The use of mass media interventions for health care messages about back pain

What do members of the public think?

Prepared by Nuffield Orthopaedic Centre NHS Trust for the Health and Safety Executive 2006

RESEARCH REPORT 480
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What do members of the public think?

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Mass media interventions are used to inform the general public about health issues. There is a lack of research regarding the involvement of members of the public in the development and evaluation of mass media interventions. This study aimed to identify and explore the opinions, beliefs and views of members of the public regarding the use of media interventions for the delivery of health care messages using a draft back pain campaign looking at the level of credibility, acceptability and trust in the authority of these messages.

A qualitative study using semi-structured focus groups and a sampling frame including gender, age, socio economic groups, and experience of back pain were used in community locations with 68 members of the public.

Three main themes were identified. 1) Media consumption. 2) Credibility. 3) Specific issues surrounding the proposed sample media campaign. The use of media to provide health care information was viewed positively, with the NHS perceived as the most trustworthy source, and Government bodies viewed with scepticism. Issues surrounding the language, terminology and tone of campaigns were raised.

A closer collaboration between health care professionals and the public is advocated to achieve valuable and effective media campaigns.

Supporting Organisations:

The Modernisation Agency Spinal Collaborative Programme commissioned this work. The Department of Health Occupational Health Department, Department of Health Directorate of Access and Choice, Department for Work and Pensions and the Health and Safety Executive funded this project and it was agreed that this report would be published by the latter.

This report and the work it describes were funded by the Health and Safety Executive (HSE). Its contents, including any opinions and/or conclusions expressed, are those of the authors alone and do not necessarily reflect HSE policy.
ACKNOWLEDGMENTS

The idea for this study was generated by the steering committee of the Modernisation Agency Spinal Collaborative Programme, who commissioned and supported this work. The input of Jeanette Hucey, Sharon Barrington, Fiona Jenkins, Sue Brandrick, Paula Renshaw, Anne Daykin, Francine Toye & Jane Reeback is gratefully acknowledged. The financial backing of the Department of Health Occupational Health Department, Department of Health Directorate of Access and Choice, Department for Work and Pensions and the Health and Safety Executive who funded the project is acknowledged with thanks.
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Executive Summary

There was broad acceptance by respondents in our sample of the value of health messages delivered via mass media.

And there were clear roles for advertising for the majority of the target audience of both low back pain sufferers and non-sufferers:

- To reassure those who currently treat their own low back pain by keeping active that they are ‘doing the right thing’.
- To inform those who are open to persuasion that previous advice about rest has been replaced by the ‘keep active’ message.

The NHS was both a credible and acceptable source for this information about low back pain management.

In line with mass media communication of commercial messages to a very broad target audience, TV was the preferred medium for interventions though there might be a specific targeting role for other media.

Research indicated that in developing low back pain interventions that are clear and motivating, the following are required:

- Be cognisant of low back pain sufferers sensitivities in terms of acknowledging the pain/impact e.g. show people suffering/recovering from low back pain.
- Be sympathetic in tone.
- Meet the communication challenge about applicability of message e.g. state that 4 out of 5 low back pain sufferers will benefit; state the types of low back pain that will be relieved; state that it will be beneficial at the recuperation stage.
- Get tone of voice correct i.e. add ‘sympathetic’ to ‘straightforward’ and ‘positive’ at briefing.

Further points of learning that can be applied to developing effective low back pain interventions:

- Avoid references to work-going to work in order to avoid encouraging scepticism about the motivation for the campaign thus undermining both its acceptability and credibility. And also to prevent raising the concern that employers will use this information against low back pain sufferers.
- Consider being direct about this change in advice to benefit clarity of message and the health motivation. This is especially relevant given that the target audience does not seem predisposed to be critical of change (‘progress’) on this issue.
- Avoid suggesting ‘Don’t take painkillers’ or ‘Don’t go to the doctors’ in communications.
- ‘Keep active’, ‘keep moving’ (gently, gradually, etc.) seemed more appropriate and more motivating language than the term ‘exercise’.
- The creative approach can reasonably be allowed to determine whether examples of ‘keeping active’ are necessary since there was no clear guidance from respondents on this. However, if activities are featured, interventions should avoid featuring examples which are potentially seen as too strenuous or too specialist and thus limited in applicability and targeting.
1. INTRODUCTION.

1.1 Background

There is widespread use of mass media campaigns to inform the general public about health messages; ranging from discouraging smoking in young people to the promotion of sun protection. A recent survey found 75% of respondents rely on media coverage when making health care decisions. Few other options exist apart from the use of mass media with potential to alter and influence social attitudes and norms, although altering awareness and beliefs within the population may not automatically lead to changes in health care behaviour. A systematic review concluded that mass media interventions have an important role in influencing the use of health care services and in providing health care information to the public.

Although mass media is widely used to inform the general public, there is little published data regarding general public involvement in the development and evaluation of these interventions. The role of “consumers” in health care and research is strongly advocated to enhance its relevance and quality. Whilst research exists which explores perceptions of existing media messages, such as smoking images and how public perception is affected by the media, there is a lack of research involving the general public in the development of campaigns and about the public’s perception of the use of mass media interventions to deliver health care messages.

This research aims to explore opinions of members of the public about the use of health media campaigns with specific reference to a sample low back pain campaign. Back pain is one of the most common reasons for seeking health care and is considered a public health challenge due to its considerable functional, psychological and social implications. Back pain was considered to be a topic suited to exploring the trustworthiness and acceptability of mass media campaigns because recent evidence conflicts with popular opinion. Traditionally, low back pain has been treated using rest; now strong evidence exists advising staying active and continuing activities as normally as possible.

There has, as yet, been no mass media campaign to promote effective self management of non specific low back pain in England (the location for this research) so there has been no prior exposure to the effects of an advertising campaign, which might have affected the results of this study. Such mass media campaigns have been run in Scotland and in Victoria, Australia. Whilst the former has yet to be fully evaluated, positive results are reported for the latter. No previous study has explored the acceptability, value and credibility of a campaign from the perspective of the consumer.

This study will identify and explore the opinions, beliefs and views of members of the public regarding the use and value of media interventions for the delivery of health care messages. Secondly, it will investigate credibility, acceptability and trust in the authority of the various potential sources of health information campaign.

This report outlines findings from research conducted mid-October to mid-November 2004 among the target audience for low back pain mass media interventions.

The Nuffield Orthopaedic Centre appointed The Bridge to develop a mass media campaign with the aim of influencing the general public’s beliefs about back pain.

This initiative was in response to the following:

- Back pain incapacity is considered a public health challenge as it has considerable functional, psychological and social implications.
• There is a gap between the public’s knowledge and expectations of how low back pain should be managed and current evidence based guidelines.
• There is some evidence to suggest mass media interventions may have an important role in encouraging the use of effective services and discourage ineffective practices.
2. RESEARCH OBJECTIVES

2.1 Overall research aims

Research among the target audience for mass media interventions i.e. the general public, was required to:

- Identify and explore the opinions, beliefs and views of members of the target audience regarding the development, use and value of media interventions for the management of low back pain.
- Develop media interventions promoting self-management of low back pain for use in future research.

2.2 Detailed research objectives

1. To test the effectiveness of the media interventions in meeting communications objectives as set.

2. To assess the various media interventions for level of comprehension, message interpretation, perceived acceptability/appeal and motivating power.

3. To determine credibility, acceptability and ‘trust’ in the authority of the various potential sources of the interventions.

4. To provide guidance on both strategic direction e.g. role(s) for interventions; and executonal development of the interventions.

Particular attention was given to exploring the different media, specifically their individual strengths for the communication of persuasive low back pain management messages.

Research also aimed to answer two very specific questions i.e. How important /persuasive is it that ‘all experts agree’? And, is it better to dramatize the solution as a generality e.g. gentle exercise, or to specify types of appropriate exercise?
3. METHOD AND SAMPLE

3.1 Method and sample recruitment criteria

Local Research Ethics Committee approval was gained. An advertising agency experienced in health care mass media campaigns developed draft adverts. The key campaign messages were those summarised by Klaber Moffett et al 14 including advice to stay active. Two main creative routes were proposed and developed to create draft television, radio and print advertisements. This enabled the use of different modes of media for the same material to be discussed as well as the creative content itself. In addition two further radio commercials, dramatising how to optimise recovery from back pain were also developed. Overall therefore, eight pieces of stimulus material were used. These were used in the focus groups as stimulus material for discussion about media

3.1.1 Sample.
A purposive approach was used. The sampling frame (Appendix A) included key factors thought to influence people’s views and beliefs and to enhance group dynamics; these were: gender, age, socio economic group, rural or urban locations and experience of back pain. A screening questionnaire was used to recruit participants who matched the sampling frame (Appendix B and C)

As in similar research, 14 no attempt was made to define an episode of low back pain since no universally accepted definition exists. The participants decided whether they had experienced low back pain.

68 people participated in the research. Data saturation was achieved and no further data collection necessary.

3.1.2 Recruitment.
Members of the public were approached on the street and invited to a local focus group, held at convenient venues for participants such as hotels and community centres. Informed consent was sought at the groups. All focus groups were lead by MR, an experienced social scientist. The focus groups were based around a discussion flow guide but were semi structured (Appendix D). Discussions lasted approximately 90 minutes and were audiotaped. The stimulus material used in the groups was rotated to control for any order effect. At the end of the group, participants were requested to complete a brief questionnaire to collect information about back pain history, used to aid the contextualisation of the data (Appendix E)

All groups were held in October and November 2004.

The sample included men and women, split equally, and interviewed in separate focus groups to enhance good group dynamics.

The age range was very broad i.e. 20-60 years and split into age bands, again for good group dynamics.

All socio-economic groups (SEGS) were represented with C2DE groups made up of 50% manual workers.

The sample also included a 50/50 split between those who have, and those who have not, suffered low back pain. We allowed respondents to self define ‘suffered low back pain’ at recruitment.
Respondents living in five locations - Oxford, Peterborough and rural surroundings and Urban and Rural South Devon were interviewed.

3.2 Sample Summary

- Group 1 Male, 20-39, ABC1, with back pain, Oxford.
- Group 4 Male, 40-60, ABC1, without, Rural Peterborough*
- Group 5 Male, 40-60, C2DE, with, Urban South Devon
- Group 6 Female, 20-39, ABC1, without, Urban South Devon
- Group 7 Female, 20-39, C2DE, with, Rural Peterborough*
- Group 8 Female, 40-60, C2DE, without, Oxford
- Group 9 Female, 40-60, ABC1, with, Urban Peterborough
- Group 10 Female, 40-60, ABC1, without, Rural South Devon

* Rural Peterborough groups were augmented with a full focus group among women and a mini focus group (4 respondents) among men, due to low turnout rates on the first attempt.

3.3 Stimulus materials

Essentially, two creative routes each with TV, radio and print were explored. These are identified as:

- *Pill Bottle* and *Prescribe* (radio).
- *Recommend/Clinic* and *Voices* (radio).

Each TV script was presented as a narrative on audiotape with storyboards.

In addition, two radio commercials *Scratch* and *Banjo*, which dramatise recovery, were explored.

The intervention materials that were tested can be found in the Appendix.

3.4 Data analysis approach

Data using full transcripts of audio recordings of every focus group discussion was listened to until the researchers became familiar with the data. Transcripts were analysed line by line identifying concepts and their properties. Data were coded to describe and relate categories and subcategories of concepts such that they could be represented as addressing the research objectives 19. Two of the authors independently undertook the data analysis.

Given the project aim to identify and develop effective mass media communications, emphasis was to find, if possible, shared motivating concepts or ‘themes’.

In fact, responses were fairly consistent between the various demographic subgroups. And geographic location – part of the country/urban or rural – similarly seems to have had no significant impact on responses; except that Oxford respondents (particularly men) were in general more skeptical.

Responses to interventions split most notably between those who have had, and those who have not had, low back pain (LBP). But even here there is clear common ground between these groups.
4. SUMMARY OF THE KEY FINDING - REDEFINING THE COMMUNICATION CHALLENGE

4.1 The challenge for communications is not as anticipated

At the outset it was hypothesised that the advice - you should stay active when you have low back pain - would be difficult for people to believe since it seems counter-intuitive. This research found in fact that ‘staying active’ is what many LBP sufferers currently do. It also makes sense for many non-sufferers when they are asked to consider it.

However, resistance to believing and accepting this advice persists. Essentially respondents did not believe the claim, communicated in each test intervention, that this advice has general applicability to all low back pain and to all sufferers. That is, by not specifying exactly who will benefit, the credibility and acceptability of the message is undermined.

...generally its giving you the answer to all back pain but obviously exercise is not the answer to all back pain, because some people have more seriously wrong than other people who’ve got back pain. I felt the script was giving you the answer to all back pain and it’s not that simple.

(Male, 20-39, C2DE, had LBP, Rural South Devon)

Yeah, it’s automatic lumping every form of back pain as “Don’t rest…”

Just the way it says “You shouldn’t rest”, it’s too general. There might be a time when rest is needed.

(Females, 20-39, C2DE, had LBP, Rural Peterborough)

I would interpret that (Voices, radio) as every single back pain. So from severe to twinges because it doesn’t actually state ...some people might...do gentle exercise and then they could be laid up even longer.

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

I just think it’s a generalisation.

Sometimes maybe you have got to keep active and others you have got to have a rest.

(Females, 40-60, ABC1, had LBP, Peterborough)

Respondents consistently, and from across the sample, suggested how the target audience might be made specific thus aiding credibility i.e. by characterising the low back pain in sufficient detail; and/or by indicating the percentage of sufferers who would benefit from the advice.

Basically it just says if you have a back problem, it doesn’t say if you fell off a building and hurt your back then you need to seek medical advice. I think they should qualify it. Or if you’ve just bended wrongly, you’ve picked something up and you’ve got a twinge in your back then you need to keep exercising...it’s not telling you what sort of back ache.

Yes they need to qualify it more for people to actually interpret it as it should be.

(Females, 20-39, C2DE, had LBP, Rural Peterborough)

I’d like to see them come up with percentages (of LBP sufferers who would benefit from taking this advice), if they could. I think that would encourage people.

