The perplexing condition of chronic pain, particularly low back pain, is the catalyst for interest in this research project. It is specifically focused on treatment trajectories of individuals experiencing chronic low back pain. The predominant interest is the utilization of alternative treatments and that of mainstream medicine (also referred to as western medicine) within Australia's medical system. Ten individuals experiencing chronic low back pain, each over the age of 18, and residing in the Sydney area, voluntarily comprise the study population. Research consisted primarily of a semi-structured, in-depth interview with each participant and a second interview of the same type with four of the ten participants. Data was analyzed, compared across the population, and revealed patterns in successful management and treatment of chronic low back pain, which includes an element of consistent exercise and mobilization, whether it be stretching or low impact strengthening and massage. While chronic low back pain deserves increased preventative measures, many individuals living with and experiencing this form of pain have discovered ways to manage, decrease, and eliminate the presence of chronic low back pain. For most of this population, this means utilizing a combination of treatments, predominantly alternative.
Chronic Low Back Pain: Patient Perceptions and Treatment Trajectories in Australia’s Medical System

By
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Carissa Miller, Author
ACKNOWLEDGEMENTS

It is my great pleasure to acknowledge those individuals that have provided or given the love, patience, encouragement, prayer, and participation that have driven this degree and this research project to reach completion.

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Thank you to my family for raising me to be free to accomplish any goal I set my mind to and for providing for me along the way. Thank you for encouraging me academically and supporting me throughout all of my studies, and for smiling on these accomplishments.

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Chapter 1 - Introduction

Chronic pain, particularly chronic low back pain, is a very difficult condition to understand. It is for this reason that research on effective treatments is vital for the health and welfare of individuals around the world. It is my hope that these research results will help the participants involved and other readers, by providing information on effective treatments.

My goals in this research project are to reveal and to analyze treatment trajectories of chronic low back pain patients in Australia's medical system, to discover which types of treatment are utilized, and to indicate which treatments are the most effective based on patient experiences and perceptions.

Before taking any further steps in this study, it should be noted that mainstream medicine (also referred to as western medicine) includes all treatments covered by the public health care system in Australia, such as physiotherapy, chiropractic treatment, medication, and mainstream medical practitioners. Alternative medicine includes those treatments that are not typically covered by the public health care system, such as massage, acupuncture, faith healing, homeopathy, yoga, Pilates, and exercise programs.

The study population consists of ten individuals from the Sydney area. These individuals are patients experiencing chronic low back pain. Contact made with these individuals was made possible by serving as an intern at Equilibrium Wellness Centre, an alternative care facility in Avalon, Sydney. This study is a qualitative ethnography. The study population is not a random sample, nor is it large enough to make generalizations in regard to a greater population. This study population and the discussion of data found is reflective of this study and of the experiences of the individuals who have participated.
Patient perceptions and experiences, treatment trajectories, and effective treatments have surfaced through semi-structured, in-depth, recorded interviews with each participant. A second in-depth interview was conducted with four of the ten participants, as they were willing. Once the data had been collected, the interview results were compared across the study population to reveal similarities and differences in treatment trajectories and treatments that patients found to be the most effective.

It is my assumption that the needs of patients experiencing chronic low back pain are not satisfied with mainstream medicine and that this dissatisfaction causes a shift to the utilization of alternative treatment for this pain. I also assert that maintenance of mobility, strengthening, and flexibility, particularly of the trunk or core region improve the well-being and functionability of individuals experiencing chronic low back pain. These two considerations have served as two research questions or statements for consideration throughout this research project and will be discussed later in accordance with the data collected from this study population.

In order to thoroughly discuss the research conducted, the data collected, these research questions, and the literary information collected prior to conducting research, the following chapters will address key factors and influencers in each of these phases of research. Chapter two, the literature review, informs readers of the background information collected prior to conducting research and classifies this information in three sections.

Information found in the first section will address living with a chronic condition, chronic low back pain, as a condition, and treatments or preventative methods for this condition. One will find discussion of Australia’s medical system and health insurance in the second section. Information included in the third section will state the theoretical premises of this research with discussion of psychological functionalism, critical medical anthropology, symbolism, and other theoretical concepts.
Chapter three, on methodologies, illustrates the step by step process followed while conducting this research and analyzing the data collected. Chapter four gives an account of the results and information obtained through interviews with the ten participants and takes a closer and more detailed look at the four case studies that included a second interview. These results have been analyzed and presented using an adaptation of the cultural consensus model and the grounded theory approach. Chapter five reflects on the research results in relation to the literature and theory presented in Chapter two, satisfying the final step in the grounded theory approach, while presenting themes from the findings in greater depth. Finally, Chapter six concludes the study with reflections on how it could be improved, suggestions for future research, and final remarks.

The information gathered and presented here is reflective of my own research, understanding, and interpretations. I do not claim to be an expert in the area of chronic low back pain, but merely a student of the informants, researchers, and writers that have shared information with me or have made their work available by publishing it. The various treatments and programs discussed here are a fraction of those available, but have been selected and included in this study because of perceived relevance and research constraints.

Conducting this research has been a journey, presenting it here will be another one. I admit to falling short of objectivity, as perfect objectivity seems to be impossible. However, I shall do my best to present all of this information in a worthy manner. I also admit to harboring my own biases. My personal experiences and the experiences of those I have held close, along with my academic paradigms, and limited experience in the field will have surely shaped this research experience from start to finish. That said, I welcome you to read, consider, question, and analyze this work in the hope that it will reveal new information to you in the process.
Chapter 2 - Literature Review

Chronic Low Back Pain

Low back pain, particularly in its chronic state, is a condition of such complexity that it is incredibly difficult to identify or to determine its precise cause or causes. Literature shows that in most cases there are confounding factors influencing the development of low back pain and that influence the further development of chronic low back pain. Other than those cases with a distinct cause, such as an accident resulting in low back pain where there were no previous episodes of pain, the majority of low back pain and chronic low back pain cases are nonspecific in origin. In this chapter, living with a chronic condition and what that might entail, some potential causes and symptoms of the condition, treatments, and preventative methods will be discussed to further understand the complexities and possibilities associated with the experience, treatment, and management of chronic low back pain.

Living with a Chronic Condition

Unfortunately, chronic pain and chronic conditions are not always as simple as a diagnosis and corrective treatment. Many individuals experience symptoms of these conditions that go beyond the reach of empirical science, mainstream medicine, and the physiological symptoms discussed in the following section. Medical anthropologists have studied chronic conditions and have since delved into the personal and social struggles faced by these individuals, which sheds light not only on the complexity of chronic conditions, but on some difficulties in treating them. For now, let us consider what these researchers have to say about living with a chronic condition in western society.
The experience of a chronic condition can sprout into particular manifestations that will not necessarily be cured by medicine. For instance, an individual experiencing chronic low back pain will most likely manifest psychological symptoms and struggles while coping with and managing his/her condition and will face struggles in society as s/he becomes marginalized due to the condition and as s/he continues to pursue a means of pain relief within or between various societal institutions (mainstream medicine, alternative medicine, spiritual communities, family).

Gaylene Becker (1998) conducted research considering the deaf community, ways this community copes in society, and some of the stigmas this community faces while adapting to society and their condition throughout their lives. While this study does not consider chronic low back pain within its discussion, some of the social stigmas and coping struggles draw parallels to those of the community of persons experiencing chronic low back pain.

Becker (1998) says that deafness is an invisible disability. Chronic low back pain can be said to be the same. No one knows there is anything different about these individuals until they begin to communicate (in both cases) or when they begin to exhibit limited movements (in some cases of chronic low back pain). Otherwise, no one would know that these individuals are physically any different than anyone else.

Becker (1998) continues by discussing ways in which the deaf community must cope and adapt in society in order to maintain interactions and connections inside of the outskirts of society. Otherwise, they are marginalized as a result of social stigmas attached to their condition, many of which, quite possibly stem from fear of something different or fear of not knowing how to communicate, where the rest of society is concerned. This too can be said for those experiencing chronic low back pain. They are marginalized because medicine and society do not know of a definite cure for
their condition, so they are left to search and find something that works enough to manage or cure their pain on their own, or with little help from others. Furthermore, the rest of society might function in “fear” with this community as well. For instance, they may not know what to say/communicate to these individuals to provide comfort or counsel, and where medical institutions are concerned, they may function in “fear” because they are concerned that they cannot do anything for them, to alleviate pain. Thus, these individuals are marginalized and quietly moved to the outer perimeters of society where they are left with little help from society and are forced to seek out coping and pain management techniques on their own.

Marcia Inhorn (1998) conducted a study on becoming discreditable in American Society as the result of living with genital herpes. Farmer and Kleinman (1998) did a similar study on AIDS and human suffering through this condition. Again, there are similar stigmas involved that work to marginalize a community of individuals experiencing a chronic condition. One struggle these individuals face is whether or not to tell their partners, family, or friends about their condition. If they do, they could be stigmatized and cast away as a dirty person, promiscuous, unfaithful, or having a disease that is contagious (where normal contact would not allow contraction, but others may act or behave fearfully regardless).

Individuals with chronic low back pain wouldn’t necessarily experience these stigmas or the extremity of them, in the struggle of whether or not to tell others of their condition. However, the struggle of whether to tell others could affect employment, for instance. These individuals could become discreditable employees or possible employees, as their condition could be considered a detriment to the workplace, causing them to be unable to perform job duties, in the opinion of the employers. This community then becomes a risk in employment, which stigmatizes them as being disabled, marginalizes them by not allowing them to participate in the workforce, and discredits them as
functioning individuals. For some with extreme chronic back pain, work is not an option, but for others it is possible, provided they are given an opportunity. Herein lays the struggle for those who could work, but are not given the opportunity because of their condition.

Individuals experiencing a chronic condition or chronic pain enter into the social arena with different perspectives than others. The stigmas and marginalization through individual struggles with identity and ability, as noted above, work to shape communities of individuals with chronic conditions by setting them apart from the rest of "functioning" society and in doing so, ascribe to them a new identity and a new set of abilities, or a lack thereof. These individuals have "...experienced a revolution of consciousness. They have undergone a metamorphosis" (Murphy 1998: 323). Consider that a disability is defined as a chronic condition, in this case, chronic low back pain. This chronicity, the long-term, day-in and day-out experience of one painful state of being becomes just that, a state of being. It becomes the way you are, the way you are in the world, and affects the way you interact with the world and often, how the world interacts with you (Murphy 1998).

"People diagnosed as having a particular disease learn "how" to have it by negotiating with friends and relations as well as with people in the treatment system; this process is affected by society’s beliefs and expectations for that disease." (Waxler 1998:147). This means that communities of chronic sufferers must learn to adapt and re-enter society once they have been marginalized as a result of their chronic condition. Individuals experiencing chronic low back pain might face struggles of negotiating their ability or inability to work. This might happen with family, friends, medical practitioners or institutions, or places employment. These individuals will have to learn how to live or work in a different way than they had before they experienced chronic pain. They will have to negotiate treatments they are
receiving and seeking, in order to find one or a few that they feel are best suited to managing their pain, or curing it.

Where chronic low back pain is concerned, medical institutions have not yet discovered appropriate treatment regimes that will best suit the condition, as each case is unique and very complex. This affects these individuals because there are no expectations of healing or permanent relief for them in the medical sector of society. They are led to believe that they can only manage their pain, if they are lucky enough to find a way to do that, that they must live with some degree of permanent pain, and that there is really nothing else they can do. This discouragement has indeed moved many to seek relief on their own, leading them to combination therapies, faith healing, and alternative treatments, which will be discussed more later on.

While there are many personal and social struggles for those experiencing chronic pain and chronic conditions, there yet remain many physiological causes and symptoms as well. It is imperative to discuss and understand both the less obvious and the recognizable causes and symptoms of pain in order to understand the complexities of chronic pain more completely. As we have discussed some of the less obvious personal and social causes and symptoms of chronic pain, let us move now to a medical discussion of some of the physiological identifiers of this condition.

A Discussion of Causes and Symptoms

There is a plethora of information detailing the various physiological conditions that are said to cause or contribute to chronic low back pain. These can range from herniated or prolapsed discs, slipped discs, sciatica, failed back syndrome, and more. ([See Table 1: Leading Contributors to Chronic Low Back Pain located on the following page](#)). It is important to have a clear understanding of the physiological aspects that cause or contribute to chronic low back pain in order to conduct informed research.
Table 1 - Leading Contributors to Chronic Low Back Pain

<table>
<thead>
<tr>
<th>Contributing Factor</th>
<th>Description</th>
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<tr>
<td>Poor Adherence</td>
<td>Poor compliance to advised treatments, programs, and exercise regimes</td>
</tr>
<tr>
<td>Biopsychosocial Factors</td>
<td>Biological factors, medical factors, psychological factors, motivation, fear, pain, social factors, economic factors, life style, education, age, sex</td>
</tr>
<tr>
<td>Deconditioning</td>
<td>Deterioration of functional health explained as the deterioration of musculoskeletal strength</td>
</tr>
<tr>
<td>Duration of Sickness</td>
<td>Previous episodes of LBP and chronic duration of LBP</td>
</tr>
<tr>
<td>Economic Factors</td>
<td>Economic factors often dictate occupation. Some occupations have higher risks for LBP and CLBP</td>
</tr>
<tr>
<td>Fear</td>
<td>Fear influences behavior and bodily movements (fear avoidance behavior - fear of reinjury).</td>
</tr>
<tr>
<td>Life Style</td>
<td>Unhealthy living, i.e. smoking, unhealthy eating, and inactivity</td>
</tr>
<tr>
<td>Pain</td>
<td>Perceptions of pain affect behavior and can act as an inhibitor where pain seems overwhelming</td>
</tr>
<tr>
<td>Perceived Level of Disability</td>
<td>Perception of disability affects behavior, activity level, bodily movements, and can act as an inhibiting factor toward returning to work</td>
</tr>
<tr>
<td>Psychosocial factors</td>
<td>Lack of social support and/or professional support during treatments affects coping ability and motivation</td>
</tr>
<tr>
<td>Poor Strength and Fitness</td>
<td>Poor muscular strength, physical endurance, flexibility, aerobic and cardiovascular fitness</td>
</tr>
<tr>
<td>Vocational Factors</td>
<td>Aspects of working environment, lifting, twisting, bending, vibration, repetitive movements</td>
</tr>
<tr>
<td>Weak Trunk Musculature</td>
<td>Trunk flexibility, extensor performance/trunk strength, coordination, ROM (range of motion) of spine</td>
</tr>
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The human spine consists of vertebra, making up what we know to be the vertebral column. Each vertebra is considered the site of a joint and they are separated by tissue that acts as a cushion between the bones. This cushion in referred to as a disc and is made up of 2 components, the outer shell called the annulus fibrosus and the inner liquid cushion called the nucleus pulposus.
When a disc is prolapsed or herniated, the annulus fibrosis has become weakened and the nucleus pulposus either has become or begins to become displaced. This means that it has herniated or ruptured out of its casing. This causes severe nerve irritation and is often the catalyst for symptoms of sciatica when the area of herniation is in the lower back, such as the lumbar or sacral region of the spine (Borenstein 1995; McGill 2002).

Sciatica is identified as pain along the sciatic nerve that runs from the lower back and down either or both legs. This nerve is responsible for all control, feeling and reflexes in the legs. Often, an individual will experience symptoms of sciatica (numbness in one or more areas of the foot/leg, loss of reflexes in the foot and leg, loss of control, and if an individual has severe sciatica, loss of control of one’s organs, ie: the bladder) as a result of displaced or herniated tissue from a disc in the lower back or as the result of an irritated or pinched nerve root in the lower back (Borenstein 1995).

### Review of Treatments

Once an individual is experiencing symptoms of sciatica as a result of a herniated disc, mainstream medicine generally suggests that surgery is the solution, in order to remove the displaced tissue and allow relief for the surrounding nerves. The most common back surgery and the least complicated is called a laminectomy. Laminectomies offer just over an 80% chance for complete recovery and regained reflexes and mobility. However, in some instances individuals may experience some immediate relief and then experience a reoccurrence of the symptoms of sciatica, low back pain, and pain and numbness in the leg, buttocks, and/or foot. When this occurs, the condition is referred to as failed back syndrome. In this case, the surgery was successful in that, it removed all the displaced tissue, but did not have a
positive outcome for the patient’s well-being and often results in chronic low back pain (Tilscher 1991).

One can imagine that the experience of chronic low back pain, while varying in degree of physical limitations on an individual case scenario, can be incredibly painful and debilitating. This debilitation can and does influence whether or not an individual returns to work. Several studies have been conducted to formulate prevention and intervention programs addressing chronic low back pain, in order to return individuals to work and reduce the costs poured into worker’s compensation and medical expenses related to the condition. These programs typically offer multidisciplinary approaches, where both mainstream medicine and alternative medicine are used to compliment one another (Carpenter and Nelson 1999; Manniche 1996; Storro et al. 2004).

Early in the 19th century, intensive exercise for rehabilitation was prescribed to individuals experiencing chronic low back pain. It has been said that lack of understanding of the condition moved practitioners to seek other forms of treatment in hopes of finding or developing curative treatment programs. Over the years, practitioner approaches toward treating chronic low back pain changed to passive treatments, rather than the aggressive exercise regimes prescribed in earlier years. Passive treatments include therapies such as massage, manipulation, bed rest, ultrasound, electrical stimulation, traction, hot and cold packs, medications, stretching, back schools, enzyme injections, and the like. Since the late 1970’s and 80’s, practitioners and medical researchers have been shifting back to aggressive treatments and particularly to exercise regimes (Carpenter and Nelson 1999; Manniche 1996; Storro et al. 2004).

Intervention attempts during the last two decades are neither reliant purely on aggressive nor passive treatments. Rather, they are a collaboration of both, commonly referred to as multidisciplinary programs, designed toward the effort of improving individual condition and return-to-work rates through a
more holistic approach. A number of recent research projects specifically addressing the effects of multidisciplinary programs on work return rates, where exercise regimes were a major focus, give support to these programs' effectiveness for the improvement of individual well-being, for return-to-work rates, and for the reduction in costs and expenditures poured into worker compensation and medical expenses (Carpenter and Nelson 1999; Hartigan et al. 2000; Manniche 1996; Niemisto et al. 2004; Storro et al. 2004). While each prevention program is different, most of the more recent programs and schools of thought addressing chronic low back pain and work return consider a number of contributing factors. While there are numerous other factors, considering the leading contributors is imperative in formulating an effective prevention or intervention program for chronic low back pain. (See Table 1 shown above).

With so much medical research placing emphasis on new combinations of therapy and treatment, what is really being said about mainstream medicine? A closer look at studies of mainstream and alternative medicine conducted by medical anthropologists will provide further explanations for the function or lack of function, of mainstream medicine within society and for specific people groups, in this case, individuals experiencing chronic conditions or chronic pain.

Joan Paluzzi and Paul Farmer (2004) combined efforts to critique and discuss health policies in relation to primary care and chronic conditions (namely AIDS). Their article addresses some of the ways in which health care policies are not integrated but are in an integrated world. That is to say, they discuss health care inequalities between the rich and poor while raising some of the socio-economic conditions that affect health care access. Using this research loosely in relation to this study and the discussion of mainstream medicine and medical treatment programs for chronic low back pain mentioned thus far, it becomes more evident that inadequacies in health care systems,
particularly in dealing with chronic conditions do exist in abundance within mainstream medical institutions. In this article, it is stated that necessary health care is often unattainable until the condition (AIDS) is fully developed and is then untreatable because individuals (namely the poor) cannot access appropriate health care.

Similar circumstances affect those experiencing chronic low back pain. Allow me to explain. Chronic back pain can occur and persist as the result of multiple back injuries or progressively poor spinal health and care. This is often due to lack of accessing medical treatments and allowing oneself to recover with increased rest for a few days or a week, for instance, rather than seeking medical advice. While Australians have free access to health care, and so this is not the problem, whether or not they access it can be, especially where spinal health is concerned. By the time many individuals do seek help or medical treatment, they have injured their backs to the point of permanent damage, after which, the matter becomes one of management, corrective treatments, and individual compliance to treatments thereafter. As there is no definite cure available to them through mainstream medicine, they seek other options. Mainstream medicine becomes inadequate in treating their condition, as there are no guarantees of recovery.

Mainstream medicine has, throughout the history of the western world, or at least since the 1800’s, played a dominant role in medical treatments and in capitalist societies. Generally speaking, individuals in western societies seek medical assistance from mainstream medical institutions before turning elsewhere. However, as mainstream medicine fails to improve the individual well-being of certain people groups, these individuals turn to other systems of healing. The western world is becoming part of a medically pluralistic world (Baer et. al 1997). Individuals on the fringes, such as people with chronic low back pain, partake of this medical pluralism and begin to integrate treatments
from multiple medical institutions or at least, include them in their search for the ‘right’ one.

