 20 year old girl saying "don't carry that Dad you might hurt yourself" and you're thinking "I'm 46" you know. So it's, you kind of, you do lose a bit of your identity as a male because you kind of, sort of, the whole sort of male, sort of identity, particularly you know husband,*

> *father, provider and you know we move bits of furniture around the house and it's my wife and my eldest son* [that do it] *and you feel…impotent, is possibly about the closest word I can think about in terms of, perhaps in those sorts of circumstances you know.*

I took Don back to the notion of public understanding and compassion for visible injury that he seemed to want to legitimise his 'invisible' pain. However, he went on to detail an opposing view to the one he had expressed earlier as he stated that what he considered to be an invisible and private pain manifests itself physically. The pain is overt to all those who know the individual well and even those who don't – *the ministry of funny walks*. Ultimately this publicly displays a weakness, everyone can see. For Don there is a clash between private and public self-image, he doesn't want people to see the overt physical manifestations of CLBP:

> *…it's so obvious, I suppose, that you're showing a weakness.*

He would much rather be able to explain to someone:

> *"Oh my back's giving me a bit of grief today" rather than them saying* [to him] *"Gor your back's giving you grief today".*

Don's vacillation, between seeking endorsement and legitimisation of his pain conferred through its visible physical manifestations (to avoid any connotations of malingering), his desire to be in control of managing others' reactions towards himself and his CLBP, and the difficulty that he has accepting the lack of visible injury, suggests that he has not accommodated to his condition and he is relaying a chaos narrative.

His inability to conform to the masculine male stereotype is similar to Cyril's preoccupation with being, *the breadwinner*. Don's use of the strongly emotive term, *impotent,* is significant. Not only does it convey the concept of lacking in physical strength but interestingly has connotations alluding to lack of sexual capability which is considered a momentous deficit in terms of traditional masculinity (Connell, 2005) and this adversely affects Don's male identity. It is noteworthy that Don would choose to play cricket, which reinforces his masculine identity, and suffer the subsequent consequences in terms of pain.

Back pain for Don has meant a loss of spontaneity – he now has to consciously think about his back prior to doing anything and whether or not he can participate in whatever is on offer (he gave the example of being invited to a go-carting event and on balance having to decline). His life is circumscribed, essentially he needs to constantly undertake a risk assessment of what he can and cannot do. Don is always aware of his pain or the potential to induce it, this constant reminder in his life impinges on everything he does. It affects his self-concept - there is no escape physically or mentally. He reports that not being able to pick up his young daughter to give her a hug, *broke my heart that she wanted to be cuddled*, and he had to explain that, *Daddy can't lift you darling – he's got a bad back*. While this provides an insight into his self-concept as a father with CLBP he went on to explain how by getting his daughter to stand on a chair they could have the hug without him taking all of her weight however he continues to be concerned that, *she felt a sense of rejection*. This concurs with Cyril who had similar feeling of inadequacy as a result of how CLBP had impinged on his ability to interact with his children.

Don still wants to do the things he would like to do but not only does he have to consider what his body is feeling capable of and quantifying the risk of taking part in an activity but he has to contend with others telling him what not to do. Conversely the visibility issue raises other concerns:

> *…you might be walking around looking absolutely top bananas then* [when asked to help someone with something] *you say "Oh, I can't help you I've got a bad back" and they might look at you and go "What, you?"*

There is an overriding sense of frustration, *22 years worth of frustration…a heck of a lot of frustration* and anger that is very evident in Don's narrative. Don can't shake off his pain with the resulting impact on his life and his relationships with others. While Don is forty six years of age he details how:

> *…there are definitely times when I feel like I am a seventy year old…I feel that I am a lot older, my body's a lot older than I am, which I don't like very much.*

This is a negative self-image and very different from Harry's, 'life's for living, so let's do it,' attitude to life. He is frustrated that people have to make a, *compensatory adjustment…not making the same sort of demands*, of him because he has a bad back. Some of that frustration is also aimed at health care providers. He feels he hasn't, *had any help really from the medical profession,* and even from the people he has paid to see there is such, *a conflict of information,* that he is never sure what he should be doing. Being told by an Orthopaedic Physician there was nothing they could do other than refer him onto the pain management clinic was really not what he wanted to hear at 41 or 42 years of age; the effect on him has been far-reaching psychologically.

A major turning point for Don came in the last 18 months/two years when, in discussion with his osteopath, he realised that his back was never going to be return to how it was in the past. Don recognises that there is, *a low self-esteem issue…*[that it has] *been on the slide for a year or two now*. He doesn't know if this is linked with the turning point, realising, *that it ain't getting any better than this*, but the time frame of how he feels about himself coincides with the prognosis. Don recognises that at forty six years of age:

> *…it takes some physical effort to bend down and get a breakfast bowl out of the cupboard, it's pathetic…*[and is likely to have caused] *a bit of a dent on the old self-esteem.*

As Don says this is, *a reminder every single day that you know, I've got a duff back*. He is however, aware of current thinking and recognises the need to improve his muscle function, he wants to self-manage but needs a little help, *some 'one-to-one' instruction in terms of the things I can and can't do*. Despite everything, pain, diminished physical function and self-esteem, Don hasn't given up, he continues to look for a way to manage his CLBP, he just needs some guidance. Once again resilience is evident albeit manifested in a different a way from that seen in both Cyril and Harry

Don feels that his family would define him by his bad back and he doesn't want to be perceived that way. While there is a degree of acceptance, he remains angry:

> *I don't want to be defined as someone with a bad back.*

He tries to make light of it by a reference to what will be written on Blackadder's gravestone:

> *Here lies Edmund Blackadder and he's bloody annoyed – well I feel bloody annoyed if I'm really honest.*

The 'looking-glass self' (Cooley, 1902) that Don perceives, especially as the significant others are his family and therefore emotionally close, causes Don to be angry and frustrated and this is compounded because he can see no resolution of the issue.

The interview was conducted in my study (at my house) as this was convenient for both of us. Don spoke very freely but did appear quite low in mood, which he later confirmed; there were on-going problems at work which may have affected the tone of the interview and furthered his negative view point at that time.

4.5 Living with Back Pain: Sam's Story

Sam is thirty nine years of age and Swedish by birth. He moved to England in 1981 and so has lived here for almost thirty years. He works in an office for a software company - this essentially entails sitting all day which is difficult with back pain. His work is sedentary and he would be categorised as middle class. He is married and has a two year old son; he lives in a comfortable house and didn't appear to have any financial concerns.

Sam was very keen on badminton and used to spend a lot of time windsurfing; he has now been advised not to do these activities because of how they impact on his back pain. Sam has found other things to do instead; principally swimming, this was initiated on medical advice and more recently cycling. With the cycling he has to get his posture right and not go too far, but if he complies with these constraints then it works well. He is determined to remain physically active, finding alternatives; he is not going to give up. Once again the resilience evident in the previous participants is apparent.

Sam's back pain started when he was twenty years old for no apparent reason so he has had back pain for nineteen years and he would rate his pain on average at a 4 or 5 on the VAS (see Chapter 3 – Methodology and Method). Once again, as with Don, there is a very specific point in time but no specific event that triggered the problem. Prior to his back pain Sam lived a very active, carefree life which included, in addition to the sports that he is unable to undertake now, rugby and cricket. Sam stresses the fact that he:

> *…didn't have to think about any, any movement problems at all I just lived life actively…err participated in a lot of sports and…umm yeah just…err carefree, didn't have to think about any problems so I could do anything I wanted basically.*

There were no known precipitating factors, Sam just woke up one morning while he was working in Germany and couldn't move because of excruciating pain. X-rays were taken and Sam received treatment and advice while in Germany. On his return to England he brought back the x-rays so he could continue his treatment, although he wanted help he was told that:

> *…there was no problem according to the x-rays and…err therefore there was nothing much they could do.*

Sam admits that during this phase of his back problems he did the, *man-thing and just got on with things*, and didn't really seek advice when he should have done so. This approach can be seen as adherence to a stereotypical masculine identity, just getting on with things, a grin and bear it attitude (Moynihan, 1998; Lack *et al.*, 2011). The problem at this time was not in Sam's low back but in the middle of his back on one side. He then experienced an intermittent pattern where he wouldn't experience any pain - once for a couple of years. Six or seven years ago the pain moved to the low back and became worse; movements were restricted which impacted on daily living activities and meant, for some of the time, Sam was unable to drive. He saw some specialists, had physiotherapy which didn't really help and was given epidurals (injections in to the spine) but these only really helped in the short term.

Meeting his wife and contemplating having a family seems to have been a turning point for Sam. This was an important occurrence that affected Sam's emotional and physical self – he wanted self-fulfilment by being able to actively participate as a father (to play with his child) and husband (to take on his share of household tasks). He recognised that like Don he wanted to be an:

> *…active father…physically capable of having a family and so…umm whether that involved helping my wife with something or doing the housework or playing with my children, I knew I had to really take some action to resolve the issue if possible before that* [children] *happened.*

Once again he went to see a specialist and they discussed having surgical intervention. The specialist wanted to avoid surgery if possible and a final course of physiotherapy was initiated which has proved successful. Because of the turning point detailed above, Sam was highly motivated to do whatever it took to be able to live his life as he wanted. Sam puts the successful outcome down to both the physiotherapy expertise and his compliance with the advice given and the exercises prescribed:

> *…my mind-set was I am gonna follow this every single day and do these exercises every single day.*

Once again the issue of resilience is evident, not giving up, with total commitment to the prescribed programme, Sam has *actually done that* [followed the exercise programme and advice] *every day since* [he] *started the treatment*.

Sam is not cured but he now has some control of the problem:

> *... it's been brilliant so I am now...err able to control the, the issues, so whilst I still can't do certain things and I'm more wary...umm I am certainly more mobile than I've been for about seven years.*

This has come at the perfect time for Sam as he particularly wanted to be able to actively play and run about with his son. Unlike Don, he has specific strategies to keep his back pain under control which has allowed him to participant as fully as possible in family life. Sam recognises that he really shouldn't ski but having skied since he was three he is not prepared to give that up and can now ski whilst keeping his back pain under control. This again gives an insight into Sam's masculine identity, this is something important to him, like Don's cricket, which he is just not prepared to give up and so, like Harry, he just gets on with it, albeit with a carefully thought through programme to keep his pain under control.

We met at Sam's house; he was articulate and succinct in the interview providing a detailed picture of his life and the problems he has experienced. He came across as a sensitive, caring man who was very concerned about being able to fully contribute to family life. Like Don, Sam is, *aware and more conscious* of the need to risk assess his activities, having gained some control over the pain he doesn't want to revert to how he was previously. Sam explained how the back pain made him feel:

> *...more self-conscious, it makes you feel down sometimes err it can make you feel low* [depressed]. [He recognises that], *inside I'm quite upset that I can't still do some of the things that I really wanna do,* [and] *disappointed* [that he], *probably won't ever be able to do all those things.*

This concurs with Don's reported decline in self-esteem when he realised he was unlikely to make a full recovery from his CLBP. Crucially however Sam concludes his answer with, *but I'm still positive*. This unmistakably illustrates both Sam's keen self-knowledge about his CLBP and positive attitude towards life.

Sam's wife has been very understanding and helpful, he worried that in the past she has taken, *on a lot more of the household work load than* [he] *would have liked*. His wife, her parents and his parents are all very good at preventing him undertaking tasks that pose a risk to him. Sam is concerned that in undertaking the, *heavy tasks,* his wife exposes herself to the risk of back injury. He recognises how good their parents and wife are in protecting him from risks he would otherwise take, *my wife will step in and say "No, you are not allowed to do that"*. While this causes Sam to experience feelings of frustration and anger at his inability to take on not only a masculine role but his fair share of normal household chores, he still can amazingly find humour in some situations. Sam explained about the time when he was having a very bad episode of back pain, his wife was heavily pregnant and they were shopping. He was hobbling, supporting himself on the trolley, unable to do anything else and his wife was lifting all the groceries into the trolley. Sam was the recipient of many filthy looks because he was seen as:

> *…one of those blokes who didn't do anything and let her, you know the wife do everything – heavily pregnant as well.*

While part of him wanted to explain the situation to the onlookers, the other part of him, *just…erm, found it amusing*. Sam's ability to find humour in this type of experience undoubtedly contributes to his positive self-image. While he does feel frustrated, he is able to prevent that from negatively impacting on his self-concept and so he is strong enough to withstand the negative perceptions of others. His situation is now much more under control so he is able to do things around the house that would not have been possible previously.

Sam described the major turning point, with regard to his back problems, as occurring about two and a half years previously when he met a different consultant. He details how it was:

> *…probably for the first time that I had actually had someone spend some time really explaining all the detail.*

Essentially this was because he was at the point of potentially having surgery and he really needed, *to understand the options and causes*. The *real spike* [turning point] however was meeting the physio the consultant had referred him to, who was able to identify what was happening to cause him the pain that he was experiencing; the ensuing explanation provided Sam with such a detailed understanding that, he reported, he was able to:

> *…visualise all the things that were going on between my head and toe.*

Sam detailed how the subsequent explanation of specific exercises and why they would work for:

> *…the type of pain I was experiencing really made sense and for me was like an enlightenment…from this point* [onwards] *everything's been positive.*

This understanding along with not wanting surgery and concern for his family if surgery went wrong appears to have driven Sam's compliance with the advice given and the exercises prescribed, resulting in his subsequent improvement. Sam clearly had goals as both a husband and father; he was prepared to follow advice as this gave him the best opportunity to live his life as fully as possible.

Sam's employers have been understanding about him having to have time off sick and allowed him to work from home if required. They have been very supportive in providing him with an electrically adjustable desk so he can work in either sitting or standing positions along with a special mouse and chair. He has, *a stroll around every…err sort of hour or so*, and makes a point of going to see his colleagues face-to-face rather than phoning to limit the time he spends sitting. This suggests that the education provided by his physiotherapist, regarding posture and limiting the length of time spent sitting down, has been understood, recognised as important and subsequently complied with.

Sam does not feel defined by his back pain now although he did prior to the major turning point that occurred two and a half years ago. He recognises that he is still unable fully to be the person he could have been but he doesn't see this, *as a hindrance any more*. Prior to the turning point described he felt, a *burden*, to his family because of all the things they had to do for him. Sam has always been a very independent person and when he was suddenly reliant on others he did feel, *like a burden*, and this caused him to experience feelings of anger, frustration and upset; he liked to help others and struggled to be the one needing help. Fortunately he is now returning to his, *independent self*. This concurs with Cyril who described how he felt he was a, *liability*, to his family. Now Sam can contribute significantly more to his family, there is much more of an appropriate balance in their roles allowing him to feel, *a lot more positive now*.

4.6 Living with Back Pain: Adam's Story

Adam came to see me and I interviewed him in my office at the University of Southampton. Adam is thirty one years old, married with two young children. He is a National Account Manager for a manufacturing company with a remit of covering South East England including London. This involves a significant amount of driving which was, in Adam's opinion, a contributing factor to him developing back pain. It is immediately obvious why he works in this role as he was highly engaging and extremely personable. He is interested in all sport, is very involved in the local music scene and very active generally, enjoying dog walking, cooking, DJ-ing, socialising and spending time with his children. He is a 'hands-on dad' explaining how, once prepared (braced), he can give piggy backs to his little girl which she loves and he takes his turn in changing his young son's nappy.

Adams portrays his life as very full; masculine activity and roles are very evident. He describes himself as, *very, very easy going…very easy to please…very, very simple guy really*. Prior to developing back pain Adam was a county swimmer but moved on into county football – he would play any sport and was, *an avid gym goer*. He led a very active lifestyle, very focused with regard to his cardiac fitness, regularly running and conscious of his diet. Since developing back pain Adam has tried to return to sport (an important part of his masculine identity) but five-a-side football just made everything flare up. Even swimming, the back pain sufferer's panacea, has not worked out for him, he developed severe palpitations and thought he was having a heart attack, he explained how, *that scared the living hell out of me*, understandably Adam has not continued with his swimming. Interestingly the only sport he can now play is badminton, which he really enjoys. Badminton allows Adam to retain a component of his previous lifestyle and therefore his identity as a proficient sportsman albeit in a more restrained manner.