(Males, 40-60, ABC1, no LBP, Rural Peterborough)
That (statistics on LBP sufferers who would benefit from this advice) would be confidence for people not to rush to the doctor.

I think they should put a time limit on it somehow, you know, if you are suffering from back pain for over a week or two then you should make another decision.

(Female, 40-60, C2DE, no LBP, Oxford)

It (the advice on managing LBP) has not been qualified with statistics or backed up with medical research...

(Male, 20-39, ABC1, had LBP, Oxford)

A further refinement of this barrier to both credibility and acceptance is the belief that in the more severe cases, ‘activity’ is part of the recuperation process only after initial diagnosis/rest/treatment. Respondents would like this to be acknowledged.

When I have a bad back I have to rest for so long, I’m not saying days and days and days, but I have to have a few days when I don’t do anything and then gradually do some exercising and get better…. That’s just the way it works.

(Female, 40-60, ABC1, had LBP, Peterborough)

4.2 Is this advice on how to manage lbp seen as ‘new’ news?

Response to this question splits the sample and further confirms that a redefinition of the challenge is required.

That this advice is being given can be said to be ‘new’ for most respondents; but it is surprising only in claiming universal applicability.

Among those who have suffered LBP, ‘keeping active’ is exactly what many do for relief – a minority have been given this advice, others are reassured to know they are doing the right thing.

They (doctors) do advise you to keep moving...

I don’t go to the doctors, I just keep going...

(Females, 20-39, C2DE, had LBP, Rural Peterborough)

(...the idea of “if you exercise with low back pain you recover faster...?”)

Maybe not recover faster but it certainly makes it easier while you are recovering.

(Male, 20-39, C2DE, had LBP, Rural South Devon)

...personally I have a back problem and I lay down too much it creates more problems; the muscles stiffen up and stuff and I get even more back pain. So I can’t lay down for that long anyway.

(Male, 20-39, C2DE, had LBP, Rural South Devon)

Well, without sounding like I’m taking advice from the advert, I do just tend to carry on and I don’t get a locked back.

(Male, 20-39, ABC1, had LBP, Oxford)
At recuperation, i.e. after initial rest/treatment, many other sufferers do then get moving. If this were to be acknowledged i.e. initial diagnosis/rest/treatment, it would seem the advice becomes acceptable.

...exercise will probably help but... you’ve got to be mobile in the first place to do so.  
(Male, 40-60, C2DE, had LBP, Urban South Devon)

...obviously when you are in extreme pain you are going to be flat out, basically. Once you are over that then it’s a matter of gently exercising, swimming is brilliant.

...have they treated the person first...is this (advice about gentle exercise) before or after?  
(Males, 40-60, C2DE, had LBP, Urban South Devon)

I think if you slipped a disc you would be in severe pain...I do think that (examples of gentle exercise such as walking) is too much.

I think it is part of probably recuperation.  
(Males, 20-39, C2DE, no LBP, Peterborough)

Only a very small minority or those interviewed claimed that they need (bed) rest for an extensive period and believed that this message can never apply to them.

(...you are not going to be convinced by any of these are you?)

No I ain’t.

(You’re body language tells me, you were turning your back on that ad there.)

You need to rest up till you’re ready; all this exercising ain’t going to work.  
(Male, 40-60, C2DE, had LBP, Urban South Devon)

More non-sufferers (than low back pain sufferers) were ‘surprised’ at this new information, which they do recognise as counter to past advice about lying flat, etc.

However, the majority are open to conviction and this new information makes sense to them. After defining the scope of relevance, research suggests most of this sub sample was likely to find this advice credible and acceptable.

It’s new information knowing that it is good for you because I wouldn’t specifically think ‘Oh my back hurts I will go for a walk’. But now you think about it...well you think that is good for you, you are not just ‘carrying on’ you are doing good rather than hoping (it is the right thing to do).

((Male, 20-39, C2DE, no LBP, Peterborough)

Without a rational underpinning of the ‘stay active’ message e.g. to keep muscles strong and supportive, respondents without low back pain must and eventually do draw on knowledge about other injuries, general keeping fit, etc. to make sense of it.

I think I believe that you have to keep moving. I think I believe that.  
...not to do anything unless you are absolutely forced to...is not good for the body in general so it is probably wise to say if you can keep moving, keep moving. 
(Male, 40-60, ABC1, no LBP, Rural Peterborough)
(Did you know you were supposed to keep moving?)

Yes I think so.

Because anyone who has had a muscular strain knows that if you sit around and do nothing it gets far worse.

Yes it does.

It’s just quite common knowledge really.

(Females, 40-60, ABC1, no LBP, Rural South Devon)

The majority of low back pain sufferers draw on their own experiences.

4.3 Suffering Low Back Pain

Low back pain sufferers are generally sensitive about:

- The fact that low back pain cannot be seen;
- Recent adverse publicity about workers abusing this;
- Having their condition acknowledged and ensuring that the condition is presented as genuinely painful.

Interventions which are insensitive to this risk hostility and immediate rejection by the core target audience of low back pain sufferers.

Non-sufferers are also generally sympathetic to this sensitivity.

I mean a lot of doctors...they think we are skiving ...You can say you have got a bad back but there’s no proof to say that you have got a bad back. If you’ve got a broken arm then you can prove that you have got a broken arm.

(Males, 40-60, C2DE, had LBP, Urban South Devon)

It (Scratch Radio) seems to acknowledge that you actually do have back pain whereas some of the others the inference is that you haven’t really got it you are just skiving, and that you need to be doing something about it.

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

It’s not actually showing anybody in pain is it that you can relate to and think “God, yeah, every time I do that...”

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

I think it would have been better to start off with someone who was suffering with back pain and then going on to show you to prevent this or to alleviate it this is what you should be doing....perhaps it would be better just to emphasise the back pain right at the start.

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

That radio advertisement there it was good but just to have a bit of visual input on seeing somebody suffering with the problem and show that...(adds)...authenticity

...and sympathy as well, as to understand the complaint.

(Females, 20-39, C2DE, had LBP, Rural Peterborough)
4.4 The new communications challenge

The new challenge for communications is both easier and more complex than that hypothesised.

The broad target audience – the majority of sufferers and non-sufferers - is clearly willing to believe and accept the intended message about self-management of low back pain.

• But only when its applicability is defined more specifically.
• And only when low back pain is presented ‘sympathetically’.
5. MASS MEDIA HEALTH MESSAGES AND MEDIA CONSUMPTION

5.1 Attitudes towards mass media health messages

There was broad acceptance from across the sample of the value of health messages delivered via mass media on the broad basis that it is always good to be better informed.

*I mean if it’s being used to inform, accurately, then I don’t see that it’s a bad thing because obviously giving people information on how…to treat it or where to go for help, or the system, that isn’t a bad thing.*

*I think it’s a good thing.*

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

*What do you think of the idea of getting health messages across on TV or radio or whatever*…?

*It’s definitely a good idea.*

...*Well it’s got to be (good) for your own health hasn’t it?*

*That’s really the only way you are going to learn it.*

...*it’s not as if you are going to get a book out…the adverts and things tell you what, and you decide from that.*

((Males, 20-39, C2DE, no LBP, Peterborough)

Criticism of conflicting health messages were almost exclusively reserved for advice on food and ‘healthy eating’. The only exception to this was among mothers in Wisbech who introduced discussion of the MMR vaccination issue as one where advice was conflicting and not helpful.

*We don’t know what to believe, one minute you are told something is good for you, the next minute it’s not.*

*Well it’s about sugar content is the big thing now…*

*High salt content is what they’re saying.*

(Males, 40-60, ABC1, no LBP, Rural Peterborough)

...*they sort of give you a message, you eat this, then another time it can change completely.*

*There are scare stories, like the one about eating your omega fatty acids and your tuna and your salmon and then they were like “Oh, God they contaminate your salmon as well”*

(Females, 20-39, C2DE, had LBP, Rural Peterborough)

In the context of low back pain, change in expert advice was accepted (with the ongoing caveat about scope of applicability) as ‘progress’.

*Well medicine moves on, dunnit? People find out more things as technology advances…*

(Male, 20-39, C2DE, had LBP, Rural South Devon)
5.2 Media consumption and preferences

This research indicates that respondents consume health messages through different media in very similar ways to commercial messages.

So, TV is regarded as best at targeting the broadest range of people, and ‘most’ people. This suggests something about the intended breadth of targeting. It is also seen as adding a stronger sense of ‘commitment’ (if only by choosing what respondents tend to know to be an expensive medium) to the message and the intervention itself.

*I mean to put it (Hay fever relief ads) on TV, it must be a high percentage of people suffer from it.*

(Male, 20-39, C2DE, no LBP, Peterborough)

*(Communicating on TV means)*

*Not cheapskates.*

*It has to be important to spend that sort of money.*

(Females, 40-60, ABC1, had LBP, Peterborough)

...*you might reach a lot more people through TV because a lot of people have got TV’s and not necessarily as many people listen to the radio as watch TV.*

(Male, 20-39, C2DE, had LBP, Rural South Devon)

TV is consumed relatively passively and ‘easily’, requiring little effort from respondents, making it attractive.

*It’s just more visual isn’t it, it takes less effort sort of, if you (see) it in a newspaper you have to read; you have to make more effort.*

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

*Visual impact is much greater than hearing somebody saying something: you just switch off far easier.*

(Female, 40-60, ABC1, had LBP, Peterborough)

*The visual medium is the best medium to use; I mean one picture is worth a thousand words. I mean TV is your best medium.*

(Male, 40-60, C2DE, had LBP, Urban South Devon)

*I think they are effective when they are put simplistically like that (e.g. TV ad highlighting the link between smoking and fat in arteries), you know, in a very catchy way. It makes you sit up and take notice. Whereas if you just have a pamphlet through the door, perhaps not written in layman’s terms, you wouldn’t bother reading it maybe or it wouldn’t catch such a large audience.*

(Female, 40-60, C2DE, no LBP, Oxford)
Press advertising, for its part, is heavily edited by readers, making it potentially highly involving when selected for attention. It was considered more likely effective as communicating messages about low back pain to sufferers, given its particular relevance to them.

*I mean if it something that catches your eye, obviously, but if it is something that is more personal to you, you are going to notice that, if it’s personal to you.*

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

*... TV works quite well...because with papers you would, or I know I would, if it’s no interest then you skip those pages and get on to something (else). Whereas TV unless...you can fast forward, you sit there sort of watching it.*

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

Radio is considered least able to reach the whole target audience at which the message seems to be aimed. A recurring debate emerged in the group discussions about radio as background and radio as personally involving.

*...if the radio is on you’re probably doing something else and half listening to the radio but eventually there is the little jingles that are in your head and you know them and sometimes you hum them or sing them and you think you’ll never get it out of your head...*  

*I think television has more of an impact; well it does for me, definitely. I agree that ...it’s just background noise, radio to me...*  

(Females, 40-60, ABC1, had LBP, Peterborough)

Respondents differentiate between outdoor billboards which can be seen as impactful and broad in reach and indoor posters e.g. in surgeries, where targeting is specific (though perhaps relevant). Each is seen as working best when the audience is captive e.g. at traffic light, in GP’s surgery.

The majority of respondents, regardless of the test initiative, which they preferred, claimed that the most effective medium for the low back pain message would be TV for reasons of broad targeting and reach; and for ‘importance’ of the message.

Oxford men and a few individuals across the sample expressed the belief that the message deserved multiple, even ‘blanket’, media delivery.

As part of a general discussion about mass media health communications among our sample the best recalled ads were all recent and predominantly from TV:

- A TV ad showing fat in arteries, as result of smoking.
- A TV ad of a man who dies of a smoking related illness before he sees his daughter again.
- A TV ad with a slug suggesting too much salt is dangerous/kills.
- A poster/print ad featuring fat in arteries.

It is recommended investigating further whether this recall is an indication of impact of different media or simply of spend levels.

And it would also be worth accessing published data from the commercial market i.e. from media planning/buying experts, on the roles and strengths of different media given the similarity of consumption of both health and commercial media.
6. GENERAL POINTS OF LEARNING FROM THE INTERVENTIONS

6.1 There is a role for advertising

Research suggested that mass media interventions around managing low back pain are welcomed by the target audience.

Respondents are not hostile to interventions in principle and distinct roles for advertising emerged. These are:

- To reassure those who currently treat their own low back pain by keeping active that they are ‘doing the right thing’.
- To inform those who are open to persuasion that previous advice about rest has been replaced by the ‘keep active’ message.

These two groups of respondents make up the vast majority of the sample.

However, research indicates that it is likely this message will only be credible and acceptable if the new communication challenge, as outlined earlier, is met.

You’ve always felt that sort of carrying on won’t do it any harm but now it’s actually saying ...I mean I get back pain just from my everyday work which isn’t particularly manual, it’s just bending down a lot and picking up, stuff like that. It’s reassuring you in a way.

(Male, 20-39, ABC1, had LBP, Oxford)

...to get over the pain I’ll just stretch, try and stretch your body out. ...I call it stretching; well I suppose it is exercise.

(Male, 20-39, C2DE, had LBP, Rural South Devon)

...when you know your back is starting to get tight...then you start to seize up but they say like exercise frees it all off. I mean I would do that.

(Males, 40-60, C2DE, had LBP, Urban South Devon.)

Once I have got rid of the initial pain, even though it’s slow, I always try to sort of keep going.

Yeah, I agree with you there, like once you have got it under control, like the pain killers, like you are gradually getting up. But it’s natural, your brains telling you to do that anyway.

(Males, 40-60, C2DE, had LBP, Urban South Devon)

Yeah I exercise.

It’s common sense, stop seize up, keep moving, don’t.

(Males, 20-39, C2DE, had LBP, Rural South Devon)

Keep active.
It’s the reverse really of all the advice that used to be given to you about back pain.

(Female, 40-60, ABC1, no LBP, Rural South Devon)

I think it’s quite interesting because most people are under the impression that if you’ve got a bad back you lie down, don’t you, and rest.
I was under that impression. 
Well if you stop using it everything seizes up.