In John Janzen’s book titled The Quest for Therapy: Medical Pluralism in Lower Zaire, he discusses the intricate relationships between mainstream medical practitioners and the people group called the BaKongo. These people traditionally collaborate to care for family members, whether it is through a woman’s pregnancy and delivery, or for some sort of illness.

Janzen (1978) addresses medical pluralism as he illustrates ‘multidisciplinary programs’ or therapy regimes that this population formulates by incorporating traditional medicines with mainstream medicine. Throughout everything, social dynamics are presented. Individuals take on a ‘sick-role’ when treated or seeking treatment, family and practitioners respond in different ways, but need to work together for the patient.

In BaKonga society, the patient has a group of advocates working to find the correct combinations of treatments or therapies (Janzen 1978). This could cause and eliminate some of the stigmas discussed earlier that were concerned with marginalization in society for those experiencing a chronic condition. Perhaps this situation is true for some individuals experiencing chronic low back pain. Family and friends would inevitably recommend various remedies and treatments and while they might not actively advocate for the suffering individual, they are playing an active role in seeking therapy or treatments. This illustrates that particular social groups work both toward and against perpetuating stigmas, but in the mix, they encourage multidisciplinary treatments.

While an individual lives with chronic low back pain, facing personal and social struggles, medical battles, and the search for a treatment(s) that will effectively manage or cure his or her pain, there is often the frustration and
dissatisfaction of not knowing exactly what needs to be treated in the complexity of the condition. In seeking treatments,

...it must be recognized that what counts as therapy depends first upon what is defined as a problem. A fundamental transformation of experience takes place when suffering is recast as disease in medical practice. Moral practice is made over into technical practice, and the latter then defines how the outcome will be defined, managed, and assessed (Csordas and Kleinman 1996: 4-5).

Mainstream medicine is not equipped however, to treat suffering as a disease. It is unable to identify or treat emotional or spiritual dissatisfaction that have resulted from living with a chronic condition. Mainstream medicine can only treat empirical ailments. This is known as Cartesian dualism, which is separating the mind from the body or the spirit from the body (Lock and Scheper-Hughes 1998). Therefore, these individuals turn to alternative treatments, multidisciplinary treatment programs, or faith healing to address these needs.

Let us take a look at some of the literature and information available on faith healing. Of the study population, a total of 70% reported an increase in spirituality with benefits resulting from that increase. A total of 60% of the study population consists of individuals proclaiming healing benefits from their faith in Jesus Christ, as Christians, literature specifically discussing Christian faith and prayer in medical research is included. (A Christian is defined as any person believing in personal salvation and reconciliation to God, from personal sin, by the blood of Jesus Christ. Christians are believers in the Holy Trinity. They believe in One God in three persons: God the Father, God the Son, and God the Holy Spirit.)

Occurrences of healing by faith have become increasingly more recognized by those in the medical profession over the last few decades. While blatant claims that faith alone can heal a body may not be the sounding proclamation of those physicians willing to give credit to this movement of
healing, they are openly expressive of the power of prayer, faith, and spiritual belief in an individual’s motivation to heal and the impact one’s beliefs have on one’s rate of healing, where those with faith and prayer tend to heal more quickly. An increasing number of medical practitioners, both mainstream and alternative, are taking hold of the benefit of spirituality in healing on behalf of their patients (Holmes 1998).

One mainstream medical practitioner stated, “Most physicians have been trained primarily in empirical science, chemical formularies, and surgical technique. In the process, we have created a great divide. We separated the mind from the body” (Holmes 1998: 16). Research and exploration in the medical and academic sectors of western society have been delving into the link between faith, prayer, ways in which spirituality shapes individual health, and one’s ability to recover or be completely healed from serious illness. For over five years, Harvard Medical School’s Department of Continuing Education has held a conference course on this topic attracting over 600 mainstream medical practitioners, nurses, and social workers. Now, more than half of the leading medical schools in the U.S. offer courses on the link between spirituality and healing in medicine (Kalb et al. 2003; Holmes 1998).

Medical students and researchers are continuously trying to prove whether or not spirituality and faith can heal, slow cancers, reduce depression, lower blood pressure, heal a body more quickly after surgery, and so on. Mainstream medicine demands empirical evidence. Prayer and spirituality in relation to healing is one of the most controversial research topics in medicine today. However, the lack of medically appropriate evidence in the clear link between faith and healing cannot be overlooked or dismissed, despite its inability to be explained by mainstream medicine and academia. Many hospital staff and practitioners around the nation have reported observations and have been witness to multiple instances where an individual accredited healing to faith or spirituality, while the medical field could not explain it any
other way. Mainstream medicine and research has also proven that regular church going has elongated individual life expectancy: the more often individuals attend church, the longer they tend to live and they tend to live healthier as church going promotes healthier life choices (Kalb et al 2003).

Some researchers have presented the case of healing by faith and spirituality as an issue of empowering the mind to overcome: mind over matter. In this case, individual’s believing to be healed are, in a sense, insisting that he or she will be. This has been addressed for those in the position of counseling persons of faith in illness as well as those treating them medically. While the mind is an important aspect in one’s faith, faith does not rest in one’s mentality or mental knowledge (Belcher & Hall 2001). On this note, it is valuable to consider the possibilities of the mind combined with human will to produce healing and change within the physical body. However, there is little evidence or research to support this idea and it tends to be promoted under the guise of faith healing when it is not the same.

I argue that the individuals attempting to explain faith and spirituality that generates physical healing by promoting that it is merely an issue of mind over matter or one of psychotherapy are not genuinely tapping into or experiencing faith themselves. Rather, these individuals are studying the phenomenon of healing by faith. Studying, rather than believing and experiencing does not allow the individual to gain a full sense of the phenomenon itself or its manifestations. Studiers making the claim that healing by faith is the result of the mind conquering matter shows a great misunderstanding and a lack of understanding of what faith is, let alone the ways in which faith can heal a physical body.

Theodore Chamberlain and Christopher Hall (2000) studied and presented numerous scientific studies on faith, prayer, and healing in medicine in their book titled Realized Religion. The studies presented were conducted
by credible researchers and medical practitioners throughout the last several decades. These studies were conducted using patients with serious illness that were placed into control groups or groups that were receiving intercessory prayer by born again Christians of varying denominations. The control groups received standard medical treatments and the groups that were prayed for received medical treatment only if or when the illness worsened. Repeatedly, the studies showed that those who were receiving prayer fared better and their health improved or stabilized more often and more quickly than those in the control groups.

The discussions of the studies just mentioned do not prove that faith and prayer generate healing. They illustrate that there is consistent evidence supporting the healing benefits of faith and prayer in the physical body. These healing benefits stretch across the areas of surgical healing, mental illness, prevention of suicide, marital and life satisfaction, lifestyle choices, and serious illness. For instance, the link between depression and spirituality discussed through a number of studies showed that individuals prescribing to a Christian faith, attending church regularly, ‘conquered’ and reported lesser numbers of depression than those outside of these circles (Chamberlain & Hall 2000).

This is contrary to what many might think, as Christian religiosity is associated with sin and repentance, which could lead individuals into a mental depression and state of feeling unworthy continuously. But because Christianity takes sin and repentance a step further, where through repentance sin is cast away, forgiven and no longer remembered by God, individuals prescribing to this faith system experience freedom and liberation from regrets, sin, mistakes, or misunderstandings in life. This in turn has a positive effect on one’s mental health and wellbeing, challenging and conquering states of depression as individuals let go of troubles or hurts by faith (Chamberlain & Hall 2000; Hardesty 2003).
An interesting argument made about Christian healing is presented by Meredith McGuire (1988). She presents a side of Christian healing that has not yet been addressed here. Through her research and interviews with those from the Christian population, she observes that the Christian idea of health and wellbeing is not necessarily what the larger community or the medical community perceives them to be. Christians tend to define a state of health and healing as coming to a place of peace and trust in God and His sovereignty over one's life. This does not always mean physical healing from an illness, but can mean either physical healing or acceptance of one's illness as part of God's divine plan (which assumes healing in the mental, emotional, and spiritual state). In the case of the latter, living with illness without divine healing in the physical is said to be a tool for ministering the power and eternality of God to others as they witness faith in trial(s) (McGuire 1988: 40-46).

The healing and grace that an individual receives from having faith in God can, as mentioned above, result in physical healing or as an increase in one's mental, emotional and spiritual state as s/he accepts one's illness as part of God's divine plan. In doing so, the individual is not only accepting what is, but what will be. Within the Christian faith system, nothing physical is permanent. Believing this, Christians are able to release even the state of their physical body to Christ, as they do in the process of releasing sin, anger, or hurts. In return, they receive a greater impartation of God. They are letting go of pieces of themselves to receive more of God's divine presence, which in turn allows them to become more like Christ in Spirit and mind (Hardesty 2003; McGuire 1988).

The power to be healed by God is available to everyone who has received His presence in their hearts by grace through faith in Jesus Christ and who has, in that faith repented and released themselves of sin and hurts into the freedom of God's forgiveness and healing. Everyone who has done this and
who believes in the name of Jesus Christ can call upon God and receive His

There have been accusations that faith for healing in Christian
communities can kill, as some individuals have died as the result of serious
illness that has not been divinely or medicinally healed. Most often, the
choice to access medical treatments within Christian groups is encouraged by
the larger group for the individual. Many Christians believe that God created
all things, including medicine, and He gave people the mental capacity to
continue growing in this field. Baring this in mind, we can appreciate the faith
that moves behind divine healing and that the same faith that can call upon the
power of God by His Holy Spirit and receive complete and restorative healing
in the physical body can also look to and receive healing through modern
medicine (Hardesty 2003).

It is evident that individuals experiencing chronic low back pain are
reaching out to healing opportunities other than what mainstream and
alternative medicine offer. It is also evident that these individuals are
navigating through social institutions to find combinations of treatment and
support to aid them in the endeavor to find relief and healing from pain. In
this search and social navigating, alternative treatments are becoming more
popular and many alternative practitioners have caught on to this, as have
individuals experiencing chronic back pain. As a result, multidisciplinary
programs to manage, treat, and prevent chronic back pain are in effect at select
alternative treatment centers. Equilibrium Wellness Centre is an alternative
treatment centre located in Avalon, New South Wales, in Australia. I was able
to intern for at Equilibrium for a time, which assisted the collection of these
data and the completion of this research.

The treatments available at Equilibrium include: acupuncture, zen
shiatsu massage, chen style tai chi, remedial massage, Chinese herbs, Bowen
therapy, yoga, reiki, psychotherapy, counseling, personal training, meditation, naturopathy, homoeopathy, flower essences, reflexology, and lymphatic drainage. Equilibrium also offers the services of one mainstream medical practitioner. A number of these treatments are commonly used to treat and manage chronic low back pain through Equilibrium's Wellness Program. (See Table 2 on the following page).

Any of these forms of treatment are available to clients participating in what Equilibrium refers to as the Wellness Program. The Wellness Program is a specifically tailored multidisciplinary treatment plan designed for individual clients, in order to effectively reach personal health and healing goals. The key players in the Wellness Program include: the client, the practitioners, and the wellness consultant (also referred to as a wellness coach). The client receives and participates in the treatments selected for his/her personal Wellness Program. The practitioners administer treatment and work collaboratively within an individual's program, to address personal health and healing needs and to assist in meeting personal health and healing goals while receiving multiple forms of treatment. The wellness consultant initially interacts with the client and through a series of questions and surveys, determines the client's health and healing goals and begins to place the client with practitioners and treatments that are appropriate to his/her needs.

At Equilibrium, health and healing goals are measured numerically on a scale from one to ten through a survey presented to the client in the initial meeting with the wellness consultant. The client is asked to rate his/her current state of physical, mental, spiritual, and emotional health on a scale from one to ten. S/he is then asked to rate on the same scale where s/he would like to be for each given category of well-being. This scaling system is used to assess which practitioners and treatments may be appropriate for the given client. The wellness consultant organizes an appointment with each recommended practitioner, the client determines whether or not each practitioner is suitable,
Table 2 – Alternative and Mainstream medical treatments Commonly Used to Treat Chronic Low Back Pain at Equilibrium Wellness Centre

<table>
<thead>
<tr>
<th>Type of Treatment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alternative Medicine</strong></td>
<td>Treatments that are not covered by public health insurance in Australia</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>A traditional Chinese practice of puncturing the skin with needles at specific and strategic points to cure disease or to relieve pain</td>
</tr>
<tr>
<td>Bowen Therapy</td>
<td>A form of massage therapy that works to balance the nervous system</td>
</tr>
<tr>
<td>Chinese Herbs</td>
<td>A medicinal treatment that administers traditional Chinese remedies (made of Chinese herbs) that attempts to restore an individual to full health</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>A medicinal treatment that administers a remedy (generally made of essential oils) that attempts to restore an individual to full health</td>
</tr>
<tr>
<td>Personal Training</td>
<td>Guided physical exercise specifically geared toward achieving individual goals or meeting individual needs</td>
</tr>
<tr>
<td>Reflexology</td>
<td>A massage technique used on hands or feet, which are considered a map of the body. Massaging pressure points on hands or feet according to the ‘map’ affects a particular part of the body</td>
</tr>
<tr>
<td>Remedial Massage</td>
<td>Massage focused on increasing blood flow to damaged area, readjusting soft and muscular tissue in order to readjust skeletal structure, and to release endorphins, which serve as pain relievers</td>
</tr>
<tr>
<td>Yoga</td>
<td>An exercise technique used to obtain increased flexibility, strength, mental control, and overall wellness</td>
</tr>
<tr>
<td><strong>Mainstream Medicine</strong></td>
<td>Treatments that are covered by public health insurance in Australia</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>A form of therapy that generally targets the spine for realignment and manipulation, in order to restore normal nerve function and overall health</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>A form of therapy that treats disease or pain both physically, ie: massage or exercise and mechanically, ie: light, heat, electricity, magnetics</td>
</tr>
</tbody>
</table>

Table 2 Source: Internship training and reading material on each treatment at Equilibrium Wellness Centre, Avalon, Australia and Merriam-Webster Online Dictionary at http://www.m-w.com/dictionary/
and those found suitable hold a case conference to discuss possible treatment trajectories for the client based on the client’s goals and needs. The case conference is a time for the practitioners to unite professional efforts for a common cause: the client’s health and healing goals. The practitioners pool together thoughts and suggestions for treatment plans both individually and as a team.

There are usually multiple plans proposed to the client in writing following a case conference. The client then chooses a plan that is suitable. Plans last for three or six months and vary in cost. The plans map out an itinerary of treatments over the course of three or six months. Along with the itinerary of appointments where the client is receiving treatment, the client is also meeting with the wellness consultant at least once per month. This meeting serves as a check point in the program. The client is able to discuss the program and any changes or concerns s/he would like to make or share are often expressed during these meetings. The wellness consultant is responsible for communicating between the client and the practitioners and facilitating the program and practitioner meetings (case conferences).

Each practitioner is required to compose a report of findings for each case conference. The report of findings is each practitioner’s written assessment of a given client, proposed treatments, and treatment intensities. The client is shown all reports in the next meeting with the wellness consultant, where the information in the reports is discussed with the client.

The Wellness Program is a health care approach that functions through social support and by supporting the client with structure and encouragement to take initiative when considering his/her personal well-being. The outcome and possibility of reaching predetermined health and healing goals is dependent not only on quality treatments, but on the individual’s participation as well.
Preventative Methods

Much literature enlightens readers on the subject of chronic low back pain statistics. Here, a general look at chronic low back pain in industrialized nations will make the case for preventative methods to encourage preventative pursuits in the future. Australia is an industrialized nation and bears similarities to others mentioned here, considering the presence and prevalence of chronic low back pain among the population.

Chronic low back pain has been identified as having psychological, biological, social, and economic indicators playing both independent and interconnected roles in the recovery or lack thereof, for individuals collecting worker’s compensation with unknown probability of returning to work (Hartigan et al. 2000; Niemisto et al. 2004). These indicators vary greatly within the chronic low back pain disability population. Each case is specific to the work environment and demands required of the individual within that environment, the individual’s healing ability, the individual’s economic situation, and the social support each individual has.

Studies often insist that the dominating causes of low back pain and work related disability are related to overall fitness, trunk strength, and flexibility, which can be addressed and corrected to return individuals to work through exercise and training (Rissanen et al. 2002; van der Velde and Mierau 2000). While there is clinical proof that intervention programs addressing these factors have had success in both improving individual well-being and return-to-work rates, there remain far too many factors influencing an individual’s spinal health to create a successful prevention program based on these alone. Thus, low back pain and that which is chronic, are conditions that require successful multidisciplinary intervention programs aimed at managing pain and returning individuals to work.
Chronic low back pain has typically been categorized as low back pain lasting over three months. This condition is noted as the leading cause for disability, worker absenteeism, and worker compensation costs in the U.S. and other industrialized countries (Hodselmans et al. 2001; Ohlund et al. 1996; “Philadelphia Panel” 2001; Taylor and Bonfiglio 1992).

Individuals suffering from chronic low back pain over the course of one year, with little or no symptomatic improvement have a reported return-to-work rate of less than 2% (Carpenter and Nelson 1999). Greenberg and Bello (1996) maintain that 85% of worker compensation costs are due to workers who have developed chronic low back pain as the result of an occupational injury. The 2003 Survey of Disability, Ageing and Carers in Australia, reported that back pain accounted for more disability than any other medical condition, affecting 34% of people with a disability (Australian Bureau of Statistics 2001).

The plaguing conditions of both chronic and low back pain have a great impact in industrialized societies. Approximately 21% of the Australian population has reported having chronic back pain, while 45% of chronic pain reported in the Sydney community has been recorded as chronic pain located in the back. It has also been noted that this is the most common area of the body to experience chronic pain, within this community (Australian Bureau of Statistics 2001; Blyth et al. 2003).

An estimated 60-90% of the population in the Netherlands, Canada, the U.S., Sweden and other industrialized countries will suffer from low back pain at one time in their lives (Hodselmans et al. 2001; Ohlund et al. 1996; “Philadelphia Panel” 2001; Taylor & Bonfiglio 1992). Those who develop chronic pain in the lower back due to a work related injury represent approximately 30% of the larger population of those suffering from low back pain (“Philadelphia Panel” 2001).
Chronic low back pain has become an economic burden for many industrialized nations (Keel et al. 1998; Williams et al. 1998). For instance, the U.S. spends an estimated $50 billion per year on both direct and indirect costs for low back pain, while the Netherlands spends approximately $4.3 billion Euros per year accounting for 1.7% of the gross national product. Australia spends an estimated $2.1 billion on back pain expenses per year, with nearly $1 million going to chronic back pain alone. Of these expenditures, approximately 93% was used for indirect costs related to work absenteeism and prolonged disability and 7% was used for direct medical costs (Australian Bureau of Statistics 2001; Koopman et al. 2004; Staal et al. 2002). As a result of these exorbitant costs, intervention, prevention, and work hardening programs have focused on identifying preventative and corrective measures, decreasing the prevalence or occurrence of low back pain, and returning individuals to work.

Prevention programs and programs designed to manage pain are excellent when implemented and individual participation is consistent. However, individuals must often submit to the means and resources available to them within their culture. This could include financial capability, and mobility, both physical mobility and means of transportation to access treatments, health care policies, social and familial support, and so on (Freund et. al 2003). Let us take a look at Australia’s medical system, in order to generate a feel for the types of circumstances affecting individuals in Australia, in conjunction with the medical system and health insurance.

**Australia’s Medical System and Insurance Reviewed**

The Australian national health care system is funded and organized by the government with the promise of universal access to health care for all Australian residents.
Australia's health care system is characterized by (1) its federal structure of government, with all three tiers – commonwealth, state and local – involved in the system; (2) the dominant role of private practitioners in providing care, mostly on a fee-for-service basis, but with governments increasingly influencing the structure of health services through their financing arrangements; (3) universal access to high-quality medical care via commonwealth and state funding for Medicare; And (4) substantial private funding supported and regulated by the commonwealth, so that the system offers a degree of choice (Podger, 1999).

(For an explanation of health care expenditure see Figure 1 and 2 and for allocation of expenditure funds, see Figure 3, located below and on the following page).