Adam's back pain first started when he was twenty six or twenty seven years old. He had travelled to Scotland to play five-a-side football with some work colleagues and he could feel, *heat in his back… you kinda know when you feel like you've done a sprain*. He played gently, took Ibuprofen that night and woke with a stiff back but as soon as he put weight through his legs the pain:

> *…absolutely spasmed all the way up through and it was like a pain behind my eyes and I was like, "I think I've broken my back" and walking was agony, absolute agony.*

The resilience evident in the other participants is unmistakable in Adam, he felt it was wrong to have a day off work because he had played football so he, *necked another two Ibuprofen*, and spent the day in the office *walking like John Cleese out of the Ministry of Silly Walks.*

While the time of onset is very precise there doesn't appear to have been a specific event that initiated the onset of Adam's problem. Driving to Scotland would have meant sitting for a prolonged period which may have had a role in initiating the problem or it may have just been the 'final straw' of a cumulative type pathology. Averaging his pain out over the last four and a half years Adam would score it at around 6-7 on the VAS as a conservative estimate (see Chapter 3 – Methodology and Method). His management has essentially been through medication and physiotherapy but he has also had a couple of Cortisone (steroid) injections. Physiotherapy has, however, really helped him manage his pain and he describes the physios he has worked with as, *absolutely legends the pair of the 'em.* The physios Adam describes are clearly significant others in his life who have helped him to both retain his identity as a physically capable person and to gain some control of his condition (Cooley, 1902). Adam is also quick to explain that his company, *are amazing*, they have been, *incredibly understanding* providing him with, *a new company car within a week* [that] *had lumbar support and heated seats and all this kinda business, which is brilliant.*

Adam clearly detailed two epiphanies or major turning points in his life which were initiated by two separate injuries. The first was a rupture of the anterior cruciate ligament (ACL) in his left knee. This occurred when he was 24 years of age and when he, *was really hitting form with county football* [the injury] *just instantly killed it* [the chances of a football career] *but you know that's fine*. The knee issue was resolved:

> *I had an operation: it was fixed. I had physio that was it, it's done, I gotta new ligament, everything's gravy.*

In contrast Adam describes walking into his consultant's office and being shown a scan of a 60 year old man's back with, *a big balloon* (herniated disc) *at the end of his spine*. Adam states, *and I was like "yeah that's gotta suck"* and then the consultant said, "*and here's yours", and I was like, it was pretty much identical*. Adam describes his reaction:

> *I can't believe that that's my back, surely that can't be my back because you just showed me this presentation of this 60 year old chap and you were like…"yeah he was ruined"*

This self realisation of his condition was a major epiphany for Adam (Patton, 2002). The consultant planned to operate on the 60 year old the next day to remove the herniated disc; Adam's options were limited to conservative management because he was too young for the operation. The consultant didn't want to consider any type of surgical intervention until he was nearly fifty years old (approx twenty years away). Therefore Adam has, *no closure on it*. It is difficult to fully understand how much this impacted on Adam, it seems likely that it would have affected his self-esteem and confidence and that would potentially have been further exacerbated by the time frame proposed. He remains pragmatic however, realising that his options are limited:

> *…so it's just a case that I have to put up or shut up really, err and it's, it's gotta be the former and I'm gonna try to do my best to, to manage that err, on me own.*

Adam wants to manage his pain and minimise any impact on his immediate family:

> *…my wife's amazing with it but I often think to myself like, if I was in her shoes, I mean there's gotta be a lot to put up with. I mean me walking in going "I'm absolutely ruined you know I can't, I've gotta sit down immediately" or "I've gotta stretch" or you know I'm doing a tiger pose on the blimmin lounge floor just to try and relieve some form of pressure.*

Adam recognised that the impact on his life course was going to be far-reaching, it is unlikely however, that initially he fully realised just how all-embracing it would prove, twenty years is a protracted period when you are experiencing that amount of pain. He sums up the epiphany concept by explaining how:

> *…the back is in itself a major turning point because it's stopped so many activities that I used to do err, and used to love doing.*

Adam was very articulate and honest providing a detailed insight into his life that does not always portray him in a positive light. Constant tiredness and a decreased tolerance, both linked to medication, appear to be prominent features in his life with CLBP. Prior to developing CLBP Adam reports that he never really said:

> *"I feel tired"* [laughing] *whereas that's all I seem to say these days or err, "My back's killing me".*

Adam detailed how reliant he is on medication for the pain, *I still pop Co-dydramol like sweets*, it makes him, *just feel knackered all the time* and he is more irritable. He constantly struggles not to react negatively:

> *…my temper has shortened and I am very conscious of trying to make sure that I don't bite…I just can't walk around all day thinking my back's killing me therefore it should cost other people.*

Adam doesn't like taking pain killers but he recognises that:

> *…if I don't take the Co-dydramol I can definitely feel it in my back…I know that if someone says something it's just gonna be like, "just shut up"* [laughs]*. You know you just bite, that's all it is, you bite quicker…which is crap to be totally honest cos its not my personality…you just find yourself getting wound up by the smallest things.*

It seems reasonable to suggest that Adam's short temper is aggravated by his frustration over his lack of autonomy and pain. This easily provoked anger is also evident in both Cyril's and Harry's stories. Adam recognises that while he continues to be happy his current happiness is different to how it was previously. Like Don and Sam his life is, *all about calculated risks*…[having to think about] *every single action that I take* [which is] *heartbreaking*. He explained about how his daughter, who is almost four years old, loves 'piggy backs' which he copes with but has to consciously, *take a couple of seconds just to gear myself up in the right way*, before she swings off him.

Adam continually made mention of his physical appearance (first time approximately 30 seconds into the interview), he is concerned that he appears, *haggard* and *hunched over* – he recognises that he is preoccupied with how he looks and regularly checks himself to, *bring me shoulders down and stand up straight*. If he has slept with a twist he will, *wake up like an old boy*. He recognises he is a, *nightmare,* to his wife because he constantly asks her, *do I look knackered and you know am I hunched over?* He has never, *been so conscious of shuffling*, in his life. Adam's self-concept of his body image appear to be very important for his self-esteem; he is very aware that he is too focused on this aspect (this was not evident in the other, older participants). This contrasts markedly with his previous image as a young, fit and physically capable young man:

> *…it's a stark contrast to…the bloke that I was before I had the pain…it just limits everything, everything's changed…I feel like an old man…I can't believe I'm 31 and I am in a position where I'm literally waiting for something to happen to allow my back to not have the pain.*

CLBP has clearly affected his identity and may cause him to feel depressed and frustrated. Despite all the problems, Adam never saw himself, *being like this at thirty one,* there is positivity, resilience and the ability to laugh at himself which is neatly captured by his comment:

> *I had no luck with the knee when I was like twenty four, that didn't help then, now the back, you know it's, it's a nightmare. I'll probably be amazing at chess in like ten years.*

Adam's amazingly positive attitude is evident when he describes how he is now unable to regulate his weight through exercise as he used to:

> *On a positive side it has impacted on my overall diet* [laughing] *because I am so careful of what I eat now anyway to make sure I'm not piling on the weight, you know.*

Outwardly Adam is incredibly tolerant of everything that has happened to him as evidenced by how he accepted the abrupt end to his county football future:

> *…just instantly killed it but you know, that's fine.*

He goes on to explain:

> *I'd say that* [CLBP] *is the sort of catalyst to me trying to be more outgoing…*[in] *a hundred years we'll all be dead* (laughs)*, you know, let's just try and enjoy it* [life] *and, and not let it* [CLBP] *get on top of me.*

This concurs with Harry's, *get on with it,* attitude. Adam would describe himself as:

> *…a very confident individual…I'm in sales…I'm the first one through the door, I'm all hands and smiles and chatting to everybody, I'm always trying to make people laugh…just outgoing really.*

Since the injury Adam is very conscious of how he feels and this has driven him to portray even greater confidence; to be more outgoing, he doesn't want the pain to get the better of him.

Adam's ability to punctuate his account with humorous quips despite being in a situation that, *sucks,* is commendable. At times however, Adam feels, *like the absolute, you know, wiener*, when he is asked to help someone lift something and he has to explain, like Don, why he can't help. He explains his frustration at how the person requesting his help looks at him and comments, *you look fine*, because their perception is of a:

> *…young, fit, healthy lad - surely you should be able to help me?*

Adam then feels the need to explain:

> *I'm an absolute 'write-off' so I'm really sorry and that's pretty frustrating.*

As this clearly shows, Adam maintains a generally positive public identity however his private knowledge of the situation, and his concerns about his self-image are not positive. He remains clear however, that he is not defined by his CLBP. His frustration with his CLBP has inevitably led Adam, at times, to undertake tasks that he knows are detrimental to his condition and predictably he recognises afterwards, *that really did me no favours*. The need to explain this private knowledge of his self-image in a public domain is likely to impact on his self-esteem and ultimately his personal identity. This is exemplified when Adam uses the word, *heartbreaking*, to describe his situation. He then explains:

> *I'd say physically I've never been so insecure about how I look in my life…which is a big change for me 'cos like I'm not, I'm not a woos or anything, you know, I mean I've never been vain or anything, you know, I've never been one to look in the mirror every two minutes but…it just makes you feel like you've changed.*

Adam realises that compared to the person he was before back pain he has changed, *mentally, massively*…[it] *just permeates every single aspect of your life, period*. Adam recognises that his close friends would suggest that over the last year or so he has become more insecure generally and specifically about his appearance. He also indicated that they would highlight how acutely aware he is of his back and the physical limitations it imposes. They wouldn't however, to Adams great relief, define him by his back pain. Having always been the, *life and soul of the party,* and hoping that publicly he still retains that identity, Adam admits to recently becoming more insecure (privately) which is probably the catalyst for him trying to appear outwardly (publicly) more confident. Adam desperately needs to retain his previous identity and is prepared to engage in emotional labour in the pursuit of that credible self (Hochschild, 1983; Huy, 1999; Bernardes and Lima, 2010). The contradiction between private and public identities continues despite him gaining some control over his back pain. If Adam had to sum up the whole situation is one word it would be, *heartbreaking, I wouldn't wish it on my enemy… it sucks*!

4.7 Summary

This chapter has provided insights into the lives of each participant. These narratives were then analysed thematically to elicit interesting and recurring features (Braun and Clarke, 2006) and are examined in the next chapter. The emergent themes evident will be interpreted and discussed in the light of previous research.

5. Discussion: Bringing Participant's Stories Together

5.1 Introduction

This chapter considers the themes that were generated by examining and interpreting the participant's stories as detailed in the last chapter. While it is recognised that each individual's story is unique, there are some commonalities that have emerged through analysis and are presented here as overarching themes (Riessman, 2006). Some of the larger themes will be broken down into smaller sub-themes for clarity; therefore, a degree of overlap may be evident. It is hoped that this research which considered the stories of men with CLBP, will ultimately allow their voices to be heard, and as a result advance the management of individuals with back pain.

5.2 Identity

The aim of this biographical study was to explore the narratives of men living with CLBP in order to elucidate the impact of long term back pain on their individual lives and identities. The study aims to illustrate how their stories can be employed as vehicles to enable a better understanding of their lives. In doing so the study aims to illustrate different ways of being that veer from the norm but are nonetheless legitimate so that men living with back pain can more effectively manage their lives. It was hoped that more general insights about the effects of living with CLBP would be illuminated so that others, including professionals treating men with CLBP, listen to their stories and regard these individuals holistically rather than as a set of symptoms.

Previous research suggests that pain and illness does significantly affect identity. Sparkes *et al*. (2005) detailed how through pain Jessenka's body and identity both gradually disappeared and he returned to a previous undesired self (Brown, 1998). Frank's (1995) proposed illness narratives provide an insight into a person's self-concept and identity while Charmaz (1994) suggests that how chronically ill men view their condition (as an enemy, ally etc) again influences their identity. Therefore identity is used as the core theme and forms the basis for the analysis of the narratives. Identity compromise is evident in all the participants' narratives.

Discussion

An individual's identity is unique and can be affected in different ways by similar circumstances (Charmaz, 1994; Baumeister, 2011). Findings suggest that how the participants' experiences of living with CLBP has impacted on their identity varies between these individuals. Nevertheless each participant's identity was compromised by having CLBP and there are some commonalities between their narratives. Therefore it is necessary to consider identity in depth. In this study identity can be considered a master theme with a wide variety of sub themes contributing to the bigger picture.

5.2.1 Defined by CLBP

While interviewing Don he expressed very early how he was no longer known as just Don, he was known as *Don with a bad back*. This was clearly a major issue for him and it seemed very important to him to make sure he expressed it during our conversation. He feels that his wife and children would definitely define him by his back pain. In some way it seemed the crux of the issue for him that his problem was so extensive and overt, the *ministry of funny walks*, and had been present for so long that it now defined who he is. Don really struggles with fact that he is publicly displaying weakness, a flaw, that concurs with Sparkes' (1996) account of how his visible weakness resulted in verbal abuse. Don would much rather be able to quietly explain to a close friend:

> *Oh my back's giving me a bit of grief today" rather than them saying* [to him because it is so obvious] *"Gor your back's giving you grief today.*

The fact that he is in pain is so noticeable colleagues don't need to ask the question, they merely state the obvious. How Don is known and perceives himself (Cooley, 1902) is a constant reminder to him of the gap between his present and 'ought' (Higgins 1987 in Brown, 1998) or 'possible self' (Markus and Nurius, 1986).

Sam also discussed the issue of being defined by CLBP and explained how prior to two major turning points (meeting the Consultant and the Physiotherapist who ultimately allowed him to gain some control over his problem) he also felt defined by his back pain. By nature Sam is very independent and his inability to take on his fair share of household tasks and particularly 'male roles' led him to feeling he was a burden to his family (wife and both sets of parents). Their insistence that he must not undertake certain tasks like carrying heavy suitcases, resulting in his wife having to struggle with them, reinforced his perception of being a burden. The supermarket incident detailed in Chapter 4 (Living with Back Pain: Sam's Story) when Sam's back was so bad that he needed to support himself on the supermarket trolley meant that his wife, who was, *heavily pregnant,* was having to lift all the groceries into the trolley. The looks he received from other shoppers left him under no illusions as to what they thought of him and how they would define him; which couldn't have been further from the truth. Happily for Sam this type of incident no longer occurs, he has gained some control of his pain and is in the process of resuming his 'ought self' (Higgins 1987 in Brown, 1998) and previous identity, he therefore no longer feels defined by his CLBP.

Cyril, in his justification of how CLBP has *blighted* his life explains how people no longer simply ask him how he is; they specifically enquire after his back, it is seen as such an intimate part of him that they are unable to divorce Cyril from his back pain. This suggests that, like Don, he is labelled in people's minds as not merely Cyril but 'Cyril with a bad back'. This links closely to one of Krieger's (2005: 350) critical claims for embodiment that, *bodies tell stories that people…choose not to tell*. Don's and Adam's bodies blatantly tell their stories through the medium of *funny/silly walks* whether they want them to or not. Adam is obsessed with his appearance, he worries that he is, *shuffling, hunched over*, that he looks, *tired*, *knackered*, *haggard,* or that he is, *moving like an old boy.* His concern is that his body is telling the story that he would, *choose not to tell*, (Krieger, 2005: 350) a story that defines him because of CLBP. Adam has never been as insecure about how he looks to others, it is out of character for him to be concerned about his appearance and this is evidence of the fact that he fears his identity has changed (see Chapter 4 Living with Back Pain: Adam's Story, page 84).

Adam is not sure if his friends would define him by his back pain:

> *I'd like to say no err, but I know that jokingly they probably would. Umm, but no think, I think I'll go with no, I don't think they would because I think they know that that's not how I want to, want to be defined.*

This is quite poignant as it reveals less about how his friends would define him in reality and more about how they would conform to his wishes not to be defined that way; Adam clearly hopes that they would not define him this way. Charmaz (1994: 277) discusses how visible disability becomes the, *master identity because it defines every other identity*. Adam is desperately concerned about his visible disability, he is always conscious of his appearance; he is constantly trying to prevent being labelled. Previously Sam felt defined by CLBP, Don is referred to by his condition, both he and Cyril and perhaps even Adam, to a degree, feel labelled by visible disability, the master identity (Charmaz, 1994).