It’s just encouraging you to be more active, but yes I was under the impression that rest is best. 
(Females, 20-39, ABC1, no LBP, Urban South Devon)

The old fashioned idea when you had back pain was to lie down on the floor and not move for days and days and days, so this is the new way which is to keep yourself mobile and you won’t get even more stiff. 
(Female, 40-60, C2DE, no LBP, Oxford)

6.2 (Self) defining low back pain can be problematic

Recruitment of our sample of respondents highlighted real difficulties in (self) defining ‘low back pain’.

The question at recruitment was - Have you personally suffered from any of the following?

- Serious illness affecting diet
- Low back pain
- Skin complaint/condition/eczema

And it emerged that respondents answered ‘no’ to low back pain if:

- They genuinely had not suffered from it
- They had not suffered from it for some years
- It was seen as a one-off incident in the past
- It was “just a twinge” now and again.

Well I think it’s not enough to sort of worry about. 
(Male, 40-60, ABC1, claimed no low back pain but did suffer regularly, Rural Peterborough)

...it was a back injury I had. I mean back pain is a bit different, if you are having it constantly. 
But I had a back injury, which I don’t have any more. I’m fine. 
(Female, 40-60, C2DE, no LBP, Oxford)

But I don’t get it now, it doesn’t bother me anymore. At the time I couldn’t walk. 
(Male, 40-60, ABC1, claimed no LBP ‘now’, Rural Peterborough)

In four of the six groups that should not have had anyone who had suffered from low back pain, at least two sufferers showed up.

This suggests a difficulty at the outset of identifying and characterising the target audience of low back pain sufferers with a single, simple phrase.

6.3 Dealing with low back pain

Appendix A shows sufferers’ experiences of low back pain in detail via their responses to a questionnaire which respondents completed at the end of each focus group.

Broadly, findings are as follows:

- A third of respondents had low back pain on the day of interview.
- Episodes of low back pain lasting more than 24 hours is very prevalent with around half the sample having suffered more than ten episodes; a quarter suffering ‘a few’ and a
further quarter ‘quite a lot’ though less than ten episodes; only one respondent’s low back pain had lasted less than 24 hours.

- 19 of the 32 respondents described their low back pain as, on average, ‘Discomforting’.
- Others descriptions of their low back pain were spread evenly between ‘Mild’ (particularly Oxford men), ‘Horrible’ and ‘Excruciating’ (3 Peterborough women and a man in Rural South Devon).
- Almost all in each group had seen a health professional about their back with the exception of Oxford men.
- GPs were most likely to have been seen (by 19 of the 32 respondents) followed by physiotherapists (by 12) and osteopaths (by 11).
- Older women in Peterborough visited the broadest range of specialists.
- Over three quarters of the sample described their health as either good or very good, suggesting that respondents can ‘isolate’ and discuss low back pain as separate from overall health.

6.4 Barriers to accepting the intended message

The single greatest barrier to accepting the message ‘keep active’ was the apparent claim that it will benefit everyone with any form of low back pain.

*It’s like saying…everybody who suffers from cancer - there is one treatment.*

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

This claim raised a series of questions and concerns on which respondents require additional information:

- What if you cannot move at first, especially if you have been seriously injured? When should you get moving?
- What if low back pain is more than muscular – most often cited is a ‘slipped disc’ – and you risk doing more harm than good by keeping active? Or don’t you…?

(Do you think this advertising…will encourage people to keep active if they are suffering from back pain?)

*It depends how serious it is.*

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

...if it was excruciatingly painful low back pain you wouldn’t walk and swim and play golf.

*Well you couldn’t do it could you?*

...It would have to be obviously back pain that you could tolerate.

...low level.

*Niggley back pain.*

(Females, 40-60, ABC1, no LBP, Rural South Devon)

That would suit me but it may not suit you or you (other respondents in the group)...Because that’s what I do, I just keep going. Mine might not be as bad as yours, so you’ve got variations of back pain.

(Male, 40-60, C2DE, had LBP, Urban South Devon)
Are they not kind of saying that anyone can do this? And that with exercise that it could be causing damage for one in two people to do that exercise. There doesn’t seem to be any warning with that, that it might not be suitable for everyone.

(Female, 20-39, ABC1, no LBP, Urban South Devon)

There are so many different causes of back pain. I could suddenly start suffering from back pain tomorrow and think it could be this, it could be that, and it might be quite dangerous for me to keep moving around it might be something internal.

...Yeah because if you really suffer badly from back pain like my sister does that’s just taking the mickey. Because she is just flat out, she can’t do anything.

(Females, 40-60, C2DE, no LBP, Oxford)

...if you’ve got a slipped disc or you’re in absolute agony with the pain in your back then you are not really going to be sort of bounding around trying to keep active too much but ...the small sort of niggle where it’s giving you some jip...then it would probably work.

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

I think it might do more harm than good, you might have broken a vertebrae or something.

(Female, 40-60, ABC1, had LBP, Peterborough)

6.5 Role of the website

When respondents perceived it to be ‘highlighted’ in the test interventions, the website could be seen as providing a solution to the outstanding question about scope of the advice i.e. go on to the website to determine severity/type of back pain to which this advice applies.

I think they are expecting you to go on to the website. ...I would think there are all kinds of low back pain. I mean you can suffer from it in different ways.

(Female, 40-60, ABC1, no LBP, Rural South Devon)

Well if you cycle for back pain you want to know (from the website) to what extent it is good to do these sorts and to what extent you should be wary of doing it.

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

If you had a search engine then you could type in your specific problem and it comes up with specific exercises to help you deal with that problem. That would be helpful.

(Male, 20-39, C2DE, had LBP, Rural South Devon)

This in turn introduced for a few the further concern, indeed potential barrier, about the dangers of ‘self-diagnosis’.

However, the website could also be seen as providing valuable insight into the best sorts of activities and gentle exercise for relief of low back pain; a role which respondents (with internet access) tended to welcome.

How much exercise each day, sort of thing.

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

Respondents also suggested the website might provide information about local low back pain clinics or practitioners who could help sufferers.
6.6 Suggesting ‘gentle exercise’

‘Gentle’, as a term, was considered both credible and acceptable in being sympathetic and acknowledging pain.

But ‘exercise’ emerged in research as tending to suggest ‘special’ activity, even if only in terms of putting aside specific time. As such, ‘exercise’ could become a barrier to accepting the message, since respondents pointed out that not everyone enjoys exercising e.g. sports activities, and not everyone has time for exercise.

(You don’t call it ‘exercise’?)

No, that’s where you go down the gym or something?

(Male, 40-60, C2DE, had LBP, Urban South Devon)

I think people generally know what sort of things keep them active...they lumped in vacuuming and mowing because other than that it’s exercise, specific sports which people probably either don’t like or can’t do for whatever reason, where just things like walking...around the house...

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

(So ‘stay active’ and move around’ is easier than ‘gentle exercise’?)

Yeah I would say that was easier. The moving around that would be gentle exercise.

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

Suggesting ‘exercise’ could in fact provoke a degree of resentment rather than reassurance among those who do keep active with low back pain, with respondents indicating that their work or looking after a family provided more than enough exercise without having to do more.

It only applies to the over sixties, because anybody with a family, you can’t do gentle exercise every day, you’ve got to go out and earn a living.

(Male, 20-39, C2DE, had LBP, Rural South Devon)

That might apply to some people but generally if you’re working and looking after kids you can’t do that. ...by the time you’ve finished at the end of the day you’re aching and the last thing you’re going to want to do is gentle exercise. You’ve already overdone it in the daytime.

(Female, 20-39, ABC1, no LBP, Urban South Devon)

More acceptable phrases than ‘gentle exercise’ for respondents across the sample were ‘keep moving’, ‘stay active’ and variations on these.

I think the gentle exercise one implies that you have got to go and do something whereas with the active (one) you are just being active, just keep moving, you don’t have to do anything special.

(Male, 40-60, ABC1, no LBP, Rural Peterborough)
I would just say try to keep active and go about your daily activities without actually antagonising your condition. Because walking up the stairs and downstairs could be gentle exercise if you’ve got a bad back...

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

I’d cross out the exercise and put gentle movement.

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

6.7 Should the interventions show examples of activities or leave the advice as a generality?

Opinion within our sample was split on this and no clear pattern of response or preference emerged.

6.8 ‘Doctors, physiotherapists and osteopaths all agree’

The aim here was readily understood by respondents as providing reassurance that the experts in the field are in agreement about treatment.

This is reassuring, in principle, but again, the incredibility of the advice being applicable to all low back pain devalued this support.

(All three are suggesting the same course of action) to make you think that if they think it’s good enough it must be good enough but it might not be true, it is so general and vague.

(Female, 40-60, ABC1, had LBP, Peterborough)

...they are all the experts aren’t they.
I would say ...they are the ones that you are more likely to believe.

(Males, 40-60, ABC1, no LBP, Rural Peterborough)

Well they obviously know what they’re talking about.

They’re the professionals.

(Females, 40-60, ABC1, no LBP, Rural South Devon)

Some people ...won’t believe what doctors say, they’ll swear by a chiropractor whereas some people swear by so and so; so again it’s getting the message across to more people.

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

Also, though to a lesser extent, the claim was undermined for some by failing to divulge the source of the advertisements, though this would likely be overcome by ‘branding’ them.

The assertion prompted discussion of the ‘fact’ that a few respondents had had first hand experience of (and at the same time others suspected) GPs who did not suggest ‘exercise’ but gave painkillers. It is interesting to note that this observation or perception was more likely suggested as a criticism of GPs than a criticism of the advice about exercise.

(I went) to the doctors (with low back pain)…just prescribed out a few painkillers, basically, take two four times a day, da da da da.

(Female, 20-39, C2DE, had LBP, Rural Peterborough)
A few respondents suggested osteopaths and chiropractors would not be keen to give this advice as self-management of low back pain would likely have a negative impact on their business.

...a friend of mine...went to a chiropractor and I think they charged him £30 for half an hour. Would they (the chiropractor) want to say to him, go out and walk it off?

(Male, 20-39, ABC1, had LBP, Oxford)

6.9 Source of the interventions

The absence of ‘product’ and the inclusion of .org in the web address suggested that the source of the test interventions were ‘the Government’, including the NHS.

It’s not signed anything; it’s just .org, so it’s government.

(Male, 20-39, ABC1, had LBP, Oxford)

Most respondents decided that the likeliest source was the NHS and that this is both acceptable and credible in that it focuses on this as a health issue and that respondents largely trust the NHS to deliver accurate information.

One group especially (ABC1, 20-40 year old men in Oxford) were keen to have what they considered to be a more ‘independent’ source (i.e. independent of government) e.g. BMA, any Royal College, even a TV doctor. This would also contribute to the information acquiring a higher profile.

The TV doctors, they are watched by people...

...I just think it’s a new message in a way, it’s just come from nowhere and so it does need sort of interviews on TV... before you can just come out with the advert.

...The link between the NHS and government is too strong.

...I think it would have to be the BMA who are sort of independent.

(Males, 20-39, ABC1, had LBP, Oxford)

Some older C2DE men were similarly more sceptical than the rest of the sample about ‘government’ interventions, tended to associate the NHS more closely than others with government, and so were also more inclined to favour ‘specialist’ sources.

However, the majority of respondents across the sample rejected a ‘specialist’ source in favour of the NHS for various reasons i.e.:

- They were both familiar with and trusted the NHS
- They perceived a risk that the role of osteopaths is not widely understood
- They believed the reference to ‘specialists’ introduced the unnecessary complication of the concept of ‘private’ treatment (given that many respondents believed osteopaths are usually or always only in private practice).

(Coming from the NHS) ...it would give you more confidence in the information they are giving me rather than information you get sometimes off adverts...

I do trust them (NHS).
((Males, 20-39, C2DE, no LBP, Peterborough)

You have to pay physiotherapists or osteopaths, as a rule apart from NHS and I think (that) would detract from it.

I’ve not tried physiotherapists and osteopaths so put that at the bottom...but doctors, I mean NHS, is something tried, at least it’s tried.

(Female, 40-60, ABC1, no LBP, Rural South Devon)

I think the NHS.

Yeah a proper organisation who don’t benefit by people using their services to make more money.

(Female, 20-39, ABC1, no LBP, Urban South Devon)

You know they (the NHS) aren’t motivated by anything other than a desire to help people.

(Male, 20-39, ABC1, had LBP, Oxford)

The NHS was also considered a ‘better’ source of these interventions than Government/Department of Health by having practical expertise; having greater overall authority on the issue; and being more likely to be motivated by health rather than financial reasons.

(What do you think about NHS messages?)

Reliable.

Confident in it.

...I think the NHS comes across as the actual guys to treat everybody. It’s more directed (than the Department of health).

(Females, 40-60, ABC1, no LBP, Rural South Devon)

Well if it came from the NHS it would tell you the truth ...

(Male, 20-39, C2DE, had LBP, Rural South Devon)

‘Government’ can also suggest to respondents (a version of) DWP whose motivation was seen exclusively as getting people back to work for the sake of the economy. As such this was significantly less acceptable as a source and motivation for the LBP interventions than the NHS.

It (Voices radio ad) worries me that it is a government initiative to stop people being off work with back pain and they are saying “it doesn’t exist, carry on.”

(Male, 40-60, ABC1, no LBP, Rural Peterborough)
Even when motivation for NHS intervention was perceived as ‘to stop people clogging up the health service’ (as some test ads suggest) this was considered more acceptable, even reasonable for some, than the concept of getting people back to work for purely economic reasons.

…the NHS have done it because there is a lot of time wasters taking the time from more serious cases and they are saying…you do not need to come in, wasting your doctor’s time and everything, try this first.

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

…the important thing is to get people to do anything so as they are not clogging up the NHS.

(Males, 20-39, C2DE, no LBP, Peterborough)

6.10 “Don't take back pain lying down”

Multiple interpretations of this endline emerged, all of which were very positively received:

• You can do something about your low back pain
• You should get up and do something about your low back pain
• You shouldn’t lie down with low back pain
• You can still get on with your life – interpreted by a few, mainly younger respondents.

Overall, this was considered to be a very powerful phrase with strong appeal through its rich, appropriate interpretations; its positive tone of voice; it’s being ‘clever’.