Figure 1: Estimated Total Health Expenditure by Source of Funds 2003-04

http://www.abs.gov.au/Ausstats
Figure 2: Government Sector Financing of Health Expenditure 2003-04

<table>
<thead>
<tr>
<th>Source of Expenditure</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Government (grants)</td>
<td>15.8%</td>
</tr>
<tr>
<td>State and Local own Resources</td>
<td>33.2%</td>
</tr>
<tr>
<td>Tax Expenditure</td>
<td>0.5%</td>
</tr>
<tr>
<td>Australian Government direct Expenditure plus DVA</td>
<td>45.8%</td>
</tr>
<tr>
<td>Health Insurance Premium Rebate</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

http://www.abs.gov.au/Ausstats

Figure 3 – Estimated Total Health Expenditure by area of Allocation 2002-03

<table>
<thead>
<tr>
<th>Area of Allocation</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Services</td>
<td>12.2%</td>
</tr>
<tr>
<td>Dental Services</td>
<td>5.3%</td>
</tr>
<tr>
<td>Other Professional Services</td>
<td>2.3%</td>
</tr>
<tr>
<td>Other Health Services</td>
<td>22.2%</td>
</tr>
<tr>
<td>Pharmaceutical</td>
<td>24.3%</td>
</tr>
<tr>
<td>Public Hospitals</td>
<td>24.6%</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

http://www.abs.gov.au/Ausstats
Medicare is a key component to Australia’s health care system, providing free health care under public coverage, at the time of access. Citizens and permanent residents of Australia are covered by public insurance under this universal system of health care. Approximately 70% of Australians are covered by public health insurance or Medicare, while others chose to purchase private health insurance (Australian Health and Welfare 2003). Medicare is financed by income tax, taxes on sales of goods and services, and non-tax revenue. The Medicare levy (Medicare funding from income tax) is based on a person’s taxable income at an approximate rate of 1.5% of taxable income depending on an individual’s income bracket. Commonwealth funding for Medicare is mainly provided as subsidies for prescribed medicines, treatment by mainstream practitioners, and grants to State and Territory governments to contribute to provision of free access to individuals. State and Territory governments also supplement Medicare with their own funding which mainly goes to public hospitals (McGuinness and Collin 2000; Unknown Author 2004).

Australian residents have held to a philosophy maintaining that each individual should have appropriate and necessary health care. In 1984, Australia realized this philosophy through the universal health insurance program known as Medicare. “...it has been said that Australians have accepted a levy on taxation to pay for equitable access to medical office and public hospital services because of their strong egalitarian tradition” (Harris and Harris 1998). This statement suggests that Australian health care has been structured to support a social ethic concerned with social justice, altruism, and equality. Harris and Harris (1998) suggest that Australian cultural values are “...associated with a value system which supports equity in the distribution of resources, equality of human rights, access to essential services based on need rather than ability to pay, and opportunity to participate in the decision making.”
In 1788, a fleet of English colonizers including convicts, soldiers, entrepreneurs, and civil servants landed on Australian soil. The first health care system in Australia, created by these settlers, included public services that tended to the needs of all soldiers and convicts, private services for the wealthy, and volunteer/free services for the poor.

Now, Australia’s health care system ensures free health services to all individuals under public health coverage through Medicare and allows private services for a fee, to those who have purchased private coverage (Harris and Harris 1998). Australia’s current health care system seems to be a modern replica of the first.

Australia’s government consists of the commonwealth, state/territory, and local governments. The government incorporates each of these divisions into its health care system both for means of funding and for allocating funds at each level. The all-encompassing governmental involvement, broken down to the state and local levels, in order to better represent the demographics at both the state/territory and local levels, is exemplary of Australia’s national altruistic character that supports universal health care access and affordability (Podger 1999).

Geographic obstacles and barriers play a crucial role in rationing and allocating health care services. While the majority of Australia’s population (approximately 80%) resides in large cities on the coasts where health care services are abundant, others, living in remote rural areas, have fewer options for health care services as there are fewer providers and facilities (Harris and Harris 1998; McGuinness and Collin 2001; Unknown Author 2004). This predicament illustrates the struggle to maintain universality and equality in delivery of services. While the system is not entirely perfect, the incorporation of Medicare that provides services to all, maintains the philosophies and ethics of the Australian colonizers to provide, to distribute, and to care for each
individual justly and with humanity, an allocative measure that is based on social ethics of universality, equality, and altruism.

The general sense of community in Australia is consistent with the historical ethics woven into the growth and development of Australian society in relation to its white colonizing populace. This sense of communal altruism and equality supports the universal health care system. One telling example of these influences in Australia’s health care system is the inclusion of mental health coverage under the national public policy. Australia’s egalitarian ethics push for health care to be provided to all. While the majority of Australia’s population participates in the benefits of universal health care services, there continue to be discrepancies. For instance, the Torres Straight Islanders and the Australian Aboriginal populations consistently have the worst health status in Australia (McGinness and Collin 2001). Australia may seem egalitarian in health care services, but to what extent?

How does Australia’s medical system that has been rooted in these egalitarian ideologies, with the noble, all inclusive, and historically prominent movement to serve all citizens and care for their needs adequately function by today’s standards?

In order to effectively evaluate the health care system of Australia, three different criteria have been chosen: access, customer satisfaction, and efficiency. Quality is also evaluated as a sub-criteria within each of the three main criteria, as it relates to each and can be defined in relation to each (Roberts et al. 2004).

Access refers to both accessing health care and access to health care. Using access as one of the three main criteria to evaluate health care systems will assist a better understanding of the ways in which these health care systems reach across or do not reach across the whole of the population. Evaluating access will illuminate disparities in health care between the rural and urban populace, as well as between ethnic groups. These are two serious
concerns, which should be considered in evaluating and revising health care systems (Roberts et al. 2004).

Evaluating customer satisfaction within the health care system will direct attention to the satisfaction of the populace where access to health care, health care facilities/technologies, and quality of care are concerned. Roberts et al. (2004) says, “Politically, the system’s inability to provide what citizens want is often a significant driver of reform.... this allows us to capture various features of the health system, apart from its impact on health status.” Ideally, evaluation of customer satisfaction represents how those accessing health care evaluate and perceive their care (Roberts et al. 2004).

Roberts et al. (2004) gives several definitions of efficiency. For instance, he lists efficiency in relation to services produced, technical efficiency, and allocative efficiency. We have adapted these definitions for a holistic evaluation. Here, efficiency refers to that of the financing of a health care system, organization of the health care system and its contributors, and the system’s ability to deliver care overall.

The Australian health Care System has both strengths and weaknesses. Australia’s national coverage through Medicare allows access and coverage to all residents. Australia’s health care coverage includes mental health, an excellent provision, and one that is not a priority in many countries. However, disparities remain between ethnic groups in accessing health care. For instance, the Torres Strait Islanders and the Indigenous Aboriginals of Australia suffer poor health status in comparison to the general population with a life expectancy nearly 20 years less than that of the general population/non-aboriginals. The rural areas where Australian Aboriginals and the Torres Strait Islanders predominantly reside provide access to health care facilities, but they do not have the variety or choice in access that can be had in and near urban centers and these populations generally do not choose to access care to the
extent that the rest of the Australian population does (Harris and Harris 1998; McGuinness and Collin 2001; Podger 1999).

Australians generally have good health, comparable to that of other industrialized nations, with a life expectancy of approximately 76 years for males and 81 for females. Australia's health disparities between the Caucasian population and the Australian Aboriginals, including the Torres Straits Islanders, shed light on the differences of service between these populations where customer service and the quality of services are concerned. This in turn, reflects differences in levels of satisfaction within Australia's population as a whole. While the Caucasian population typically resides in urban centers with greater choice and access to health care facilities, reporting a higher level of customer satisfaction and greater quality of care, those from the Aboriginal and Torres Straits populations, in rural areas, do not have as much choice or access to health care facilities, reporting worse overall health, quality of care, and customer satisfaction (Harris and Harris 1998; McGuinness and Collin 2001).

Efficiency of health care in Australia is reported as above average and similar to that of other industrialized nations. Financing and organization depend largely on the government and the programs set up by the government. These programs have done well in reaching the majority of Australia's population. However, the quality of delivered care varies between ethnic groups and between rural and urban areas, as do the length of the waiting lists for health care services. It is clear that the rural residing, non-Caucasian populace is suffering from poorer overall health. Certainly, 'equal' delivery of Australian health care and accessibility to native peoples could be improved upon (Harris and Harris 1998; McGuinness and Collin 2001; Podger 1999).

In conclusion, Australia's health care system was very similar to that of the U.S. prior to 1984. Australia's system was run predominantly as a privately insured system, which made it very difficult for all individuals to
access care due to high costs of coverage. In 1984, Australia turned to national health coverage by implementing Medicare, providing health care to all. Implementing this system has proven to be successful for Australia’s overall population, improving national health status (Altman and Jackson 1991).

Australia’s health care system has succeeded in providing national access to health care services through governmental representation and allocation of medical expenditures. State and local representation has played a key role in distributing health care funds, ensuring representation of local demographics. From Australia’s current health care system, it is evident that governmental representation at local, state, and national levels assists the provision of equal access to care (Altman and Jackson 1991).

A Pain in the Back: Theoretical Discussions

The cultures in which we live either meet or do not meet our needs at any given time, as we function and navigate our way within them and interpret them. Culture creates interdependence where, at some level, individuals are responsible for one another and for one another’s needs. For example, if culture is considered a context in which individuals are constantly interacting through various media, then individuals, through interactions, are responsible for one another at an ethical or moral level, at a social level, political level, economic level, and so on. Culture creates an environment in which we can interact, make individual choices, and function in relation to interpretations, while navigating within and between institutions within the larger culture.

The following discussions will elaborate on these cultural underpinnings with theoretical explanations in regards to chronic low back pain as a condition, the condition creating a community within the larger culture, and the condition as one that interacts with other segments and institutions of culture, within a greater culture. Psychological functionalism,
critical medical anthropology, and symbolism are three major anthropological theories that will assist the explanation of chronic low back pain within a cultural framework. Each of these theories adds to understanding this condition, but each is lacking a complete explanation. Therefore, each will be used in accordance to that portion of the condition that it best explains and examines while shedding light on how each theory connects in an overall explanation of this condition within culture.

**Psychological Functionalism**

Psychological functionalism explains the communal institution consisting of persons experiencing chronic low back pain and its interconnectedness with other sectors of culture, functioning within the whole. Psychological functionalism is an explanation for the ways in which cultural institutions function to meet the basic physical and psychological needs of people in a society (Malinowski 1922).

Malinowski was concerned with how individuals pursued their own ends within the constraints of their culture. Malinowski believed that culture existed to satisfy basic needs including: nutrition, reproduction, bodily comforts, safety, relaxation, movement, and growth (McGee and Warms 2004).

Placing chronic low back pain in the theory of psychological functionalism allows the exploration of treatments, where persons experiencing said condition are consumers of treatments needing continuous maintenance for the greatest benefits. In order to maintain pain management, people must continue consuming and utilizing the health care services and treatments that have provided said relief. This continuation also ensures the individual that there is security in knowing one’s pain will continue to be managed, that one can continue working or return to work to earn an income, that one can work
through the day rather than move through it coping with excruciating and distracting, often debilitating pain, and that one can conquer pain and look forward to a motivating tactic to conquer the pain of the next day. This optimism, generated through continued contact and function within and between institutions or groups, generates psychological benefits that are valued enough that the individual chooses to continue negotiating and navigating within and between these groups.

The sociology of exchange, as Bronislaw Malinowski refers to it, accounts for an exchange of goods that assist the maintenance of social order. The social order consists of particular individuals and institutions that interact and maintain interaction and exchange of goods or services to continue and ensure the smooth functioning of society or culture as one system (Malinowski 1922). The continuous exchange of services for payment, in the case of those experiencing chronic low back pain and the treatments utilized by these individuals, maintains this interrelational function-ability within culture.

Individuals experiencing chronic low back pain each have a very specific and unique story, making the search for an effective chronic pain management or relief program that much more difficult. There is no universal treatment that has proven successful in treating this group. However, by continuing to interact and navigate themselves within and between the institutions of health care, finding treatments that provide pain relief, these individuals can return to work and to the "normal" or previous cultural roll that s/he provided and contributed before experiencing chronic low back pain. As individual needs are met by societal institutions, these individuals are able to move and navigate within society as functional persons. This in turn supports the continued function of society as a whole.
Critical Medical Anthropology

Critical medical anthropology considers the human body as culturally and naturally constructed while attempting to reveal and discuss the shortcomings of mainstream medical paradigms, all the while considering how the individual interacts with health care or how health care is provided in the greater society and economic system (Lock and Scheper-Hughes 1998; Singer 1998; Singer 1990). It considers medical conditions and treatment in terms of interactions. It looks at the interactions between the political body (politics, government, etc.), societal institutions at the level of health care and the community, and the individual and how s/he experiences each level and interacts between them throughout the ‘illness’ experience (Singer 1998).

Lock and Scheper-Hughes (1998) explain the complexities of a person’s body in relation to considering the body medically, especially in more complicated health circumstances, such as chronic conditions. They explain that there are three bodies, the individual body (the living experience: mind, psyche, soul, spirit, personhood), the social body (use of the body in interactions between the natural and social world: how to think about society or culture when ill or healthy), and the body politic (the regulation and control of a body: disciplining an individual body while regulating the social body through work, reproduction, sickness, etc.) (Lock and Scheper-Hughes 1998).

Chronic low back pain patients are a part of the larger culture, yet they comprise a community in and of themselves. Due to the complexity of the condition, this population both functions, and is dysfunctional, within society and culture. Individuals experiencing chronic low back pain are both disruptive and supportive of the collective function of a society or nation for that matter. They must learn how to function within the greater community by negotiating with and navigating within and between societal institutions while learning to function individually, according to personal and physical
limitations resulting from this condition. For many, this means juggling interactions amongst and between societal institutions such as, health care, the workplace, the home, spiritual communities, and so on.

Health care, as a societal institution, functions with other constituents of the larger culture, within the larger culture. Linked to health care and branching from it are mainstream medicine and alternative medicine. They each maintain their own cultural ideologies and in most societies, they are politically separate. Generally, mainstream medicine is covered by insurance and health care policies, where alternative treatments are not, thereby creating a political and financially secure association with mainstream medicine that is not associated with alternative care services.

We see that individuals experiencing chronic back pain in this study have had to link these institutions together where appropriate. All the while they are navigating through these institutions, shaping personal treatment trajectories. As they find treatments that aid them in the endeavor and pursuit for pain management and cure, they must negotiate the cost (financially and emotionally) of their choices and access of various treatments or combinations of treatments.

Where one form of treatment may fail in serving the needs of those experiencing chronic low back pain, others might produce relief. Often, these individuals will exhaust available mainstream medical or alternative treatments in the search for effective pain management programs and will turn toward a combination or multidisciplinary approach. At this point, temporary or subtle relief found in any given combination of treatments could serve the psychological needs of these persons.

When considering the individual body in relation to mainstream medicine, we see Cartesian Legacy surface. This means that the mind is separated from the body or the spirit is separated from the body in mainstream medical treatment and thinking. As was mentioned earlier, individuals are then
left to seek other forms of treatments in order to address spiritual, psychological, or emotional needs that are dissatisfied by mainstream medicine. Mainstream medicine cannot account for individual uniqueness in ‘diseases’ such as chronic low back pain. Mainstream medical practitioners cannot always place their finger on the cause or the cause of symptoms in individuals experiencing chronic low back pain and so, they are unable to affectively treat the condition as they hold to mainstream medical paradigms considering the body as a sort of machine or defined organism homogenous across human populations (Lock and Scheper-Hughes 1998; Singer 1990).

The social body accounts for bodily interactions with the social world. That is to say, healthy bodies allow a society to function healthily while unhealthy bodies can cause dysfunction and social tensions leading to imbalance. Certainly those experiencing chronic low back pain are interacting with society or the social world and those interactions are causing social tensions and a form of dysfunction. As mainstream medicine is unable to provide pain relief to these individuals, they seek treatment elsewhere. Often, they are unable to find treatments or a treatment that effectively alleviates pain for quite some time, if ever. This creates and perpetuates a constant dissatisfaction to some degree for these individuals, whether it’s at an emotional level, financial level (as the may be unable to work or find work), or a spiritual level (Lock and Scheper-Hughes 1998). They become dysfunctional in a harmonious society.

It becomes clear that the chronic low back pain community connects the institutions of health care based on the treatments that these individuals access or utilize. Likewise, these individuals also connect the health care institutions to the laboring and economic institutions of the larger culture, as they are dependent on the medical sector to improve or manage their physical well-being to continue laboring in the workforce. With these individuals navigating between institutions, relationships with others within these
institutions are also incorporated into the individual’s path as they navigate between and within society and its institutions.

The body politic of critical medical anthropology is concerned with control and power relationships. Here, the body is to be controlled in a healthy state, to continue on with the smooth harmonious functioning of the social body, while purging out those bodies that are unharmonious or dysfunctioning. This thought runs from the idea that when a sense of order (social order) is threatened, symbols of control (self-control and social control) become magnified and are clung onto (Lock and Scheper-Hughes 1998).

Individuals experiencing chronic low back pain would inevitably feel out of control or that they are losing control when experiencing a life change in work, hobbies, sleep patterns, and daily routines as the result of their new ‘way of living.’ Some individuals surrender that control or the loss of it to the condition and treatments routines to manage pain, and some surrender their pain to their faith and allow God to heal them by His grace.

Society latches onto the idea of control with this community of people by not allowing them to re-enter the workplace in some instances, marginalizing them by placing limits on what they can or cannot do physically, or by placing these individuals in chronic pain clinics to get them out of the way of ‘functioning society,’ and so on. While there would be some limitations naturally, as the condition places them on the individual physically, society may place greater limitations on the individual as a result of social perceptions of the condition or individual’s physical state that is exaggerated beyond the physical and emotional state s/he is actually in.

Symbolism

Symbolism in anthropology is associated with Clifford Geertz, a well known symbolic anthropologist from the 1960’s and 70’s. Geertz considered
that public symbols within culture guide individual action. Geertz suggested that culture functions to give the world understandable meaning through interpretation of symbols. These symbols act as knowledge and information that individuals interpret in order to make decisions for action (Geertz 1972). Hence, symbols guide action. Individuals in a given society agree on common symbols and interpretations. These are called public symbols and are understood by the society as a whole. Within that realm of symbols, individuals make personal interpretations as well. All interpretations of symbols guide and direct individual actions and decision making.

The community of chronic back pain can be examined both on its own and within society as a whole by way of symbolic theory. Chronic conditions and the individuals experiencing them add a vulnerability to society in such a way that many of society’s basic attitudes and interpretations surface as these individuals adapt and strive to remain fully incorporated in society (Rhodes 1996).

Here, symbolism becomes obvious in the ways that individuals create and shape the culture of pain through interpretations and how their condition is shaped and interpreted by cultural symbols. Persons experiencing chronic low back pain interpret psychological variables, physical variables, and treatment variables. For instance, individuals interpret symbols of perceived disability, perceived likelihood of recovery, perceived level of pain, relationships with practitioners, perceived risk behaviors, and perceived benefits of particular treatments/programs. Each of these perceptions requires symbolic interpretation in order to formulate meaning for any given individual. Each of these interpretations affects the individual’s new concept of self or personhood, his or her new role in family and society, the individual’s identity, and role in relationships with practitioners and employers (Freund et. al 2003; Janzen 2002).
Many of these interpretations for understanding come from or are heavily influenced by the public sphere of symbolic interpretation. These interpretations will then prompt particular actions and decisions on the individual level based on the knowledge the individual assumes from the interpretations, the interpretations that have been agreed upon by the whole of society. Actions and behaviors that might reflect one’s interpretations of these public interpretations could be choosing one form of treatment over another, outwardly confessing disability, refusing to claim the title of disability, surrendering control over one’s pain and situation, or attempting to take or gain control over one’s pain and situation by way of pain management, for instance (Freund et al. 2003; Janzen 2002).

Furthermore, individuals that perceive high levels of pain and disability along with low perceptions of recovery and benefits from treatments will most likely participate in inactive, protective, fear behaviors; behaviors that protect further injury based on the assumption that certain movements will induce greater pain and therefore, greater injury. In contrast, individuals who perceive greater likelihood for recovery and benefits from treatments, have a low level of perceived disability, and do not consider or acknowledge risk behaviors might recovery more quickly or at least, participate in treatments and programs with the full intent to improve and to manage pain, using the “full” range of motion, rather than constricting movements out of fear that they are risk behaviors.

Symbolism is useful in assessing and discussing chronic low back pain because it accounts for the individual’s perceptions and interpretations of both public and personal symbols (such as: compliance to treatments, level of disability, pain management, fitness level, necessary medications) and gives an explanation for individual behaviors and choices. This allows ethnographic recordings to be more objective and from the perspective of the individual participating in the research project rather than from the researcher. However,
the difficulty presented here, is that the researcher will then be interpreting and giving meaning to the interpretations the participant is vocalizing. The benefit is that the interactions between individual experiences and interpretation of symbols with those of the public can be analyzed.

Looking once again at psychological functionalism and critical medical anthropology, the importance of considering cultural context is reaffirmed. It is reaffirmed on the individual level as each person negotiates and navigates through interactions between groups or institutions working within the larger culture. Individuals who are or have experienced chronic low back pain have some interesting stories, each very unique. These stories should be considered at the individual level and then be connected to the greater cultural context in which the individual functions and navigates. Critical medical anthropology allows for just such a theoretical discussion. It fills in the gaps left by the other theories and delves into the individual experience so that societal function, psychological function, and symbolic interpretation may be discussed and considered while also considering some ways in which these individuals are struggling and are marginalized within society as they continue playing a role within society as a whole.