5.2.2 Anger and Frustration

These emotions are included under the theme of identity as the manner in which they have been reported would suggest that they are out of the ordinary for the participants. Sparkes (1996: 468) refers to his painful body and details how:

> *My uselessness makes me angry with my body. At the moment I hate it intensely.*

Don aligns himself with Edmund Blackadder's comment that on his gravestone it will state that he is, *bloody annoyed*. He is frustrated and, *bloody annoyed,* that at 46 years of age he has a 70 year old's body with the consequent physical restrictions. Adam concurs stating that he feels like an old man. Don explains how:

> *…the overriding emotion is one of absolute frustration that after 20 years I've still got this problem…I haven't really had any help from the medical profession…even* [with] *the people I've paid to see, there's such a conflict of information.*

Don is frustrated that medically no one seems able to help or even agree on a diagnosis and how he should be managed. This concurs with Sparkes' (1996: 470-471) experience of trying to make sense of what has happened to him with regard to his back problem, his brother (an osteopath) provided him with an overview but:

> *Other osteopaths, chiropractors, orthopaedic surgeons, and doctors have all provided me with different terms. I remain unclear as to whether I am officially diseased, ill, disabled, or injured.*

This lack of a clear diagnosis is hardly surprising when, as already highlighted, it is not possible to establish a clear pathology in 85% of people with back pain (Nachemson et al., 2000). The frustration engendered seems justified according to Waddell (1998: 1) who highlights that:

> *Back pain is a 20th century disaster. We can split the atom and send men to the moon…yet we have no answer to simple back ache.*

For Don it is the loss of spontaneity that frustrates him. He cannot, on the spur of the moment, just go and do something. Now he has consciously to mentally undertake a risk assessment of the activity with regard to the current condition of his back to determine what the odds are of the activity exacerbating his pain and how much extra pain he will then suffer. Adam concurs explaining how he has changed:

> *…mentally, massively…I never thought this calculated…never thought like every single action that I take, what is the possible damage that I could do to myself?*

Sam echoed this change in his attitude to activity, prior to developing CLBP he was carefree, never ever having to think about any movements he might undertake. Although Sam seems to have come to terms with his CLBP he recognises that he remains upset and disappointed that he can't do what he would like to do and probably never will be able to. These feelings develop into anger and frustration when his wife and both sets of parents stop him undertaking hazardous (in terms of his CLBP) but key masculine activities. Sam explained how:

> *…my in-laws and my parents they don't allow me to do certain things…my wife will step and say "No you are not allowed to do that".*

Sam's anger and frustration stems not only from the fact that in taking on these 'heavy' tasks his wife places herself at risk of injury but additionally he is prevented from fulfilling his hegemonic masculine role (Lack *et al.*, 2011) as a husband because:

> *…heavy lifting and those kind of things, that's for me a male activity.*

Cyril detailed how CLBP made him short tempered; this was linked to the physiological and psychological impact of pain (inability to work, financial worries, becoming depressed) and lack of sleep. Adam concurs with Cyril explaining how his pain medication makes him tired and therefore his, *temper has shortened*, he strives not to, *bite*. Adam believes his previous sedative-type medication negatively impacted on his behaviour; he tries to avoid them now but recognises that his wife is likely to have seen a change in his temper:

> *…she noticed the big change and I found myself saying to her, you know, "it's the back pills" and I was never one for, you know,* [affected voice] *"the medication's making me ill", you know, I just find it a bit wishy-washy but obviously going through it, I think it did certainly influence my behaviour.*

Adam does not, *like taking pain killers at all,* even non-sedative type medication however, he reports that the effect of being without painkillers is significant, uncharacteristically his tolerance level is markedly diminished and he becomes increasingly irritable (see Chapter 4 Living with Back Pain: Adam's Story) (Waddell, 2004).

Interestingly both Adam and Cyril detailed how their decreased tolerance was particularly evident around young children. Both Cyril and Adam obviously love their children and in Cyril's case his grandchildren too. As Adam explains however, it can be very hard to keep control when you are in pain and the children are enthusiastic and demanding:

> *…you know what it's like when your kids are like "Daddy, Daddy, Daddy, Daddy, Daddy?*

Adam recognises that you need to keep control, *trying not to bite but it's difficult*. Adults can make an allowance for someone in pain, they understand that it makes you short tempered and will recognise the 'warning signals' but children's lack of understanding may be the final straw and the person in pain ends up, *just biting*. This has the potential to become a vicious circle where the person who reacted is alienated by significant others, which causes them to become distressed and angry and therefore even more likely to react next time.

While the anger and frustration experienced by the participants is primarily due to the pain and activity limitation they have experienced, perhaps some of the engendered emotions are also focused on the threat to their masculinity.

5.2.3 Masculinity: Threat to Masculine Identity

While recognising the social norms of his generation, Cyril clearly depicts gender roles and responsibilities as he explains that while your wife brought up the family, *you were the breadwinner*. This role became problematic if the breadwinner was unable to work either due to CLBP or because they were unemployed. The inability to fulfil this role not only caused psychological distress concerning his failed gender role but also financial insecurity for Cyril and his family, in day to day reality, *it meant financial stringency*, would he be able to put food on the table and pay the bills? Cyril explained how men define themselves by their occupation because, *without a job who are you?* Without a job Cyril's breadwinning capability is drawn into question as is his subsequent identity which is dependant upon being employed. This suggests that he may have experienced an 'embattled identity' because of the incompatible expectations thrust on him both as *the breadwinner* and as a person with a disability (albeit temporary) (Murphy 1990 in Gerschick and Miller, 1995). Cyril's inability to conform to the broadly accepted masculine ideals of, *being independent and self reliant,* detailed by Connell (1987 in Gerschick and Miller, 1995: 185) has clearly impacted on him psychologically.

Don, like Cyril, is very aware of his inability to conform to the hegemonic masculine role (Connell, 1995; Lack *et al.*, 2011). From a masculine perspective his use of the word, *impotent*, (with all its negative masculine connotations) to describe how he feels when his masculine role is subsumed by significant others (only to protect him) is noteworthy. His use of this terminology may well be linked to his self-esteem which he suggests has been diminishing recently (Charmaz, 1995b).

Sparkes (1996: 473) explains how when his, *pain became intense,* which made walking difficult, he was the recipient of some verbal abuse from a group of boys which would have been unlikely were he not hobbling. He described how his inability to confront the individual left him, *feeling an intense vulnerability that rocked my sense of masculinity to its roots* (Sparkes, 1996: 474). Sparkes' inability to conform to the ideals of hegemonic masculinity which Lack *et al* (2011) suggest as being:

> *…tough, independent, physically competent, mentally strong and aggressive*

led once again to an 'embattled identity' where the man is caught between his masculine and disabled identities (Murphy 1990 in Gerschick and Miller, 1995).

These embattled identities are, to some extent, furthered by the good intentions of others. The wives and families of the participant's clearly attempt to reduce the risks to which the men are exposed by not allowing them to undertake certain activities. Sam explained how his wife has taken on more of the, *household work load err, than I would have liked,* along with the heavy tasks normally associated with the masculine role, *you know heavy lifting and those kind of things, that's for me a male role*. His wife steps in and simply says:

> *…"No, you're not allowed to do that."*

Sam's wife's stance is reinforced by the family, *my in-laws and my parents don't allow me to do certain things.* While this is appropriate, the inability to conform to the accepted gender role does provoke a degree of frustration so, in a need to exert their masculinity, the participants choose at times to undertake activities that they recognise are risky but help them to feel better about their masculine selves. As an extreme skier Sam explains:

> *There are still a couple of things I do that I shouldn't do in terms of sport, like skiing but I'm not going to give that up.*

Adam's wife and a good friend are always telling him, *"Well you're your own worse nightmare",* when, even when signed off work, he pulls the lawn mower out and cuts the grass. Adam recognises afterwards that, *that really did me no favours,* but in his frustration he felt the need to do something (see Chapter 2.8 Masculine Identity, Pain and Disability). Don will play cricket, although he realises it may not be the best thing to do and just suffers the consequences because it is so important to him. This concurs with Charmaz (1994) who detailed the risks men were prepared to take, sometimes life threatening, to retain their masculine public identity.

For all their masculine endeavours the participants in this study were very focused on their role as fathers.

5.2.4 Fatherhood

Fatherhood was important to all the participants and everyone spoke about their children although Harry's and Cyril's focus, as older men, was primarily on their grandchildren (Charmaz, 1994; De Souza and Frank, 2011). Harry and his wife explained how they support their children as much as they can; at times they look after their grandchildren. Cyril describes himself as a:

> *Family man, that's the main thing, its not things that count, what I've learnt is it's umm, your family that counts.*

Cyril clearly dotes on his only granddaughter but his inability to interact actively with his children because of his CLBP led him to experience feelings of guilt and inadequacy, he was unable to go swimming or play rounders with them (De Souza and Frank, 2011). Cyril details that his children would explain that they wouldn't be able to do an activity because their dad was in bed with a bad back, unable to do anything (see Chapter 4.2 Living with Back Pain: Cyril's Story). De Souza and Frank (2011) found that parents' and grandparents' inability to engage in the customary parenting and grand-parenting roles could lead to a perceived loss of identity; this appears to have been the case for Cyril with his own children. The improvement that he has experienced in his CLBP has however, allowed him to undertake a more active and engaging role with his granddaughter.

Don's perceived inability to fulfil this role as a father has also led to feelings of guilt and inadequacy when he lacked the physical capability to lift his daughter when she asked to be hugged. He described how he had to explain his inability to lift her because of his bad back (De Souza and Frank, 2011) (see Chapter 4.2 Living with Back Pain: Don's Story). His subsequent, risk assessed and safer alternative of getting her to stand on a chair to be hugged doesn't appear to have assuaged his negative emotions. He is unable to conform to the expected paternal standard and is therefore subject to the associated emotional dissonance (Hochschild, 1983; Huy, 1999).

Sam's desire to be an, *involved,* and, *active father*, capable of, *playing with my child,* initiated the process of seeking further help for his CLBP and finally this led to him gaining some control over his back pain. The drive to take an active role as a father which was so important to Sam ultimately led to an improvement in his CLBP. Adam again chooses to be very involved detailing how the home situation has been adapted so he can change nappies and how once braced, he is able to give piggy backs to his little girl.

While clearly an important issue for all participants in this study, fatherhood is often a personal and private issue, not something that would necessarily be publicly evident. The caring and concern evident in fatherhood may be considered at odds with hegemonic masculinity (Lack *et al.*, 2011; Connell, 1995) but was clearly important to the participants in this study.

5.2.5 Public Identity

Goffman's (1959) concept of dramaturgy considers how individuals present themselves to others through the use of theatrical metaphors. Public identity could therefore be categorised as a 'front of stage' performance to manipulate the audience (Wallace and Wolf, 1995). Since developing CLBP Adam has become obsessed with his image reporting how he, has never, *been so conscious of shuffling, feel*[s] *like an old man, wake*[s] *up like an old boy,* thinks he looks, *haggard,* and, *feel*[s] *knackered all the time*, and yet how he looked prior to developing back pain was not an issue for him. Don is very aware that when his pain is bad it impacts on his gait (*ministry of funny walks*) which essentially lets everyone know that he has a weakness, this is clearly at odds with the accepted hegemonic masculinity (Lack *et al.*, 2011). Both participants are unhappy with their performance or public identity and strive to manipulate the audience more convincingly. Adam has:

> *…never been so aware and so conscious of my own appearance.*

He keeps asking his wife, *do I look knackered…am I hunched over?* The vulnerability of the ‘back of stage’ persona is apparent and clearly at odds with hegemonic masculinity (Lack *et al.*, 2011; Wallace and Wolf, 1995). He is very focused on not allowing the physical manifestations of his condition to become publicly apparent, remaining vigilant and working hard to retain his public identity and not show weakness (Charmaz, 1994). Along with both Don and Sam, Adam is forced however, to address this weakness issue head-on. They all make reference to their inability to assist others with a lifting task and how difficult it is to explain when to those around them they appear to be, *top bananas*. This not only portrays the discrepancy between private and public identities but is also the rationale for accusations of malingering, *you look fine to me, what do you mean you can't work?* [author's words]. There is no comprehension by others of the thought and effort that may have gone in to accomplishing the perception of looking fine (Charmaz, 1994). The need to continually explain their inabilities is likely to reinforce psychologically their feelings of inadequacy and worthlessness. As Charmaz (1994:279) says:

> *Being unable to measure up to the past self results in further preoccupation with it, and heightens identity dilemmas.*

5.2.6 Private Identity

From a dramaturgy viewpoint private identity is categorised as ‘back of stage’, hidden from the audience, no need to make an impression, it's where a person can be themselves (Wallace and Wolf, 1995). It was in this context that Don explained that his:

> *…self-esteem has been on the slide for a year or two now.*

While he was not able to categorically link it to the realisation that his back was never going to return to its previous condition, the time frame would suggest a close association with this growing awareness. This realisation can be interpreted as a cumulative epiphany, *a reaction to events that have been going on for a long period of time* (Patton, 2002: 451; Denzin, 1989). A similar situation is apparent when Adam details how recently he has become increasing insecure which has resulted in him trying to portray publicly an increasingly more confident persona as the, *life and soul of the party*. Adam is engaging in emotional labour (Hochschild, 1983) in order to retain his previous identity or 'front of stage' persona, in reality his current insecurities result in a markedly different private identity or 'back of stage' persona (Goffman, 1959; Wallace and Wolf, 1995). Huy (1999: 310) suggests that when an individual is constrained to a, *narrow range of prescribed emotions,* this can result in emotional dissonance and ultimately lead to, *emotional exhaustion and burnout*.

Cyril details how CLBP has impacted on him both mentally and physically. The physical manifestations of being restricted and not being able to work are compounded by the psychological issues like anxiety over financial insecurity and not surprisingly result in poor sleeping and becoming short tempered. Cyril details how, *it* [CLBP] *wears you down mentally*, and how if you are honest about having CLBP when applying for jobs, it is probably going to rule you out. The individual faces a moral dilemma between not being honest about their back pain and obtaining work or honesty that culminates in not having a job and therefore struggling to support the family. This type of moral choice provokes anxiety but when combined with the failure to secure stable, ongoing employment, it makes an individual prone to being depressed and the potential for a vicious circle is clear. Once again the vulnerability of the private identity is evident. It would be hard to imagine Cyril detailing this kind of information, as a younger man to his work colleagues in the ship building industry.

5.2.7 Liability/Burden

Brannon (1976 in Sabo and Gordon, 1995: 6) identified masculine identities such as, 'the sturdy oak' which are characterised as being independent and self-reliant. Lack *et al.* (2011: 103) developed this further, suggesting that traditional masculine attributes are being *tough, independent, physically competent, mentally strong and aggressive*. Against this background Cyril explained how as the main breadwinner it is:

> *…a big thing when you get back problems and you're out of work and you can't do your job…you feel a liability to your family.*

Thanks primarily to an inheritance Cyril and his wife, in their retirement, are financially secure in a way that they have never been previously. As a consequence Cyril no longer feels a liability to his family and fortuitously his CLBP is significantly improved.

Similar sentiments are also echoed by Sam. Prior to his major turning points that gave him some control over his CLBP, Sam felt a burden to his family because of all the things they had to do for him. He explains:

> *…I'm a lot more positive now and I know I can do a lot more for my family and that's the most important* [thing] *for me. I think I'm less of an impact to them; I'm less of a burden.*

The use of the words liability and burden convey negativity and are at odds with the accepted masculine traits of being tough and independent (Connell, 1995). As Charmaz (1994: 283) however points out:

> *Men's assumed difference between masculine identity and the "lesser" identities of women and children shrink as they lose ordinary "masculinizing practices".*

Despite any 'shrinkage' in their identity that may occur, constantly feeling a burden or a liability to one's family is likely to compromise any identity because of the negative impact on an individual's self-esteem and not living up to the male image of being 'the sturdy oak' (Brannon 1976 in Sabo and Gordon, 1995).

5.2.8 Physicality

The lack of physical capability or decreased capability was very evident during the interviews with the participants. Once again the inability to fulfil the hegemonic masculine role of being, *tough, independent* [and] *physically competent*, draws the masculine identity into question (Lack *et al.*, 2011; Connell, 1995). Don's role in moving furniture around the house has become redundant as he has been superseded by his son and wife. His feelings of impotence are further compounded when his 20 year old daughter advises:

> *… don't carry that Dad you might hurt yourself.*

Sam explains how he remains upset at his inability to do certain things that he really wants to do and is, *left feeling a bit disappointed*, that he, *probably won't ever be able to do those things*. Adam feels like, *the absolute wiener who can't lift a box,* but will mow the lawns while he is signed off-sick with his back almost as if he is trying to prove his physical capability or at least that he has some capability. Interestingly Don, Sam and Adam all highlight their inability to assist with physical lifting and the impact that their lack of capability has upon them psychologically. The participants find themselves at odds with concept of, *the perfect man, signifying strength and control* (Moynihan, 1998: 1074). Oddly enough it is their control or self-control that prevents them undertaking the lifting role and it could be argued that it is that loss of self-control that results in Adam's lawn-cutting escapades. The pressure of fulfilling a gender role both from a societal perspective and as a means of retaining a previous identity is considerable (Charmaz, 1994). Both Sam and Cyril discuss how their back problems have made them wary of undertaking activity that may exacerbate their problems. For Don it is the loss of spontaneity, he has to deliberate about whether he can do something or not; essentially he has to *risk assess* every activity that has the potential to cause problems which may be as simple as sitting for too long. Adam has never had to be so, *calculated*, every activity now has to be risk assessed to determine the potential impact on his condition. Adam's four year old daughter, *loves piggy backs*, which he can manage but he needs a few seconds to prepare and brace himself appropriately; the spontaneity is lost.

5.2.9 Significant Others: Support

The support the participants have received from their families and employers has had a significant effect on their abilities to manage their CLBP.

Family

An evident theme was the support the participants had from their wives and families. Harry explained that his wife has, *always been supportive*, of him and this support encompassed the broad picture of their life together including Harry's CLBP. Harry's wife comments that initially the back problems, *didn't bother us at all…it was just a damned nuisance*; the use of the word '*us'* implying a shared problem, something to be managed together. Cyril concurs acknowledging how difficult things would have been for him financially, physically and psychologically without the support of his wife and family and he expresses how hard things would be if you were on your own. Charmaz (1994: 274) looked at men with chronic illness and described how single men without children or close friends, *were particularly bereft*. As already highlighted and to his frustration, Sam's wife and family are very effective at limiting his exposure to risks. Unlike Sam, their judgement is not clouded by the need to fulfil a gender role (Connell, 1995; Lack *et al.*, 2011), they merely want to protect him from further pain. De Souza and Frank's (2011) study detailed how valued the support received from a spouse or partner was to the participants with chronic back pain.