I quite like that (endline), it means ‘get up’ doesn’t it and...

Exercise

Yeah exercise, it means don’t take it lying down, do something about it.

Don’t lie down.

…it’s a play on words, isn’t it?

…it’s quite good how many ways you can take it.

((Male, 20-39, C2DE, no LBP, Peterborough)

Maybe they are saying there is a way, even if you do have back pain, there is a way you can continue with your life. You …don’t have to lie there all your life.

(Females, 20-39, C2DE, had LBP, Rural Peterborough)

Also it’s saying don’t sit around and mope about it, get up and do something. move around, it’ll only get worse when you sit around...

(Male, 20-39, C2DE, had LBP, Rural South Devon)

Again that’s quite good because again the stereotypical thing is to lie down on a hard surface and they are saying don’t lie down on a hard surface.

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

Keep moving.

...Don’t give up.

...It’s quite a catchy phrase.
...it’s very clever, a play on words, very clever. (Female, 40-60, C2DE, no LBP, Oxford)

6.11 An order effect emerged

Research indicated that order of showing the test materials had an effect on comprehension and perhaps to an extent, on the appeal of the interventions. Those ads shown later were generally, though not always, preferred.
7. DETAILED LEARNING FROM RESPONSE TO THE TEST INTERVENTIONS

7.1 Description of Stimulus Materials used.

*Pill Bottle Print and TV* – picture of a traditional medicine bottle with pharmacist label and with the bottle full of running shoes rather than pills. Strap line saying “Don’t take back pain lying down”.

*Prescribe* – radio advert. Voices saying that when have back pain shouldn’t rest but stay as active as possible. Strap line saying “Doctors, physiotherapists, chiropractors and osteopaths will all tell you the same. Don’t take back pain lying down.

*Recommend / Clinic TV.* – Doors to a clinic open with variety of people with active equipment e.g. golf clubs, walking shoes etc on walking out through the doors. Voice over says, if you have back pain “Doctors, physiotherapists, chiropractors and osteopaths all prescribe the same simple course of action – daily gentle exercise.”

*Voices – Radio advert* – conversation between a man and a woman saying if you have back pain you shouldn’t rest but should stay active. Strap line that “Doctors, physiotherapists, chiropractors and osteopaths all tell you the same. Don’t take back pain lying down.

*Prescription Print* – Poster depicting a prescription pad with the words written on it “Gentle exercise everyday 1/0”

*Scratch and Banjo Radio* – Banjo playing fast music followed by sound of a string breaking. Music stops and voice over says that back pain can bring your life to a halt. Banjo player starts again and gets gradually faster and faster….voice over says "as you do more you will start to feel better "… banjo at full speed .. “until you are back to normal again.”

7.2 Response to *Pill Bottle Print and TV*

7.2.1 Comprehension

Immediately in response to both the TV and print versions of this intervention an executional problem arose i.e. it was not apparent that the bottle has shoes in it. Eventually, however, respondents did understand the visual as walking shoes inside a pill bottle.

*How big is that poster going to be because from here it just looks like a bunch of leaves or something...*

(Male, 20-39, C2DE, had LBP, Rural South Devon)

This intervention could in some groups generate a debate around the term ‘prescribe’ i.e. the perception (and experience of some) was that they do not offer the same advice nor about exercise or keeping active.

*It’s misleading. When the opening comments were that physiotherapists, osteopaths, all prescribe the same thing. I will speak from experience; they don’t prescribe the same thing.***

(Males, 40-60, C2DE, had LBP, Urban South Devon.

There was also some debate around the significance of the types of shoes in the bottle to nuances of communication e.g. different types of shoe to indicate broad targeting; sports shoes to underline ‘exercise’; everyday walking shoes to clarify ‘gentle’ exercise that anyone can do.
Well if you are going to do gentle exercise you wouldn’t be putting on trainers. You put on trainers to go running...

Well the sort of shoes that are in there are just ordinary brown shoes that everybody or anybody could have, so anybody could just go for a walk...

(Males, 20-39, C2DE, had LBP, Rural South Devon)

7.2.2 Message interpretation

The message was readily understood across the sample as ‘For low back pain you should walk (taken from the shoes) or take gentle exercise (from the bottle label)’.

Continue to be active if you’ve got back pain.

(Male, 20-39, ABC1, had LBP, Oxford)

But it also communicated ‘Don’t take pills (painkillers), take exercise’. And even, for some across the sample ‘Don’t go to the doctors (or any of the other professionals)’.

Don’t take pills, do something.

Get your boots on.

(Males, 40-60, ABC1, no LBP, Rural Peterborough)

‘The most effective way…’ was seen as a very strong claim and believable, but only for some forms of low back pain i.e. less serious conditions/episodes. And respondents (sufferers and non-sufferers) are unclear how many low back pain sufferers this would cover.

Therefore the exact target audience for this message remained an outstanding issue for respondents.

7.2.3 Appeal

The shoe creative device polarised to a degree, though, on balance more respondents found it clever and intriguing than not, especially as a TV ad.

It’s different, you go look up there “what’s in that bottle?”

(Male, 20-39, C2DE, had LBP, Rural South Devon)

Nevertheless there were respondents who wholly rejected this intervention (on both TV and print) for the lack of clarity of the shoes.

7.2.4 Key points of learning

A direct contrast between pills and exercise as presented in this intervention can easily lead to miscommunication of ‘don’t take pills’ and to lesser extent, ‘don’t go to the doctors’. Neither of these was intended or desirable and care must be taken to avoid them in future communications.

TV was overwhelmingly the preferred medium.

7.3 Response to Prescribe Radio

7.3.1 Comprehension

Ostensibly this was easy for respondents to understand. However, comprehension problems emerged along with a dual message.
7.3.2 Message interpretation
This intervention communicated two distinct messages. For most respondents it was ‘Keep moving if you have low back pain, do these sorts of things’. But for some it communicated a far more general message about exercise for prevention. This seemed to come predominantly from the phrase “People who stay active…get less back pain…” and served to suggest the message is therefore aimed at everyone.

7.3.3 Acceptability/credibility of message
Prevention could readily be seen as a less problematic, more credible and therefore more acceptable message.

*If you have low back pain then you carry on as normal.*

*Keep doing the same things you have always done.*

*Don’t lie on your back (or) rest….just carry on your normal activities.*

(Males, 40-60, ABC1, no LBP, Rural Peterborough)

*That is much better…because it’s saying that you can prevent it and it’s giving examples of what gentle exercise is.*

...(Aimed at?)

*The average couch potato.*

*...but the important message is that people recover more quickly from it if they are taking gentle exercise...*  

(Females, 40-60, C2DE, no LBP, Oxford)

7.3.4 Appeal
Respondents often contrasted this radio ad with Clinic TV ad, with Prescribe being perceived as suggesting more accessible, more realistic forms of activity than that presented in Clinic.

*The best one for me, in terms of how it would help most people, would be the advert with people playing different sports and all the rest of it…and I think ideally it would be good to have that as a TV advert if you are trying to capture a wide audience...skiing and hiking aren’t things that most people do necessarily, whereas hoovering and gardening...*  

(Female, 40-60, C2DE, no LBP, Oxford)

Golf, however, as a suggested activity emerged as widely unacceptable in being too extreme in the context of the ‘keep moving with low back pain’ message. Similarly vacuuming was also rejected as too extreme for a few.

*I don’t think you can play golf because most of it is about swinging from your lower, twisting.*

*Vacuuming is awful. The position that you are sort of in.*  

(Males, 40-60, ABC1, no LBP, Rural Peterborough)

*“Where have you been?” “I’ve been golfing for my back; I’ve got a really bad back. Sorry boss I couldn’t come in”.*
Nevertheless, the perceived aim of ‘an activity for everyone’ was well received.

A request was made by those favouring this concept to have it produced as TV rather than radio.

**7.3.5 Key points of learning**

This intervention does not single-mindedly communicate the ‘keep moving with low back pain’ message.

What is perceived as a much more broadly targeted ‘active lifestyle or low back pain prevention’ message is easier to accept than the intended message. Consequently it is leapt upon by respondents when there is any hint of it and threatens to overshadow the communication as intended.

**7.4 Response to Recommend/Clinic TV**

**7.4.1 Comprehension and message interpretation**

This TV intervention featured characters dressed for what many considered fairly strenuous activities. This, in conjunction with the phrase “…get less back pain…” led to widespread confusion over the ‘action’ with respondents agreeing that these sorts of people do not get back pain.

As such the message was interpreted by many respondents across the sample as about prevention, and broadly targeted.

...*I think it’s saying that if you do gentle exercise you’re not going to be in there (the low back pain clinic).*

(Female, 40-60, ABC1, had LBP, Peterborough)

...*the message was that it’s very easy to avoid back pain and you know how to do that.*

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

Further confusion and debate could arise over why these active people were at the low back pain clinic.

*Get on and do something to prevent it…*

*...You have got to ask yourself why are they in the clinic. because they are saying if you do all this stuff you will be alright.*

((Males, 20-39, C2DE, no LBP, Peterborough)

The intended interpretation and message usually emerged through discussion but then the suggested activities, as presented, seemed too extreme.

*Hiking is a bit ridiculous.*

*...needs better examples.*

*...Walking the dog’s probably of more interest.*
Swimming.

But he’s not swimming is he, he’s snorkelling. He’s got all the gear on.  
(Females, 40-60, ABC1, no LBP, Rural South Devon)

Very few detected a humorous tone in this ad and so translated it very literally.

7.4.2 Appeal
Respondents in two groups amended this intervention to replace its characters with ‘real’ people and more realistic and accessible activities. This served to make the ad easier to relate to overall.

I’d say you’re better off looking at a home environment or whereby somebody who has actually got a back problem. And showing them trying to get on with their daily life.  
(Female, 20-39, C2DE, had LBP, Rural Peterborough)

Also, it was suggested that this intervention would benefit from being more sympathetic in tone by ‘showing’ that the characters have low back pain.

7.4.3 Key points of learning
Response to this intervention in particular highlighted a desire by low back pain sufferers to have their genuine condition acknowledged and depicted sympathetically.

This might also go towards characterising the low back pain at which this advice is aimed.

7.5 Response to Voices Radio

7.5.1 Comprehension
Respondents easily followed the narrative.

There was some debate over the multiple voices device. It was usually perceived as an indication that the message is relevant or aimed at both men and women, with a few linking it with the point about Drs, etc. giving the same advice.

I think it’s for women and men, that’s why there are two voices.  
(Female, 40-60, C2DE, no LBP, Oxford)

... that was the doctors talking to you directly.  
(Male, 20-39, ABC1, had LBP, Oxford)

7.5.2 Message interpretation
Essentially, the message is taken as intended i.e. ‘keep active with low back pain’; but it was also seen as much more than this.

There was a tendency for respondents across the sample to pick up immediately, and dwell upon, the assertion “Going to work can actually be good for your back.”

The discussion here focussed on issues which were particularly negative in content and tone and which were in danger of detracting from the core message and overall intention of the intervention.
For instance, the motivation for advertising was perceived as an attempt by the government to get people back to work and this as a consequence of the large number of lost sick days due to low back pain. It could be seen as targeting ‘malingers’ and (perhaps inadvertently) providing ammunition for unsympathetic bosses.

"...was that advert perhaps connected with the statistics of people who stay off work because they are saying “I’ve got a bad back I’m not going to work”? Is it trying to say to people “we’re not taking these excuses any more; you shouldn’t be staying at home saying you are resting your back you should be going to work”?

(Female, 40-60, ABC1, no LBP, Rural South Devon)

Keep going to work.

...they probably think too many days lost (to low back pain).

...Sounded a bit naggy to me, actually.

...It certainly sounds as if they’re trying to encourage you back to work but I don’t necessarily think it’s a benefit. Again it depends on what the work is, what the back pain is...and how sympathetic the boss is.

...much more pushy...if I had a bad back and I heard it I would not be overly happy to be told to go back to work and keep moving.

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

...don’t go to see a GP with back pain because the best thing you can do is just go back to work. I think they are trying to get the majority of the workforce back.

(Female, 40-60, C2DE, no LBP, Oxford)

The intervention could also be seen as not appropriate for those with desk jobs i.e. they do not ‘keep moving’ by going to work.

Well, for me it would mean just a normal day’s work which involves physical work.

...see my work is different. There is no gentle exercise.

I think it will depend on your work.

(Males, 40-60, ABC1, no LBP, Rural Peterborough)

“You shouldn’t rest” underlined the perception that this advice must be for minor low back pain. While “You shouldn’t lie in bed” presented a direct but not unacceptable challenge to past advice.

...very much to the point in that you remember that actually laying down flat will make it worse which is quite important to know. And just moving around gently...

(Female, 20-39, C2DE, had LBP, Rural Peterborough)

...if the idea is that you shouldn’t just camp up in bed then yeah, fair enough, but I don’t think that is what that is portraying: that is saying you shouldn’t rest. That doesn’t seem right.

((Male, 20-39, C2DE, no LBP, Peterborough)

The introduction of advice about taking pain killers as a point of difference in this intervention was usually noticed and welcomed (as realistic).
I thought it was useful to say to take painkillers.
(Female, 40-60, ABC1, no LBP, Rural South Devon)

7.5.3 Appeal
This was the least well-received intervention with almost all respondents finding the ‘back to work’ references at best demotivating and often unacceptable.

Tone of voice of this ad was often perceived as harsh, haranguing (perhaps exacerbated unintentionally by the multiple voices) and overall unsympathetic.

...if you have got very bad back pain I think that would give you some stick as they say.

I think that’s right yeah – don’t lie in bed, don’t do this, they are getting at you. You have got to get going, but I think they are a bit pushy on that one.

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

...it’s like it’s haranguing you.

Yeah, it’s almost disturbing.

(Males, 20-39, ABC1, had LBP, Oxford)

There was appeal in the directness of some aspects of the message/advice, especially ‘You shouldn’t lie in bed’; continue to move around with low back pain; and take mild painkillers which acknowledges the pain.