Using these three theories together, as an approach to discussing and analyzing chronic low back pain, allows discussion of the condition in the context of individual experience and interpretation within the greater context of culture. Each theory is arguably fallible. It is my hope and intention that considering the three together will fill in some of the spaces left by each theory, covering more theoretical ground, more thoroughly. Using these theories while accounting for their shortcomings and maintaining consideration of the originality of data, where the individual’s interpretations are maintained rather than the researcher’s, wherever possible, will allow a world of knowledge about this community of chronic low back pain and the individual variation within to surface.
Chapter 3 - Methodologies

The purpose of this study is to review treatment trajectories, patient perceptions, and patient experiences, in order to better understand chronic low back pain, the culture of chronic pain, and to expose any treatment patterns within the participant population that may reveal both utilized and effective treatments for this condition.

Study Population

Feeling that I had more knowledge base in mainstream medicine, I began my research hoping to interact with alternative care facilities. I made contacts and was able to set up an internship and research agreement with Equilibrium Wellness Centre, an alternative care facility in Avalon, Australia. While I was interning at Equilibrium, I was exposed to a number of alternative treatments that are useful and administered to chronic low back pain patients, which provided the opportunity to learn about and understand these treatments from personal observation and from direct communication with practitioners.

The sample or study population is representative of chronic low back pain patients experiencing consistent or reoccurring low back pain for over three months. All participants reside in the Sydney area and seek treatment or have sought treatment within the Sydney area. Subjects for the study population have been recruited voluntarily through my involvement at Equilibrium Wellness Centre and also include four individuals I met and befriended during my stay that were personal contacts and unrelated to Equilibrium, but were experiencing chronic low back pain and met the requirements of this study.

The participants in this study are a sample of convenience. That is to say, they were individuals who were willing to participate in this study.
voluntarily once they became informed through either myself or information provided through Equilibrium Wellness Centre, where I participated in an internship. Therefore, this study population is not representative of a larger population. It is not a random sample, which would allow for some general conclusions to be drawn from the data collected. Rather, this population is representative of itself and the data collected comprises a qualitative study and report of the ten individuals and their personal stories and experiences with chronic low back pain.

I had not met the individuals from Equilibrium prior to the interviews, but information explaining my research had been clearly posted throughout Equilibrium for clients to view and practitioners mentioned it to individuals who qualified to participate. Telephone numbers were accessed only with permission from the Wellness Centre and permission from potential participants after these individuals had received information about the research project along with my personal contact information detailed in a letter sent to each potential participant.

Contact details were obtained through Equilibrium for 29 individuals as potential participants. While the original goal was 30 participants, a total of ten participants volunteered for this study: six from the Equilibrium contacts and four from personal contacts. Of those ten individuals, four volunteered to participate in a follow-up interview for closer observation and case study information. Three of the case studies are individuals contacted through Equilibrium and one is a personal contact. While individuals on the contacts list were more than friendly, most proved to be exceedingly uncooperative and chose not to participate.

It should also be noted that the four case studies presented in the following chapter are included because these four individuals agreed to a second in-depth interview, providing a greater amount of information and detail of information about their experiences. This detail and abundance of
information provided through two interviews versus one was the qualifying criteria for these individuals to be included as individual case studies, enriching the data collection and personalizing the individual accounts and information given throughout this study.

The study population was not restricted to any gender or ethnic group. However, all participants are white or of Caucasian background. The population consists of seven women and three men, all of whom were adults over the age of 18, ranging from the age of 29 to the age of 76. Of the ten participants, five were covered by public health insurance and the other five were covered by private health insurance. To maintain confidentiality, the identity of each participant has been protected by ascribing fabricated identifiers or names throughout the research study.

The results from this study will be shared with each participant, with the hope that the knowledge accumulated throughout this project can be used to alleviate some pain by providing information about the most effective treatments available to these individuals, according to the perceptions of these participants.

**Process of Interviews**

Informed consent was obtained at the initial interview and reviewed at the follow-up interview. The participant had an opportunity to read through the form before the initial interview and before agreeing to participate. The participant then received a copy of the Informed Consent Document at the beginning of the initial interview to be signed, returned to, and kept by the researcher.

Research was conducted in the form of semi-structured interviews from September, 2005 through the month of November, 2005. Interviews were held at Equilibrium in a private room, at the home of the participant, or at a location
of the participant’s choice. At the time of each interview, the participant was asked to answer a set of quantitative survey questions as part of the interview process. The data from the surveys have been analyzed and recorded along with the qualitative interview data. All interviews have been transcribed, coded and analyzed for discussion of data.

Interested and willing volunteer participants agreed to participate in an initial interview. This interview lasted approximately one to one and one-half hours and was audio-tape recorded. The participant was initially asked a set of quantitative survey questions. (See appendix 1 for Survey Questions). Semi-structured interview questions were then introduced to prompt discussion by the participant and to manage the interview in the most efficient manner for time and quality of research. (See appendix 2 for Initial Interview Questions).

Follow-up interviews were conducted with four of the ten participants. These individuals were willing to volunteer for another interview approximately two months after the initial interview. The follow-up interview lasted approximately one hour and was audio-tape recorded. This interview was structured in the same manner as the initial interview. Again, the participant was initially asked a set of quantitative survey questions, this time, to reveal any changes. The semi-structured interview questions were to prompt discussion and to clarify any information that was in need of clarity after the initial interview. (See appendix 3 for Follow-up Interview Questions).

The interviews exposed independent variables such as the experiences chronic low back pain patients have had with both mainstream and alternative treatments. Dependent variables include the patient’s perceptions of both types of care, reasons for utilization of both or one over the other, and satisfaction or dissatisfaction with both/either forms of treatment. Social and cultural factors have been addressed in the interviews as well. For instance, the perceived accessibility of treatments and which treatments are affordable or covered by health insurance (Bernard 2002: 205).
Analytical Approach

I implement comparative analysis of this field research through utilization of similarity matrices, adapted from the cultural consensus model, that will be used to organize, compare, analyze, and discuss data and trends that surface within the study population. The cultural consensus model rules that one can discover similarities, differences, and cultural truths by seeking knowledge of individuals from the same culture (sharing the same cultural knowledge) independently of one another. The three requirements of this model of research include: (1) questioning only those informants who share a common culture, (2) these individuals must share answers independently of one another, and (3) the questions asked must be grounded in the same cultural domain as the basis of the individual’s cultural knowledge. These questions are typically structured for an answer of yes or no, true or false. The answers are then placed in similarity matrices charting the answers across the population for analysis and to reveal the ‘cultural consensus’ on various topics (Bernard 2002: 193-198).

The fundamentals of the cultural consensus model will be used to analyze the data collected here. However, the model has been adapted, in that, questions were not necessarily asked to collect answers of yes or no, true or false, but rather, to allow the participant to answer freely within a given realm of cultural knowledge. These data will then be placed in similarity matrices for analysis.

Similarity matrices will reveal types of treatments that have been utilized, treatment trajectories, and patient perceptions toward the effectiveness of these treatments (Bernard 2002: 193-198). Furthermore, the similarity matrices will compare patient experiences and perceptions of mainstream medical treatments to patient experiences and perceptions of alternative treatments while considering perceived satisfaction with the treatment and the
reasons for using each form. This design will make known the original treatments utilized by the patient and will provide clarity in viewing and uncovering any shifts in treatment utilization, as well as some reasons for that shift (Bernard 2002: 122-124).

This research also requires a qualitative analytical approach or text analysis. The qualitative methods approach of grounded-theory will support the research methods of this project, by extracting and comparing major themes or ideas in each interview based on the similarity matrices. These interview themes will then be compared across the study population. In coding each interview’s themes, similarities and differences will surface for comparison and discussion. This method will work in cooperation with the similarity matrices previously mentioned, by adding greater depth from coding and analyzing each interview more closely (Bernard 2002: 462-3).

The presentation of these results will show prominent treatment trends for each participant and for the study population as a whole, for both mainstream and alternative treatment, revealing treatment trajectories and common themes therein. Variables that influence utilization of both mainstream and alternative treatment such as the patient’s perceptions of both types of care and satisfaction or dissatisfaction with both/either forms of treatment will also be exposed for comparison and reliability throughout the study population (Bernard 2002: 462-3).

While my own theoretical stance and premise for this research considers psychological functionalism, critical medical anthropology, and symbolism, I have chosen to use a grounded theory approach for analysis of my data (Bernard 2002: 462-487). This will allow theory to emerge from the data and the participants to speak for themselves. Through coding interviews and finding common themes to compare in similarity matrices, theoretical assumptions discussed in chapter 2 will either be supported or proven irrelevant to the study population and the experiences this population has had.
It is my assumption that through coding and analyzing the data, these theoretical standings will prove to be valid explanations for the experiences of the study population. I do not doubt that other valid theoretical models will also explain patient circumstances. It is for this reason that I have chosen the grounded theory approach. This will illustrate whether or not the combined theoretical models of psychological functionalism, critical medical anthropology and symbolism truly represent the data.

The steps for analysis in the grounded-theory approach include:

1. Producing transcripts of interviews.
2. Identifying potential analytic categories: that is, potential themes that arise.
3. As the categories emerge, pull all the data from those categories together and compare them.
4. Think about how categories are linked together.
5. Build similarity matrices to compare and further analyze similarities and common themes between cases.
6. Present the results of the analysis using quotes from interviews that illuminate the theory/theories. Tie the results into the theoretical basis for the research through discussion.
   (Bernard 2002: 463)

Research Limitations

This research, like all research has its limitations and a number of these limitations surfaced while conducting research. As was mentioned earlier, I was unable to recruit my desired 30 participants and have ten instead. I have been able to gather interesting and relevant data and have been able to present it in order to generate a better understanding of the experience of chronic low back pain in Australia’s medical system. Unfortunately, the data is representative only of these research participants and not of a larger population, due to the small size of this participant population and the fact that they are not a random sample taken from the general populace. As the study
population is a sample of convenience, conclusions and generalizations cannot be drawn from the data collected, in order to be applied to the larger community.

Participants in this study are predominantly individuals from Equilibrium Wellness Centre, an alternative care facility that offers the services of only one mainstream medical practitioner. These individuals could be said to favor alternative treatments from the start. In fact, two of the three individuals in the study that have expressed having a ‘faith’ in mainstream medicine are from the four personal contacts I made outside of Equilibrium. All but one of the individuals from Equilibrium prefers alternative treatments over mainstream medicine. Therefore, this population could favor alternative medicine more than the general population.

Equilibrium has a large client base, and supplied a contact list of 29 individuals, however, this list alone, did not meet the desired 30 participants originally hoped for. Contact was made through Equilibrium with nearly 20 other practitioners and alternative care facilities in the area to recruit more participants. Alas, every single contact declined the opportunity to promote clients or patient participation in this study, despite Equilibrium’s recommendation. Therefore, six participants came from Equilibrium and four from personal contacts.

**Concluding Remarks on Methodologies and Research**

In sharing this information, I hope that the research participants in this study will benefit. I plan to distribute summarized copies of my study results to each of the persons included in this study population. This will give them information concerning other potential treatments based on treatment utilization of other participants and may possibly provide information about a treatment they have not tried and could be effective in alleviating pain.
Chapter 4 - Research Results

Each of the ten participants that shared so willingly in this study has his or her own story, with specific details that make each story distinct, as each one is a personal account of a similar circumstance. The multitude of information obtained from each individual and across the study population could be discussed and analyzed repeatedly with the confidence that new themes and interesting information would arise. The research results discussed here, the tables located at the end of the chapter, and the themes raised are reflective of one researcher's optic window.

First, the tables representing themes found within the data across the study population as a whole will be presented in writing, with the corresponding tables located within the text. All data and percentages presented in this chapter are calculated directly from the information found in the tables. Quotes from the study population will be presented to support the data collected and will be referenced in Chapter five as well.

Here, I will recap the findings across the study population as a whole, linking them together. This will be followed by four detailed case studies telling the story, or the information shared through both the initial and follow-up interviews with these individuals. Each given a fabricated name to protect participant confidentiality. The case studies will personalize the circumstance and experience of chronic low back pain and will clarify the themes discussed prior to the case studies.
Themes and Data Presented from Across the Study Population

Supposed Causation of Original Injury and Number of Known Re-injuries

Table 3 – Supposed Causation of Original Injury and Number of Known Re-injuries

<table>
<thead>
<tr>
<th>Participant</th>
<th>Causation</th>
<th>Known re-injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Undefined</td>
<td>Multiple accidents</td>
</tr>
<tr>
<td>2</td>
<td>Twisted/ contorted at birth</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Lifting something</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>Child bearing</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>Lifting something</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Cleaning</td>
<td>7</td>
</tr>
<tr>
<td>7</td>
<td>Lifting something</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Sports injury (football)</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>Bending/ leaning over</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>Severe fall (on wet concrete)</td>
<td>0</td>
</tr>
</tbody>
</table>

Causation and the time of original injury are often difficult to determine when considering chronic low back pain. An individual’s back may be slightly damaged over time with no symptoms realized. He or she may experience one particular instance or injury that is perceived as the cause, while the injury may have existed previously and led up to the perceived cause.

Table 3 suggests the assumed or known causes for each individual’s back pain according to his or her own perceptions and experience. The participant responses for causation support common instances of strain on the lower back. Of the total population, 50% injured their back with a bodily movement that involves bending over, 30% involved bending over and lifting weight or lifting weight improperly, placing excessive strain on the lower back. These are the most prominent similarities found for causation of chronic low back pain across the study population.
Only one case was reported as undefined in cause and is listed as having multiple accidents that over time have perpetuated and continued this individual’s chronic low back pain. Another participant was noted as having a severe fall, which has caused over one decade of chronic low back and neck pain. Other than two cases, the cause of chronic low back pain was the result of some degree of musculoskeletal or spinal strain.

The data show that 40% of the population did not experience a known occurrence of re-injury. That is to say, these individuals have experienced chronic low back pain as the result of one known incident or injury. There seems to be no connection to the incidence of re-injury and the extent of pain an individual experiences based on these data. Participants 5 and 6 reported normal mobility, job functionality, and minimal debilitation in life-style while managing chronic low back pain. These two individuals also consume minimal medications (pain killers) and have found at least one method of treatment to satisfy their needs physically.

Participants 2, 3, and 7 reported the greatest level of debilitating pain within this population. Participant 7 is no longer able to work, participant 3 has changed occupation from business person on the run to an incredibly talented artist, and participant 2 is past the age of typical retirement. Of these individuals, two experienced one case of re-injury, but all reported chronic pain existing from the first instance of injury.

While re-injury certainly does not assist the betterment of one’s health and wellbeing, based on the data collected, re-injury cannot be said to have a significant effect on the cause or increase of chronic low back pain. However, it is rational to leave this comment open to results from studies with larger populations, as re-injury has great potential to cause further physical and psychological damage to individuals already experiencing chronic pain.
Occupation and Reported Occupational Cause of Injury

Table 4 – Occupation and Reported Occupational Cause of Injury

<table>
<thead>
<tr>
<th>Participant</th>
<th>Occupation</th>
<th>Occupational Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Receptionist</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Mother</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Artist/ painter</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Librarian</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>Nurse (intensive care)</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Manages personal business</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Nurse (assistant)</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Educational instructor (college)</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Educational instructor (college)</td>
<td>No</td>
</tr>
<tr>
<td>10</td>
<td>Primary School Teacher/ currently a student</td>
<td>No</td>
</tr>
</tbody>
</table>

Occupation can have an influence on one’s spinal health. Careers that require excessive sitting, standing, or lifting are especially risky. One-hundred percent of the study population works or has worked in career positions that create stress on the lower back in at least one of the aforementioned positions or movements. Within the population, 20% are currently working or have worked in the medical field, performing the duties of a nurse (requiring repeated lifting of heavy objects), 30% are or have been educators (requiring nearly equal time both sitting and standing), and 50% participated in other work. Thirty percent reported the cause of their pain to be work related. Of this 30% of the total population, 67% have worked in the medical field and 33% were injured while cleaning, as part of a profession. It can be said, based on the literature in Chapter 2, that occupation can cause and affect chronic low back pain, as is evident here.
Treatments Used in Order of Use (Treatment Trajectories) and the Most Effective Treatments based on Participant Perceptions

Table 5 – Treatments Used in Order of Use (Treatment Trajectories) and the Most Effective Treatments based on Participant Perceptions

<table>
<thead>
<tr>
<th>Participant</th>
<th>Treatments Used (Treatment Trajectory)</th>
<th>Most Effective Treatment(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chiropractic, supplements, osteopathic, heat, ice, electrode, acupuncture, massage, yoga, walking, Pilates</td>
<td>Massage, acupuncture, chiropractic, walking</td>
</tr>
<tr>
<td>2</td>
<td>Two cervical laminectomies (surgery), supplements, acupuncture, chronic pain clinics</td>
<td>No treatments alleviate pain</td>
</tr>
<tr>
<td>3</td>
<td>Practitioner, medications physiotherapy, back specialist, joint specialist, pain clinic, acupuncture, faith healing, osteopath</td>
<td>Faith healing, acupuncture</td>
</tr>
<tr>
<td>4</td>
<td>Chiropractic, physiotherapy, Pilates, massage, walking</td>
<td>Pilates, massage, walking</td>
</tr>
<tr>
<td>5</td>
<td>Physiotherapy, interferential short wave therapy, massage, stretching, bed rest, sports therapy, medications, acupuncture</td>
<td>Physiotherapy</td>
</tr>
<tr>
<td>6</td>
<td>Shiatsu massage, chiropractic, supplements, walking, acupuncture</td>
<td>Walking</td>
</tr>
<tr>
<td>7</td>
<td>Physiotherapy, medications, exercise, swimming, traditional Chinese massage</td>
<td>Massage</td>
</tr>
<tr>
<td>8</td>
<td>Chiropractic, physiotherapy, surgery (laminectomy), medication, swimming</td>
<td>Swimming</td>
</tr>
<tr>
<td>9</td>
<td>Practitioner, physiotherapy, chiropractic, medications, bed rest, exercise</td>
<td>Exercise</td>
</tr>
<tr>
<td>10</td>
<td>Chiropractic, physiotherapy, remedial massage, swimming, exercise, baths, aromatherapy</td>
<td>Massage</td>
</tr>
</tbody>
</table>
Treatments that have proven to be used significantly across the study population include: acupuncture at 50%, chiropractic at 60%, exercise of some form at 70%, massage at 60%, medications (pain killers) at 50%, physiotherapy at 70%, and supplements at 30%. Participants chose for the initial treatment: chiropractic in 40% of cases, massage in 10%, physiotherapy in 20%, and a mainstream medical practitioner in 30% of the cases represented by this study population. The second type of treatment sought by participants was an alternative treatment 20% of the time and mainstream treatment 80%. The third type of treatment sought was alternative 70% of the time and mainstream 30%. The fourth type of treatment sought was alternative 60% of the time and mainstream 40%. While four types of treatments were the most that participant number 2 sought, continued breakdown of order of treatments sought exhibits continuity in alternative care being sought at a higher percentage than mainstream.

Most individuals were dedicated to the search for a treatment or combination of treatments that would alleviate, manage, and cure the chronic low back pain they have been experiencing. Throughout the journey, there was substantial consensus in the choices of treatment: exercise and physiotherapy were used by 70% of the population; massage and chiropractic treatment, ranked at 60%; and acupuncture and pain killers, at 50%.

As the journey of seeking treatment and alleviating pain continued, the study population was quick to turn to alternative treatments where 70% chose an alternative treatment as the second type of treatment sought. The continued pursuit of alternative treatments as preference after the second type of treatment sought is evident across the entire study population where more than 50% continued to seek alternative treatments over mainstream medical treatments. Alternative treatments ultimately prove to be the preference across this study population for managing and alleviating chronic low back pain.
Which treatments in particular are considered the most effective based on participant perceptions? Acupuncture was listed by 20% of the participant population; exercise was listed by 40% (if physiotherapy were included in this category, as it provides exercises to be performed regularly, exercise would be listed by 50% of the population); and massage was listed by 40% of the participant population. Faith healing and chiropractic treatment were each listed by 10% of the population.