Discussion

The love and support that Don receives, while welcome, seems to be linked to his CLBP. He explained that there are people around him who love him (family and some friends) but they, *make some sort of compensatory adjustment*, because he has a bad back. He feels, it seems, that some of that love is conditional because he has back problems. While he doesn't want them to stop loving him, their love, *doesn't feel quite the same as being loved because you haven't got a bad back*. Don struggles to express how he feels about this but clearly it causes him concern. It may be that he perceives the additional concern that has been extended to him because of his CLBP is conditional on him having that pain and were it to resolve the concern would diminish. Rather than treating him as they would anyone else, he feels as if family and friends are making special allowances for him because he has CLBP. He doesn't however, want to be afforded special treatment, he wants to be treated the same as anyone else. This line of reasoning does not support why the concern was initially evident, simply because he is loved and Don may subconsciously be expressing his frustration for the allowances or, *compensatory adjustment*[s], that are made for him.

Supportive Employers

It was heartening to hear about how understanding and proactive Sam, Don and Adam's employers have been in the provision of equipment to allow them to undertake their work. Adam reports that:

> *My company are incredibly understanding of it* [CLBP] *because of course it's a fully diagnosed condition…I've certainly showed my governor the x-rays 'cos he just couldn't get over the size of the sort of herniated area.*

Adam recognises that driving, while an integral part of his job, is detrimental to his CLBP however as previously highlighted (see Chapter 4 Living with Back Pain: Adam's Story) his company have provided him with a new car with specific upgrades to help manage his CLBP. Clearly Adam is a cherished employee who is likely to be very good at his job which covers a prime sales area (London and the South East) and as such is very valuable to the company. He has, like Sam, seemingly received unmitigated support from his employers as endorsed by the 'Blue Flags' initiative (Kendall *et al.*, 2009). It would be interesting to speculate what support would be forthcoming were he a mediocre worker without a, *fully diagnosed condition*, (definitive evidence of pathology) (Nachemson et al., 2000).

Sam also struggles with prolonged sitting which is problematic as his job is office based so his employers, once again in conjunction with the 'Blue Flags' recommendations (Kendall *et al.*, 2009), have provided him with an adapted working environment (see Chapter 4 Living with Back Pain: Adam's Story) to ensure he is able to both maintain a good sitting posture and if necessary work effectively while standing. Additionally Sam's employers have been very understanding if he has not been able to come into the office and are happy for him to work at home.

It came as a surprise, although a welcome one, that none of the participants reported any problems due to having to take time off work because of their CLBP. Even Cyril, who expressed his unease at ringing in sick and worry at the detrimental impact that having time off-sick when redundancies were looming may have had, didn't indicate that he had been unfairly treated when in employment. Discrimination was only evident on declaring a history of CLBP when applying for jobs. The lack of any issues recently reported with employers is perhaps indicative of a better understanding and acceptance of disability as well as the implementation of the approaches advocated by the 'Blue Flags' whose primary focus is the relationship between health and work (Kendall *et al.*, 2009). The requirement for the guidance provided by the 'Blue Flags' (Kendall *et al.*, 2009) is testament to the need to more effectively manage this relationship between health and work which historically has been problematic. The support provided by Sam and Adam's employers while laudable, would not have been forthcoming for Cyril who would have found his wages stopped (by some employers) if he was unable to work making him reliant on Sickness Benefit and payment from his Friendly Society.

5.3 Management of CLBP

Another core theme to emerge was that of how the participants have managed their CLBP. This issue is, like the overarching theme of changes to identity, evident in all of the participant interviews, and as each participant talked about living with CLBP their narratives explored how they had coped with, and managed their condition in different ways.

5.3.1 Sick Role

The chronicity evident in all the participants' stories about their back pain would suggest that Parsons' (1951: 436) 'Sick Role' concept, based as it is on a model of acute illness with timely resolution (Charmaz, 1999) was never fully applicable – the persistent nature of the back pain meant recovery did not occur. Interestingly Harry, the oldest participant and, who because of his age and his socio-historical context, could be seen as the participant most likely to identify with the Parsons (1951) 'Sick role' appears to have engaged with the medical profession the least of all the participants. Harry explained:

> *I didn't approach the NHS about it for years…just wasn't a thing the NHS seemed interested in.*

He went to see a, *bonesetter*, instead to try and gain relief. All the other participants engaged with the idea of being 'sick' and engaged, to a point, with the biomedical model of healthcare. They have all sought medical help, have followed advice to a degree but the, *voilà, recover,* was not forthcoming (Charmaz, 1999: 213). Cyril adhered to the classic sick role for several years and this culminated in a laminectomy in 1980. Following the advice of his orthopaedic consultant (requirement of the 'Sick Role') he did take up swimming which he subsequently used as a means of self management for thirty years. Additionally, however, he spent a lot of money on acupuncture and manipulation. Likewise Sam initially followed medical advice but long term his adherence to prescribed exercise programmes was poor. Both Sam and Adam ultimately found themselves in situations where their options were extremely limited (especially Adam's). The 'Sick Role' model (Parsons, 1951) of medical treatment was evident in their referral to physiotherapy (medical treatment) and arguably in the requirement for them to cooperate and comply with medical (physiotherapy) advice. Charmaz (1999) proposes that the hierarchical doctor-patient relationship so evident in Parsons' (1951) sick role, has changed to a partnership where options are discussed and decisions regarding health care are negotiated. Patients are empowered to take responsibility for, or ownership of, their health and illness (Charmaz, 1999). The interaction between the physiotherapist and patient could be interpreted as that partnership; discussing options and negotiating decisions from the standpoint of an empowered patient (Charmaz, 1999) rather than the hierarchical doctor – patient relationship (Parsons, 1951). Having been empowered Sam was able to self-manage his condition:

> *…my mind-set was I am going to follow this* [advice] *every single day and do these exercises every single day…I've actually done that every day since I started the treatment…it's been brilliant.*

Don interestingly finds himself in a 'no man's land' – he is frustrated and angry that the recovery inherent in Parsons'(1951) 'Sick Role' had not occurred. He has no access to a partnership with a medical practitioner that would empower him, in conjunction with appropriate medical advice, to take some control in the management of his CLBP (Charmaz, 1999: 213). There are aspects of Parsons' (1951) 'Sick Role' model that continue to be evident in the management of the participants in this research, however the crucial component of recovery is lacking. Charmaz's (1999) proposed concept of managing chronic illness is also very apparent. It seems therefore, reasonable to suggest that while both concepts are evident in the management of the participants, giving individuals' ownership of their condition and then empowering them to manage it, is the most appropriate approach for those with CLBP. Further pointers to how best manage an individual's CLBP can be elicited from the type of story they tell.

5.3.2 Narrative Types

Frank (1995) proposed three types of illness story: restitution, chaos and quest. Early on in their experience of back pain it could suggested that all participants would have told a typical restitution story to the effect:

> *I've got a bit of a back problem at the moment, I'm looking after it and getting some treatment, before long it will be fine again* [author's words].

The chronicity element for all of the participants and the outlook evident in their interviews suggests that none of them are ever expecting to attain the pinnacle of restitution, *as good as new* again (Frank, 1995: 77). As much as that would be their hope, they are realistic enough to recognise it is unlikely. Neither are they telling chaos stories where there is no hope, no future, and no control (Frank, 1995). It is evident that Don craves something, anything that will give him direction and control, while clearly he is not telling a chaos story; there are certain aspects of chaos narrative evident in his frustration. Rather, they are telling quest stories, not the, *this is happening for a reason, I'll be a better man at the end of it*, [author's words] type of quest narrative but an accepting, make the best of things approach (Frank, 1995). The quest story offers an alternative way of being ill; one that isn't going to end in restitution (Frank, 1995). While all of Frank's criteria for the quest story are not met (Frank, 1995) there is a clear focus on a key component that is seen to be integral to the positive aspects of the story. For Cyril and Harry it's exercise, for Sam it's the consultant, physiotherapy and education, for Adam it's Physiotherapy.

5.3.3 Exercise

By virtue of the recruitment process (primarily using an exercise focused self-help group - BackCare) exercise as a management approach was inevitably going to be recommended. Only two participants (Cyril and Harry) however were recruited from this group and not surprisingly they clearly extolled the virtues of hydrotherapy; continuation with the programme for, in Cyril's case, 30 years would be unlikely unless you feel the benefits. At seventy seven years of age Harry attends hydrotherapy every Monday evening, a Thursday session used to also run but that:

> *…has been stopped for some time now but it's a pity because if I could, if there was one on a Thursday, I would be inclined to do that as well.*

Sam and Adam have had very clear epiphanies (Denzin, 1989) regarding their CLBP and their self-management of it through exercise. Having very limited options open to them in regard to their CLBP both have made a concerted effort to heed advice and adhere to an exercise regime to self-manage their problem as advocated by the most recent guidelines from the National Institute for Health and Clinical Excellence (NIHCE) (Savigny *et al.*, 2009) and the European guidelines for the management of chronic non-specific low back pain (Airaksinen *et al.*, 2006). Adam has essentially been managed by medication and physiotherapy, he refers to the physios, *as absolute legends the pair of 'em*. Don remains, *bloody annoyed*, with what has been offered to him and the lack of consensus on management; following an epiphany regarding the fact that his back is not going to return to its previous condition, he is now desperate for some advice to allow him to actively manage his condition through exercise.

These findings are supported by the most recent guidelines into the management of persistent non-specific low back pain (Savigny *et al.*, 2009) which suggest that a key priority in the management of this type of patient is to offer an exercise programme, manual therapy or acupuncture depending on patient preference. Of the three options suggested the exercise programme is the only one that can be utilised for continuing self-management without on-going input from a health care professional. Therefore, men with CLBP need to be carefully taught appropriate exercise thus enabling them to own and self-manage their condition.

5.3.4 Education

A major theme from this study is that there is clearly a need to manage these types of patients more effectively and primarily that can be accomplished through education from a health professional (Savigny *et al.*, 2009). They need to understand the pathology, they need advice on functional activities of daily living and need to be taught how to undertake specific exercise/activity and be regularly monitored in this (Savigny *et al.*, 2009; Waddell, 2004). Don craves this in terms of the management of his pain so that he can start to exert some control over his situation; he wants to hear what he can do to self-manage his condition. Education is something that has been really beneficial to Sam. He talks about epiphanies/turning points for him occurring as a result of the education he received from both the consultant and physiotherapist. Sam explained that the first turning point occurred in his discussion with the consultant, it was the first time he felt anyone had really taken the time to explain everything, the causes for the pain and the options open to him (see Chapter 4 Living with Back Pain: Sam's Story). After seventeen years finally Sam has some comprehension of what was going on with his back but it had taken him essentially half his lifetime to acquire this understanding. He felt that the detailed explanation was provided only because he had run out of all the other options and he was facing serious surgery with all the associated risks. Sam continued, explaining how the major turning point was meeting the physio because he was able to quickly identify the causes of his pain and could explain them in a way that he could understand very clearly what was happening to cause him the pain he was experiencing. The exercises he was taught and the explanations provided as to why they were appropriate for his condition made sense, it was like, *an enlightenment*, for him and things have been very positive from then on (see Chapter 4 Living with Back Pain: Sam's Story).

The impact of education has clearly been fundamental for Sam's management of his CLBP. The control he now has over his CLBP has impacted positively both on his identity and his life generally. It is that overview and specific understanding with the resulting impact on both identity and life generally that Don desperately seeks. Interestingly for Don it is not so much cure that is now sought – although that would of course be optimal – he has come to terms with how that is unrealistic; he just wants to understand what is happening, what he should avoid doing and what he can do to exert some type of control. Don explains:

> *You kind of want a bit of hope, you know, where you could do this and you could do that and it will help you manage it better and it will keep you away from the surgeon's knife and it will keep you from having to pump chemicals [into your body]....be a bit careful and actually you'll probably be fine.*

The findings of this research concur well with the most recent guidelines into the management of persistent non-specific low back pain (Savigny *et al.*, 2009 - Quick Reference Guide: 7) whose first key priority for implementation is to:

> *Provide people with advice and information to promote self-management of their low back pain.*

Don lacks the understanding and direction of the others and is therefore frustrated; he wants to gain active control of his CLBP but ultimately all the medical profession have offered to date is a referral to the pain management clinic which he perceives as passive, comprising of drug therapy and having an 'end of the line' status. The ensuing identity is passive, receiving treatment, no ownership of the problem or autonomy in its management and mirrors the traditional sick role (Parsons, 1951) and biomedical model (Waddell, 2004). He wants to self-manage his pain rather than have his pain managed through drug prescription (Charmaz, 1999). He continues with his Osteopathy but feels let down, he has been unable to obtain a diagnosis and a clear management approach, he has no direction and therefore no control. Don wants autonomy and the identity that it will bring (the sturdy oak) (Brannon 1976 in Sabo and Gordon, 1995; Moynihan, 1998; Lack *et al.*, 2011), he wants to be able to apply his determination but there is a stage missing in the management process, he hasn't had the education, he doesn't know what to do and therefore he can't progress with the life he wants to lead.

5.3.5 Resilience

Fraser *et al.* (1999) suggest that resilience is seen in:

> *...individuals who adapt to extraordinary circumstances, achieving positive and unexpected outcomes in the face of adversity.*

All the participants show a determination to gain some control over their CLBP. Both Sam and Adam have really benefited from their interaction with both a consultant and a physiotherapist, they have an understanding of their condition and the options open to them. They both have very clear management strategies to which they are committed and are therefore adherent to them. Cyril and Harry have experienced the benefits of exercise (hydrotherapy) through BackCare and attend weekly. At 77 years of age Harry, the oldest participant states that were there another session available during the week he, *would be inclined to do that as well*.

Harry's resilience is apparent when he is determined to go on a boat trip with his wife and grandson even though it means boarding a boat from a sandy beach. This is all the more remarkable because at that time Harry needed to use a walking stick because due to his back problem, one leg kept giving way, and the walking stick just sank into the wet sand. As Colleen, Harry's wife, points out, Harry's attitude is, *get on with it…he doesn't let it get him down*.

After experiencing his first excruciating bout of pain Adam didn't want to appear to be 'swinging the lead' so he, *necked another two Ibuprofen*, and spent the day hobbling around the office.

Having been advised by his consultant that swimming would help his back, Cyril swam everyday Monday to Friday. He needed to get better and he was prepared to do whatever was needed, *achieving positive…outcomes in the face of adversity* (Fraser *et* al., 1999). Cyril has continued with hydrotherapy every week for the last 30 years. When he was made redundant in his mid fifties, he went to every local job centre and scanned the papers looking for work until he got another job, he didn't stop trying until he gained employment again.

5.3.6 Humour

Humour is evident in some of interviews and while this can be attributed to a coping strategy (Martin and Lefcourt, 1983) it may alternatively just represent the personality of the participant and how they communicate with others. Martin and Lefcourt's (1983) study found that humour had a significant moderating effect on mood disturbance when an individual experienced negative life events. Adam exemplifies this when he discusses the major turning points in his life, the first being the knee injury that meant he had to give up playing county football which he simply attributed to bad luck. The second turning point, his CLBP, he recognises as being a nightmare but he is able to quip how good he will be at chess in ten years time.

Harry and Colleen's account of Harry trying to use his walking stick on soft sand to enable him to climb into a boat on the beach literally had all three of us laughing out loud. The ability to find humour describing what was potentially a scary experience in a relatively formal interview situation would suggest that the ability to see the 'funny' side of things and laughter are present in their day to day lives. This is an important aspect of managing difficult situations and the ensuing emotions and thereby minimising depressive feelings (Martin and Lefcourt, 1983).

As previously described Don tried to inject humour, albeit in a more macabre vein into the interview with his reference to what would be written on Blackadder's gravestone:

> *"Here lies Edmund Blackadder and he's bloody annoyed" – well I feel bloody annoyed if I'm really honest.*

The humorous intent was lost however, the real anger and frustration that he so clearly felt took precedence. It should be remembered however, that the intent was to make light of the situation and introduce humour, while it may not have worked, it was at least attempted.

Sam's account of receiving accusatory, *filthy*, looks whilst shopping in the supermarket does suggest using humour as a coping strategy. His back pain at the time was so bad he was, *hobbling along*, literally having to use the trolley for support and his wife who was heavily pregnant was picking up all the items and putting them into the trolley. He felt people assumed he was just a chauvinist who would let his wife, although heavily pregnant undertake all the bending, lifting and carrying. A part of him wanted to explain the situation but the other part of him just found it amusing how people judge a situation. Sam explained how if you can't find humour in this type of situation you just become angry, while anger could be considered a normal response in these circumstances, it would have impacted negatively on both Sam and his wife. Sam's self-concept (Cooley, 1902) allowed him to interpret the negative reactions of others in a positive way, he was able to find humour in the situation despite his pain and the, *filthy,* looks he received (Martin and Lefcourt, 1983).