7.5.4 Key points of learning
Reference to work seemed to show insensitivity towards low back pain sufferers concerns about being seen as genuinely in pain. Moreover, the suggestion that motivation for this campaign is primarily about ‘getting people back to work’ is largely unacceptable.

A direct statement about ‘not lying in bed’, with an acceptable creative approach, is worth consideration.

7.6 Response to Prescription Print

7.6.1 Comprehension
Respondents easily understood the copy and the prescription pad device though there was some puzzlement over ‘1/0’ on the prescription.

7.6.2 Message interpretation
The ad was readily interpreted as intended i.e. for low back pain take exercise.

The message ‘Don’t bother/go to any of these specialists’ also emerged from across the sample.

Well they are saying they are not going to get anything – a drug from the doctor – he’s going to suggest carry on with gentle exercise.

(Male, 40-60, ABC1, no LBP, Rural Peterborough)

I think people will interpret that as if they go to the doctors that’s all they’re going to tell them (i.e. do gentle exercise)...I don’t think that’s actually welcoming people.
But this execution seemed to exacerbate the suggestion (present in all test interventions) that this advice is the answer to all low back pain which respondents find incredible.

Well if I go to the doctor and I've got back pain and he says go and exercise mate and the next person goes in...had a nerve removed or something, gentle exercise would be out of the question wouldn’t it...

Respondents understood the point and the intention of having the experts in low back pain all giving the same advice, though the more literally-minded took issue that it would be all Drs etc.

You see doctors, physiotherapists and osteopaths; you might think only some doctors, physiotherapists and osteopaths...I’m cynical.

7.6.3 Appeal
This intervention was perceived as more straightforward than Pill Bottle print but also as more bland and visually uninvolving, leading to its rejection.

Comments emerged about this ad’s lack of standout - and press ads in particular are believed to require standout as a prerequisite for being ‘noticed’ and ultimately effective.

A bit dull really.

7.7 Response to Scratch and Banjo Radio

7.7.1 Comprehension
The majority understood the musical device and storylines of each of these test interventions.

7.7.2 Message
The message was interpreted as ‘Keep active with low back pain’.

Scratch introduced the concept that low back pain can also affect young people through its music style and the voiceover reference to ‘any age’.

And so an additional message emerged that a radio campaign of this sort could reasonably target (age) groups by the music type featured.

Well the music is very integral in that and you need the right music for whatever age group you are targeting.

So it’s not for our sort of age group.

The second one was better.

7.7.3 Appeal
These ads were often perceived as sympathetic in tone. They were seen as acknowledging the impact of low back pain through the phrase (LBP can) ‘bring your life to a halt’ and the inherent
The concept communicated via the music (which starts slow and speeds up), that getting back to normal has to be gradual. The tone was described as upbeat and positive.

*I think that was just to show...to take it at a nice comfortable pace if you are going to do some exercise. Just do what you can, when you can, and try to get back to your feet.*

(Male, 20-39, C2DE, had LBP, Rural South Devon)

Use of the word ‘Normal’ was an overstatement for some whose low back pain is chronic.

*I just wondered what they meant by normal really because I’ve normally got a back ache or something somewhere...*

(Male, 20-39, C2DE, had LBP, Rural South Devon)

These radio ads could be disliked on the basis of the type of music featured.

Some respondents mentioned that these ads provided a degree of much sought after clarification of the concept of exercise/keep moving/stay active i.e. it will be slow at first.

*I think it told a lot more information on how we were all thinking ‘oh, how much exercise do you need to do in case you hurt yourself’, but that sort of tells you to start slow and then work your way back up again rather than trying to do a lot more...*

((Male, 20-39, C2DE, no LBP, Peterborough)

Communicating that low back pain also affects young people was seen as valuable, in particular for several of the young people and a few mothers who were interviewed.

**7.7.4 Learning**

Acknowledging that the condition/pain/impact of low back pain is real is very welcomed across the sample.

It is also both realistic and sympathetic to demonstrate that any suggested activity and progress will be gradual.

There were some indications in the research that it would be more acceptable, because more credible, to present the benefit more accurately as relief rather than cure.

*Well even the wording is different. That guy is not going to be cured overnight and he actually specified it...in the wording - until things start improving and getting better it will gradually improve. Which actually infers they are empathetic to your situation and understand that immediately you may not be able to do everything you want to, but if you keep staying active, each day is going to get easier.*

(Female, 20-39, C2DE, had LBP, Rural Peterborough)
8. EXPLORATION OF USE OF LANGUAGE / JARGON USED BY HEALTH PROFESSIONALS AND HOW IT IS UNDERSTOOD BY THE GENERAL PUBLIC.

8.1 Background to the study
During the research into the use of media in communicating messages about back pain it became apparent that the general public perceived unintended meanings of seemingly simple terms e.g. gentle exercise, used in back pain management.

This raised the question, “Are commonly used medical terms in the language of back pain – acknowledged as both complex and difficult - understood differently by health professionals in primary care and members of the public?”

8.2 Purpose of the research
The aim of the research is to identify and explore the meanings of commonly used medical terms for back pain from the perspective of health care professionals and members of the public who have and have not seen a health care professional regarding back pain.
9. METHOD AND SAMPLE

9.1 Method and sample recruitment criteria
Focus groups, each lasting 1 hour, among primary health care professionals and the general public enabled the depth of questioning and understanding required.

A purposive sampling approach achieved a sampling frame including Chiropractors, General Practitioners, Osteopaths and Physiotherapists.

Over 50% of the work of professionals (except GPs) was spinal. All health professionals were British trained and had fluent English. And each group included both male and female professionals.

The sampling frame also included members of the public: men and women, a broad spread of Socio Economic Groupings and ages, and those who have and have not experienced low back pain.

In addition, sample criteria for the general public demanded that all those with experience of back pain had sought professional help; and that 50% of those in C2DE groups had manual occupations.

All professionals who were interviewed worked in Birmingham or West Midlands.

All members of the public lived in West Midlands (Sutton Coldfield and Solihull). Fieldwork took place in September 2005.

9.2 Sample summary
The sample of health professionals included one separate group of each of the following:
1. Chiropractors
2. General Practitioners
3. Osteopaths
4. Physiotherapists.

The general public sample consisted of one group of each of the following:
3. Women, ABC1, 40-60, with back pain.
5. Men, C2DE, 40-60, with back pain.

9.3 Stimulus materials
A list of medical terms used in the language of back pain was presented individually both verbally and written on cards.

Groups 1, 4 and 5 discussed each term in turn in the order below while groups 2 and 3 were shown them in reverse order. This was to minimise any potential order bias.

The terms discussed were:
* back pain (and low back pain, plus mild, moderate and severe)
* back ache
* sciatica (and radiated pain)
* specific and non specific back pain/ache
* mechanical back pain/ache
• acute
• chronic
• recurrent
• muscle spasm (and strain and sprain)
• muscle imbalance
• muscle weakness (Seen as a permanent or temporary phenomenon?)
• instability
• nerve root pain (and trapped nerve, nerve compression, neurological involvement)
• sensation, paraesthesia
• managing your back pain
• psychological pain (including coping)
• disc (and slipped disc, prolapsed, herniated, ruptured)
• facet joint
• arthritis
• wear and tear
• alignment (and posture)
• exercise
• activity
• manipulation (and mobilisation)
• soft tissue technique
• spondylitis
• stenosis
• rehabilitation
• disability
• Impairment
• functional impairment
• degenerative change.

In addition, respondents were asked to express their understanding of what having an X-ray, an MRI, and their reflexes checked, will show/indicates. And what they thought taking analgesics, antidepressants, and anti-inflammatories does?

9.4 Data analysis approach
Data using full transcripts of audio recordings of every focus group discussion was listened to until the researcher became familiar with the data. Transcripts were analyzed line by line identifying concepts and their properties. Data was coded in order to describe and relate categories and subcategories of concepts such that they could be represented as addressing the research objectives.
10. DESCRIPTION OF THE HEALTH專業 GROUPS

To give context to their response to the terms, below are tables outlining age, gender, years in practice/treating spines, percentage of time currently treating spinal.

All practiced full time.

All were members of their appropriate professional registration body.

10.1 Chiropractors

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Years treating spinal</th>
<th>Time spent on spinal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>41</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>32</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>57</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>30</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>46</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>23</td>
<td>1 ½</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>37</td>
<td>1 ½</td>
<td>90%</td>
</tr>
</tbody>
</table>

10.2 Osteopaths

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Years treating spinal</th>
<th>Time spent on spinal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>46</td>
<td>23</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>36</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Male</td>
<td>46</td>
<td>23</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>52</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>28</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>37</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>32</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>29</td>
<td>8</td>
<td>100%</td>
</tr>
</tbody>
</table>

10.3 Physiotherapists

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Years treating spinal</th>
<th>Time spent on spinal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>29</td>
<td>6-10</td>
<td>Over 50%</td>
</tr>
<tr>
<td>Male</td>
<td>36</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>Male</td>
<td>67</td>
<td>40</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>30</td>
<td>12</td>
<td>75%</td>
</tr>
<tr>
<td>Male</td>
<td>46</td>
<td>24</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>58</td>
<td>40</td>
<td>75%</td>
</tr>
<tr>
<td>Female</td>
<td>46</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>66</td>
<td>40</td>
<td>100%</td>
</tr>
<tr>
<td>Female</td>
<td>n/a</td>
<td>10-20</td>
<td>Over 50%</td>
</tr>
</tbody>
</table>
10.4 GPs

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Years in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>57</td>
<td>25</td>
</tr>
<tr>
<td>Male</td>
<td>53</td>
<td>22</td>
</tr>
<tr>
<td>Male</td>
<td>52</td>
<td>25</td>
</tr>
<tr>
<td>Male</td>
<td>49</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>46</td>
<td>20</td>
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<td></td>
<td>45</td>
<td>16</td>
</tr>
<tr>
<td>Female</td>
<td>48</td>
<td>12</td>
</tr>
<tr>
<td>Female</td>
<td>52</td>
<td>25</td>
</tr>
</tbody>
</table>

To enable each group to cover all of the terms in the available time the moderator explained and reminded respondents that after having discussed each term consensus would be assumed unless alternative viewpoints were offered. The group would then move on to the next term.

Almost all terms were covered in every focus group.
11. OVERVIEW AND GENERAL POINTS OF LEARNING

11.1 Some common terms do have unintended meanings
The hypothesis that common terms in the language of back pain have unintended meanings for
the general public has been borne out by the research.

Those respondents who have been treated for low back pain have some greater insight into some
very specific terms (i.e. usually those which have been used to discuss their own conditions),
and a somewhat wider vocabulary. However, areas and levels of understanding or
misconception are (perhaps remarkably) similar between these members of the public and those
who have never suffered low back pain (lbp).

At least one person, and usually more, in each group discussion with the general public
attempted to define unfamiliar terms e.g. psychological pain; these were often simply ‘guesses’.
Only with terms where respondents could not find any ‘clues’ e.g. stenosis, were no meanings
suggested.

Terms, as understood by the general public, can be split into broad categories; those which:
• Are not understood or are misconstrued and have inadvertent negative connotations or
implications.
• Are not understood or are misconstrued but this does not lead to negative emotional
responses.
• Are understood as HPs intend.

Research indicates that familiarity with a term is no guarantee of understanding.

11.2 Some terms are recognised as potentially problematic by health professionals
Professionals in primary health care who were interviewed seem sensitive to terms and phrases
used in discussing back pain with patients, which might be misconstrued and lead to anxiety or
worse in their patients.

*I think people’s rate of recovery and their perception of how well they are is strongly
affected by the language that we use. So you tend to make it kinder and gentler.*

(Osteopath)

...*I think patients do make assumptions...once they’ve heard that (e.g. instability) from
you they think that’s something I can’t actually deal with or that’s something that’s
going to take so long to correct I can’t deal with it. So I try and use maybe more
positive phrases that don’t scare them.*

(Chiropractor)

Consequently, health professionals (HPs) claim a tendency to avoid these terms verbally though
they do still tend to write some of them in notes for other HPs.

However, research indicates that HPs do not recognise all of the phrases which can lead to
problematic misunderstanding by patients or potential patients. Nor do they always have it front
of mind that patients can and sometimes do access their medical correspondence.

Physiotherapists and GPs in our sample in particular seemed more inclined to write terms in
correspondence and shared notes than other HPs interviewed.
This is perhaps because the GPS and most Physiotherapists interviewed were working within the NHS framework unlike the other HPs in our sample.

HPs do claim an active and important role in explaining terminology, which patients bring to them from other HPs or, increasingly, have found on the internet.

...I’m certainly finding (patients) spend a lot of time looking things up on the internet and they come back with all these big complicated word they don’t understand. It becomes our role because he have about half an hour with them to actually explain these things to them to calm them down.

(Osteopath)

One Osteopath noted there was perhaps less need for consistency of use of language for sole practitioners than for those through working in larger practices/organisations.

I think because ...most of us work on our own, it’s different. I think if we were all working in the same place we’d have to start using phrases ...so if we’re picking up each other’s patients you’ve got to have more uniformity of description. We write notes for ourselves and so it’s much more individual.

(Osteopath)

11.3 The use of visual aids
Research highlights the widespread use of visual aids – spinal models, diagrams on treatment walls, drawings by individual HPs – as invaluable, even essential in explaining terms to patients.

Visuals is really important because it’s very difficult for someone to explain something to them and they can’t see it. If they see the picture of it ...or the model it’s much better. People have very different ideas of what they think their body looks like or what they think things are, so if you can point out this part on your body then it’s like “OK”.

(Osteopaths)

11.4 Using patient’s terminology
HPs report that it is often the patient who introduces terminology at consultation - sometimes accurately and sometimes not – in particular terms, which are descriptive of symptoms.

...you’re asking us to talk about how we handle the language as symptomatic; its presenting and describing the symptoms language which 80& or 90% is coming from the patient. We’re listening, were at the receiving end.

(GPs)

Many HPs from across the sample saw value in working at first within the framework of the patients’ understanding of terms, even if flawed, to establish trust and encourage communication.