The data show that both massage and some form of exercise prove to be the most effective treatments in managing and alleviating chronic low back pain. The most common forms of exercise reported by participants include: swimming, walking, yoga, and Pilates. Each of these forms of exercise is a low impact sport. That is to say, each of these forms of exercise places minimal pressure or strain on a body’s joints, which seems to work well for individual’s experiencing back pain. Exercise and massage are reported by those individual’s utilizing these forms of treatment as providing the most consistent and lengthy episodes of pain relief. Both are said to loosen up the lower back and provide relaxation for musculature in that area of the spine, thereby relieving pain.
Treatment Trajectories: Shifts between or from Mainstream and Alternative Treatment and Attitudes behind the Decision

Table 6 – Treatment Trajectories: Shifts between or from Mainstream and Alternative Treatment and Attitudes behind the Decision

<table>
<thead>
<tr>
<th>Participant</th>
<th>Shift in Treatment Trajectory</th>
<th>Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mainstream to Alternative</td>
<td>“I always lean toward alternative care that is multidisciplinary.”</td>
</tr>
<tr>
<td>2</td>
<td>Mainstream to Alternative</td>
<td>“Nothing works... so I just keep seeking help for the pain.”</td>
</tr>
<tr>
<td>3</td>
<td>Mainstream to Alternative</td>
<td>“I never gave alternative medicine a thought until mainstream medicine failed me.”</td>
</tr>
<tr>
<td>4</td>
<td>Mainstream to Alternative</td>
<td>“I have family members who practice natural health care. I trust it. It frees my body up and I’m relaxed for longer periods of time.”</td>
</tr>
<tr>
<td>5</td>
<td>Mainstream to Alternative</td>
<td>Trusts physiotherapy and mainstream medicine, but is open to alternative care</td>
</tr>
<tr>
<td>6</td>
<td>Alternative to Mainstream to Alternative</td>
<td>“I always go to alternative medicine first. Mainstream medicine is the alternative for me when nothing else works.”</td>
</tr>
<tr>
<td>7</td>
<td>Mainstream to Alternative</td>
<td>“Before I thought doctors knew what they were doing. Now I know that in the area of back pain there are no guarantees.”</td>
</tr>
<tr>
<td>8</td>
<td>Mainstream to Alternative</td>
<td>“Before I thought that mainstream medicine was the answer to all medical conditions. My successful surgery has increased my confidence in mainstream medicine.”</td>
</tr>
<tr>
<td>9</td>
<td>Mainstream to Alternative</td>
<td>Never really sought after treatments aggressively. Feels better with exercise</td>
</tr>
<tr>
<td>10</td>
<td>Mainstream to Alternative</td>
<td>“I had bad experiences with the chiropractor and physio didn’t help much either. Massage and exercise are important.”</td>
</tr>
</tbody>
</table>
Results from Table 5 showed a consistent movement from mainstream treatments to alternative treatments from the second type of treatment sought through the remainder of treatments sought by the majority of participants. Ninety percent of participants moved strictly from mainstream medical treatment to alternative treatments, while 10% moved from alternative to mainstream, and returned to alternative. To the latter pattern, this was said, “I always go to alternative medicine first. Mainstream medicine is the alternative for me when nothing else works.” It seems then, that this individual was seeking alternative care initially, considered that mainstream medicine had something to offer, and returned to alternative care after seeking mainstream medicine for an improvement in health.

It is important to note that while 90% of the population first sought mainstream medicine and moved to alternative, at least 33% of this portion of the total population reported satisfaction with mainstream treatment, but incorporated treatments such as exercise or massage later in pain management. It is not entirely fair then, to say that these individuals shifted from mainstream to alternative treatment, but rather, they incorporated alternative treatments into the mainstream treatment regime.

Of the total population, 30% have reported that they prefer alternative treatments and their comments suggest that this has been the case for these individuals for some time. Some comments read like this: “I always lean toward alternative care that is multidisciplinary.” “I have family members who practice natural health care. I trust it. It frees my body up and I’m relaxed for longer periods of time.” “I always go to alternative medicine first. Mainstream medicine is the alternative for me when nothing else works.”

Participants reported clear discontentment with mainstream treatment in the shift to alternative care 40% of the time making statements such as: “No treatments work... so I just keep seeking help for the pain” (although, this statement seems to also imply that alternative treatments provide no relief as...
well). "I never gave alternative medicine a thought until mainstream medicine failed me." "Before I thought doctors knew what they were doing. Now I know that in the area of back pain there are no guarantees." "I had a bad experience with the chiropractor and physiotherapy didn’t help much either. Massage and exercise are important."

Thirty percent of the population suggested that mainstream medicine worked for them. Sixty-seven percent of this portion of the total population reported comments such as: "Before I thought that mainstream medicine was the answer to all medical conditions. My successful surgery has increased my confidence in mainstream medicine" or that he/she trusts physiotherapy and mainstream medicine, but is open to alternative care. The remaining 33% of this portion of the total population reported that treatments were not sought aggressively, but that relief is found with exercise.

It can be said, based on these data, that the shift to alternative treatments is predominantly a reaction to discontentment in mainstream treatments. Seventy percent of the population has stated, as represented in the data above, that they prefer to utilize alternative treatments over mainstream treatments.

It is also interesting to note that 67% of the 30% portion of the population reporting confidence in mainstream medicine is covered by private health insurance. This poses the question of whether or not satisfaction with care is affected by the type of insurance held. The data show that the majority of the study population prefer or have shifted to alternative treatments while 30% reported satisfaction with mainstream treatment as well as incorporation and satisfaction with alternative treatments. Based on these numbers, statements concerning the type of health insurance affecting satisfaction or treatments utilized are unable to maintain validity. A closer look at health insurance and the links between health insurance and treatment trajectories is considered in the next section.
Insurance: Type of Insurance, Perceived to affect Treatments, and some Remarks

<table>
<thead>
<tr>
<th>Participant</th>
<th>Insurance</th>
<th>Perceived affect</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Public</td>
<td>Yes</td>
<td>“I get money back from the treatments that are covered.”</td>
</tr>
<tr>
<td>2</td>
<td>Public</td>
<td>Yes</td>
<td>“I had to go on a waiting list for my first surgery.”</td>
</tr>
<tr>
<td>3</td>
<td>Private</td>
<td>No</td>
<td>“My insurance covers both mainstream and alternative treatments.”</td>
</tr>
<tr>
<td>4</td>
<td>Private</td>
<td>No</td>
<td>“My insurance covers both, but not the entire cost for alternative care.”</td>
</tr>
<tr>
<td>5</td>
<td>Public</td>
<td>Yes</td>
<td>“Physiotherapy all came out of my pocket.”</td>
</tr>
<tr>
<td>6</td>
<td>Private</td>
<td>Yes</td>
<td>“I can only do what is covered otherwise I can’t afford it.”</td>
</tr>
<tr>
<td>7</td>
<td>Public</td>
<td>Yes</td>
<td>“Public insurance doesn’t cover much.”</td>
</tr>
<tr>
<td>8</td>
<td>Private</td>
<td>No</td>
<td>“Insurance didn’t really affect my treatment choices.”</td>
</tr>
<tr>
<td>9</td>
<td>Private</td>
<td>No</td>
<td>“My treatments weren’t affected.”</td>
</tr>
<tr>
<td>10</td>
<td>Public</td>
<td>No</td>
<td>I’ve done treatments I’ve wanted... “I’m not sure what private insurance would give me.”</td>
</tr>
</tbody>
</table>

Health insurance in Australia is generally categorized as either public, paid predominantly by the government and available to all Australian citizens, or private, paid through a third party, such as an insurance company. Within the study population, 50% are covered by public health insurance and 50% are...
covered by private health insurance. Of those covered by public health insurance, 80% stated that the treatments they utilized were affected by the type of insurance held. Of those covered by private health insurance, 20% stated that the treatments they utilized were affected by the type of insurance held.

It seems that those covered by public health insurance feel limited or perceive limitation in the types of treatments they are able to access and utilize under their health coverage. Some of the statements regarding this dilemma, made by those individuals that reported an influence from insurance on the treatments used include: (from those covered by public insurance) “I get money back from the treatments that are covered.” “I had to go on a waiting list for my first surgery.” “Physiotherapy all came out of my pocket.” “Public insurance doesn’t cover much.” (from those covered by private insurance) “I can only do what is covered, otherwise I can’t afford it.” Money matters and these statements suggest that health care is what an individual can afford, either by paying out of pocket or relying solely on insurance coverage. Comparison of out of pocket health care costs will be presented in the next section.

As a matter of displaying perspective, statements from those who have reported that insurance has not affected their treatments will also be listed. (from those covered by public insurance) I’ve done treatments I’ve wanted… “I’m not sure what private insurance would give me.” (from those covered by private insurance) “My insurance covers both mainstream and alternative treatments.” “My insurance covers both, but not the entire cost for alternative care.” “Insurance didn’t really affect my treatment choices.” “My treatments weren’t affected.”

It is a matter of perspective and of personal monetary funds that go beyond health care coverage, to access and utilize desired treatments that influences an individual’s treatment trajectory and those treatments that are utilized in the first place. The individual’s perspective on health care
limitations is likewise influenced by his or her capability to fund desired treatments not otherwise covered by his or her insurance policy.

**Estimated Out of pocket Costs per month**

Table 8 – Estimated Out of Pocket Costs per month (listed with type of Insurance)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Estimated Out of Pocket Cost (per month)</th>
<th>Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$48</td>
<td>Public</td>
</tr>
<tr>
<td>2</td>
<td>$80</td>
<td>Public</td>
</tr>
<tr>
<td>3</td>
<td>No comment</td>
<td>Private</td>
</tr>
<tr>
<td>4</td>
<td>$0</td>
<td>Private</td>
</tr>
<tr>
<td>5</td>
<td>$200</td>
<td>Public</td>
</tr>
<tr>
<td>6</td>
<td>$230</td>
<td>Private</td>
</tr>
<tr>
<td>7</td>
<td>$90</td>
<td>Public</td>
</tr>
<tr>
<td>8</td>
<td>$8</td>
<td>Private</td>
</tr>
<tr>
<td>9</td>
<td>$0</td>
<td>Private</td>
</tr>
<tr>
<td>10</td>
<td>$23</td>
<td>Public</td>
</tr>
</tbody>
</table>

The total estimated out-of-pocket cost per month reported for treatments by those covered by public health insurance documented across the study population is $441. The average per person per month covered by public health insurance is $88.20. The total estimated out of pocket cost per month reported for treatments by those covered by private health insurance documented across the population is $238. The average per person per month covered by private health insurance is $47.60.

Individuals covered by public insurance are shown to be paying nearly twice as much on average per month, out of pocket, when compared to those covered by private insurance. Evidently, an individual must have the appropriate funds to utilize desired treatments that are not covered by health insurance or that individual must seek treatments within the limitation of his or her insurance coverage. There is a clear disparity represented within this study.
population, where the benefits in affording private health insurance are clear, as far as estimated monthly out of pocket expenditure is concerned. However, it is relevant to note that an individual’s private insurance may cost more per month than what those covered by public insurance are spending per month out of pocket. This would be dependent on the type of insurance policy an individual is covered by privately and there are not enough data represented here to fully discuss this issue.

**Spiritual Life: Was there an Increase and Reported Healing or Benefits as a Result?**

Table 9 – Spiritual Life: Was there an Increase and Reported Healing or Benefits as a Result?

<table>
<thead>
<tr>
<th>Participant</th>
<th>Increase in Spirituality</th>
<th>Reported Healing/ Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td>Praying and thinking about Jesus is calming, relaxing, and brings peace – alleviates pain</td>
</tr>
<tr>
<td>3</td>
<td>Yes</td>
<td>Miraculously healed by prayer and faith in Jesus Christ</td>
</tr>
<tr>
<td>4</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>5</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>6</td>
<td>Yes</td>
<td>Relaxation, peace, understanding, and rest</td>
</tr>
<tr>
<td>7</td>
<td>Yes</td>
<td>More faith in Jesus, peace, calm, relaxation – alleviates pain</td>
</tr>
<tr>
<td>8</td>
<td>Yes</td>
<td>Faith strengthened in Jesus, uplifting, encouraging, peace, calm, relaxation – alleviates pain</td>
</tr>
<tr>
<td>9</td>
<td>Yes</td>
<td>Relaxation, peace, strengthened faith in Jesus Christ</td>
</tr>
<tr>
<td>10</td>
<td>Yes</td>
<td>Increased faith in Jesus, I press into my faith more, relaxation, peace, alleviates pain and tension</td>
</tr>
</tbody>
</table>
As a matter of interest and curiosity, participants were questioned about how chronic pain has affected their living circumstances. This question included areas of life such as: hobbies, relationships, career, and spirituality. The answers to each portion of this question were interesting. Participants consistently reported that some hobbies and pastimes had to be sacrificed, or the time spent indulging in them was decreased due to pain. Relationships were affected only when pain was severe enough to cause irritation in the participant which would, at times, trigger him or her to interact or react in an unfavorable manner with those around him or her. Twenty percent of the total population reported a necessary change in career. This percentage also includes report of the permanent inability to participate in the workforce.

In response to the portion of the interview concerned with spirituality, 70% of the population reported an increase in faith or spirituality through the course of managing and treating their pain and then gave accounts of the benefits and healing this produced. Miraculously, one participant experienced healing between the time of the initial and follow-up interview and reported the healing testimony of faith during the follow-up interview (this account is documented in case study 3 on Susanna later in this chapter).

Some of the fascinating accounts of increased spirituality report faith that has generated healing and other benefits such as: praying and thinking about Jesus is calming, relaxing, brings peace, alleviates pain, miraculous healing by prayer and faith in Jesus Christ, relaxation, peace, understanding, rest; more faith in Jesus, clam, alleviated pain, faith strengthened in Jesus, uplifting, encouraging, alleviates pain and tension.

Again, 70% of the total population reported an increase in spirituality or faith during and through their journey with chronic pain and 100% of this portion of the total population reported healing or benefits resulting from that increase in spirituality or faith. Of this portion of the total population, 86% affiliated faith in Jesus Christ with these healings and benefits, identifying
themselves as Christian. This means they hold to any form of Christianity that is based on belief in the Holy Trinity. The Trinity is a word to describe the belief that God is One God in three persons: God the Father, God the Son, and God the Holy Spirit. The Christian faith discussed here is strictly that of Trinitarian belief. No other spiritual affiliations or religious denominations were stated within the population. Thirty percent did state that they had no increase in spirituality or spiritual practices during their experience of chronic low back pain.

From the 70%, the reported benefit of peace was stated by 86%, relaxation was reported by 86%, calm/calming effect was reported by 43%, and alleviation of pain was reported by 57% of participants included within the 70% who reported an increase in faith or spirituality.

This percentage of believers and particularly Christians, or believers in Jesus Christ, is surprising and unexpected. While researching, I did not anticipate interacting with this number of believers, as the majority of the study population came from an alternative care facility where eastern treatments and some spiritual guidance predominate. However, this study population has proven that particular generalization or bias incorrect.
Table 10 – What these Participants would like Others to Know about Chronic Low Back Pain

<table>
<thead>
<tr>
<th>Participant</th>
<th>What Others Should Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“Seeing the right person in the beginning makes a difference.” “It’s a quest to get your back right.”</td>
</tr>
<tr>
<td>2</td>
<td>“I look healthy so no one knows there’s anything wrong. I couldn’t tell anyone about it because we would be speaking a different language unless they’ve experienced it themselves.”</td>
</tr>
<tr>
<td>3</td>
<td>“Never give up! Never believe that you have to live in pain. Living in pain is not the Truth it’s just a situation.” This person experienced a physical manifestation of healing in her body because of faith in Jesus Christ and prayer.</td>
</tr>
<tr>
<td>4</td>
<td>“Just as with anything, life-style, nutrition, and exercise are all influencers.”</td>
</tr>
<tr>
<td>5</td>
<td>“If it doesn’t look like something’s wrong then people don’t believe you. It becomes phantom aches and pains. Don’t forget that people could be in pain and you might not realize it.”</td>
</tr>
<tr>
<td>6</td>
<td>“Know yourself, develop a social support system and allow other people to help you, find Jesus and talk to the LORD.”</td>
</tr>
<tr>
<td>7</td>
<td>“Try not to be depressed.”</td>
</tr>
<tr>
<td>8</td>
<td>“Consider regular exercise to protect your back.”</td>
</tr>
<tr>
<td>9</td>
<td>“Watch out for the frig., look after yourself, preventative exercise is the best way to go.”</td>
</tr>
<tr>
<td>10</td>
<td>“You can’t see chronic pain from the outside, so try not to judge from the outside. Don’t underestimate the pain that people go through. We need to show compassion. We never really know what a person is experiencing.”</td>
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Participants gave several types of comments when asked what they would like others to know about chronic low back pain. Some gave health advice, others spiritual advice, others gave some insight into the sub-culture of chronic pain. Individuals sharing on the latter made up 30% of the total
population and shared comments such as: “I look healthy so no one knows there’s anything wrong.” “If it doesn’t look like something’s wrong then people don’t believe you. It becomes phantom aches and pains. Don’t forget that people could be in pain and you might not realize it.” “You can’t see chronic pain from the outside, so try not to judge from the outside. Don’t underestimate the pain that people go through. We need to show compassion. We never really know what a person is experiencing.” These haunting statements reveal a group of people that have been misunderstood when interacting with other groups and institutions within culture as a whole. The childhood lessons of treating people with compassion and kindness take on deeper meaning when individuals experiencing such extreme pain at times and constant irritating pain and discomfort at others share statements such as these.

In accordance with other comments made, participants suggest preventative and regular exercise to protect your back, seeking qualified and appropriate health care providers, and to “never give up, never believe that you have to live in pain.”

Concluding Remarks from Data Representing the Total Population

Chronic low back pain is a complicated condition to experience, treat, and manage. The data represented by this study population show that chronic low back pain is often caused by improper lifting and bodily positions or movements that compromise the lower back by placing excess strain on the musculoskeletal structure of the lower back. Occupation can influence an individual’s experience of back pain through consistent movements or postures that irritate or strain the lower back.

The study population proved to favor alternative treatments. Over half of the study population shifted treatment utilization from mainstream treatment to alternative treatment and the two most effective treatments reported were
both alternative treatments. These treatments were some form of low impact exercise and massage. Also worthy of noting is the fact that 80% of the population created a personal multidisciplinary treatment program. A mere 10% of the population knowingly created and maintained a multidisciplinary approach to his or her treatment regime. It seems that individuals show a natural tendency to incorporate multiple angles in health care, as with many areas of life.

Health insurance has been shown to affect an individual's treatment trajectory where personal funds are not adequate to provide for desired treatments that are not covered by one's health insurance. It has also been noted that private health insurance covers a greater number of types of treatments and individuals covered under private insurance spend less per month out of pocket on health care expenses than those covered by public insurance.

Spirituality has proven to be a blessing to those who have experienced a spiritual growth spurt during their journey with chronic low back pain. There are consistent benefits and alleviation of pain reported as a general consensus across the population, along with one case of miraculous healing.

Finally, participants maintain that the experience of chronic low back pain and chronic pain of any kind, can be socially challenging. There are days were individuals experiencing this kind of pain simply do not feel up to par and could benefit from some humanitarian compassion. It was made clear, and I attest to being guilty of the same attitudes at times, as we all are, that if something is not visible from the outside, than nothing must be wrong. Chronic pain is such a condition. To coin some key words from one participant, "We should not underestimate the pain that people experience, we do need to show compassion, because we never really do know what someone is experiencing." If these words became our attitude in the public sphere and were maintained at all times, all individuals, regardless what they may be
experiencing, would experience compassion and would probably be more likely to show it themselves. This is something for each of us to think on.

**Individual Case Studies**

The following four case studies are the in-depth stories and information shared by four participants for this research project. Participants have been given fabricated names to protect promised confidentiality. Many of the themes presented earlier in the chapter when discussing the results will become clear as you read through them. The individuals who decided to participate in a second interview are those four included in the individual case studies here. These case studies add an exciting element to the research, as they personalize, humanize, and make the experience of chronic low back pain more realized to those without this experience, while building a relationship of understanding and intimacy as the reader connects the data to personal accounts.

**Case Study 1 - Anna**

**Initial Interview**

Anna is a vibrant, eccentric, compassionate woman. She is very intelligent and seems quite happy and satisfied with her life and with her life choices. Anna is 54 years old and has been experiencing chronic low back and neck pain for approximately 35 years. She is covered by public health insurance, but is fortunate to work as a receptionist for a business that provides her free access to a number of alternative treatments, which she gladly utilizes and incorporates into her pain management regime. Her story is one of gradual and consistent chronic low back pain and the ways in which she has managed it.
While she could not determine exactly how she had originally injured her back, she made mention that she had fallen a lot and had been in several accidents, but none of those were incidents where she could say that her back had not been the same since. She also mentioned briefly some of her work history in relation to her progressive back pain. Anna used to work in the film industry where she would stand all day. She would also do a lot of twisting and lifting and would spend long periods of time in the same position. Anna has also been guilty of poor posture in the past, confessed that she had poor posture during the period of time working in the film industry, accredited some of her pain to these circumstances, and is working to conquer her posture even to this day.

She told me about her travels when she was around the age of 19. She traveled steadily for four years and ventured all over the world. She was experiencing pain in her back at this time and had been for some years prior. This is also right around the time she was working for the film industry and satisfying other jobs to maintain the finances necessary for travel and living. Her boyfriend at the time introduced her to an osteopath, one of his friends. Anna received a treatment from this person and stated that she felt great relief.