5.4 Summary

The themes discussed in this chapter relating to both the identity of men with CLBP and their management suggest the need for recognition and inclusion of their narratives into the future management of men with this condition.

There also remains the need for an alternative story that men with CLBP are able to tell. A story that is credible, socially acceptable and that will not diminish their masculine identity.

6. Conclusion

6.1 Introduction

This chapter considers the key findings of this research in the context of the relevant literature. Recommendations for the management of CLBP in clinical practice, in the light of the research findings, are provided. The limitations of this study are highlighted and recommendations for further research are detailed. Finally an individual perspective is offered in the form of my own personal reflections on undertaking this research study.

6.2 Overview

The aim of this biographical study was to explore the narratives of men living with CLBP in order to elucidate the impact of long term back pain on their individual lives and identities. The study aimed to illustrate how their stories could be employed as vehicles to enable them to have a better understanding of their lives and in doing so illustrate different ways of being that veer from the norm but are nonetheless legitimate. Furthermore these narratives may also help other men living with long term back pain to understand their own stories so that they can more effectively manage their lives.

Five men were recruited to this study with ages ranging from 31 - 77 years. The number of years they had experienced CLBP extended from 4.5 - 50 years with a mean severity over the period of their CLBP rated between 3 - 6.5 on the Visual Analogue Scale (VAS - see Chapter 3 – Methodology and Method). In-depth, audio-recorded interviews were undertaken and then transcribed verbatim. These were then analysed to identify common themes (Braun and Clarke, 2006; Riessman, 2006).

As evidenced in previous research studies, the identity of the all the participants in this research has been affected by CLBP (Charmaz, 1995b; Sparkes, 1996; Sparkes *et al.*, 2005; De Souza and Frank, 2011). The impact on their identity has been significant for the majority of the participants. Being defined by their CLBP was very evident in their narratives. As Charmaz (1994) suggests, the fact that their disability is visible or at least the physical manifestations of CLBP are visible, means the participants were ascribed first and foremost a disabled identity. Visible disability becomes the master identity as it defines every other identity which means that whatever identities were previously held, or sought, have been subsumed by this new and unwanted master identity (Charmaz, 1994). For example Don is no longer known as just, *Don but Don with a bad back*, and this irritates him. The constant reminder of the gap between his undesired self (Brown, 1998) and his possible self (Markus and Nurius, 1986) has resulted in negative emotions such as anger and frustration and a lowering of self-confidence.

The participants' narratives detail, in a variety of ways, frustration and anger over the inability of their body to perform as it should without pain (Sparkes, 1996). Firstly, living with a body that is perceived as significantly older than their chronological age gives these men the feeling that life is passing them by and they are prematurely aging. Don's frustration is evident when he explains that at forty six years of age he feels like a seventy year old, his body feels a lot older than he is. Secondarily, their fragility (in terms of pain) results in the need to formally calculate or risk assess the potential impact of any activity they want to undertake or are being prevented from undertaking by a significant other, for example Sam's wife. This makes them feel inadequate and undermines their masculine identity which in conjunction with the loss of spontaneity results in frustration and anger. Thirdly, frustration and anger are also apparent as a result of being constantly tired due to medication or being unable to sleep because of pain. Before developing back pain Adam never said that he felt tired whereas now he explained, *that's all I seem to say these days*. Finally, the ensuing financial concerns when unable to work were also a source of frustration and anger for Cyril. Cyril explained how when his back was bad it, *meant time off work and also it meant financial stringency.*

The inability to fulfil the hegemonic masculine role (Connell, 1995; Lack *et al.*, 2011) such as breadwinner and being physically capable, that support a traditional masculine identity, has further influenced the participant's identity. Don used the word, *impotent*, to capture his feelings associated with his inability to conform to the accepted masculine stereotype. Participants found themselves caught between their masculine and disabled identities and as such experienced embattled identities (Murphy 1990 in Gerschick and Miller, 1995). In an attempt to assert their masculinity Don, Sam and Adam would instigate overt risk taking behaviour to alleviate the constraints placed upon them. They were willing to risk undertaking dangerous activities (in terms of exacerbating their pain) and were prepared to suffer the consequences. This provides some understanding of the extent to which their CLBP has impacted on their identities and what they would be prepared to do to regain, albeit short-lived, those valued, previous identities.

Cyril and Sam detail how their inability to fulfil their masculine role (Lack *et al.*, 2011; Connell, 1995) for example as the breadwinner or to be able to undertake tasks that are perceived as within the masculine remit, led to them feeling that they were a burden or a liability to their families. This will further contribute to the embattled identities detailed above (Murphy 1990 in Gerschick and Miller, 1995).

Fatherhood was another key issue highlighted in their stories. The participants detailed their engendered feelings of guilt and inadequacy over their inability to engage physically with their children (De Souza and Frank, 2011). Don worried that his incapability to lift up his daughter for a hug resulted in her experiencing feelings of rejection. Interestingly for Sam his desire to be able to take on a full paternal role, to be able to actively play with a future (hoped for) child, provided the impetus to seek further help with his condition which ultimately resulted in him gaining control of his CLBP.

Concern over public identity is very evident in the younger participants (Don, Sam and Adam). The physical manifestations of CLBP and the side-effects of medication may be evident in how they appear facially or how they move which causes concern over how they will be perceived by others (Cooley, 1902) and more fundamentally that they are displaying weakness, which they regard as a flaw and as such are vulnerable (Sparkes, 1996). The participants reported that their private identities were altering as a result of their CLBP and also how they thought that others perceived them; their self-esteem was diminishing and insecurities were increasing. These changes caused Adam to undertake emotional labour (Hochschild, 1983; Huy, 1999; Bernardes and Lima, 2010) in an effort to retain his previous identity of being the, *life and soul of the party*. His increasing insecurity has made him labour in an attempt to appear outwardly (publicly) more confident. The long-term impact of CLBP also affected the older participants. Cyril explained how on meeting acquaintances they not only ask the usual, *how are you keeping,* they also enquire specifically, *how's your back?* This endorses the fact that his public identity is of a man with a bad back, he is labelled as a man with a bad back.

The contrast between the public and private identities of the participants was apparent and a cause of concern. The dichotomy between the two identities is illustrated by the Don and Adam's inability to assist when asked to help lift something and the requirement for them to publicly detail their physical incapacity. This admission once again impacts of their hegemonic masculinity (Lack *et al.*, 2011; Moynihan, 1998; Connell, 1995) and it reinforces their feelings of inadequacy and worthlessness.

However if they are looking physically fit and moving well the admission of being unable to perform a task because of back pain has the potential to lead to accusations of malingering. These issues ultimately create a vicious circle which further impacts on their confidence and self-esteem. The potential for negative consequences is evident in Adam's situation; he is obsessed with his appearance and works hard to present a valued public identity. His success in achieving that identity ultimately means he is more likely to be asked to help if something needs to be lifted or moved (he looks young and fit) which then requires him to divulge his true private identity.

Significant others have been fundamental to the participants in this study; the support they have provided has been crucial in allowing them to cope with the pain and associated disabilities. The problems caused by Harry's CLBP were seen by his wife as something that was jointly managed; it was a partnership and as such the problem was 'owned' by both of them. Recognition of how hard it would be to manage CLBP alone was evident which concurs with Charmaz's (1994) findings. Sam explained how, in addition to the support he received from his wife, both sets of parents have been very vigilant in preventing him undertaking any tasks that could pose a risk to his back. Both Cyril and Adam are aware of how supportive their wives have been and continue to be. Employers were also extremely understanding, this was especially evident for Sam and Adam. While this would be hoped for today, and is a requirement under employment legislation, it is not always evident in the working environment. Even Cyril, as one of the older participants, doesn't report being discriminated against because of his CLBP although he was concerned that it might be a problem. This is particularly interesting considering the traditional perception of employers in the construction and shipbuilding industries in the early 1960s (many didn't even provide sick pay) as evidenced by Cyril's repeated redundancies. Cyril never intimated that his redundancies were predicated on the fact that he had CLBP and as such required some quite considerable time off work. He did state however, that he would rather work for a company that allowed unions because of the protection you received as an employee. Union membership may have shielded him somewhat as a worker who often needed time off-sick because of his CLBP.

The classic sick role (Parsons, 1951) wasn't an option for these participants as they weren't going to be cured – this astounded and dismayed Don and also to some extent Sam. Rather, as particularly evidenced by Cyril, Sam and Adam, they have engaged in a partnership with health professionals where options have been discussed and negotiated and in doing so they have been empowered to take responsibility for their condition (Charmaz, 1999). Their narratives are not the usual restitution story rather they are more akin to the quest story, accepting of their CLBP and trying to make the best of the situation (Frank, 1995). Sam detailed how once he understood the issues through someone taking the time and explaining his condition (the educational component of his treatment), he was prepared to follow whatever was required (exercise and advice) to gain some control of his CLBP. Don is still hoping to access that type of support and education.

The use of exercise is recognised as crucial by all the participants in the management of their CLBP (Airaksinen *et al.*, 2006). The ability to access, understand and adhere to an appropriate exercise programme has been problematic and still remains that way for Don. Adherence to a prescribed exercise programme would appear to be, in part, contingent on an individual's understanding of both their problem and how exercise will be beneficial in managing that problem, as illustrated by Sam's story. Education therefore is the fundamental requirement for managing this type of condition (Savigny *et al.*, 2009; Waddell, 2004).

Resilience in the face of adversity (Fraser *et al.*, 1999) is evident in all of the participants' stories. For most there is an acceptance of their condition and a desire to undertake whatever is necessary to help them manage it more successfully. The resilience is furthered by the use of humour, which while it can be considered a coping strategy (Martin and Lefcourt, 1983; Chapple and Ziebland, 2004) also endows its proponents with a positive attitude. Adam provides a very good example of this type of attitude, speaking about his CLBP and how it has prevented him doing the activities he enjoys:

> *…the back, you know it's, it's a nightmare. I'll probably be amazing at chess in like ten years.*

The attempted use of humour by Don, who has yet to find an appropriate management approach for his CLBP, was ineffectual; it lacked the positivity, the underlying anger and frustration being very apparent.

6.2.1 Originality of the Research

This research has given voice to five men living with CLBP. By allowing them to tell their stories, new perspectives and dimensions of their lives and their condition have emerged. It is hoped that the narrative approach has been enabling for the men in this study by providing them an opportunity to reflect on their self-concept thus facilitating the formation of an alternative and yet credible identity that allows them to live with their CLBP in a positive manner rather than simply coping with their pain.

This is significant as CLBP will affect 84% of the population and have a considerable impact on the individual, their family and society (Walker, 2000; Maniadakis and Gray, 2000). Using a narrative approach as part of treatment give men a vehicle with which to express themselves that may be therapeutic in its own right by allowing them to legitimise their CLBP but also by offering the potential for an alternative narrative that is credible, not emasculating and ultimately offers hope.

Therefore, it is hoped that anyone reading this research, especially the health professionals treating individuals with CLBP will listen to the voices presented here and understand these men's perspectives. In doing so it is hoped that it will catalyse health professionals to not only hear but really listen to the voices of their own patients. Adopting this approach may help them gain insights into the lives of their patients so that the treatment they provide can be truly holistic.

6.2.2 Summary of the Key Points

Men become defined by their CLBP and this in conjunction with decreased physical capability, the need to risk assess any activity and tiredness brought on by medication or lack of sleep due to pain, causes them to become frustrated and angry. This is furthered by their inability to assume a traditional masculine identity (there is a dichotomy between their public and private identities) and a normal paternal role. The role of significant others was crucial in supporting the participants (Cooley, 1902).

In the management of the participants' CLBP the traditional sick role (Parsons, 1951) does not apply, neither does the restitution narrative (Frank, 1995). Education and exercise are seen as vital aspects of gaining control of the condition (Airaksinen *et al.*, 2006; Savigny *et al.*, 2009; Waddell, 2004).

6.3 Recommendations for Practice

The catalyst for this research was a statement in a study by Osborn & Smith (2006: 220). It was suggested that the:

> *…contradiction between the painful body and the preferred self could represent an important obstacle to therapeutic rehabilitation if not acknowledged or resolved.*

The findings of this research with regard to how CLBP has impacted on the identity of the participants supports Osborn & Smith's (2006) contention and highlights that the issue of self-concept and identity should be considered in more detail with this type of patient. Self-concept and identity could also be potentially included in the list of 'Yellow Flags' which are psychosocial factors that increase the risk of developing CLBP and the associated disability (Kendall *et al.*, 1997). CLBP and the associated disability will not be eradicated from society; men therefore need to be offered an alternative, masculine narrative that will allow them to retain a credible identity e.g. the tenacious and resilient man coping with pain and/or disability while still functioning in society. This may be facilitated by using narrative as a therapeutic tool so that people are treated holistically rather than as a set of symptoms.

The findings of this study also concur with recent guidelines from the National Institute for Health and Clinical Excellence (NIHCE) (Savigny *et al.*, 2009) and the European Guidelines for the Management of Chronic Non-Specific Low Back Pain (Airaksinen *et al.*, 2006) that suggest that both exercise and education are important in the management of individuals with back pain. As is evident with Sam's story his adherence to a programme of exercise and advice only occurred after he understood the problem and realised he had no other options. It would therefore, seem to be of paramount importance to consider the holistic picture of an individual with CLBP, to establish through a multidisciplinary team the options available and then to instigate patient education and a tailored management approach as soon as possible.

6.4 Limitations to the Research

The primary limitation to this research lies in the fact that the findings are based on the interpretation of the author. Any biographical study however, brings with it a degree of researcher bias. I am aware of the need to position myself within the research and recognise that as a white, middle class, male physiotherapy lecturer with an interest in back pain I am likely to have certain biases. However, as I have indicated in this thesis, I have done all I can to overcome any bias I may have. While this individual bias may be seen as a limitation, it has enabled me to understand the lived experiences of my participants and hopefully others who I will see in the future. In better understanding these individuals, it is hoped that I can help others to more effectively manage their CLBP.

As with all qualitative research, the results of this study are not necessarily generalisable to a broad population. Rather the purpose is to provide a detailed explanatory premise which will allow inferences to be drawn from one setting to another (Pope and Mays, 2006). While it is hoped that sufficient detail has been provided in this thesis, it is reasonable to assume that there are some aspects that could have been developed further.

6.5 Recommendations for Future Research

The logical development from this research is to undertake a similar study of women. The literature suggests that women's reactions to illness often differ to men's (Charmaz, 1994; Charmaz, 1999; Charmaz, 1995a) however, recent research that considers how men and women with chronic pain appear to others, would suggest some similarities (Bernardes and Lima, 2010). Whatever the similarities are however, understanding the impact of CLBP on the self-concept and identity of women could provide information that would assist in a greater understanding of how appropriate rehabilitation can be designed and implemented in the future for everyone.

Another opportunity for further research was suggested by one of the participants in this study. Their suggestion was to interview the man's significant others rather than asking the man with CLBP questions about themselves and how they felt others perceived them. Gathering the insight of wives, partners and others close to men with CLBP would provide a different perspective and illuminate the issue from a broader and more holistic stance. Designing a study that sought the opinion of both the person with the CLBP and their significant others would allow the opportunity for the information gained to be compared and contrasted. The ability to consider both the man's subjective view and the significant other's objective perception could be extremely valuable.

6.6 Reflections

This research project has allowed me to hear the detailed stories of five men who have lived with CLBP for between 4.5 and 50 years. Having initially heard and audio-recorded those stories, I have heard them repeatedly and analysed them both for their content and in relation to the pertinent literature. This has provided me with a depth and understanding never previously attained as a practicing clinician. During a consultation you do ask the patient to tell their story, to provide a subjective overview of the problem but during this process you are trying to formulate a potential diagnosis which you can then test out during your objective assessment that is generally based on a medical model of health. As such you focus on the specific relevant detail rather than the holistic picture. The time pressures in clinical practice mean that you need to ignore extraneous detail because you are trained to focus on key issues but in doing so you lose significant detail and a depth of understanding that I had not fully realised prior to engaging in this research project. So when I say I have heard the participants' stories, I mean really heard them, thought about them, examined them in detail and tried to interpret them. I have had the opportunity to experience really hearing a story in a way that I have never experienced before.

From a professional perspective, I now realise just how important it is to really listen to a patient's story and to consider it holistically. Patients with CLBP are not candidates for the 'quick fix'; they need to develop a relationship with the health professional and to trust that person. Only then will the health professional be able to really understand the patient's situation and be in a position to consider what is best for them. From the perspective of the patient, a trusting relationship will allow their identity to be legitimised and this will mean they are more likely to be open to any advice and education offered. It is hoped that, as in Sam's case, through education and having a better understanding their condition, they will subsequently adhere to any specific advice given or exercise prescribed. I think this study has encouraged me to slow down in my interactions with people, to really listen to what is being said both verbally and non-verbally through gesture, hesitancy and humour. While I consider that I already know and understand the need for reflection in my working practice, I feel that as a result of the process of undertaking this study I have come to a more profound appreciation of the value of reflection. I hope that through really listening to and reflecting on what is said to me, I can become a more perceptive and thoughtful individual who subsequently has more to offer patients, students and colleagues.