I find sometimes you spend two minutes explaining why it isn’t sciatica and then they go, “oh so I’ve got sciatica then”, and that really does happen sometimes. And I think sometimes it’s better for the person to actually be part of the process...if they feel comfortable and you’ve got the patient’s trust and they know what you’re doing and you’re on the same page then the actual words from you become less important.

(Osteopath)

I suspect that what you probably do to a great degree is reflect back what they say to you because it’s a lot easier to say yeas you’ve got a trapped nerve because they have
an understanding of that and that’s a phrase that you can encompass within your professional ways of understanding.

(GP)

I think in some respects you do have to start like that (discussing the patient’s suspicion of a disc problem, though you probably disagree with the diagnosis) and follow their pattern, their knowledge.

(Chiropractor)

The thing is, if a patient comes in and says “I’ve got a trapped nerve”, you don’t go “No you haven’t, you’ve got an impinged nerve”. …it sounds a bit patronising; so, you’ve got to go with the flow.

(Chiropractor)

Whether a term was explained to patients, and to what degree, depended on several factors:

• Whether the HP perceived the term as complex or likely to be misconstrued. 
  I think it’s important that people have a handle on the mechanism of pain because it can be quite a frightening experience. I think it’s important that they know for instance that there are things that they can do to help.

(Chiropractor)

• The HP’s judgement about how much the patient can/wants to know. And what they believe each individual patient will gain with detailed explanation.
  But if you become too complex with people, it does depend on the individual. In some people you can see their head spinning.

(Osteopath)

Some do (like to hear a detailed explanation).
I think it depends on each patient.
Some say what’s the diagnosis; others couldn’t care less as long as they’ve got rid of it.

(Chiropractors)

• The HP’s personal communication ‘style’ with patients. Some seem to have relatively detailed discussions with every patient, while others prefer to concentrate on treatment with minimal explanation and discussion.

In each of the HP discussions however, the importance of providing information on prognosis alongside diagnosis, especially if this involved medical terminology, was stressed.
  If I’m touching on a diagnosis then I like to try and give them reassurance on the prognosis.

(GP)

11.5 Some broad differences emerged in use of terms by HPs

In general, GPs claim to minimise their use of very specific terminology given that they often see patients prior to a full investigative diagnosis.

I find I’m putting less and less detail into our sick notes. If somebody’s got back pain…
I write back pain on a sick note; I just keep my nose out of trouble.

(GP)

GPs also have less time per consultation than other HPs which limits their opportunity to explain terms and this can lead some GPs to avoid using complex terms verbally with patients though they might still write them e.g. in referral correspondence.
GPs pointed out that the terms they can use in written form is dictated to some extent by those available on their software system.

Physiotherapists seem to use more of the common phrases on our test list than other HPs. Is this because those interviewed were older, more experienced HPs than in other groups; because they have more need to correspond with other HPs within the NHS and therefore more need to use specific terms; because of the nature of Physiotherapists’ work with patients where several claimed an educational role? Research among this one group of Physiotherapists could not answer this.

There was a tendency for osteopaths to introduce further technical phrases specific to osteopathy; more perhaps than other HPs.

There was a tendency for our group of Chiropractors to use less of the phrases tested than other HPS (with the exception of GPs). However, this might simply be a result of the individual makeup of this one group rather than a more widely applicable feature of this profession.

11.6 Insight without jargon

HPs believe that patients are keen to have a diagnosis in terms of acknowledgement of their condition/pain, preferably with a comprehensible name or ‘label’, but most importantly patients want appropriate treatment. This is borne out by patient comments.

_I think their main issue is one, that you understand how it impacts and two, that you get access to right treatment. They’re not there to have a discourse with you about the terminology._

(GP)

_I think there’s also a massive group of patients out there who really feel happy when they’ve got (e.g.) arthritis ... Rather than low back pain because it reinforces their honest behaviour...some people actually like to have a diagnosis._

(Physiotherapists)

In addition, some patients want to learn as much as possible about their condition and treatment; and this group of patients, as witnessed by HPs from across the sample, seems to be growing.

_ I think a lot more people, I find increasingly more want to know why, what. They keep coming back and asking._

(Chiropractor)

However, HPs also believe that providing increased insight for patients does not mean introducing new ‘jargon’.

_ I think also patients don’t want to be baffled either. They come in, especially with the doctor first, he’s told them what’s going on, he’s given them all these tablets ...and they’re getting no better and they don’t want to be blinded by science._

(Osteopaths)

And all stress that of course no HP wants to use terms which mislead, distress, insult or alarm patients.
12. DETAILED RESPONSE TO COMMON TERMS IN BACK PAIN LANGUAGE

Respondents – both professionals and the general public – were asked for the meaning of each term shown to them. In addition, they were asked if they used it with patients (HPs) or were familiar with it (general public) as a term used in the context of back pain.

12.1 Terms with unintended meanings for the general public which could prove problematic.

12.1.1 Non-specific back pain

Neither those who had been treated for low back pain nor non-sufferers were familiar with this phrase.

Three interpretations among the general public emerged. They were, in order of frequency of mention:

- The health professional does not know the cause; or it cannot be diagnosed
  
  *You’ve got this, but they don’t know why.*
  
  (Male, ABC1, 20-30, no lbp)

- The pain is not located in a specific place
  
  *You wouldn’t be able to locate it.*
  *Yeah you’d feel it all over really.*
  
  (Males, C2DE, 40-60, with lbp)

- The pain cannot be connected to a specific injury or habit.

_Specific back pain_ is understood as the opposite of these i.e. most likely definition is that the back pain has a diagnosed cause.

_Non-specific back ache_ is generally understood – in line with broader interpretations of ache vs. pain – as a less painful version of non-specific back pain.

_Bearable ache is, pain needs treatment._

(Male, C2DE, 20-39, with lbp)

For some across the general public sample, _specific back ache_ seemed a contradiction since _ache_ readily suggests to people that it is not located in a specific place but is rather a general all-over (albeit less severe) pain.

As a phrase, _non-specific back pain_ has emotive, often very negative connotations for the general public, suggesting to some that it sounds as if the health professional believes the patient is making it up.

_It’s non-specific...non-existent._

(Female, C2DE, 20-39, No lbp)

Some suggested it would be inadequate on an employee ‘sick note’ for this reason.

_That’s not what you put on a form at work for a couple of days off._

(Male, C2DE, 40-60, with lbp)
The phrase also has implications for treatment i.e. it instantly suggests referral for further investigation; and that the hp does not know how to treat it – which can be of concern to respondents.

That spells referral to me.  
(Male, C2DE, 20-39, with lbp)

Health professionals interviewed agree on intended meaning i.e. that a cause has not yet been diagnosed.

They also recognise the potential negatives i.e. that patients want a diagnosis and the reassurance that the HP knows what they are doing. For these reasons, all HPs interviewed claim they would not use the phrase verbally with patients.

Yes it is don’t know back pain, non-specific. It’s a posh way of saying I haven’t got a clue.
...We never use it.
...Because we’ve got adequate descriptors without needing it.
...It hurts our pride to put it down.

(GPs)

Physiotherapists and some GPs said they would tend only to use the term in written notes. Physiotherapists point out they do not want to disappoint their patients.

Non-specific means it hasn’t really got a diagnosis.
No I don’t use it with patients I sometimes put it in the notes if we’re still trying to diagnose what the back pain is.
... (Patients) don’t like it.
They don’t like you if you tell them.
...Patients come to you because they want a diagnosis.
...and you’re not giving them one.
... (Non-specific back pain can also suggest) she doesn’t know what she’s doing.
Neither of which we particularly want our patients to think.

(Physiotherapists)

12.1.2 Acute
The general public are less familiar with the term acute than with chronic in the context of lbp. As with several of the test terms, respondents draw on their knowledge of terms in other medical contexts for help with interpretation.

Acute is usually understood as severe; in a specific spot; and sharp.
...acute could be more localised...its acute, just one spot.
Like acute appendicitis. It’s just that area.

(Females, ABC1, 40-60, with lbp)

Though for a few it can suggest a pain that is milder than chronic.

A minority of respondents (all lbp sufferers) acute means recent, even current.
It’s now.

(Male, C2DE, 40-60, with lbp)

Health professionals believe that the public interprets acute as a term which quantifies severity of pain rather than recent onset as intended. It tends not to be used by GPs or chiropractors except in notes.

I don’t use it very much with patients. I don’t ways you’ve got acute back pain...I would occasionally put it on o note.
...it’s only really useful on a file for somebody else where it’s acute. Yeah, they don’t need to know really because they know it started two days ago.

(GPs)

I think patients if they go “Oh I’ve got acute back pain” they think it’s like a quantifying factor …that’s why I don’t tend to use it because it’s incorrect language.

...I use it as I write a diagnosis.

...It’s a temporal thing rather than a qualitative.

(CHIROPRACTORS)

Some Osteopaths find the phrase helpful with patients to describe intensity as well as recent onset.

...sharp, intense.

It’s recently happened

I think it’s really useful describing the recovery...they say “It’s acute, it’s sharp, it’s intense, it’s recently happened...next week they become less acute and there’ll be less sharp pain it’ll be more just occasional aches. So I use it a lot (to) explain that progression of recovery.

(Osteopaths)

I use acute when it’s something which has happened very recently.

...Or suddenly.

(Physiotherapists)

12.1.3 Chronic

The public are very familiar with the term chronic in the context of lbp.

The most salient meaning is very severe:

Severe, chronic terrible pain.

Chronic means absolute, the pits.

(Female, C2DE, 20-39, no lbp)

(Male, C2DE, 40-60, with lbp)

Perhaps even:

Couple of steps from a wheelchair.

(Male, ABC1, 20-39, no lbp)

It can suggest incurable to some.

The interpretation centring on severity of pain was, in some though not all groups, augmented by additional meanings:

- Long-term
- Constant
- Repeated over and over – though this is more often an interpretation of recurrent.

(Chronic) lasts as well, doesn’t it? Acute can be a short period of time.

I think chronic is long-term.

(Male, C2DE, 40-60, with lbp)

Health professionals are aware that the general public tend to interpret chronic as severe and sometimes unduly negative i.e. “incurable.”

It means long-term, long-standing.

Ongoing.
Ongoing yeah. Whereas colloquially people use it - I don’t know whether its just Birmingham – but “I’ve got the most chronic (back pain)”. ...Severe. To them chronic means severe.

(GPs)

It implies again something that’s...going to be there forever.
I don’t use it that much) because again it’s like degenerative, it’s unfair with “Is this it?” Am I going to be stuck with this?”
It’s scary

(Osteopaths)

Most HPs prefer to use phrases such as long-term, long-standing and ongoing as simpler alternatives.
I think long-term is just a simpler word to use and it’s something they will pick up on straightaway...

(Chiropractor)

Mention was made in both the Chiropractors’ and Osteopaths’ groups of the term chronic being useful in providing reassurance and the prospect of a long-term treatment or pain management plan.
...the only time I might use things like chronic...if somebody has had a condition for a very long time and they’re wanting relief from that in terms if a diagnosis, then you can say this is a chronic condition and they can go “OK, now I can manage it” because you’re actually giving them something....whereas before it’s like “where am I, what’s going on?”
...sometimes people can be relieved by having a label put on it...

(Osteopath)

I would sometimes use it with patients when I’m trying to explain a treatment plan and trying to explain why they might need x amount of treatment as opposed to y amount of treatment...

(Chiropractor)

Physiotherapists tend only to write and not say chronic. They recognise the different interpretations by patients.
It’s a horrible word (chronic).
I don’t say it much to patients; I write it down in my notes.
It’s a bit depressing.
...I think there are two definitions actually. One is comparing it with acute – in fact acute is like a thunderstorm if you like and chronic is like its raining for a long time.
But the patients, the elderly patients particularly often use the word chronic as something which is absolutely bloody awful.
Chronic means long-term.

(Physiotherapists)

One Physiotherapist pointed out that ‘Chronic Pain Clinic’ might not be helpful nomenclature given the negative connotations chronic has for the general public.

12.1.4 Recurrent
By contrast to chronic this term is interpreted by the public as less severe and pain that comes and goes. Some see chronic pain as never entirely going away.

You think it’s gone and then it comes back.
You’ve always got chronic. It comes in waves. But recurrent it can, chronic can’t ever go down to zero; you’ve always got something wrong.

GPs agree that recurrent is often more accurate (and more useful and positive) than chronic in describing a patients back pain.

...I don’t think that’s a word I really use for patients. They know that it’s chronic…I think recurrent is more of a description of it. Chronic implies that it goes on and on and will never go away.

Physiotherapists use recurrent, and in discussion of it express what they see as the important educational role they have with patients.  
More than one episode.  
...it keeps happening.  
What I often tell patients ...our role ...is really to prevent recurrence by teaching the patient how to manage his back.

(Male, ABC1, 20-39, no lbp)

12.1.5 Muscle weakness
The general public claimed to be unfamiliar with this phrase in the context of lbp.

However, all groups attempted an interpretation:

An underdeveloped muscle.

(Male, ABC1, 20-39, no lbp)

- Muscles aren’t exercised and giving adequate support.

- Weakened through lack of use.
  
    It’s not using your muscles properly.  
    So if you were in plaster you wouldn’t use the muscles in that particular leg. That would create muscle weakness.

(Females, C2DE, 20-39, no lbp)

Many believe the condition is probably permanent:

Well that’s fair enough in my case, I’m wasting away.

(Male, C2DE, 40-60, with lbp)

And some respondents broaden the meaning:

Just not working...
You aren’t very strong.

(Females, C2DE, 20-39, no lbp)

These suggestions by the public of permanence and that it implies a person is weak, were seen as concerning by at least one GP.

I use weakness if you’re talking about physio, muscle strengthening exercises and that sort of thing; not very often though.

...But the weakness might imply permanent.
It doesn’t mean you’re a weak person.
No I wouldn’t go there.

(Female, ABC1, 40-60, with lbp)

(Male, ABC1, 20-39, no lbp)
Chiropractors were similarly wary of an implication of permanence in the term *muscle weakness* and for that reason claimed to avoid using it.

Physiotherapists mentioned that they use it to mean *reduced power* and usually in temporary cases.