Anna claimed that her public health insurance influences the treatments she accesses because she receives money back from treatments that are covered by her insurance. She does not utilize treatments that are not covered by her insurance, unless they are available for free through her current work facility. The treatments Anna has utilized include: chiropractic, supplements, osteopathic, heat, ice, electrode, acupuncture, massage, and yoga. She has reported that each provides a degree of relief, but that the combined treatments of massage, acupuncture, and chiropractic work the best for her. She also incorporates exercise into her treatment regime. She prefers walking and Pilates, as yoga loosens up her lower back a bit too much, causing pain and tension in other areas as a result.
Anna gave an account of her consistent physical state when she explained to me that her hips are often out of balance. Her hips are usually tilted slightly which causes her lower back to tighten. This bodily compensation often causes her upper back and neck to tighten and as a result of this constant shifting and tightening with her spine out of alignment, she has slight scoliosis. It is almost as though her upper and lower back are working against each other because of the misalignment in her hips. Whether or not this is the result of one leg being slightly longer than another, she did not say, but it seems quite possible. This then, would cause the physical chain of events that tighten and distort Anna’s back regularly.

Anna claims to have had a very gradual story of back pain because of her physical state, as mentioned. She also stated that her pain is not severe, it is manageable and mainly it is problematic because it causes discomfort. However, this discomfort varies and when it is at a heightened state, her pain increases and can become mentally debilitating.

Anna explained that she could cope with the lower back pain and discomfort, but when her upper back and neck are excessively tight, it affects her mentally. She is unable to focus, concentrate, or make clear decisions. She described having terrible headaches as well. She made it very clear that severe tension and pain in her neck and upper back can get the best of her at times and seems to perpetuate and exaggerate all other pain she is experiencing in her lower back and hips. These are some of the comments Anna made regarding these experiences: “Sometimes it feels like my lower back is cemented together and then my upper back and neck get tense and it really hurts…. If my neck goes out, my brain’s not as sharp and the tightness makes my range of motion and ability far less….then I try to compensate for the pain rather than sitting straight and maintaining good posture, which just makes it worse because I’m all out of alignment.”
Anna told me about how this pain has affected her life in other areas as well. She discussed her clothes, hobbies, relationships, and quality of living. She began with her clothes. She softly complained about her shoes. She wears orthodics now and wears them regularly. She strongly dislikes the way they look. She dresses very fashionably and expressed her want to be more fashionable, but that her shoes disrupt her nice outfits every time. She then reminded herself of the benefits of wearing these impressibly unattractive shoes when she told me that they are ugly, but they are very comfortable and they really help to prevent back pain that would otherwise exist and persist if she were to try to wear shoes merely for fashion purposes. Alas, she admitted that she can do without fashionable feet.

At one point in our interview, Anna leaned forward in her chair and with visible excitement, proclaimed her love for golf. She told me that she used to play golf frequently and that she misses it sometimes. I responded by asking if she still played. She sat back in her seat and smiled while she said with disappointment, “I always divot the grass and it hurts my neck, so I had to stop.”

She then moved on to share that she is always protecting her back and that because of this she is not as free to participate in things like golf, as others may be. She commented that she does not have the ease and ability to perform different movements as others do and so she feels restricted from things sometimes when she used to be able to participate with greater ease and little to no thought of her back or her pain.

Anna bounced back from this conversation by telling me about what her perception of her personal quality of living is. To this she claimed, “... it’s not too bad. But with all of these restrictions and blockages in the things I can do and can’t do, I feel like my energy’s not flowing. I’m just learning to manage the pain myself.” She maintained that sometimes, this means choosing not to
do something that she would like to do based on the premise that she might regret the time spent in a given activity if it causes her pain later on.

“There is no way of helping to be rid of the pain,” she stated. “You just accept it, it’s just the way it is, because of things that have happened in life, like accidents, falling down, the way I was born, those sorts of things. It can be very inconvenient sometimes. It is incredibly uncomfortable having tight areas in your body and having to compensate for soreness in one area or another in your back is always frustrating.” Anna went on to say, “I believe I have a strong pain threshold, but it’s worse some days than others and then you do things to relieve the pain. It’s really just an inconvenience.”

Anna explained that her condition hurts, it is uncomfortable, and can be socially limiting because people without this kind of pain do not know what a person with this pain is experiencing or the limitations that person may have. Others do not understand because they have not experienced this type of pain or the lifestyle that is created because of it.

Anna finished our first interview commenting on Australia’s medical system and by giving advice to others. She expressed that she did not think the medical system had anything to offer those experiencing chronic low back pain. She stated that it was not set up to help these individuals and she wonders what mainstream medicine in Australia’s medical system can do to help these individuals other than prescribe drugs, give x-rays, and perform surgery. She said, “When people go to doctors, I think why? They’re just going to send you to someone else and the cost will just keep going up.” She then advised, “Try to look into things yourself, be an investigator for your own body. Investigate the path that is best for you and money will determine what you’re able to access. Do exercises and don’t do ones that aggravate your problem area. Trunk strengthening and exercise are very important in managing chronic low back pain.”
Follow-up Interview

Two months after the initial interview, I met with Anna again and asked some similar questions in a follow-up interview. She seemed to be doing quite well and was in a very chipper and uplifted mood. Her entire attitude seemed to have improved. While she was kind, humorous, and sincere before, she seemed more lighthearted this time. So began our interview.

Anna started by telling me that she had not tried any new treatments in the last two months, but that she had been doing things more regularly than she was before. She said that she had particularly been walking and doing Pilates regularly and more frequently than she had previously. She said she had also been doing her recommended stretches and floor exercises regularly.

Anna reported that her back feels more stable and that she is not in as much pain. She remarked that both her upper and lower back feel better. She also stated, "Exercise is keeping the tension out of my upper and lower back." She also commented that she has a higher level of energy and that she is able to perform more household duties and work duties with a far lesser degree of pain accruing as a result. An added bonus, Anna proudly told me that she has lost some weight as a result of these regular activities as well.

Thinking back to the initial interview and recapping on the previous 2 months seemed beneficial for both Anna and me. She recognized that regular low-impact workouts have been key to improving her overall health and to managing and preventing pain and tension in her lower and upper back. Furthermore, we both realized the benefits of exercise: more energy, weight loss, the increased desire to eat healthier, and motivation to continue with the routine, act and function in a cyclical fashion. The more she exercises, the more weight she loses, the more energy she has, the more she desires to eat healthy foods, the more motivation she has to continue, because all of these circumstances are reducing tension, pain and discomfort by replacing those
symptoms with better health, stamina, strength, flexibility, and again, motivation.

With this new revelation of Anna’s health and activities, she and I glanced at one another, smiled and went through a conversation on how obvious this cycle should be, but that it took these interviews to blatantly discover this wisdom. Both sharing in that moment of enlightenment and encouraged at her improvement, we thanked one another, hugged, and said good-bye.

Case Study 2 - Sarah

Initial Interview

Sarah is the type of woman that everyone would love to have for a grandmother. She is witty, has some amazing stories, loves to laugh, enjoys a great hug, and has a kind heart. Sarah is 76 years old, she has experienced lower back pain all of her life, but especially since she was about 48 years old. She has had work outside of her home, but over the years, she has predominantly worked as a mother and homemaker for her family. Anything she has done outside of her home was part-time and was mainly reception work.

Sarah is covered by public health insurance and has had two cervical laminectomies (surgeries in the upper back), taken supplements, tried acupuncture, and visited chronic pain clinics. She argues that nothing helps to be rid of pain or to alleviate pain for any length of time.

Sarah has suffered from back aches her entire life. She remembers them clearly as a child. When I asked her what she thought had caused her back troubles, she said, “I’ve always had a bad back. I think it was my birth. I
was a very breech baby. I was twisted, my body was very twisted and I think that damaged my back. Then as I got older, it only got worse.”

Aside from the origin of her pain, Sarah claims that her pain increased and that it really manifested itself when she was about 48 years old. She knew that there was a serious problem when she felt her left pinky finger become numb and then her ring finger. She sought a specialist who responded to her experience by telling her that the condition was psychosomatic. She left and dealt with her pain and numbness for nearly ten years. She commented that back then, if a specialist told you nothing was wrong, then nothing was wrong. She did visit her general practitioner, who then referred her to a neurologist. This person recommended exercises and self-administered treatments. She did not experience any relief.

At the age of 55 she began experiencing more pain and the numbness persisted. She had an MRI and the physicians found that she needed to have surgery. The surgery was called a cervical laminectomy, which removes displaced joint tissue from the spinal column, in this case, from the neck. The surgeon informed Sarah that her condition was unable to be corrected, as the condition had been present for so long, but that the surgery would slow down further deterioration and keep her out of a wheelchair. This proved to be correct.

Covered by public health insurance, Sarah was placed on a waiting list and had to wait for several months to have the surgery that she needed years before. After one year, she went back to the same surgeon and needed another cervical laminectomy, as the pressure and weakness in her spinal column from the damage before, was affecting the rest of her spine and had caused damage to the joint below the damaged area.

After these surgeries, Sarah was experiencing extreme pain and was given pain medication to cope with it. Her pain was consistent and relentless. The areas of tension and pain seemed to spread over her back. Her legs began
to give out frequently and she was falling down a lot. She was referred to chronic pain clinics and participated in programs to alleviate and manage her chronic pain, but she found that her pain was not relieved and she continued to live and manage her pain as she had before. Sarah was also taking supplements and trying acupuncture. She reported once more that she did not feel relief. She explained that, “Nothing works better than another. The pain really gets to you, your legs are on fire and your hands are burning, but you just have to keep going.”

Over the years, Sarah’s pain progressed down her back and to her limbs. She still experiences pain in her neck, but the pain in her lower back is becoming more and more excruciating. Her mobility and ability to function day to day is decreasing.

Sarah’s pain has affected her life in many ways. She said that she feels complete and utter frustration every day of her life because of little things that she is unable to do because of the pain and deterioration in her back and limbs. For instance, she mentioned the frustration that she feels because she cannot open bottles, especially those that are child proof.

Her relationships have suffered because her pain is so unbearable some days. Sarah talked about the want and the need to hang on to control all the time because you feel like you are constantly losing control and you can see and feel your body losing control each day. “When you cannot function normally, or in ways that you could before, you begin to hold on to control and develop a need and want for it because you see it slipping away.” She mentioned that she felt and understood that some days it would be difficult to live with her because of the pain and how it manifests itself.

Sarah did share that she feels some emotional and possibly some spiritual relief when she thinks of Jesus Christ, His sufferings, and when she prays. When she is able to look at suffering outside of her world, by someone
she believes is bigger than her, in this case, God, she feels relief and some comfort.

Sarah had the television on in the background and the news came on. She was reminded of news stories she had heard or watched previously and told me, “I look at the pain that others go through and think I have nothing to complain about. There’s no magic wand to wish all of the pain away with, you just live the best that you can. If I were in another country, I might be starving to death, but I have a nice home, a family, friends, and my back pain. My life is a grain of sand in the big world. I just cope with the pain.”

She concluded the interview by commenting, “People want to tell you about their problems, they don’t want to listen to yours. You can’t really tell anyone about chronic back pain, because no one comprehends the pain you’re in. I couldn’t tell anyone about it because we would be speaking a different language unless they’ve experienced it themselves. I look healthy so no one knows there’s anything wrong with me.”

Follow-up Interview

Two months had passed and Sarah had not tried any new treatments. Her loss of mobility was inhibiting her from venturing out to access treatments. She also restated that she did not believe or think that anything would help her anyway. Her condition, had continued to worsen over the two months I had not seen her, but her character and heart remained charismatic, humorous and kind.

Sarah described to me how her left arm had become and remained numb from her elbow to her wrist and that her pinky and ring finger both remained numb. She explained that the pain had become extremely intense down her entire arm and in her hand. She was baffled that her arm could be numb and yet, that she could experience so much pain from it. She also told me that the soles of both of her feet were also numb. I became concerned as she explained
that she is also now numb from about two inches above her waist to two inches below her waist on her left side. She assured me that this had been the case for at least two weeks. She also stated that it was the result of one of her vertebrae collapsing in her lower back, causing side affects in her feet and waist. Her mobility has greatly suffered. She is very unstable when walking and standing and has a very difficult and painful time doing either.

Sarah shared these experiences with me and followed them with, “It’s very upsetting because I played so much golf when I was younger and now I can’t even go down the stairs of my house. I can’t garden, I can’t cook, I can’t sew, I can’t do anything that I’d really like to do.” She reported that some days she becomes very depressed and her mood and the pain get the best of her. She spoke of feeling sorry for herself because she has more time to think about things and to think about her pain, because it has debilitated her and keeps her from doing things that would otherwise occupy her time, energy, and thoughts. Sarah communicated that she wishes that certain other people could experience the kind of pain that she has been experiencing for one half of a day, only so that they could understand and could better comprehend what life is like with pain and debilitation.

Amidst all of her pain and thinking, she has also had time to consider the medical systems in both Australia and the U.S. She said that she was glad that she lives in Australia because she can at least access health care when she really needs to. She commented, “We have free service here and that’s better than in America and other countries.” She discussed how health care and insurance is so costly in other areas of the world, mainly the U.S. She moved to the next topic by commenting with a smile, “Sometimes you go crazy if you can’t find something to do.”

As our interview concluded, Sarah recapped on her condition by stating, “I think you’ve either been given good genes or bad genes. Back pain runs through my family, but I think mine is probably the worst. It’s just genetics
and as you get older, it gets worse. My back is deteriorating all the time.”
However, she ended on a lighter note. After referring to her circumstances and considering why she might be experiencing them, she suggested that people need to keep a sense of humor and to get pleasure out of little things. These pieces of advice will help you get through pain from day to day. She also said, “I ask God to help me bare the pain and remember the cross. I thank Him for all the good things that I have in my life and that I don’t have to worry about.”

Case Study 3 - Susanna

Initial Interview

Susanna is a most interesting character. She is a spunky, talented, artist who traded in her career as a successful businesswoman for a paint brush due to her exceedingly painful experience with chronic low back pain. She is 42 years old and experienced chronic low back pain for nearly five years. She is covered by private health insurance and has submitted herself to a number of treatments in her attempts to heal and to manage her pain. She is fortunate to have private insurance, which covers both her mainstream and alternative treatments.

Susanna is a Christian believer, like many others from this study population, but her story is unique in her experience of faith, as we will see from the follow-up interview. For now, let us consider the initial interview with Susanna and the information she shared during that time together.

Susanna’s back pain began with an injury damaging her L4 and L5 discs in the lumbar region of her spine (lower back). She was lifting something and somehow twisted in an awkward motion while lifting and a few days later, she realized that she had seriously injured herself. Susanna did not have back
surgery and her physicians didn't recommend it. Instead, she was given anti-inflammatory medication.

Susanna consumed the medication, but felt little relief. In fact, she started experiencing shooting pains down her back and legs. She reportedly became worse as the pain continued to increase. She could not eat or hold any food down and eventually, she could not be out of bed for more than three minutes or so. Susanna spent six months living in her bedroom as the pain progressed into illness. She developed shingles in a nerve root of her lower spine and began having fits and would become incessantly shaky.

It was after these developments that she sought treatment from physiotherapy (which provided no relief), a back specialist (who told her that her condition was the result of anxiety), a joint specialist (who did not provide any new information), and at a pain clinic (where she was taught that people can live with chronic back pain). To this Susanna exclaimed, "I refused to live with back pain and wouldn't allow people to say that that was all there was for me. That just wasn't o.k.!!"

During her time in bed and in much pain, Susanna turned to God and found salvation and comfort in Jesus Christ. Her new faith, combined with her determination to not live in pain, brought her to seek prayer for healing at a Bible college she was attending through her church. She told me that over 100 people prayed over her. She said, "People's prayers just water the seed of healing and I'll ask them to keep watering and watering and watering and I'll keep going until I have no pain. When my pain is gone, I'm going to cure other people too. If it can happen to me it can happen to other people too. One person that prayed over me on one occasion is known for having a gift of healing and he was healed from a bad back too. He prayed over me and I didn't have any pain for two days. I thought, if I can have no pain for two days, then I can have no pain for the rest of my life."
Susanna continued with her faithful search for healing, both in her faith and in other treatments. She started having acupuncture done and she said that it provided some relief, when all the other treatments did not seem to provide any. She continued with acupuncture and faith healing for a while. She sought acupuncture treatment from a Christian practitioner as well. She mentioned that he would pray over her before and after the treatment and she felt very relaxed knowing that they shared a common faith. She had expressed a concern that acupuncture and other Chinese medical treatments often have a spiritual attachment to them or a spiritual aspect included by the practitioner and she wanted to be sure that her practitioner shared her faith, as she had already experienced the healing power of Jesus Christ and was seeking more. Later, she switched practitioners in order to have treatment at a facility closer to her home.

I asked Susanna to reflect and share some of her sentiments and feelings during the five years she had been experiencing and treating her lower back pain. She told me about how excruciating the pain was and that it would often get the best of her. She said, “When I was in so much pain, I wanted to die. Everyone said that was a terrible thing to say, and then tell me it was anxiety or something. They just don’t take notice and they don’t help you, especially mainstream medicine. Doctors don’t understand chronic pain and chronic conditions. They act like they don’t have the space or time to care. There is no recognition of chronic pain unless you need surgery. Eventually they will get rid of you by referring you to someone else. What really needs to happen is they need to understand that it totally changes your life being in chronic pain and they need to give and provide more care.”

Susanna shared with me about her spirituality during her journey with chronic pain. She told me that the pain and being bedridden gave her time for faith because she was not able to do things she normally would do to fill her day. She said, “When you’re sick you only pick up what’s important.” She
spent more time at church and went to Bible college there. She reassessed her priorities and goals. She remarked, “My pain gave me time for faith and without it, I never would’ve become a visual artist and I love being that and using my artwork as part of my ministry.”

Susanna shared with me that she is now a completely different person. When I asked how her relationships have been affected by her experience of pain, she said, “All my relationships have changed for the better. I have more sympathy and more time for people.” She went on to tell me that her friendships have particularly improved because she is now very reliable and was not before. She also shared that she feels very lucky to have a husband who is supportive, dependable, and loving.

My initial interview with Susanna concluded with encouraging statements of advice to others. To these, Susanna stated, “Never give up! Never believe that you have to live in pain. Living in pain is not the Truth it’s just a situation. Try different treatments even if you are skeptical. Try faith healing.” Susanna shifted her comments to the general public when she said, “I loathe being considered disabled. People always questioned me with my disabled sticker in my car because I look fine, so they think there’s nothing wrong. It’s as if they need to see blood or something.” From here she addressed the general public saying, “We need to have more compassion, patience, and consideration because you never know who is suffering from pain.”

**Follow-up Interview**

My follow-up interview with Susanna took place two months after the initial interview. She had informed me that she had had a miraculous experience during the time between our interviews and I asked her to share it
for the follow-up interview session, as it concludes her story and experience of chronic low back pain. So, the interview took place.

Susanna told me that she had started taking a healing course through her church. She said that she took the course seeking and believing for a breakthrough in her health and healing. During those few weeks, she received a lot of prayer and did a lot of praying herself. Four weeks into the course and approximately four weeks after we had our initial interview, Susanna experienced her breakthrough. She spoke of her faith and knowledge of Christ’s healing building up to the point of this breakthrough. She explained that she was given visions and had revelations of a number of things that she needed to deal with from her past. For instance, forgiveness, guilt, and other burdens she was carrying aside from her physical condition.

For four weeks Susanna read and meditated on Biblical scriptures teaching and talking about healing. She proclaimed them as truths over her own life and her own body. On the 26th of September, at 4:00 in the morning, she woke up from a physical presence touching her body. She sat up and the presence dropped through her and she knew that she was healed and restored. She repeated that it was a physical manifestation of healing in her body. She reiterated that it was also mental because she was given the knowledge and mental reassurance in that knowledge that this was happening and was very real. “It was a God thing.” She said, “It’s not something that you can fully describe other than that I know it was a God given presence, it dropped into my body, and it was a physical manifestation of healing given with knowledge of it. I was overwhelmed with the presence of God and with joy! It was like a wave of knowledge and healing rippling through my body once it entered.”

Since her experience of healing, Susanna has not experienced the pain she had before and has been inspired to paint images of healing. She claims that this is a way of meditating on what has happened within her, as well as a means of ministering Jesus Christ’s healing power to her audiences.
I asked Susanna what her life was like now, from the inside. She said, "Peaceful. It’s like there was a war that was raging and then there was peace. My body was the battle ground and now that all the weapons have been put down, the soldiers have gone home, and my body is no longer a war zone, the battle ground can heal. I have peace now. It’s quieter. There’s a quietness now. It’s the same body, but quieter."