While I am tired and at times frustrated with having to 'tie up' the final 'loose ends' of this study, I do find that I am facing a dichotomy, relief that it is finally coming to an end but wondering how I will function without Cyril, Adam and the other participants in my daily world. I have found myself absorbed not only by my participants but by the whole process, particularly the biographical, narrative approach. I wonder if I have the energy to undertake another challenge but the outcomes from this study as well as specific suggestions from participants are already pushing me in that direction. We need to understand this whole concept of identity in CLBP much better, we need to offer alternative, credible identities but how and where will these be found? Perhaps the first hurdle is to get this research published, listen to the feedback and suggestions as to where it should go next and then possibly think about another study…I really can't believe I am writing this.

6.7 Summary

The specific ways in which the identity of the participants in this study has been altered are various and include, feeling defined by their CLBP, experiencing uncharacteristic feelings of anger and frustration, a threat to their masculinity and their ability to fully engage with fatherhood. Issues of both their public and private identities, feelings of being a burden or liability and the impact on their physicality were also evident.

The support received from significant others (family and employers) was very apparent and of great benefit to the participants in managing their day to day lives. The narratives of the participants were essentially quest narratives (Frank, 1995). The majority of men in this study found different ways to accept their situation and even though they begrudge what has happened to them they have to some extent sought ways to understand their condition and learn how best to manage their lives. Self-management through education and exercise were also very evident in the participants' stories and these factors have helped them come to terms with their CLBP and lead a more productive life. These approaches were not always available or successful for everyone and the resilience of the participants along with their use of humour to help moderate difficult circumstances, were also apparent in their stories. The narratives of these men have been relayed in the hope that they can be used to help others with this condition and ultimately allow a credible, masculine identity to be established for those who have CLBP.

Appendices

Appendix 1	Recruitment Pack
Appendix 2	Consent Form
Appendix 3	Coded Transcript
Appendix 4	Ethics Permission
Appendix 5	Interview Schedule

Appendix 1

Recruitment Letter

Dear Sir

My name is Julian Pearce; I am a Lecturer in Physiotherapy at the University of Southampton. I am undertaking a research project that is looking at how chronic low back pain affects men; specifically does it change how you see yourself?

I need to recruit men with chronic low back pain who are willing to be interviewed. The interview will take place at a convenient location for you (at your home, work or the University); it will last about an hour and will be audio recorded.

Please find enclosed a Participant Information Sheet with further details.

If you are willing to be involved or have any questions regarding this project, please contact me on:

Telephone 02380 595304

Email jmp6@soton.ac.uk

Or alternatively please complete the enclosed sheet and return it to me in the stamped addressed envelope (also enclosed) and I will be in touch.

Thank you for taking the time to read this letter.

Yours Faithfully

Julian M. Pearce

Appendix1

Participant Information Sheet

Study Title: A biographical study of men with chronic low back pain.

Researcher: Julian Pearce

Ethics number: RGO Ref: 7696

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

The research I am undertaking is part of my Doctorate in Education but is also clinically relevant due to the nature of my post as a Lecturer in Physiotherapy at the University of Southampton. The research will examine the identity of men who have chronic low back pain and consider if their back pain impacts on their identity as men. Understanding this subject area and addressing it is thought to be important if those with back pain are going to receive optimal treatment.

Why have I been chosen?

You have been invited to take part in this study because you fulfil the inclusion criteria of being male and having back pain.

What will happen to me if I take part?

On receipt of this letter you can choose whether to take part in this study. If you are prepared to be involved please can you let me know either by:

- filling in the attached slip and posting it to me in the stamped addressed envelope
- emailing
- telephoning

I will then contact you and arrange a mutually convenient time and location (this could be at your home or at the University of Southampton) to meet with you and interview you. With your permission the interview will be audio recorded. The interview will take no longer than two hours. The plan would be to meet only once.

Are there any benefits in my taking part?

Although it is unlikely that there will be any direct benefit to you, the information you provide will, it is hoped, mean that we are able to treat those with back pain more effectively in the future.

Are there any risks involved?

The interview will be focused on how your back pain has affected your identity as a man and will ask questions that will take you back in time. Remembering and discussing these aspects of your life could possibly be upsetting; should this be the case, I will pause the interview and explain that you can end the interview now and if you so chose recommence at another time. I will also provide details of BackCare’s helpline and you may, if you wish, make contact.

Will my participation be confidential?

Please be assured that this study will fully comply with the Data Protection Act and the University�much s data protection policy. Information received about you will be coded so that you are not personally identifiable and stored on a password protected computer that only I have access to. All personal information will remain confidential and ultimately be destroyed.

What happens if I change my mind?

Please be assured that you have the right to withdraw at any time without giving any reason and without any consequence from this study.

What happens if something goes wrong?

In the unlikely case of concern or complaint please contact:

Professor Melanie Nind
Chair of Ethics Committee
School of Education
University of Southampton. SO17 1BJ

Where can I get more information?

Should you have any questions following your reading of this letter/information sheet please feel free to contact me, Julian Pearce at:

Faculty of Health Sciences
Building 45
University of Southampton
Highfield
Southampton
SO17 1BJ

Telephone - 02380 595304

Email - jmp6@soton.ac.uk

Should you wish to know more about the overall findings of the study you may request an executive summary when you complete the Consent Form.

Thank you for taking the time to read this letter and information sheet.

Acceptance Slip

A biographical study of men with chronic low back pain.

☐ I am willing to be interviewed for this research project

Name………………………………………………………………………………….

Signature…………………………………………………………………………

Date……………………………………………………………………………………….

The best way to contact me is:

Telephone ☐ Number……………………………………

Email ☐ Address……………………………………

Letter ☐ Address……………………………………

……………………………………………………

………………………………………….……………………………………………….

……………………………………………………………………………………………………

Thank you for your willingness to be involved in this project, I look forward to meeting you in the near future.

Best wishes

Julian M. Pearce

Appendix 2

CONSENT FORM (Version 5)

Study title: A biographical study of men with chronic low back pain.

Researcher name: Julian Pearce
Study reference:
Ethics reference: RGO 7696

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (8 June 2011, version number 8) and have had the opportunity to ask questions about the study	☐
I agree to take part in this research project and agree for my data to be used for the purpose of this study	☐
I understand my participation is voluntary and I may withdraw at any time without consequence	☐
I understand that the information I provide, having been anonymised, may be used in reports/books/articles/presentations	☐

Name of participant (print name)………………………………………………………

Signature of participant…………………………………………………………..

Name of Researcher (print name) ……………………………………………………

Signature of Researcher……………………………………………………………..

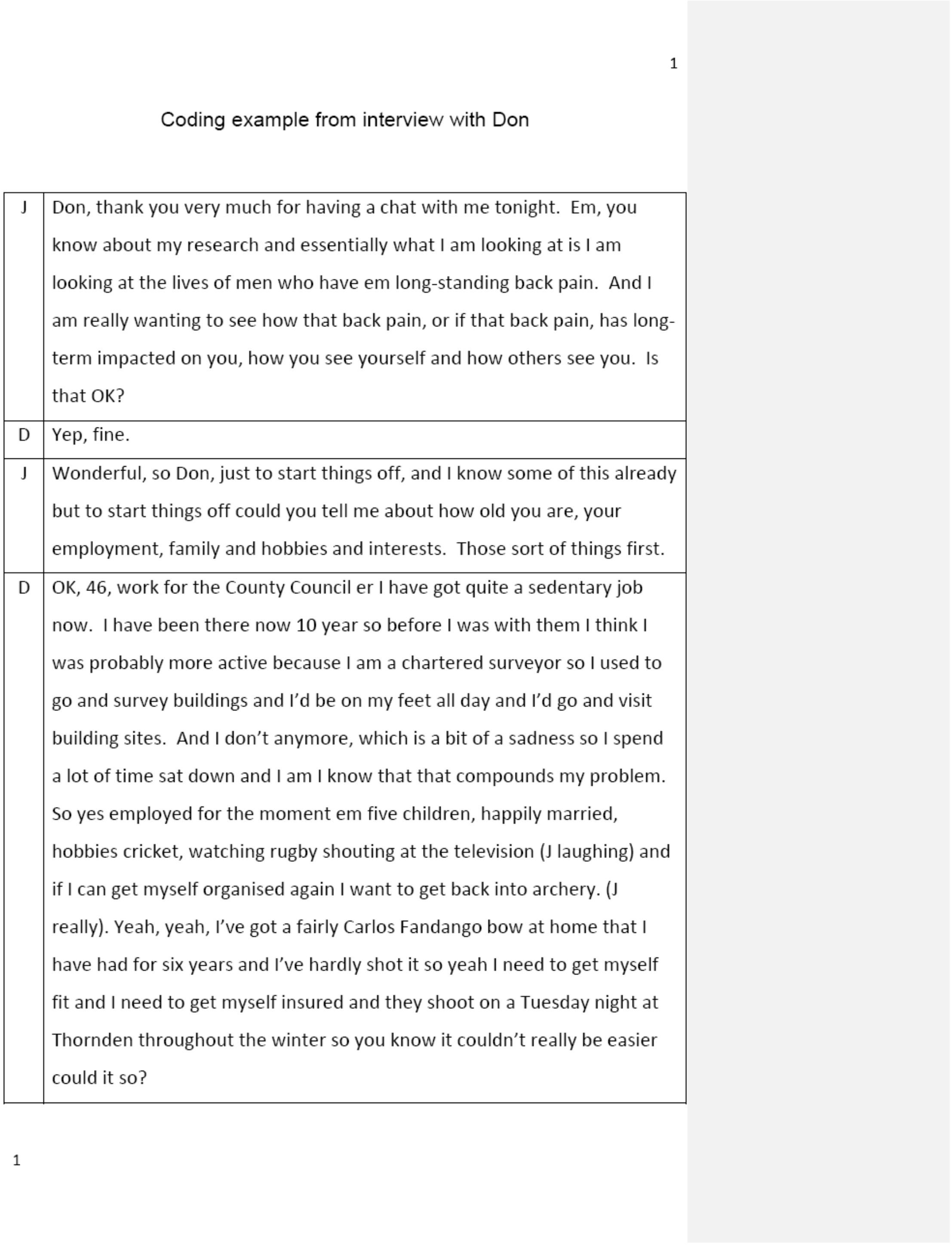
Date…………………………………………………………………………………

Please initial this box if you would like to receive an executive summary of the research findings. ☐

Please indicate over an address (postal or email) where you would like to receive this summary.

Address – Postal or email

Appendix 3



1

Coding example from interview with Don

J	Don, thank you very much for having a chat with me tonight. Em, you know about my research and essentially what I am looking at is I am looking at the lives of men who have em long-standing back pain. And I am really wanting to see how that back pain, or if that back pain, has long-term impacted on you, how you see yourself and how others see you. Is that OK?
D	Yep, fine.
J	Wonderful, so Don, just to start things off, and I know some of this already but to start things off could you tell me about how old you are, your employment, family and hobbies and interests. Those sort of things first.
D	OK, 46, work for the County Council er I have got quite a sedentary job now. I have been there now 10 year so before I was with them I think I was probably more active because I am a chartered surveyor so I used to go and survey buildings and I'd be on my feet all day and I'd go and visit building sites. And I don't anymore, which is a bit of a sadness so I spend a lot of time sat down and I am I know that that compounds my problem. So yes employed for the moment em five children, happily married, hobbies cricket, watching rugby shouting at the television (J laughing) and if I can get myself organised again I want to get back into archery. (J really). Yeah, yeah, I've got a fairly Carlos Fandango bow at home that I have had for six years and I've hardly shot it so yeah I need to get myself fit and I need to get myself insured and they shoot on a Tuesday night at Thornden throughout the winter so you know it couldn't really be easier could it so?

1

J	Well I hope you make it in, that sounds good, um Don, how old were you when your back pain started?
D	24
J	That's very clear, obviously is it clear in your mind?
D	Yeah, yeah no I mean I'd kind of moved, I'd moved jobs, it was about the time I qualified so it was you know it was all around that sort of time. And I was playing hockey at the time and and that didn't help I don't think. So em yes I was 24 (J right) first incident which had nothing to do with work, nothing to do with hockey except it was a hockey acquaintance shall we say. So yes I had someone sat on my lap and then my back went into spasm, (JP wow) Yeah (JP OK).
J	Um, Don em a very tricky question but if we look at the culmination of the years that you have had your back pain and we look at trying to understand how to quantify that back pain and if we think of of a scale of a ten point scale where at one end you've got nought and that's no pain and at the other end you've got 10 and it's the worst pain imaginable, averaging out over the years where would you rank your pain?
D	That's always a hard question to answer erm there have been times when it has been 10, umm but thankfully not very often. Err there are times when there is probably, probably no pain at all, though I'm, every time I think oh my back's good I can't feel anything, within an hour it could be playing up so, erm I don't know 3.
J	Thank you. Right so em thanks for that Don. Now what I want to just move on to em a little bit is can you talk to me about, about your life before you had back pain Don?
D	Erm in what regard
J	I suppose what I am interested in is is how would you have defined

	yourself, who was Don before you had back pain? 4:11
D	Fit, active, you know felt indestructible, wasn't particularly (J said we all do at that age mate) (both laughing) yeah, wasn't you know wasn't working out or into fitness at all. I used to play a reasonable amount of hockey. Oh I suppose you know you just sort of rock up and you'd play and you'd go home and it was never a problem. Umm and that you know it's not the case now. So err yeah
J	And so if we stopped to think about your back pain, I suppose what I am really interested in is, is how that has, since it started how's your life been different. How's your life been affected really?
D	Umm, well I said this to you before I, there have been times when I've very much felt that I've been defined by my back pain or defined by my back. I don't know that I call it an injury but it probably is an injury. Doesn't feel like an injury because it is not a visible injury if that makes sense.
J	No, it does make sense.
D	It's not like a cut (J said No) and I can't see it so, umm so yeah well you know Don's bad back and 'don't carry that you might hurt your back' and you know just yesterday simple stuff you know bringing daughter home from University. Got a 20 year old girl saying don't carry that Dad you might hurt yourself and you're thinking 'I'm 46' you know. So it's, you kind of, you do lose a bit of your identity as a male because you kind of, sort of, the whole sort of male sort of identity, particularly you know husband, father, provider and you know we move bits of furniture around the house and its my wife and my eldest son and you feel impotent is possibly about the closest word I can think about in terms of, perhaps in those sorts of circumstances you know. So yeah it's a, it's a bit of a umm,

Comment [CS1]: Defined by CLBP

	it's a bit of a pain in that regard. And you're not, you know I have to think about whether I can do that or not. I have to think about whether I'm, you know in a good phase or whether I am in a not so good phase. Erm, and I have to sort of engage my sensible head whereas you know when you are 24 you just did it didn't you, because you felt like doing it. You, if someone said "oh we are go on, we're gonna go Go-Carting" or something like that you just did it whereas now, I might think, I am not sure that is such a good idea, so I might not go. So, there are definitely times when feel like I am a 70 year old – you know, lot of times when I feel that I am a lot older, my body's a lot older than I am, which I don't like very much.
J	Thank you Don. I just want to stop it there a sec. 7:42 BREAK Don, can I just take you back to something you were saying just now which I thought was particularly interesting. You talked about the fact, you know you are trying, in your head, to work out umm, whether it was an injury or was a back problem and I suppose I was just quite interested in the fact that you know you're saying you cut your arm, you know you can see, you can't see it I can't see it, do you feel in some way that if you could see it that would would make a difference?
D	I don, I don't know its just that, I suppose it's, you feel it when your backs bad and everyone that knows you, because by that by that time I've been working with the same colleagues for, some of them, for ten years probably. So they know that if you're walking as if you're in the 'ministry of funny walks' the chances are you've done your back in but you can't see it unless you look in the mirror. So, it's an in, it feels internal but it's, at times, it's so obviously external.
J	And does that, is that a negative point about it, do you wish that didn't I