*A lot of back patients, particularly those after surgery do have permanent muscle weakness and change in body shape after many years. But a lot of them it’s temporary.*

(Physiotherapist)

Osteopaths claim not to use the term. Exploration of this phrase led Osteopaths to discuss their perception that Physiotherapists tend to treat conditions such as muscle weakness as primary conditions whereas they as Osteopaths prefer to diagnose and treat the underlying cause of which in this case muscle weakness is a symptom.

### 12.1.6 Instability

Very few from across the general public sample are familiar with this term.

It was most often interpreted as the back could ‘go’ at an time:

*...if they get you back to working order the back is unstable because the least little thing can actually throw it off again. Instability.*

(Female, C2DE, 20-39, no lbp)

Or, for one group:

*Something’s a bit loose. It’s liable to pop out.*

(Male, ABC1, 20-39, no lbp)

For one older man with lbp *instability* had extreme connotations:

*If you get chronic back pain and that you can fall over.*

(Male, C2DE, 40-60, with lbp)

*Instability* in the context of backs was considered worrying. It tended to suggest a permanent condition and one from which a sufferer could never relax.

*You’re on a knife edge sort of thing.*

(Male, ABC1, 20-39, no lbp)

*It is not in a stable state so it can’t be localised and controlled. It can flare up at any time, there’s not a lot you can do about it.*

(Male, C2DE, 20-39, with lbp)

‘Loose’ is used by some Osteopaths as an alternative, less worrying term. Although one Osteopath pointed out that using such a serious sounding term as *instability* can encourage self-help.

*They get a bit worried. I do use the word loose. It’s a bit loose at the moment and we’re going to actually try and help it stabilise. ...It’s a good way to almost, not scare the patients into it, but encourage patients to actually go and strengthen an area. If you said it’s unstable it makes sense to them because they would go and strengthen it...*

(Osteopaths)

Chiropractors tend to avoid *instability* seeing it as having the potential to cause alarm, suggesting something more serious than it is.
I think sometimes the word unstable, if you put that idea instability it might panic patients a bit but again it depends on the context and the patient. ...I think they just assume it’s perhaps worse than it is.  

(Chiropractors)

Other HPs interviewed use the term only in notes.

12.1.7 Neurological involvement
Both lbp sufferers and non-sufferers have rarely come across this term.

A few understood it to have something to do with nerves or nerve endings.

Most general public respondents however, on hearing it, immediately mentioned heads and brains:

*Something’s going wrong in your head.*  
(Male, ABC1, 20-39, no lbp)

*Well neurologicals in the head, isn’t it.*  
(Male, C2DE, 40-60, with lbp)

Some seem to have muddled neurological with cerebral; while others – and they often point to the base of the skull while explaining it – take this meaning from the link between spinal chord, brains and backs.

*Because it all stems from the brain doesn’t it.*  
(Female, ABC1, 40-60, with lbp)

*I think nerves because I think the brain.*  
(Male, C2DE, 20-39, with lbp)

*Could be a tumour.*

...*Your whole spinal cord runs up there doesn’t it so your main nervous system runs up your back.*  
(Males, ABC1, 20-39, no lbp)

Neurological involvement is one of the most alarming of the terms tested. It can even suggest the possibility of imminent death.

*When your heads involved you start worrying don’t you.*

*Definitely.*

*Death within six months.*  
(Males, ABC1, 20-39, no lbp)

Physiotherapists use the phrase but stress that they always also explain it e.g. in terms of symptoms such as a loss of sensation.

*(This is a phrase we use with patients) with an explanation.*

*With qualification and demonstration.*

*(In layman’s terms it is) weakness in the muscles or loss of sensation.*

*Or changes in the reflex.*  
(Physiotherapists)

It might also be more readily written down than discussed.

*You’re more likely to write it down in your records, your notes, your assessment. It might be something that you’re going to go and talk to the doctor ... or the consultant about...*  
(Physiotherapist)
Neurological deficit was mentioned in the Physiotherapist group as preferable to involvement because it is more accurate. Neither Osteopaths nor Chiropractors tend to use the term neurological involvement while GPs claim they would not find it helpful even in notes, especially without a diagnosis. It’s not necessary. It doesn’t add anything to the descriptors that we’re already using. It’s too vague really. You write it down, you’ve committed yourself to further investigation, which may be undesirable.

(GPs)

Not to patients.
Not a reassuring thing.
(Instead of neurological)- nerves.

(Chiropractors)

12.1.8 Trapped nerve
This is a very common phrase, used by the general public.

Overall, definitions can be fairly vague.

It is understood as somehow stuck which in turn can be seen as more or less ‘drastic’.
(Treatment for a trapped nerve is) traction.

(Male, C2DE, 20-39, with lbp)

On probing, it is believed to be trapped between bones/vertebrae or by discs. You’ve literally got a trapped nerve I think. It’s pinched between the bones.. In between the slipped disc.

(Males, ABC1, 20-39, no lbp)

For some it involved ‘inflammation’. And for a few others, it meant no more than leading to pins and needles. All the muscles are inflamed. ... Or the vertebrae if it’s a slipped disc. But I don’t know because none of these things have ever been sat and explained. It’s just things that you perceive yourself.

(Females, ABC1, 40-60, with lbp)

Pins and needles. ...So you could have inflammation of your muscles or something at the bottom of your back as well if you did something and that could trap it.

(Female, C2DE, 20-39, no lbp)

Trapped nerve is readily interpreted by some as either the same or related in some way to sciatica.

Isn’t that what sciatica is, it’s just a trapped nerve where it runs down the back of your leg from your spine.

(Male, C2DE, 20-39, with lbp)

This is one of a set of phrases, which HPs report are brought to them by patients rather than introduced by HPs themselves.
It’s one that patients come in with a lot and you have to quantify to them exactly what a trapped nerve is to them so they don’t use it again.

It’s another misnomer really, a bit like a slipped disc. (Osteopaths)

It is sometimes not introduced or used by HPs through a concern that is sounds overly serious and potentially untreatable or permanent.

I don’t (use it). I tend to say nerve root irritation. Again I think trapped nerve sounds a bit drastic and negative.

...irritations something that can be alleviated or eliminated. (Chiropractor)

It can also be a catch all cause of back pain.

That’s the patients use that quite a lot don’t they?

You might correct it sometimes when people talk about ...having their trapped nerve which implies that it can’t move and nothing can be done and you might just explain that it’s probably a nerve that has some pressure on it and then discuss the different causes of pressure and some may be alleviated easily and some may not. But patients talk about trapped nerve.

They think everything is a trapped nerve don’t they? (Physiotherapists)

Osteopaths discussed how the term trapped can mislead patients by suggesting that an expert must separate the bones to untrap the nerve. Introducing the concept of inflammation can encourage patients to self help and contextualises the correct and non-threatening treatment.

Well they assume a trapped nerve is bone on bone or something that’s literally compressing the nerve.

...and it relies on somebody separating it.

...often advising patients to ice the area to reduce inflammation...if they’ve got an image of swelling there it makes sense and it encourages them to do it, whereas if it’s trapped...

(Osteopaths)

GPs were concerned that trapped sounded unduly threatening and at the same time demanded detailed, lengthy and unnecessary explanation and so was avoided by some GPs although patients wanted to use it. Other GPs claimed to find it useful.

I’ve often avoided the phrase trapped nerve because they want to know exactly what’s trapping it and if it’s serious. (GP)

12.1.9 Parasthesia

None of our general public sample had come across this term.

It was seen as a medical term, which some groups would not attempt to translate.

Others did attempt interpretations.

Several respondents believed it suggests paralysed in sounding like it.

It sounds like paralysed or something. (Male, C2DE, 20-39, with lbp)

Para?

Paraplegic.

...Paralysis.
Paralysis, yeah, that’s what I was thinking. (Males, C2DE, 40-60, with lbp)

It was also seen as including both paralysed and anaesthesia – and therefore somehow encompassing the consequences of both.

I think of numbing. I think of paralysis and anaesthesia together I could be strong but it’s just what I’m thinking. A complete numbness perhaps. (Males, C2DE, 20-39, with lbp)

Respondents say if the phrase parasthesia were used in the context of their back pain it would be very serious, extremely worrying and demanding further explanation.

Oh my god.
...I think I’d worry if someone told me that I was suffering from parasthesia. (Male, ABC1, 20-39, no lbp)

Oh, too right I would (ask about it). Give it us in layman’s terms. (Male, C2DE, 40-60, with lbp)

Sounds serious. (Female, C2DE, 20-39, no lbp)

Most health professionals interviewed prefer the patient friendly term pins and needles, though they would use parasthesia in patient notes.

Not for a patient.
Not with a patient, no.
It might go into the notes.
...tingling, pins and needles. (GPs)

Not usually (use it) to patients.
...It just saves time to say you’ve got pins and needles. (Osteopaths)

Parasthesia is a term Physiotherapists use with patients.

12.1.10 Managing your back pain
This is not a phrase, which lbp sufferers had come across in their treatment.

It was interpreted variously as:
• Living with the pain or condition rather than curing it.
• Changing your habits to live with the pain/condition.
• Adapting your lifestyle to keep pain to a minimum.

Where you have to put things in place in your life to manage when you are having an episode to you manage it yourself and you know what...tablet to take, what exercise to do and that sort of thing. (Female, ABC1, 40-60, with lbp)

Changing things, driving in different positions, sleeping in different positions.
Things that you do yourself as opposed to somebody like a physiotherapist or somebody would do for you.
...you’re going to have to live with it. (Males, ABC1, 20-39, no lbp)
For a few it meant avoiding certain activities to prevent the pain coming back.

> Go swimming instead of running that sort of thing. Just choose the things that’s good for you.
> Yes, identify what aggravates it and avoidance.  

(Males, C2DE, 20-39, with lbp)

As a phrase it could suggest that the HPs had given up and this was not well received:

> I’d feel a bit left on my own in the cold if the doctor said that to me. “I’ll tell you how to manage your back pain.” I would think well you’re not interested are you? Or there’s nothing you can do about it. ...You’ve got to manage.

(Female, C2DE, 20-39, no lbp)

Chiropractors avoid the phrase unless the condition is long-term, recognising it has long-term connotations for patients.

> It’s just a bit officious. It’s something you might read. I don’t think it’s something you would say.
> I would talk about coping mechanisms and coping solutions, ways round the problem.
> ...I’m going to help you how to manage your back pain; that would set my brain thinking this is a long term thing. Whereas if you say solutions, let’s help, you’re seeing light at the end of the tunnel.

(Chiropractors)

Osteopaths tend not to use coping but use managing your back pain especially when it comes to long-term cases.

> ...I use it where you’ve got somebody that’s really old and they got really bad degeneration ...and you really need them to look at some way that they can help with alleviating the discomfort rather than trying to make them better.

(Osteopath)

The GP group suggested good back care or taking care of your back as more positive alternatives.

> It’s too vague (to use with patients)
> They expect it to be treated.
> ...Taking care of your back of good back care you sometimes might use.
> ...I think management implies acceptance.
> ...Put up with.
> ...‘taking care of’ involves change, it implies change.

(GPs)

Physiotherapists discussed how managing was preferable to coping perceiving the latter as suggesting not managing it well. The point was also made that in the context of a treatment programme managing your back pain sounds positive, giving the patient control.

> I tend to use managing rather than coping.
> ...Coping means... you’re not really managing it very well.
> You’re only just surviving.
> (Managing) is more positive.
> You’re in control.

(Physiotherapists)

12.1.11 Coping
This term was largely interpreted by the general public as similar to *managing* i.e. as ‘living with it’, but probably with more severe pain.

*Can you live with it, can you cope with it.*

(Male, C2DE, 40-60, with lbp)

*Same as managing really, but maybe a bit more severe.*
*If you’re managing it then it wouldn’t be hurting. If you’re coping with it then you’re coping with the pain.*

(Females, C2DE, 20-39, no lbp)

Physiotherapists and some Chiropractors believed it suggests ‘getting by’ rather than dealing well with the pain and so do not use it except when fully appropriate.

*You don’t want to really talk about getting by. You want to talk about improving capability and moving forward.*
*I think in the short term you do want them to get by because once they leave your clinic they’ve got to cope until their next appointment.*

(Chiropractors)

### 12.1.12 Psychological pain

This is not a familiar phrase in the context of back pain for the general public.

Immediately it was understood as imagined pain. A few interpreted the term as referring to the psychological effect of the pain e.g. depression.

*There’s no pain there; actual physical pain.*
*You’ve made it up.*

(Females, C2DE, 20-39, no lbp)

*It’s in your head.*
*Depression.*
*Mental.*

(Males, C2DE, 40-60, with lbp)

Not surprisingly perhaps it then has the implication for respondents that the HP who says it doesn’t believe you; that you’ve made it up.

*The doctor doesn’t believe you.*

(Males, C2DE, 20-39, with lbp)

When understood as ‘imagined pain’ the phrase angered lbp sufferers. It also has the potential to be very distressing.

*Say, listen pal, you live with this back; you tell me it’s psychological.*
*...yeah, you want to say look I’m not thinking, it’s aching.*

(Males, C2DE, 40-60, with lbp)

*He (the doctor) is basically giving you the Vs, isn’t he? You’d be gutted.*
*...If I went to a chiropractor and he told me that he wouldn’t be getting the money at the end of the session.*
*...If you were in pain you’d be pretty pissed off if someone said that to you.*

(Males, ABC1, 20-39, no lbp)
HPs are very cognisant of the negative interpretation of this phrase and report that they would tend not use it.

Ooh.
Ooh don’t do that.
It’s all in the mind.
You would just never consider using that term to anyone.

(GPs)

I have used that but in very severe cases.
I have used it.
Trying to get rid of the, yes.

(Chiropractors)

Osteopaths discussed how, unless they were very careful in explaining it, they risked losing patients by introducing the concept and related terms. It was generally not used by respondents in this group.

Explaining psychosomatic as being the relationship between your mind...and explaining it isn’t imaginary pain that it’s real pain, it’s just that relationship...(the patients) never come back.

(Osteopath)

An older Physiotherapist suggested this phrase was so negative not even Consultants or GPs would use this phrase nowadays though they had in the past.