I asked her what she does for her body now, other than continuing with prayer. She explained that she is now seeing an osteopath. This is to help her to relearn nonrestrictive body movements. She is learning how to move without restriction and is counteracting the restrictive movements she has been doing for five years during her experience of chronic pain in order to avoid causing more pain. This practitioner is also a Christian and they pray together at each session. Susanna finds this to be very encouraging. She also continues acupuncture nearly once per month and says she is looking forward to discontinuing. She commented that acupuncture has given some relief of pain, but suggested that since she has experienced healing, she is ready to end treatments.

With her story told and recorded, our interview came to a close and Susanna offered a few final remarks and advice. "Treat the cause, not just the symptoms and try something holistic. Have an open mind. It was a big leap for me to have an open mind and faith. I went from being a very analytically minded business woman to having a physical manifestation of God’s healing. Be open minded. Don’t accept or allow people to speak negative things over your life and health. Get desperate and don’t give up! Allow people to pray over you and take it."

Alas, our interview was finished. I thanked Susanna for sharing her very intimate story with me for this project and paper. Then both of us took a few deep breaths and reveled in the miracle and power she had experienced and allowed me to share.
Case Study 4 - Levi

Initial Interview

This 43 year old given the name Levi, for this study, has been experiencing chronic low back pain for seven years. He is covered by public health insurance. His health coverage has been influenced by work cover or workman’s compensation, as he injured his back while he was working as a nurses’ assistant. Work cover has affect Levi’s coverage because they determine which forms of treatment and which practitioners he can access based on the cost work cover is willing to pay. Levi does of course have the option to pay out of pocket for health care, aside from the work cover options. Levi’s pain has been debilitating and extremely intense, but he has exhibited courage, endurance, and a positive outlook for his future.

Levi’s story of chronic low back pain began in his workplace. He labored as a nurses’ assistant for several years. He enjoyed his work and was cautious, as his job description demanded excessive lifting, bending, and twisting. While at work seven years ago, Levi and a coworker were lifting a hospital patient from one surface to another. The coworker lost his or her grip and the patient fell on top of Levi, both of them dropping to the ground in an awkward position. The patient was lifted off and Levi was badly injured. He had a prolapsed disc in his lower back as a result of the strain and fall. He was out of work for a few months as he rested and waited for his back to relax and hopefully, to mend itself with the help of physiotherapy.

Levi returned to work, more cautious of his back and of other people’s spinal health as well. Yet, to his great dismay, Levi experienced a similar incident at work involving a lifting mishap and injured his back again. Once again he had a prolapsed disc in his lower back. The damage from both injuries was located at L4 and L5 in the lumbar region of his spine, the lower
back. He was out of work again for a total of five months of missed work as a result of his back injuries.

Work cover (Australia's version of workman's compensation) was fairly quick to pull out of paying for Levi’s treatments and tried to prove that he was not injured. However, his physicians and specialists each reaffirmed work cover that Levi would not be able to work again, as his injuries had caused far too much permanent damage. Levi went to court with work cover to recover compensation and won his case. From then on Levi’s treatments were covered by public health insurance or came out of his pocket. He also collects permanent disability each month, as he no longer has an income.

Levi has accessed a number of treatments. He initially sought physiotherapy and after his second injury he sought medications, tried to maintain a routine of regular exercises, and finally, Chinese massage. Levi sought the advice of five specialists at the time of his second injury. Of those five back specialists, one told him he needed to have surgery and four said no to a surgical procedure. Nearly five months after his second injury, Levi experienced sciatica in his right leg and foot, which lasted approximately two months. He has experienced short reoccurrences of the same in the last few years. Over the last two or three years, he has tried to maintain regular exercise, such as swimming, and has continued to have Chinese massage as a treatment for his back pain. He has found that these two treatments have helped him to cope with and manage his pain. He also reported that Chinese massage seems to alleviate some pain for two to three days after one session.

Levi’s pain has certainly altered his life. It has been a challenge for him to perform normal daily tasks, to study (he is currently a student), to cook, to clean, to do anything one might do in a day. Levi shared that “The pain is terrible. I can’t do sports, can’t bowl, sitting over 15 minutes is excruciating. I played sports over 20 years and can’t do it anymore. I can’t go to movies because two hours is just too painful.” He continued on sharing some ways
that his back pain has affected and changed his life: “My back makes me depressed sometimes, especially when I can’t do something I want to do and I can’t concentrate on it. I live off of my disability pension and collect Austudy (Austudy provides tuition and some living expenses to Australian citizens who are studying in college or university and fall under a certain income bracket), I can’t get a job because of my back. Sometimes my pain is so bad, it keeps me up all night and when I do sleep I shift around a lot and don’t sleep good anyway.”

When he shared these things with me, I became curious about his future plans and I asked Levi about possible work in the future and what he would like to do and he shared, “My pain has changed my career path because the doctors said I could never work again and no one will hire me because I can’t do much now and am on disability. I have very limited work options. But, I plan to go into the ministry. I am going to work for God now. I’m just believing that I will be a speaker in the ministry. Having this experience has made me more humble and more aware of other people’s pain. I’m more sensitive to other people now.”

Levi concluded the initial interview with some advice to others. He said, “Try not to be depressed. Get the best advice from the best doctors. People who really have chronic pain like this can’t concentrate sometimes and just have to rest. It’s a serious condition.” After an interview involving much shifting in his seat from discomfort and pain, Levi headed for home after a friendly good-bye to lie down and rest for a bit.

**Follow-up Interview**

At our second interview, Levi seemed a bit worn down physically, but his spirits seemed high. He seemed to be in a great deal of pain during our time together.
Levi began by telling me what had been happening for the two months that had come and gone between our first and second interviews. He explained that his back had gotten a little better and steadily improved over that time, but that it had been deteriorating for the last week, making him very depressed and causing a lot of pain. He said that he was sleeping all the time for that week and was unable to do much of anything that he needed to do, like his studies.

He reported that he had been trying to find a part-time job and was unable to be hired anywhere that he had applied. He confessed that the pain seemed like it was taking over his life and was interfering with things far more than it ever did before. He expressed that he would like to earn enough money to take himself off of the disability pension, but he is unable to get hired in order to earn the money he needs to survive without it. He was happy to share that he had been invited to join a ministry team at his church and that he looks forward to other doors opening in his ministries. He continues to pursue a career in ministry and holds onto that goal with outwardly expressed enthusiasm.

From sharing about his ministering opportunities, Levi proceeded to communicate, “I’ve started finding and reading every book on healing that I can find. I’m desperate for healing because I can’t handle this pain anymore. I just have to build my faith in that area and get my faith as strong as possible. The idea in these books is that you should confess you’re healed until it’s manifest in your body.” He told me that his faith hasn’t wavered because of his pain and the challenges it has presented both individually and socially. He commented that he becomes more relaxed with his situation with the encouragement from the readings he has found and so, he becomes more concerned with things other than his pain. Levi told me that he is very thankful for this because he sees his finances beginning to dwindle and things are becoming quite challenging for him. About having a future, a job, relationship,
and everything one might consider or desire for oneself, Levi remarks, “...I can’t force anything. It has to be God’s will.”

With that, Levi had to finish the interview and continue on with his day. We thanked each other for our time and said our good-bye. I watched him struggle to get up and to walk to his car in the parking lot, all the while amazed at the level of pain he seemed to live through from day to day for several years and through that, maintain aspirations and hope for the future with a good attitude. I felt very encouraged by Levi. He is an inspiration.
Chapter 5 - Discussion

The data and information collected and presented in Chapter 4 covering the research results will be discussed in greater depth in this chapter and will address each theory presented in the literature review found in Chapter 2. By delving into the theories and plugging the data into each theory and its concepts, the final process in the grounded theory approach will be satisfied. Information and quotes used for this purpose can be found in the writings and tables of Chapter 4.

Through discussion, the data will be shown in a new light, revealing more of the community of chronic low back pain and the ways in which these individuals relate to and interact with other institutions within culture or society as a whole. Once the data has been discussed in light of each of the theories of psychological functionalism, critical medical anthropology, and symbolism, the data will be considered in terms of how everything comes together and is linked by the theories as they are linked together in thought and process. Finally, the conclusion will present comments on biases in this research, what can definitely be said about the data collected from this population, and whether or not my original research statements/ideas were supported by these data.

Data in Relation to Theory

Psychological Functionalism

Psychological Functionalism explains the existence and systematic functions of culture by claiming that cultural institutions function to meet the basic physical and psychological needs of people in a society (Malinowski 1922). This theory explains the ways in which some of the cultural institutions
mentioned thus far connect with one another and how individuals move through society navigationally, in order to pull together various institutions to meet their personal and psychological needs. More obvious examples include the individual’s participation in both medical facilities and spiritual communities and institutions like Equilibrium that attempt holistic treatments.

Take for instance the institution of health care and treatments accessed by individuals experiencing chronic low back pain. If individual needs are provided for and satisfied when an individual accesses and interacts with the institutions of health care, where pain is relieved and mobility and ability is restored or managed, then that individual can return to work or continue working. This allows that individual to serve or function in the previous societal role that he or she filled prior to the experience of chronic pain. If this is not possible, an individual can join a new institution by filling a new societal role working in a new place of employment. Others might not be able to satisfy a role in society as a laborer contributing to the flow of funds. This means that he or she would be dependent on others and on the government for funds. The cycle continues where there is a demand for funds and each institution connects in the collecting and dispensing of monetary funds.

From these examples, we see that managing chronic low back pain allows individuals to participate and interact with other institutions in society, satisfying psychological needs of those experiencing pain by generating optimism in conquering and managing the pain, to function in necessary ways, to participate in the workforce (or depend on others to), and to maintain a life similar to that before experiencing pain. These concepts are illustrated in a flow chart at the end of the chapter titled, Sociology of Exchange. The idea that societal institutions and the interactions between support and supply individual needs in a continuous cycle stems from Bronislaw Malinowski’s work in the early 1900’s and illustrates the cyclical flow of exchange and goods (namely money), which in turn produces and supplies individuals with basic
needs, such as bodily comfort, relaxation, movement, and personal satisfaction. (See Figure 4).

Figure 4 – Psychological Functionalism Diagrammed
Figure 4 diagrams the exchange of labor for money, money for treatments, treatments for continued ability to labor and interact with other institutions, and so on. There are many psychological functions working at each tier of this diagram. For instance, individuals may experience personal satisfaction and a sense of accomplishment as they receive money in exchange for labor. This could be a result of the realization that they have independence, that they can function in society as they previously have, and that they can afford the treatments and possibly the luxuries that will assist them in continuing to be capable of laboring. There is satisfaction then, in laboring (if they are fit to labor as society requires them to), because the individual is reassured that he or she is capable and able to perform in society as before, or in a similar manner, and is able to continue treatments to manage chronic pain.

The level of exchange of treatments can become a bit more intricate. Here, it is the relief and management of pain that allows the individual to continue to labor in exchange for necessary funds, but there is much more. Relief of pain and the satisfaction in managing and conquering this chronic condition generates an optimism, which can positively affect an individual’s attitudes and interactions with others, such as his or her family members, spiritual community, coworkers, and individuals from other institutions.

Malinowski was concerned with how individuals pursue their own ends within the constraints of their culture and he believed that culture exists to satisfy basic needs, such as nutrition, reproduction, bodily comforts, safety, relaxation, movement, and growth. We see that individuals experiencing chronic low back pain are functioning in and between institutions in society that are in fact providing for many basic needs where possible. We also see that these individuals are accessing tools and institutions within their cultural networks and constraints to pursue the satisfaction of their needs. While there is individual effort put forth to satisfy these needs within the relationship of the individual and institution in society, society and its institutions continue
functioning. However, these individuals function and interact not in harmony with the rest of society’s function, but in personal striving to function within said society, as they have been marginalized and disconnected from the continuing functional state of society as a whole due to their physical condition.

Individuals participate and interact with multiple institutions in order to satisfy personal needs. Some become involved in institutions or communities that provide spiritual support and assistance. Spiritual communities and participation in spirituality by individuals experiencing chronic low back pain has provided relaxation, peace, alleviation of pain, healing, and encouragement. These basic psychological and physical needs are satisfied by participation and interaction with a community comprised of individuals actively seeking, believing, and living in faith or spirituality. This illustrates yet another institution that is connected and exchanging services (prayer and support, meditation, etc...) to satisfy basic needs of individuals within the larger society. However, these interactions are what seem to be the result of inadequate care and inclusion by other societal institutions.

According to the study population, 70% reported an increase in faith or spirituality while experiencing chronic pain. This could very well be proof of society marginalizing and discluding these individuals in the everyday functioning between institutions. These individuals not only seek out institutions to participate in, but seek out institutions that will provide for their needs where others do not.

Critical Medical Anthropology

Critical medical anthropology considers the ways in which the body is defined by culture and interacts with culture and society as various levels. For instance, the individual interacts with the social body and the social body and individual body together create the political body. Each body functions slightly
differently to the others. The individual body is the living experience, an individual’s experience with body, mind, emotions, and spirit. The social body functions more on the community level and the ways that individuals interact with society where work, reproduction, and illness are concerned. The political body or body politic is the level at which both the individual and social bodies are controlled or regulated in order to maintain a ‘functioning’ whole. In terms of health and wellness, critical medical anthropology evaluates these interactions to reveal hidden paradigms, or perhaps those less often considered by mainstream medical institutions.

The individuals in this population exhibit interactions and express perceptions of self at each of these levels. Considering the data from chapter four in terms of critical medical anthropology will illuminate some of the inadequacies of society and medical institutions in their interactions with these individuals and some of the ways this community has responded individually.

Chronic low back pain is a condition that has, with the participation of those experiencing the condition, generated a community that both functions and is dysfunctional within the greater society or culture. These individuals become functional within society as they learn to navigate and negotiate between and within societal institutions as a result of a condition that can lead to dysfunctional relationships and movement within society.

There are many institutions that interact and function together in society. Individuals experiencing chronic low back pain have linked several together in the pursuit of individual stability and maintenance of well-being. These institutions may include, but are not limited to: mainstream medicine, alternative medicine, families, places of employment, spiritual communities, and anonymous social interactions or interacting with society at large. In certain ways, these persons are functional as both individuals and a community interacting with other institutions, maintaining personal ability and social interaction.
The community of chronic low back pain has successfully linked the institutions of mainstream and alternative medicine together in the search for treatments that alleviate or cure pain. Each participant has utilized both mainstream and alternative treatments. Many have managed their condition by utilizing a combination of treatments while navigating within and linking these two institutions.

Many of the participants in this study population have been able to continue functioning in society through relief from the treatments they have accessed, which have allowed them to continue filling the labor role they had prior to the experience of chronic low back pain. However, some have not. Two individuals have experienced a change of roles in this area of their lives. One participant has changed laboring roles from business woman to artist. She is experiencing the satisfaction of continuing in the exchange of labor and goods in society and enjoys her work. About her condition she said, with out it, "...I never would've become a visual artist and I love being that..." She is one example of a continued harmonious relationship between the individual and society even through her experience of chronic pain, at least where her occupation is concerned.

One participant was unable to return to the workforce. He has expressed the desire to return to some form of work and has a few ideas in mind, but has been unable to accomplish those goals and satisfy those desires and needs due to disability. Several times, he said, "My back makes me depressed sometimes." At one point he said, "The pain is really starting to interfere with my life. I've tried to get a job, but I can't get hired anywhere because of my disability." For this individual, the current societal role he is filling is one of dependence, on government funds. Some of these government funds come from other individual’s incomes. This means that others are satisfying his needs for treatments and monetary funds rather than him. His physical state is causing social tension, as well as individual dissatisfaction as
he becomes more stigmatized and marginalized in society. However, this does show that culture and the functioning institutions within, are working to satisfy the basic needs of individuals, even though for some, all needs will not be met psychologically and physically.

Individuals from this study population have expressed reasons and motivations for accessing and interacting with particular institutions to satisfy needs. One participant stated, “I never gave alternative medicine a thought until mainstream medicine failed me.” The participant’s physical and psychological needs were not met by mainstream medicine and so, this person turned to another institution, that of alternative medicine. Here again we see Cartesian Legacy manifesting in mainstream medical treatments and the individual shifting to treatments that serve them more holistically, rather than just physically.

Another participant said, “I have family members who practice natural health care. I trust it, it frees my body up and I’m relaxed for longer periods of time.” In this person’s statement, we see the connection between the family and health care. This individual trusts alternative treatments because of a family connection and benefits from the relaxation the treatments provide. They are satisfying basic needs for this individual. Having support from family and friends alleviates some of the symptoms of unrest, perceived disability, depression and other social stigmas and marginalization that can occur when experiencing a chronic condition.

Cultural constraints do interfere and influence the ability and the choices an individual makes in the journey to satisfy needs. For instance, the type of insurance an individual is covered by can affect the treatments an individual is able to access, at the political and social level. The amount of money an individual is able to spend on treatments also affects the treatments an individual can access, as well as the frequency in which treatments are accessed, represented in the interactions between the individual and society.
One participant was forced to wait for treatment because she was
covered by public health insurance and was required to go on a waiting list for
a necessary back surgery. She said, "My health insurance affected my
treatments once because I had to go on a waiting list for my first surgery."
Other participants made comments such as "My insurance covers both western
and alternative treatments." "Physiotherapy all came out of my pocket." "I can
only do what is covered otherwise I can't afford it."

These individuals were able to access only what was covered by health
insurance or what they could afford to spend out-of-pocket for particular
treatments. They are navigating and functioning within their cultural
constraints to satisfy their basic needs and continue functioning within society.
Each individual has different limitations due to cultural constraints based on
their individual circumstances, in this case, health insurance and the coverage it
provides. However, as is evident here, they are a threat to the harmony of
society and thus, have been marginalized. Treatments are unsatisfactory and
the interactions between the individuals and society within the political body
are more than lacking. These individuals are not receiving the types of service
consistently, that could help them and their condition substantially.

This study population also reported clear dysfunction at the level of
individual interaction. Thirty percent of the population directly expressed
dysfunction in their interactions with others by commenting: "I look healthy so
no one knows there's anything wrong." "If it doesn't look like something's
wrong then people don't believe you." "You can't see chronic pain from
outside..." Others supported the functioning of those from other communities
or institutions and new members to their own by providing advice: "Seeing the
right person in the beginning makes a big difference." "Never give up! Never
believe that you have to live in pain." "Just as with anything, life-style,
nutrition, and exercise are all influencers." While there are clearly moments
that this community does not function with social members of the larger
society, it is also evident that the community of individuals with chronic low
back pain does function and encourages future connections and between
societal institutions. The individuals represented here also provide examples of
how to navigate between institutions to alleviate pain and in some cases, to cure
their condition.

Many individuals shifted to alternative treatments to satisfy areas of
their bodily and personal needs that mainstream medicine does not consider.
The data has also shown that many of the individuals included in this study
have turned to spirituality and have experienced a form of spiritual growth
during their experience of chronic low back pain.

These individuals have linked spiritual communities to other institutions
(mainly health care and alternative treatments) in the pursuit of pain relief.
Seventy percent of the population reported having a form of spirituality and an
increase in that spirituality during their experience with chronic pain. Of these
seven individuals, six reported affinity with Jesus or faith in Jesus Christ. They
identified themselves as Christians (these references to Christian are made only
to those foundationally believing in the Holy Trinity: One God in three persons:
Father, Son, and Holy Spirit).

Individuals reported peace, relaxation, healing, rest, encouragement,
and alleviation of pain as a result of increased or new faith in Jesus Christ.
Their faith in Christ has manifested benefits that contradict the theoretical
consequences of social stigmas and marginalization. Beyond this, they have
entered into a new community, a community of believers that share the same
faith and encourage personal and spiritual growth, positive attitudes, healing,
and peace, regardless the struggles or trials an individual or society may be
facing. Faith in Jesus Christ has become one of the key ingredients to
alleviation of pain and to healing in this study population with 60% reporting
these benefits as directly linked to faith as a Christian in Jesus Christ and one
individual reporting miraculous healing as a result of her faith in Christ. These
events surely give these individuals a different perspective on life and their condition in society, which is in direct contrast to the grim perspectives illustrated by most of the literature on chronic conditions. Further research on faith healing through faith in Jesus Christ could prove to be very beneficial to a great number of communities and individuals.

A diagram illustrating critical medical anthropology in relation to the data and study population will assist understanding of this anthropological thought concerning interactions amidst culture (See Figure 5).

Figure 5 – Critical Medical Anthropology Diagrammed

- Dysfunctional relationship and interactions
- Harmonious functioning interactions

Each body interacts with the others either harmoniously or dysfunctionally. These interactions are motivated by social interpretations of symbols, such as: perceived disability, ability, physical norm, wellness, illness, etc.
Symbolism

Clifford Geertz argues that culture functions to give the world understandable meaning through interpretation of symbols. Culture is comprised of symbols and these symbols guide individual actions. Symbols serve as knowledge and information that individuals interpret in order to make decisions to take action (Geertz 1973). It can be said that individuals shape and create culture through interpretation of symbols. Each individual experiences a general culture that is agreed upon by society as a whole, where symbols have been commonly or publically interpreted. These individuals also interpret symbols on a personal level, a testimony to individual complexity.