Comment [CS2]:
Masculinity

Comment [CS3]:
Physicality
+ Risk Assessment

Comment [CS4]:
Defined by CLBP
+ Public Identity

	mean, in terms of you've got pain, do you wish it was something only you were aware of or in some way does it, is it useful, does it legitimise possibly in some way, that other people are, you know able to see that you have pain? 1:46
D	I don't know that other people seeing that I've got pain is helpful. (J said Right) Umm, I think for people you don't know very well you'd like to keep your persona, to yourself and therefore very outwardly you've got a problem. Umm to people you do know very well, you probably don't want to let on that, you know you've got a bit of a problem. I would much rather say to someone "Oh my back's giving me a bit of grief today" rather than them saying "Gor your back's giving you grief today." Em, I suppose it might legitimise it because if they see you walking round like a 70 year old man erm, it legitimises but it doesn't help because you still want to do the things that you want to do at any given time and say you've got your body sometimes telling you can't do it and then you've also got people around you saying well you really shouldn't be doing that and, yeah I mean it's, it's a bit, I mean it, it's so obvious I suppose that your showing a weakness and I don't know that I'm necessarily one of these that is you know, a 'rufty tufty' type I do wear my heart on my sleeve and people know that but you know I wear my heart on my sleeve I don't need people to see I've got a bad back as well. Umm, so no it's, I think the hesitation that's coming out is that the overriding emotion is one of absolute frustration that after 20 odd years I've still got this problem. It's a lot better now than it was but I'm having to try and seek the solutions for that. I haven't had any help really from the medical profession. Umm and even the guy, even the people that I've paid to see, there's just such a conflict of information and I don't work in the National Health Service so I

Comment [CS5]:
Defined by CLBP
+ Public Identity
+ Visibility
+ Masculinity

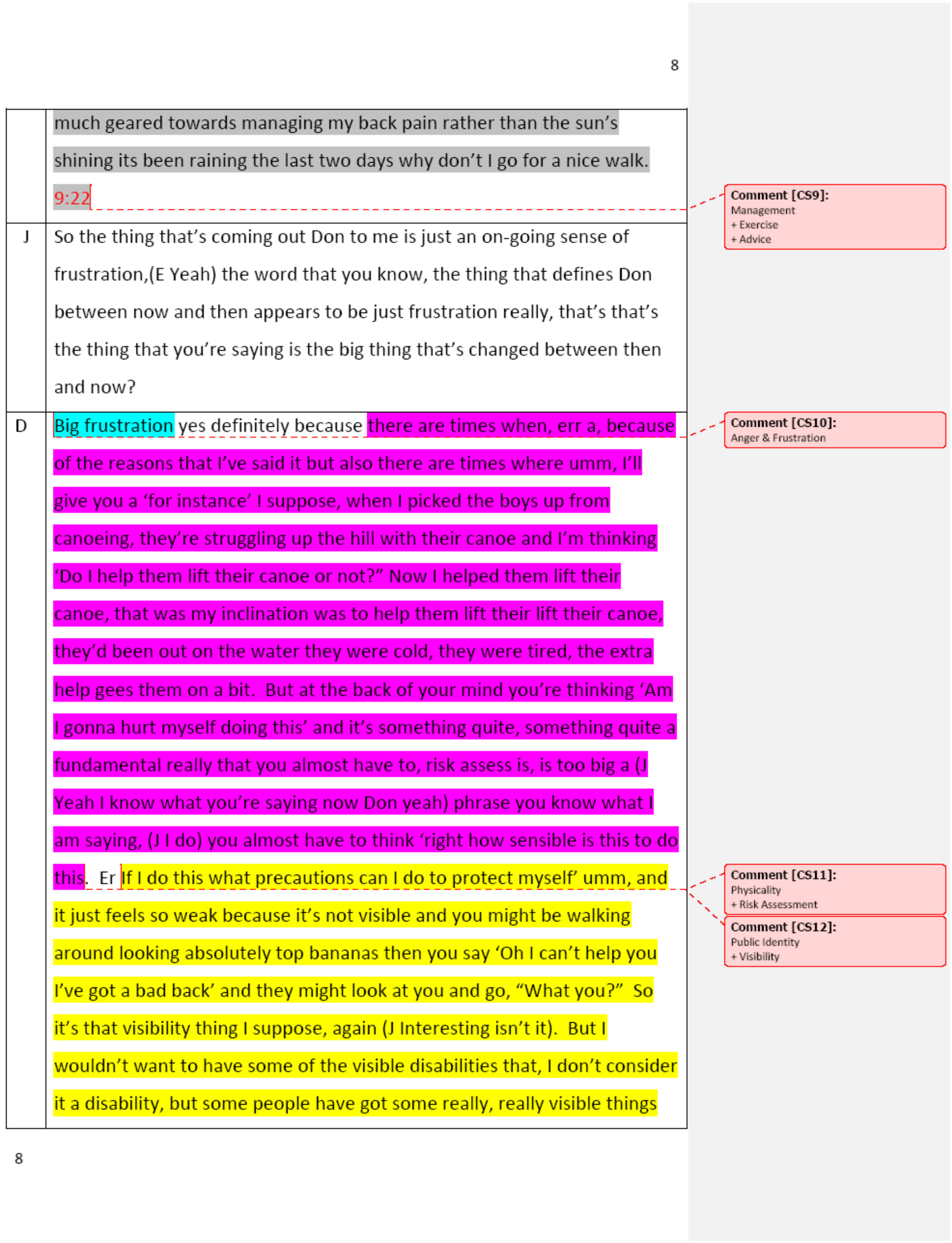
Comment [CS6]:
Anger & frustration

	don't know but I kind of got the impression that the last time I went to see someone in the National Health Service and I understand that the gentleman concerned is now no longer there, erm it was almost an inconvenience, you know we'll pump you full of drugs, we'll try and give you one of these (E said thank you) we'll give you an epidural, what are the dangers, well it could kill you, well you know genuinely I was quite concerned because I didn't want a huge needle shoved up my back thank you very much, it should make things work, better, it made absolutely not a jot of difference as far as I could tell, nothing I can do for you, just shoved, get shoved off to the pain relief clinic, well that wasn't what I wanted to hear at 42. I think I was 42, I might have been 41 but that wasn't what I wanted to hear and I kind of felt that there were no options for me. I've, I've, as I've got older and as I've got to know other people who have got back problems, if you speak to anyone whose got a bad back, they'll all tell you, a long-term bad back problem, they'll all tell you, I've got a bad back and its about management of it. But you kind of want a bit of hope, you know where you could do this and you could do that and it will help you manage it better and it will keep you away from the surgeon's knife and it will keep you away from having to pump chemicals in and you know, you can then protect, protect it and to all intents and purposes, you know, be a bit careful and actually you'll probably be fine. The problem is, that whenever I've had good times I've felt indestructible and 24 again. The last two or three years I don't think that's happened quite so much any more.
J	Right, Don so if we go back to the whole idea of 24 again and obviously that 24 is that, is that, is that, that point when you had the first incident of your back pain, how, how, how are you different now from that person

Comment [CS7]:
Management
+ Exercise
+ Education

	who was, you were before? 6:39
D	Well I think I thought they were going to fix it but I think I thought they did fix it. Umm but it having been unfixed so many times in the intervening years, you then get to the point where you think no one's going to fix this and, and you know the last you know, I definitely don't want an operation and I know I'm nowhere near one of those but you know someone with a big sharp knife scares the living daylights out of me. And I don't want to be in a situation where I'm, you know I can go and have a massive injection because I, so you've got 22 years worth of frustration actually. Fundamentally there's a heck of a lot of frustration there that I've not somehow been able to shake this off and I guess, this is kind of the first time I've thought about it, I guess when you look at people who've got terminal illnesses, I'm not suggesting this is terminal illness, but for some people who've got an illness for which there is no cure, I'm lucky I'm not, its not terminal my problem but for people who've got an illness for which there is no cure there must be one heck of a sense of frustration that they cannot fight this off and that their body cannot repair itself. And you very much, you know from most of us, from nought right the way through our twenties and thirties you just take it for granted you get a sore throat, couple of tablets, you're better, you break an arm someone puts it in a cast, you're better, erm, as you get older, you then get these things that perhaps don't repair themselves and I think that is where I am now you know I just have to, I have to erm, think about it and manage it. I mean today, I was in the car for some time this week-end, so I was on my Polystyrene roller this morning and I went for a thirty minute walk this afternoon you know and, it was a nice walk and I had my ipod in and all the rest of it and it probably did me the world of good but that was very

Comment [CS8]: Anger & Frustration



8

	much geared towards managing my back pain rather than the sun's shining its been raining the last two days why don't I go for a nice walk. 9:22
J	So the thing that's coming out Don to me is just an on-going sense of frustration,(E Yeah) the word that you know, the thing that defines Don between now and then appears to be just frustration really, that's that's the thing that you're saying is the big thing that's changed between then and now?
D	Big frustration yes definitely because there are times when, err a, because of the reasons that I've said it but also there are times where umm, I'll give you a 'for instance' I suppose, when I picked the boys up from canoeing, they're struggling up the hill with their canoe and I'm thinking 'Do I help them lift their canoe or not?" Now I helped them lift their canoe, that was my inclination was to help them lift their lift their canoe, they'd been out on the water they were cold, they were tired, the extra help gees them on a bit. But at the back of your mind you're thinking 'Am I gonna hurt myself doing this' and it's something quite, something quite a fundamental really that you almost have to, risk assess is, is too big a (J Yeah I know what you're saying now Don yeah) phrase you know what I am saying, (J I do) you almost have to think 'right how sensible is this to do this. Er If I do this what precautions can I do to protect myself' umm, and it just feels so weak because it's not visible and you might be walking around looking absolutely top bananas then you say 'Oh I can't help you I've got a bad back' and they might look at you and go, "What you?" So it's that visibility thing I suppose, again (J Interesting isn't it). But I wouldn't want to have some of the visible disabilities that, I don't consider it a disability, but some people have got some really, really visible things

8

Comment [CS9]: Management
+ Exercise
+ Advice

Comment [CS10]: Anger & Frustration

Comment [CS11]: Physicality
+ Risk Assessment

Comment [CS12]: Public Identity
+ Visibility

	and you think 'crickey, that's quite hard cos that's how I feel when I'm in back pain' you don't actually, when you're in real pain and your body's distorted and you are so obviously walking in an odd way, you don't want it to be that visible for everybody to see, because perhaps they don't see you for who you are, don't know. 11:51
J	So taking that on Don, you know, we've talked a little bit the work place, has it impacted on your work life?
D	Erm yes I think it probably has, umm I had a bit of 'teddies out of the pram' moment today where I sort of said you know 'ten years ago you told me I'd got to block my desk up, now you're telling me I can sit anyway, I'm putting you on notice that if I do sit anywhere my back condition might get worse.' I did get a big stroppy but I was feeling a bit grumpy this morning but yeah I think it has you know, I also feel and I've not tested it, that if I went for a job I'd have to declare that I've got a long-term back problem erm, and that, that might prevent me doing a more active surveying job or a more active job looking round a building site and certainly climbing scaffold with back, backache isn't particularly great umm, you know I'd even had to consider the type of car we've bought 'for crying in a bucket'. You know I, I go into a show room and I say someone "You would like this car sir, its got you know, it's a Ferrari!" Yes but can I sit my bottom on the seat, get my head above the arch of the door and swing my legs round and if I can't do that then there is no point going any further but you know its something that fundamental that even, you know choosing a car, when I've been at my worst, I have struggled to get into the car.
J	I don't want to put words in your mouth Don but are we back to that whole business of being defined?

Comment [CS13]: Defined by CLBP
+ Public Identity

D	Yeah, I think so. That whole business that actually you know I'm 46 I don't want to grow up, it's time I had my 2 door sports car (J mid-life crisis Don? Both laughing) Yeah, I'm right in there and I know full well that actually mine would be, you know rather than a Golf GTI, it would be a Golf Plus GTI because I've got more head room (J laughing).
J	Erm Don, Don just in thinking about your personal life and I don't mean you know, I don't mean anything particularly personal, I mean just your life with your wife and your children, your family and friends, your hobbies and pastimes, that sort of broad picture. Back pain and has, how has that, has that impacted on that?
D	Yeah definitely, erm, it's actually impacted quite dramatically I think on my fourth child, because when she was born I think I was in quite a good phase. When she was about two, I was probably not in a great phase and toddlers like being picked and it nearly broke, you know, broke my heart that she wanted to be cuddled with her head up on my shoulders, you know her head sort of nuzzled into your neck as they do and 'Daddy can't lift you darling he's got a bad back'. And yeah it affected her and it affected me. We've got over it the pair of us, she's now eight and when she stands on a kitchen chair I can give here a really good hug and she can nuzzle her head in but when she was two and three you know she commented on it and erm, I'm not convinced, not absolutely certain but I think she felt a sense of rejection.
J	That must be very hard Don.
D	Yeah I mean I've tried to convince her (J I am sure you have) Yeah but I think she was very much and she still is 'Can I have a hug?' And I don't know whether she is thinking well now I'm eight and if I stand on the kitchen chair he can give me a proper hug and I'm making up for when I

Comment [CS14]: Defined by CLBP

Comment [CS15]: Fatherhood
+ Guilt

Comment [CS16]: Fatherhood

was two and he had a bad back and he couldn't but, I think she was fourth child particularly when the fifth one came on and it was 'nose out of joint' slightly anyway, I, I think she did feel a slight you know, Mummy couldn't be with her cos Mummy was feeding the baby, Daddy couldn't pick her up because he had a bad back. So yeah I think there was a little bit of that, so yeah I think there was an impact there. Umm, I don't think I've given my wife any fireman's carries anywhere, (J laughing) I think I just about managed to carry her over the threshold when we got married but you know that was one of those sort of risk assessment things you know, let me break it to you gently darling, I've got a bad back, you've married me, I am a bit of a dodgy 'bit of kit' or or do I tell you that umm, I think you're a little bit large for me to, you know so, yeah I think, I think there have been, at the risk of waffling I think there are people around me that love me and I count some friends amongst that, that make some sort of compensatory adjustment because I've got a bad back and they know I've got a bad back. And it doesn't quite feel the same as being loved because you haven't got a bad back if you know what I mean, you kinda of, I don't want people to stop cos you know then I'd feel a right, a right 'Billy' but you know, do you know what I mean, there are, you know that there are people around you, you know my wife, my children, my mother, my mother-in-law to a degree, they're all making slight compensatory adjustments and perhaps, maybe its a good thing, perhaps not making the same sort of demands is the wrong word but (J No I think I know what you're saying) you know. So I think that, I think it would be quite interesting after you've done this research to do some research with the partners of the ones that had the backache to kinda of see what impact its had on their life because I do think it goes beyond, and I don't think its

Comment [CS17]: Masculinity

Comment [CS18]: Significant Others

	major but if you're sharing a life with someone, I am not even going to say significant but, it's there. 18:49
J	That, that compensation mechanism Don that you talk about with those that love you, you seem a little bit, not clear in your mind as to whether you're happy about that or not happy about that?
D	Yeah I don't know that, I don't know how I could sort of describe that any more or not but I, I sense you're, you know, from my perspective you're asking things of other people and it, it's kind of a linked back to this sort of the frustration thing again you know if I didn't have this problem you wouldn't have to make those compensatory (J said got it) sort of adjustments ??things?? So its kind of (J Yeah) you know. (J got it, I think so).
J	Don, what about sports, hobbies, pastimes?
D	Well I wouldn't (J cos you do it don't you?) yeah, well I wouldn't read a book out of preference, and I love cricket but I've even made, there're even compensating mechanisms when I play cricket now. I've got a joke going with a guy in the pub last week. He's an alcoholic, I've got a bad back and both of us field by falling over and getting in the way. Neither of us can bend down, cos he probably can't see the bloody thing and I can't bend down, by the time I've bent down, its shot past me (J and V laughing)!! So I have to sort of fall over and I've got a little bit rounder I look a little bit like a weeble going over. So um, you know that's um, there's a, there's always a little bit of a, I'm looking forward to playing cricket on such and such a date, will my back be OK, I've got to the day before, I've got to the day, is my back OK, I've got a slight twinge you know I wear a corset which isn't necessarily particularly flattering, umm, I would much rather be fit or fitter and not be quite so obviously, you know

Comment [CS19]: Anger & Frustration
+ Significant Others

	crook but thankfully they are all my age so if they haven't got a problem now they soon will have. 21:17
J	Don, is there is there umm, is there a side of you where, let's take cricket as an example, where it is so important to you to play cricket that you have or in the past or would say, you know, sod it. I *am gonna play cricket, my back's gonna be a killer tomorrow but I've just got to go and play cricket?*
D	I'm at that now and we've talked about this before and actually its the mental side of the sporting activity that keeps, keeps me going and I am in with a group of guys that, they are just such fun, umm, and I just, you know, I love em all to bits they're all different but they're just, we are very, very lucky that we have a group of us that are so supportive and we all play for the same reasons and that is because, its not because we are gonna play for England because that's been long gone, it's not even because we wanna play that competitively, we kind of want to, I think secretly, we'd like to engineer it so that we'd always, the game would always been resolved off the penultimate or the last ball of the game because it's always nice to have a game where there's, there's always something to play for and it's, perhaps it is a bit of a tease, but you think 'cor will we, won't we, well its a good game it doesn't matter whether we win or lose but let's see if we can win (whispering not clear). And they are just such good fun. And I think if that, if someone sort of said to me tomorrow 'that's it you can't play cricket any more', I'd probably ??be going for??? an umpire to, for them, to be honest because, cos I'd still be in the game. Erm maybe that's a better option.
J	Not yet Don, it's too important (Don said Yeah). So would you, would you play and suffer the consequences to be able to play? (E I have done) but

Comment [CS20]:
Public Identity
+ Visibility
+ Humour

Comment [CS21]:
Significant Others
+ Generalised Others
+ Masculinity

	would you, you wou, and would you do it again? (E Yeah) Yeah I thought you would. 23:21
D	Yeah, (JP OK) no I, in fact the first Pilgrim's game we played together, I opened the batting with a bad back and I'd retired because my back was getting a bit sore. (JP Hmm) And also I wanted a 'not out' and a higher average but you know, but in, in you know, yeah I, I would play and, and, and suffer the consequences.
J	Hmm, Don umm, I mean, what I am interested in is umm, to ask a little bit about 'turning point' experiences – so I suppose turning point experiences or epiphanies, it's almost as like, umm, you know essentially something happens and you make that realisation 'Wow', my life from now on is going to be different, I'm gonna view that in a different way, you know it's like major, major turning points in your life. With regards to your back pain have you experienced those?
D	Erm, possibly. And when I've tried alternative medicines with my back pain, I tried acupuncture, which I don't know whether you've tried it but it's, it's not a particularly pleasant experience while someone sort of puts fifty old needles in various parts of your bottom, your upper thigh and your back and, and your head. Umm, so yes I've, i've. I've gone to the extremes of you know, ten years ago if you said "oh do you fancy acupuncture" I'd have said "No way, don't fancy needles full stop." Umm, I think the guy I'm seeing now probably has really helped me keep into context because he wasn't particularly flattering when he looked at it, first off. He's French which probably helps cos of the comedic value. Erm, he doesn't play cricket which makes that conversation quite an interesting one. And, I think he's helped me get it into a better state of repair but I think I am now at a point where I need to, I could carry on seeing him

Comment [CS22]: Masculinity

	every six weeks and shelling out my 36 quid or whatever it is. I'm convinced in my own mind, I need to, err come under, some err, instruction, some 'one to one' instruction in terms of the things I can do and can't do more. The things I can do to help myself and the things that I really mustn't do to actually sort out the stomach and the back muscles and the leg muscles to actually get myself into a better state of repair. My bones are my bones, and there's nothing wrong with my bones, they might be slightly out of alignment but I think they are out of alignment because my muscles are not doing necessarily what they should be doing. My um, vertebrae, some of them have lost their bounce but I reckon if I was able to put a good muscular core around them then it would protect them. And I think I've, I've kind of got to the point where I feel that I've got a bit of mobility but I, I think I've got a better understanding of what may or may not be wrong and that might in itself be difficulty when I then go and see the next person and I say "well yeah I've got this problem here, I've actually need to keep those muscles err tight up and pull that and that one tightens and pulls that. And I suppose, so whoever I see next will need to be quite understanding that actually this is a journey of 22 years that I've been on and I've probably have got a reasonable idea as a non-medic, and the things that I think make it better and the things that don't so, that was waffly answer. Umm 27:35
J	I hear what you are saying, I hear your link into your french chap (E Yeah). I suppose what I'm thinking of, earlier on you said 24 bang. It wasn't 'Oh I dunno I was about, it was like bang 24 and what you said was, at that time, you felt that, there was a temporary issue (E yeah) and it would be resolved and I suppose, I'm not saying this was the case Don, but an example possibly of a turning point with your back pain history may have

Comment [CS23]: Management
+ Education
+ Exercise

	been, one day actually realising, actually it's not gonna come spot on right again. 28:12
D	I think that's happened since I've been seeing Laurent, (J since you've been?) since I've been seeing Laurent I've realised (JP this chap) yeah, I've realised (J right that's the link) yeah (J got it OK) I've realised it's never gonna be, it's never gonna be ??'cock-on'?? again. Umm but I also feel in myself that you know, I've got a back problem but there's nothing wrong with my legs and my bottom and my arms (J No) so, you know and I'm getting referred pain in me knees and my ankles and I'm thinking you know, last year I thought 'Oh I've got a knee problem now thats just what I want' and then, I've been and had my knee looked at and I've gone, they've gone "No the knee's fine" so I'm thinking 'Well it's referred pain then'. It's something in my back which is causing an over-reaction muscularly, which is putting pressure somewhere else. Erm, so yeah I think probably the epiphany's been in the last eighteen months - two years.
J	That's interesting. And, yeah that's interesting. Don, if we um, if we, how would y, yeah, just sort of, trying think how to phrase this, um how would you describe yourself, how would you talk about yourself to someone and what I'm trying to capture here is how do you view yourself, who's Don?
D	I think the er, I know this is all about back pain and all of that sort of stuff and I, it's a low esteem issue, it's a low esteem issue definitely, umm, and I actually think probably, well this has only just sort of occurred to me, I think my self esteem has, has, has been on the slide, for a year or two now and I don't know whether that's sort of linked with, the realism that it ain't getting any better than this. But I do feel, ??I know?? I have said it once or twice tonight, I feel that at times like I'm a 70 year old man. A guy

Comment [CS24]:
Management
+ Education
+ Epiphany

	was throwing a cricket ball at me, you know between overs, he was throwing a ball at me and he, it was coming at around my ankles and I said "I don't bend that low to go into my fridge" (J laughing excuse me) you know and my wife said to me,' I can tell me when you've been home alone for a couple of days cos everything is at hip height and above'. And it's, 46 it is, it takes some physical effort to bend down and get a breakfast bowl out of the cupboard, it's pathetic. So yeah I think that has, probably has had bit of a dent on the old self esteem. But yeah I have to support myself on the side of the kitchen sideboard, to bend down to get a cereal bowl, so I've got a reminder every single day, that you know, I've got a duff back. 31:22
J	So there's a self esteem thing but if you erm would that impact on how you described yourself, how you think about yourself?
D	There is a lot going on at work at the moment so that's probably not a great question. Umm (J sorry I don't want to go anywhere that's not comfortable Don) No, no, no there's, there's a, I've had an epiphany in the last week or so in terms of sort of trying of put my priorities in the right order and err that takes a little bit of err wrestling with so its probably not a great question just at the moment to be able to give you the context that you are looking for.
J	OK, let's leave that one now. Umm Don umm, we're almost at the end now umm, how do you think umm and it doesn't matter who you want to put in that other person's shoes, how do you think others see you and that can be your children, your work colleagues, the cricket crew, how do they see, who's Don?
D	Umm well I think the cricket guys, cos I've known them for a couple of years they probably don't really, they don't really know that I've got a

Comment [CS25]:
Defined by CLBP
+ Private Identity
+ Self Esteem
+ Physicality

	problem, I just you know, I fall over in the cricket field and they think I'm a bit of a nutter and a bit of a laugh. What they don't realise is I can't bend down, so they think its quite amusing but you know I'm so committed (E laughs), so in some respects that's a breath of fresh air. My children and my wife umm, you know I, there is definitely, I am sure they would define me as well you know Don's like that, he's like that, he's like that, he's got a bad back, that's how I feel that all of them, well probably not Sophie but certainly down to me eight year old, they know I've got a bad back. And I don't want to be defined as someone with a bad back. You know, as I said earlier, I haven't ff, I really feel sorry for the people who've got a terminal illness because they're trying to sort their head out and yet they'll be defined as that person 'Oh you know Bob's got cancer' and you think Bob's got enough dealing with cancer as it is without being defined as (J Yes) someone with cancer. I'm not making a fair comparison (J No I hear where that comparison's going though Don) it's kind of, there a bit. Umm yeah, hopefully I've answered that (J I think you have, yeah).
J	Umm, I think final thing I'd like to say, final question Don, um how do you feel about yourself now and how is that different. I mean we talked about the fact that you were invincible, how is that different from ??before?? so I'm looking for that, I suppose we're back, I am not trying to pry into that self esteem business but just, I supp(ose), essentially we've talked frustration, we've talked esteem, we've talked invincible
D	There is a, a degree of acceptance but it's a bit like that Blackadder one, that Blackadder quote where he is in the first World War and he's having a chat with Baldrick and he says "Oh yeah here we go, got to go over the top. On my gravestone they're gonna write 'Here lies Edmund Blackadder

Comment [CS26]:
Public Identity/Visibility
+ Defined by CLBP
+ Humour

	and he's bloody annoyed'." Well I feel bloody annoyed if I'm really honest. There is that acceptance that you know I've got this bad back but there is a lot of anger that, you know, I've got this issue. Umm I mean my sister's got a bad back and she's in a heck of a worse state than me so I also then feel you know, bit of a wet winjer really because, you know, you at least go out to work, she can't. So, there are people who've got chronic, chronic, chronic problems and yet I think probably, some of the medical people I see now probably define my problem as chronic umm, but yeah I am, there is a degree of acceptance but I am, there is a lo(t), you know the frustration does boil over into 'bloody annoyed'.
J	(Smiling - ?? VP) Don that's fantastic umm (E is that alright) is there anything, is there anything else that, thank you for sharing so much with me, is there anything else that you feel I've missed, anything else that you were, you think 'Oh gosh he hasn't asked me about that and I really wanted to tell him about that', is there anything you wanted, anything else you want to say?
D	No I mean I think you've picked up, you know, it goes into your social life, it goes into your family life and it's there in your work life and it's kind of, and its there when you are on your own, so it kind of, it's not something that you know in certain aspects of your life you can, escape from it (J No). And its not, you know, you know, I could be in a lot worse situation, there are lots of people out there in a far worse situation than me, but it is frustrating and there are times when that frustration is, you know, you think ?? 'Oh Christ it's just so wearing' and there are other times when you just think 'that's alright, Phfff, it's a good day today, top bananas'. Probably it, I think.

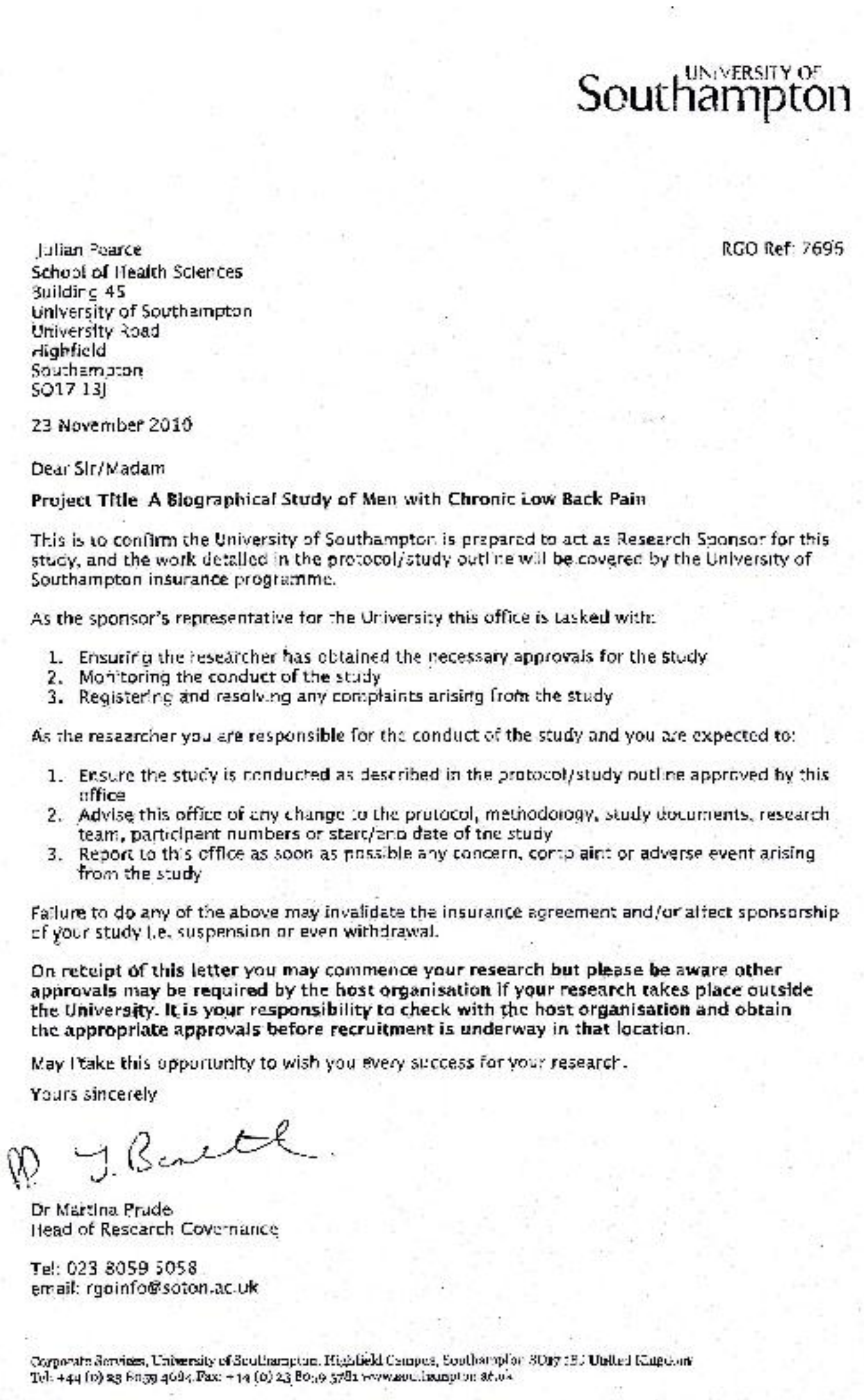
Comment [CS27]:
Anger & Frustration

Comment [CS28]:
Anger & Frustration
+ Public Identity
+ Private identity
+ Defined by CLBP
+ All Pervasive

J	Thanks Don. Umm Don, in the unlikely event that, in listening to that tape, I hear something and think ' Oh gosh you know, like we did just now almost, Don I, could I just ask you one more, could I at least give you a quick ring or pop round and have a quick word, is that alright?
D	Yeah, yeah no problem
J	And that's it. Thank you so much Don.
D	That's alright, no probs. No probs.

Appendix 4

Ethical Permission



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RGO Ref: 7695

23 November 2010

Dear Sir/Madam

Project Title A Biographical Study of Men with Chronic Low Back Pain

This is to confirm the University of Southampton is prepared to act as Research Sponsor for this study, and the work detailed in the protocol/study outline will be covered by the University of Southampton insurance programme.

As the sponsor's representative for the University this office is tasked with:

1. Ensuring the researcher has obtained the necessary approvals for the study
2. Monitoring the conduct of the study
3. Registering and resolving any complaints arising from the study

As the researcher you are responsible for the conduct of the study and you are expected to:

1. Ensure the study is conducted as described in the protocol/study outline approved by this office
2. Advise this office of any change to the protocol, methodology, study documents, research team, participant numbers or start/end date of the study
3. Report to this office as soon as possible any concern, complaint or adverse event arising from the study

Failure to do any of the above may invalidate the insurance agreement and/or affect sponsorship of your study i.e. suspension or even withdrawal.

On receipt of this letter you may commence your research but please be aware other approvals may be required by the host organisation if your research takes place outside the University. It is your responsibility to check with the host organisation and obtain the appropriate approvals before recruitment is underway in that location.

May I take this opportunity to wish you every success for your research.

Yours sincerely

J. Bennett

Dr Martina Prude
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Appendix 5

Interview Schedule

A biographical study of men with chronic low back pain.

Interview Topic Guide

This research focuses on the lives of men who have chronic low back pain.

I am hoping to explore and understand whether the back pain you experience has affected how you see yourself and how, you think, others see you.

Areas for discussion are likely to focus around:

Personal and Background Information

Please could you tell me a little about yourself?

Age

Employment

Family

Hobbies/Interests

How old were you when the back pain started?

Looking back over the years how would you rate your pain – average pain on a Visual Analogue Scale (ten point scale where 0 = no pain, 10 = worst pain imaginable)

Exploring Identity

Q1 Please can you tell me about your life before you had back pain?

Q2 Please can you tell me about how your back pain started and how your life has been since then especially with regard to your back pain?

Prompt – How do you think it has affected you?

Prompt Do you think you are different now from who you were before you had back pain?
In what ways / How?

Prompt - Do you think it impacted on your work life?
In what ways / How?

Prompt - Do you think it impacted on your personal life?
In what ways / How?

Prompt Relationships
Wife/partner
Children
Family & Friends

Hobbies/sports/pastimes

Q3 Have you experienced any major turning points in your life in relation to your back pain – (by that I mean something major happened or you realised or accepted something that would alter your life?)

Q4 How would you describe yourself / talk about yourself to someone else? (How do you see yourself?)

Prompt What, if anything is different from the time before you had back pain?

Q5 How do you think others might describe you / talk about you? (How do you think they see you?)

Prompt What, if anything is different from the time before you had back pain?

Q6 How do you feel about yourself now and how is that different form before you had back pain?

Thank you so much for sharing this with me – is there anything else you would like to say?

In the unlikely event that I need to clarify something you said would it be possible for me to have another brief conversation with you?

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