The community of chronic low back pain fits into this theoretical concept because each individual has a different perception of pain, has experienced pain differently, and yet, has experienced pain in similar ways and with similar outcomes as others in this community. These experiences are based on individual perceptions of disability, recovery, level of pain, ability, mobility, benefits of treatments, and so on. Perceptions become personal definitions or truths and these truths shape each individual’s experience with chronic low back pain and therefore, shape each individual’s interactions with other institutions while functioning in society.

An individual’s experience of chronic low back pain begins with the point of injury or the cause of the pain. Often, an individual accounts for an injury or a specific instance that may or may not have been the actual physiological moment when damage has occurred. However, the individual perceives when and how his/her back was injured based on perceptions of pain and side effects, as well as when and how those were initiated.

Once the participants had perceived pain and sought treatments, they each, based on personal experiences with practitioners and personal perceptions of the treatment’s effectiveness, chose to pursue particular treatments to
manage and alleviate pain as it continued to persist. Presented in Table 6 are some of the attitudes and perceptions the participants shared in consideration of treatment choices and preferences. Some of the perceptions of treatment were expressed in comments such as, “Nothing works...so I just keep seeking help for the pain.” “I never gave alternative medicine a thought until mainstream medicine failed me.” One participant mentioned that she trusts physiotherapy and mainstream medicine, but is open to alternative care. Others said, “Before I thought doctors knew what they were doing. Now I know that in that area of back pain there are no guarantees.” “Before I thought that mainstream medicine was the answer to all medical conditions. My successful surgery has increased my confidence in mainstream medicine.” “I had a bad experience with the chiropractor and physiotherapy didn’t help much either. Massage and exercise are important.”

From the examples above, it becomes clear that individual experiences are defined by one’s perceptions of the experience and interpretations comprising that experience. The participants each perceive treatments, practitioners, pain, and recovery differently. Yet, while an individual’s experience may be personal and unique, commonalities and public agreement remain prevalent in terms of interpretations. According to symbolism, this is due to public interpretations shaping an individual and therefore influencing his/her personal interpretations. Similarities in perceived effective treatments could be the result of public perceptions and interpretations leading these individuals to the same.

The majority of the participants, as was mentioned in Chapter 4, were in agreement that exercise and massage are the most effective treatments for chronic low back pain. This is the most common perception of the treatments across the study population and represents the theoretical concepts of symbolism in this community. Individual interpretations, perceptions, and definitions determine meaning and shape experience. These participants had
their own experiences, but the general consensus throughout the population was understood and agreed upon.

The study population also seemed to share the perception that faith or some form of active spirituality provides healing and alleviating benefits. 70% of the population reported benefits from increased and active spirituality. There is evidence here that suggests that spiritual activity and those that are perceived to be uplifting, manifest feelings and healing that were not considered present before. Some of the participants made comments like, “Praying and thinking about Jesus is calming, relaxing, and brings peace.” “I’ve found that my faith in Jesus has been strengthened and I’ve been encouraged because of it.” Others made comments suggesting that it is relaxing, peaceful, and alleviates pain when they press into their faith more.

Finally, when considering what the study participants would like others to know about chronic low back pain, as illustrated in Table 10, interactions and differences in perception between communities surface. For instance, some participants made advisory statements based on personal experiences and perceptions of injury, cause of pain, prevention, and management thereof by saying, “Seeing the right person in the beginning makes a difference.” “Just as with anything, life-style, nutrition, and exercise are all influencers.” “Know yourself, develop a social support system and allow other people to help you…” “Try not to be depressed.” “Consider regular exercise to protect your back.” And last but not least, “Watch out for the frig., look after yourself, preventative exercise is the best way to go.” This shows that these individuals show an interest in the well-being of others in society, by encouraging good health.

Other participants made statements that suggest misunderstanding of pain or his or her personal condition by others, perhaps practitioners or individuals from other institutions. The interesting concept here is that pain is not visible and cannot be perceived by any two people in the same way, each
perceives it in his or her own way, by interpretation. Therefore, no other person can fully understand the pain that one individual is experiencing and can only rely on that individual’s explanation and definition of the experience. However, if there is no verbal communication, there will be far less understanding between two individuals interacting, which would be commonplace in general social interactions in society and less so between patient and practitioner.

Here are some of the comments participants made concerning this dilemma. “I look healthy so no one knows there’s anything wrong. I couldn’t tell anyone about it because we would be speaking a different language unless they’ve experienced it themselves.” “If it doesn’t look like something’s wrong then people don’t believe you. It becomes phantom aches and pains. Don’t forget that people could be in pain and you might not realize it.” Another participant says, “You can’t see chronic pain from the outside, so try not to judge from the outside. Don’t underestimate the pain that people go through. We need to show compassion. We never really know what a person is experiencing.” Well stated in the latter sentence and very representative of the existence of symbolism functioning within a cultural context. If we understand that everyone is experiencing circumstances differently and experiencing different circumstances for that matter, we can interact with fewer judgments from the outside. These statements also testify to the marginalization of these individuals and that in this marginalization, although they may not interact with one another, they are a community, they share the same struggles, speak the same language, and seek the same satisfaction: alleviation of pain.

A flow chart is presented at the end of the chapter, representing these concepts and some of the ways that perception and interpretations along the way can influence the experience and role an individual has within culture while interacting with other institutions. (See Figure 6 on the following page).
Figure 6 – Symbolism Diagrammed

Perceived injury or cause of pain

Initial treatments or interactions with practitioners.

Individual continues managing pain and interacting with other institutions.

Varied treatment trajectories based on perceived effectiveness and perceptions of relationships with practitioners... spiritual communities are also included here.

Others misunderstand or misinterpret the pain experience or personal behavior and attitudes of those experiencing pain.

Pain managed and individual continues interacting with other institutions.

Linking Theories and Research Concepts

Following the data through each of the theories thus far should provide some clarity concerning some of the links and connections between the theories and research concepts. This section will serve as a conclusion for this
discussion by recapping some of the ways in which the three theories are linked by the data.

An individual experiences culture and interprets cultural experience by understanding the meaning of symbols that surround him/her within a given cultural context. Each person experiences culture and circumstances in his/her own way. The experience of chronic low back pain is no different than any other experience, where theoretically, each individual experiences pain differently. Personal perceptions of pain, of relationships with practitioners, and of the effectiveness of treatments are just a few of the perceptions and factors that influence an individual’s choice and actions, where his/her role in society and function within society is concerned.

If an individual perceives that treatments or interactions and participation with other societal institutions are meeting physical and psychological needs, that is to say, if a person's basic needs are being met, that individual will continue functioning within his or her community or institution and in relation to other institutions in society. As long as an individual perceives that his or her basic needs are met, he/she will be able to continue functioning and satisfying the role that he/she plays within his/her community and within culture as a whole.

Furthermore, as the psychological and physical needs are met for individuals experiencing chronic low back pain, they interact within and between other institutions in society by exchanging goods for services, which supports societal institutions and provides the means for other institutions to continue to flourish and interact with others themselves.

On the other hand, where individuals stray from the ‘norm’ too much in their physical condition, they may become marginalized or stigmatized in society. This causes social tensions and individuals are oftentimes left to attempt to balance those tensions in society and personal life on their own, or with little assistance from social institutions. This is when we see these
individuals navigating within and between societal institutions to not only utilize their services to meet their own needs, but to continue functioning and being included within the greater society.

All of society's interactions between the individual and community, between those and the political community are determined by interpretations. These interpretations then determine individual and societal satisfaction or dissatisfaction with various circumstances. These, in turn, influenced and guide individual decisions and behaviors, societal behaviors, and political behaviors in the attempt to maintain harmonious functioning in society. A diagram illustrating the ways in which all three theories overlap in data analysis will further illustrate this information and these connections (See Figure 7 on the following page).

Discussion Concluded

Biases in the Research

Each researcher presents her own biases, which in turn affect research conducted from start to finish. This is inevitable to some degree, regardless how objective one's research may be. My biases included preconceptions of western and alternative treatments, with favor given to alternative treatments based on personal experiences and those of family and friends. Also, the fact that I am a Christian (Trinitarian) may have opened my eyes to the spiritual emphasis in the research more so than someone who is not a Christian. However, the data speak for themselves in this case, where 60% of the population were reported Christians and 70% of the population experienced health benefits from an expressed increase in faith or spirituality while experiencing chronic pain. Interestingly, I cannot say that my being a Christian attracted these individuals to me or prompted a willingness to share more
deeply with me. Most of the study population was unaware of my personal spiritual beliefs and the majority of those who discovered what mine were, did so as a result of asking me after they had shared their own. This made the interviews very interesting for me, as I was asked to share often and was given a break from frantically taking notes.

Figure 7 – Linking Theories and Research Concepts

- Individuals interpret and define personal perceptions of experiences and surroundings. These influence an individual's role and function within a sub-culture and within society as their decisions are guided by interpretations and perceptions.
- Individuals function within society when psychological and physical needs are met. Psychological needs of individuals must oftentimes be met by creative exploring by the individual, as they are generally not met by mainstream medicine, moving them within and between societal institutions.
- Individuals may become marginalized and stigmatized as chronic conditions cause social tension and disorder and become a threat at the social level.
- Individuals continue in the pursuit to find their functioning place within society, within their own body, and within and between societal institutions.
The research itself is biased because the study population consists of individuals predominantly seeking alternative treatments (discussed further below) and participation was strictly voluntary. There were no monetary benefits supplied to participants, which could have persuaded a greater number to participate if funds were provided. Furthermore, the population is far too small to be representative of any population other than itself. Therefore, the data represent only the individuals that included themselves in this study.

**What can be said**

What can be said about chronic low back pain from this study population? Chronic low back pain can be debilitating and is often an inconvenience. It affects an individual’s life-style by limiting what he or she can do or the extent to which something can be done. Some form of low impact exercise and massage seem to be effective treatments for managing and alleviating pain and relaxing the lower back. Spiritual beliefs and active spirituality, (in this case, faith in Jesus Christ within Trinitarian Christianity) is beneficial and can provide relief and healing.

**Research Statements: Supported?**

One idea I have carried as a question in curiosity from the beginning of this study has been stated in the introduction. It is that the needs of patients experiencing chronic low back pain are not satisfied with mainstream medicine and that this dissatisfaction causes a shift to the utilization of alternative treatment for this pain. Feeling that I had more knowledge base in mainstream medicine, I began my research hoping to interact with alternative care facilities. I made contacts and was able to set up an internship and research agreement with an alternative treatment facility in Avalon, Australia. My research was
approved to obtain research participants from this facility. This being the case, my study population was thrown into bias from the start.

The participants in this study have sought both western and alternative treatments, but all were seeking alternative treatments at the time of the interviews, as it seemed to be providing some relief. The data indicate that there is a preference for alternative treatments even though a portion of the population does state that they find or have found mainstream medicine to be helpful.

There is substantial support for this research statement from the data collected within this population with at least 50% of the population preferring alternative treatments and the most effective treatments reported as two that are alternative, being exercise and massage. However, this may not have been the case if the research population included individuals seeking treatment predominantly from mainstream medical facilities.

My other research statement was that maintenance of mobility, strengthening, and flexibility, particularly of the trunk or core region improve the well-being and functionality of individuals experiencing chronic low back pain. That the majority of the population concede that exercise and massage are the most effective treatments for this condition, says something in support of this idea and the research question it proposes. Yoga, Pilates, walking, and swimming are all low impact sports that increase strength in the core or trunk of the body and these are the exercises reported to have been done by the participants and that they provided some pain relief.

The data support this statement to some extent, but some might argue that there is not enough evidence supporting it. This research statement and its underlying question for this population is a bit more difficult to measure, especially from these data. For instance, a measure of the participant’s well-being based on flexibility and strength of the trunk would have had to have been measured before and after a given period of time adhering to an exercise
routine, in order to provide substantial support for this idea with some validity. Considering this specific population and from the data available, one can speculate that this may be true, as the data support exercise as beneficial. However, a blatant statement claiming this research idea as true based on these data cannot be made.
Chapter 6 - Conclusion

The opportunity to complete my graduate research in Australia has been an outstanding one. The individuals that have participated in this study have contributed to my life in deep and meaningful ways. They have shared personal accounts of extreme pain, ways in which they have managed and coped with it, and have allowed me into their minds and hearts as a result.

It was very satisfying conducting the follow-up interviews with those participants that agreed to do so. It was interesting and invigorating to witness them recount the two months that had passed since our last interview and recognize beneficial behaviors or treatments that had allowed them to progress since then. My life has been deeply touched by the relationships that have been made with those who have participated in this study.

Research started out as planned, but recruiting participants proved much more difficult than expected. In general, people seemed to be very friendly, but were far from cooperative. The possible participants that chose not to participate in the study simply could not spare one to two hours of their lives for an interview in the course of four months. I offered to come to them if necessary, but alas, they just did not wish to participate. Which was fair enough. Those who did participate were very flexible, save one, who was too debilitated to leave the house. This house visit was quite pleasant and in a beautiful area overlooking the coast.

I had originally planned to do follow-up interviews with each participant, but many did not wish to participate in a second interview. I did call each of them back and ask a few follow-up questions, which they were more than happy to participate in, but it was not an in-depth interview, as it was with the four case studies.
Solutions to these problems could be as simple as having more time, money, and contacts. If these three essentials were part of the equation, the study population could have been larger and could have come from other subcultures rather than one alternative care facility, the time between interviews could have been longer, which may have revealed different combinations of effective treatments, and more time would have also opened up the schedules of those individuals who were having a hard time penciling in an interview.

As a suggestion for future research, it is highly advised that the researcher locate participants from both western and alternative care facilities, possibly from multiple areas in a given geographic area, and to try to recruit a study population that is considered large enough to statistically represent a general population.

It would be interesting to learn more about familial ties to treatment preferences and attitudes influencing perception of pain and effective treatments. By this I mean, it would be interesting to learn about family history of home remedies, family perceptions of medical treatments, and the ways in which these influence individuals to choose one treatment over another.

In closing, I would like to wish good luck to anyone considering further research in this area. I hope that you will be successful in research and will experience the types of blessing I have in my interactions with these participants. Research on chronic pain and particularly chronic low back pain is far from satisfied. There is still a great many mysteries in this condition and how best to treat it. The more research that is done, the closer society and medical culture will be to solving some of these mysteries.

I would like to thank each participant one more time for the generosity of sharing each story and the details of each experience. Until we meet again, keep up the good work.
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APPENDIX
1 - Survey Questions

1. What is your age?

2. What was your age at the time of initial back pain?

3. Are you covered under public or private insurance?

4. How many weeks/days were between the time of initial pain and initial treatment sought?

5. How many different types of biomedical treatments have you tried?

6. Of these, how many gave a degree of permanent pain relief?

7. How many different types of alternative treatments have you tried?

8. Of these, how many gave a degree of permanent pain relief?

9. How many weeks have you been out of work due to this condition?

10. What is the estimated total pharmaceutical expenditure per month (total expenditure, including government, insurance, and individual expenditure as a result of co-pay or complete coverage)?

11. What is the estimated total treatment/medical service expenditure per month?

12. What is the estimated total expenditure for biomedical treatment/services from the initial treatment of back pain?

13. What portion of this was paid through your personal funds?

14. What is the estimated total expenditure for alternative treatment/services from the initial treatment of back pain?

15. What portion of this was paid through your personal funds?

Did you have surgical treatment? If yes, continue. If no, proceed to interview questions.

16. How many weeks/days were between the time of injury and the time of surgery?
Initial Interview Questions

(As a semi-structured interview, the questions will be asked as appropriate to the flow of the participant’s discussion. Some sample interview questions are as follows)

Would you like to take some time to tell me about your condition? What is your story?

How long have you been experiencing low back pain? (Chronic pain is over 3 months)

What caused your condition originally and when did it occur? Was it the result of an injury, accident, or of an unknown cause?

(If the person has ruptured lumbar discs) Did you or are you going to have surgery to correct the tissue displacement? How has this affected your condition? Did you feel relief due to the surgery or did your condition seem to improve? What has happened since? How has your condition changed since then?

Have you researched or read about chronic low back pain on your own time? How did you research this condition (on the Internet, in the library, etc…)? How do you think this has shaped or altered your medical decision making in terms of treatments and treatment adherence?

What sort of treatment did you seek first? Did you use alternative treatment or biomedical treatment first? Did you use any self administered treatments at the onset of your back pain (bed rest, massage, etc…)? In what ways has your medical behavior and decision making about treatments been reflective of ideas about health held by your family or from your upbringing? Or how has it not been representative?

What were your perceptions of alternative treatments prior to this condition? What were your perceptions of biomedical treatment prior to this condition? How have these sentiments changed since the onset of this condition and while experiencing chronic low back pain?

What types of treatments have you sought biomedically? Why did you choose to utilize biomedical treatments?

What types of treatments have you sought in alternative care? Why did you choose to utilize alternative treatments?

What were your experiences with these treatments?
Which ones did you feel were the most effective?

Are you aware of any other forms of treatment? Which ones? What has been suggested to you for pain management and treatments that you have not tried yet? Do you plan on trying them? Why or Why not?

Have you ever disagreed with advice from a practitioner to discontinue or to begin a particular treatment? If so, why? What was your final decision? What were the results of this decision? How has your personal agreement or disagreement with medical advice influenced your decision making in the treatment and management of your condition?

Do you generally stick to advised treatment plans? Are there any that you stopped of your own accord? Why?

Have you suffered any side affects from treatments? Which treatments and what were the side affects?

Would you like to share some of the ways chronic low back pain has affected your life? In other words, would you like to shed light on the culture of pain? For instance, how chronic pain has affected you as an individual, in terms of your relationships, spirituality, career paths, future plans, comfort and discomfort, and day-to-day living?

How do you perceive your condition? How do you feel about it? What does it mean to you? What has it meant to you in terms of your perceptions of pain? In terms of your perceptions of Australia’s medical system? In terms of your faith in medicine, both biomedical medicine and alternative medicine?

How has your life and your perceptions of life changed from experiencing chronic low back pain? How would you describe your quality of living before experiencing chronic low back pain? How would you describe your quality of living while experiencing chronic low back pain?

Have you found that you are now more protective of the spinal health of your loved ones? (If yes…) How so? Have you noticed if those close to you have changed their own behaviors related to heavy lifting or posture, indicating that they have become more aware of spinal health risks? How have you shared your world of knowledge about chronic low back pain and spinal health with those around you or have you shared this knowledge?
2 – Initial Interview Questions Continued

Do you hold public or private health insurance? How do you perceive that your type of insurance has affected your health and treatment with this condition either positively or negatively?

Do you consider yourself well informed about Australian medical policy and Australia’s medical system?

How do you think the Australian medical system/medical policy has affected you now that you’re managing chronic low back pain? How has it affected you positively? How has it affected you negatively? Have your opinions of the medical system changed since you’ve been experiencing chronic low back pain? How?

How can the medical system and/or policies be changed to allow more benefits to individuals experiencing chronic pain?

Do you have any suggestions for health care policy reforms?

In your thoughts and with your own experiences as your basis for expertise, is there anything in particular that you think could benefit individuals experiencing chronic low back pain? (Information, advice, treatments, diets, exercises, etc…)

What would you like the general public to know or to understand about chronic low back pain? If you had one thing to say to the rest of the world about this condition, what would it be?

3 – Follow-up Interview Questions

(As a semi-structured interview, the questions will be asked as appropriate to the flow of the participant’s discussion. Follow-up interviews vary and the questions are dependent on the results of the initial interview. Sample interview questions are as follows)

Have you experienced any success or digression since our last interview?

Have you tried any new treatments since the last interview? Have they been successful?

What has developed both positively and negatively with your condition? In your opinion, what has caused these developments?
Have you suffered any side affects from treatments? Which treatments and what were the side affects?

What are your current perceptions concerning the culture of pain? For instance, how chronic pain has affected you as an individual, in terms of your relationships, spirituality, career paths, future plans, comfort and discomfort, and day-to-day living?

How do you perceive your condition? How do you feel about it? What does it mean to you? What has it meant to you in terms of your perceptions of pain? In terms of your perceptions of Australia’s medical system? In terms of your faith in medicine, both biomedical medicine and alternative medicine?

How has your life and your perceptions of life changed from experiencing chronic low back pain? How would you describe your quality of living before experiencing chronic low back pain? How would you describe your quality of living while experiencing chronic low back pain?

How do you think the Australian medical system/medical policy has affected you now that you’re managing chronic low back pain? How has it affected you positively? How has it affected you negatively? Have your opinions of the medical system changed since you’ve been experiencing chronic low back pain? How?

How can the medical system and/or policies be changed to allow more benefits to individuals experiencing chronic pain? Do you have any suggestions for medical policy reform?

In your thoughts and with your own experiences as your basis for expertise, is there anything in particular that you think could benefit individuals experiencing chronic low back pain? (Information, advice, treatments, diets, exercises, etc...)