(We would not use this phrase) in front of the patient.
It implies they’re all nutters.
Not even consultants or a GP would use that.

(Physiotherapists)

12.1.13 Wear and tear
This is a commonly used and heard phrase for the general public in relation to lbp.

It is interpreted as the back wearing out or being worn out, usually through age but it can also occur through work or sport.

You get wear and tear as you get older.
Well age or if you do a job or a sport...
Yes or if you’re lifting heavy things.

(Males, ABC1, 20-39, no lbp)

Work related would account for me
Age in my case.

(Males, C2DE, 40-60, with lbp)

It was also described as general disintegration of discs or bones. Or as a natural progression - just a sign of getting old.

General disintegration.

(Males, ABC1, 20-39, no lbp)

They mean getting old.

(Female, ABC1, 40-60, with lbp)

In the extreme it could be seen as meaning rotting away.
Wear and tear makes me think that something’s actually diminishing. So, like a bone is getting thinner or a muscle is wearing thinner. It’s shrinkage and it’s unnatural. So that’s what I think of wear and tear – something’s rotting away.

(Male, C2DE, 20-39, with lbp)

To the general public sample of both lpb sufferers and those who had never experienced lpb it suggested there is no treatment, you just have to live with it; at most a sufferer could change jobs if it was work related and perhaps avoid the cause.

It’s not very nice when you hear it because you know you’re getting older and you know it’s going to get worse and you way “Oh, is this it now?”.

Exactly.

It’s expected.

You’re wearing out.

(Females, ABC1, 40-60, with lbp)

Degenerative change is recognised as an alternative to wear and tear by some in the general public and is defined as progressively getting worse, usually though not exclusively as part of aging.

Getting older.

Or I would say it’s changing, your condition is changing, it’s slowly getting worse.

But due to age...

No I wouldn’t necessarily say age...I think it might just be you’ve got one of those things. Like with arthritis it never gets better, it just gets worse.

(Females, C2DE, 20-39, no lbp)

There was also a perception that nothing could be done to treat degenerative change.

...what ever it is it’s going to deteriorate.

And probably not treatable.

(Males, C2DE, 20-39, with lbp)

There were two very different emotional responses to a wear and tear ‘diagnosis’.

Some claim they would be or indeed were relieved that their lpb in being wear and tear was not something more serious.

I’d feel relieved actually.

...Relieved it’s nothing. I haven’t got to have an operation, there’s totally nothing wrong with me.

What you expect at the age you are.

(Females, C2DE, 20-39, no lbp)

However, the majority of respondents in the general public sample reported this diagnosis of wear and tear would leave them feeling:

• Depressed – I’m getting old (before my time)
• There’s no treatment, I have to put up with this for the rest of my life
• It can only get worse
• As if they were being fobbed off for wasting the doctor’s time – and this is considered insulting
• Disappointed when they were looking for an answer and treatment.
• It does not seem to acknowledge the pain.

It’s like they’re taking the piss...Doctor sits there “Oh, it’s just wear and tear.”

...It’s quite condescending really isn’t it when they say that?

Especially when you’re suffering.
It’s quite a general term whereas a lot of the others are fairly specific and if you had a prolapsed - what is it - whatever, you wouldn’t want him to say well it’s just wear and tear.
“...wear and tear, have some antibiotics”.

Crikey I’m old before, well I mean I’m still young; that sort of thing. I’d think, oh, no.

Osteopaths use wear and tear believing it is kinder than arthritis or degeneration.
Actually degeneration alarms a lot of people.
...Younger patients, because they think, “Is that it then, is this the rest of my life going to be about this pain and this situation?”.

Similarly Chiropractors and Physiotherapists use wear and tear though some insist it be accompanied by an explanation of how wear and tear or arthritis is not necessarily serious and that something can be done.

They’re almost waving the white flag and saying oh that’s it I’m old now and I’ve got to accept a lot of aches and pains and this is just normal wear and tear this is how I’m going to be for the rest of my life. I think ...a good percentage of that can be ...helped sometimes.

Older Physiotherapists have an emotional response in line with many general public respondents; though there are worse phrases.
It is depressing, yes I don’t like the term too much – wear and tear.
I think it’s not quite as bad as people coming in and saying I’ve been told I’ve got a crumbling spine.
...if you are describing wear and tear you must also say that’s ok you’ve got this condition but we can do something to improve it.

GPs use the phrase but mention replacing it with more medical or technical terms on ‘sick notes’ e.g. degenerative spine disease.

Wear and tear is clearly not always the reassuring, kind phrase for patients that many HPs suppose when using it.

12.1.14 Arthritis
Arthritis is a common term though one more immediately associated with joints in hands or knees than backs. Many of the general public had never heard of it in the context of backs, though it made sense when they considered it.

You would think it would be quite an easy place for arthritis to target really.
No, I’ve not heard of it.
No I associate more with knees or Hands.
Joints.
Among the general public it is mainly associated with the elderly, though not exclusively.

Though a familiar term, insight into the pathology of arthritis is limited; a variety of definitions or descriptions of arthritis were suggested:

- Inflammation of the joints
- Bones rubbing together
- Crystallisation of the fluid in joints.

Inflammation.
It’s crystallisation, isn’t it...What’s it called that gooey stuff that sponges the joints so say if you’ve got a ball and socket joint and it’s the gunge in the middle. That disappears. It crystallises.

It’s corroded joints.

Arthritis in backs is seen by general public as particularly serious and worrying.
It means you’re in big trouble.

It is also considered incurable - and by that some seem to mean untreatable - and steadily gets worse.
...it’ll get worse...you’re diagnosed with that as you get older it’s going to get worse and more painful....
There’s not a lot of treatment for it that works.

The general public sample believes this would be particularly concerning for young people.

HPs are conscious that arthritis sounds worrying, even alarming, to patients and more serious than it often is.
We don’t often use arthritis...without specifically describing...We have to go into a lot of detail to try and help people stop being anxious, because they come in terribly anxious, don’t they?

Some Physiotherapists use the term because their patients are likely to hear it from other HPs and so they take the opportunity to explain arthritis and any likely treatment for it. Most prefer to use the phrase wear and tear, however.
Arthritis wounds like it’s ill health and it’s serious and a bit of wear and tear sounds just like living on this planet and normal and everybody in the room’s got a bit. If somebody comes in and says they’ve got arthritis they’re usually a bit more worried about it....I avoid the word.
...Sorry I think you have to be specific about what you’re actually explaining to the patient because if you’re not somebody else will and they’re going to turn around and say “Well why didn’t you say it was an arthritic condition or arthrosis degeneration or I’ve got rheumatoid arthritis?”
...And we do have more time with our patients (to explain things), this is a big luxury that we have.
There was some discussion in the Physiotherapists’ group about whether arthrosis is strictly the more accurate diagnostic term in most cases than arthritis.

Osteopaths interviewed could be critical of the use of arthritis (by patients and GPs) without an investigative diagnosis. They tended not to use the term.

It’s usually used to explain what the doctors have told them… use it as a weapon the doctors they’ll say “OK you’ve got arthritis and that means you know you can’t be cured to you won’t bother me anymore, just go away and take the tablets”. But they’ll come away and I’ll say “How do they you’ve got arthritis?” “Oh, the doctor told me”. “How does he know; did they do the blood test, did they do anything?” No, he just told me I had.”

…they just tend to use it sometimes and we have to sometimes look at them and say well I don’t see any arthritis I don’t know where they’ve got that from.  

(Osteopaths)

Chiropractors similarly avoid arthritis in favour of wear and tear or degeneration as perceived to be less alarming.

Oftentimes people don’t want to hear they’ve got arthritis.

Sometimes, people say the doctor’s told me I’ve got arthritis and you say it’s wear and tear it’s normal ageing process they’re quite relieved by that.  

(Chiropractors)

12.1.15 Exercise and activity

These have quite distinct meanings for the public. Exercise is seen in terms of back pain as either specific e.g. therapy, as specifically to strengthen or train back muscles; or general but planned e.g. working out/cardio exercise, keep fit/swimming.

Activity, on the other hand, means day to day movement, moving about normally.

Exercise is s specific thing for a specific area maybe. Activity is just general, keep yourself busy.  

(Male, C2DE, 40-60, with lbp)

I think exercise is when you specifically go out to do like swim, go to the gym, workout. Whereas activity is your general activity during the day and how active you are...

(Female, ABC1, 40-60, with lbp)

(Activity is) don’t lie in bed.  
Get off the settee.  

(Males, ABC1, 20-39, no lbp)

Everyday activity really; walking to the bus, walking upstairs.  

(Male, C2DE, 40-60, with lbp)

For all of the general public interviewed:

Exercise is always planned as opposed to activity (which is) just normal movement.  

(Female, C2DE, 20-39, No lbp)

Several Physiotherapists believe and use general exercise and general activity interchangeably. Others, including other HPs recognise the distinction made by the public.

You could use general exercise or general activity it means more or less the same thing. It depends on the patient’s response because some patients you say exercise and you can see that awful look of horror on their face.

They have visions of you sending them off on circuit training.
(Physiotherapists)

There’s prescribed exercise for your back and then there’s exercises like walking and swimming but not jogging.  
...Activity is anything ...other than sitting in a chair or lying down. 
...Activity implies normal lifestyle.

(GPs)

12.1.16 Disability
This is a familiar phrase among the public.

The immediate interpretation in context of backs is totally immobile, paralysed, in a wheelchair.  
Somebody’s going to be pushing you.  
(Male, ABC1, 20-39, no lbp)

Totally immobile - when you hear disability.  
(Female, ABC1, 40-60, with lbp)

Wheelchair.  
(Female, C2DE, 20-39, no lbp)

Respondents do however go on to recognise degrees of severity and disability can then mean being unable to do certain things/what you want/normal stuff.  
Preventing you from doing something, normal stuff, getting upstairs.  
(Male, ABC1, 20-39, no lbp)

There’s restrictions in movement and you could be paralysed.  
(Male, C2DE, 20-39, with lbp)

Many respondents see the term disability as implying permanence.  
It makes it like permanent...disability.  
(Male, C2DE, 20-39, with lbp)

Permanent.  
...Disability I just think it’s something that you’re never going to get over.  
(Females, C2DE, 20-39, no lbp)

It is also seen as implying a more serious condition than does the term impairment.  
(Impairment is) a lesser disability.  
(Male, ABC1, 20-39, no lbp)

I think it would be less serious so I think impairments a small problem.  
(Female, C2DE, 20-39, no lbp)

There was mention in a few groups of disability having (wholly) legal connotations i.e. implying certain rights.

The spontaneous interpretation of disability would clearly be alarming for potential patients hearing it.

Physiotherapists claim they would use disability to mean affecting what patients can and cannot do but because it misleads by sounding very serious and permanent they claim to be very careful in how they use it with patients. This group of HPs prefer to use dysfunction or impairment.
Sometimes the level of pain is such that it’s a nuisance; it’s not affecting their abilities. On the other hand it may be a disability in which case it is affecting what they can and can’t do.

...It makes it sound as though they’re crippled whereas maybe dysfunction or impairment is a better word to use.

...you can’t using the word disability if you’re going to use the ODI.

(Physiotherapists)

Chiropractors favour restrictions and limitations over disability.

Osteopaths similarly tend not use disability because it sounds overly serious, certainly not without explanation.

We would be careful when we use that one ...and we’d have to put it into context and maybe apply it to... whether it be long term or short term.

(Osteopath)

12.2 Terms with unintended meanings, which have no/few negative repercussions with the general public.

12.2.1 (Low) back pain/ache – mild, moderate, severe

Back pain is a commonly used, and readily understood, phrase among the general public.

In most cases back pain refers to low back pain but this latter term seems less widely used.

Low or lower back pain specifies location of pain according to respondents. (In previous research where intensity of pain was under scrutiny it could suggest low level pain. This meaning did not emerge here.)

Back ache suggests to the public less intense pain and often also less localised pain i.e. more likely spread over the lower back.

Backache is just when you’ve just perhaps overdone it a bit.

(Male, C2DE, 40-60, with lbp)

I always associate that (ache) being less severe.

...I think of ache as being all over rather than just one place. That would be a pain wouldn’t it? Ache is a bit; oh my whole back aches.

(Females, C2DE, 20-39, no lbp)

A few of our general public sample use pain and ache interchangeably but recognise a distinction when asked. HPs sometimes share this understanding or have found it among patients.

I suppose ache’s less acute, less painful than back pain.

Patients always say that.

(Osteopaths)

Back pain gives the impression that it’s more severe than back ache.

(Chiropractor)

(Back ache) is low level pain.

It doesn’t sound serious.

(Physiotherapist)
Mild, moderate and severe back pain are understood as referring to intensity of pain. However, discussions indicate that both mild and even moderate pain might more accurately be called an ache by the public. And to some in our sample severe backache seems a contradiction.

HPs readily use low back pain. They sometimes use ache though this is seen as terminology which patients would be more likely to use.

These phrases refer to symptoms and are reported as most readily used before a diagnosis establishes cause and more specific terminology.

Osteopaths, Chiropractors and Physiotherapists find an analogue scale (from 0/1-10) more helpful in measuring pain level and do not to use mild etc. They recognise the patient not the professional can ‘quantify’ the pain.

I’d use the scale of nought to ten
Where nought is minimal, ten’s excruciating.

(Chiropractor)

...you might have a scale of one to ten – how much does it hurt and they might say nine and a ten and then that gives you an idea of how they perceive the pain.

(Osteopath)

Words descriptive of the pain beyond simple intensity/severity descriptors can be seen as more helpful.

Quantify the severity by using aching, spasms, sharp. Shooting.

(Osteopaths)

And we might talk more about frequency; is it a constant, is it a sharp, shooting pain, is it intermittent when you’re in certain positions. So you’re asking other things as well as severity.

(Chiropractors)

Physiotherapists in particular discussed the subjectivity of pain and how the patient rather than the HP must decide severity.

You can have a visual analogue of the pain.
But the patient gives us the scale and we can’t actually say you’ve got moderate because it’s in the middle...That’s the patient quantifying the level of pain. We wouldn’t quantify it.
...we couldn’t quantify it.
We wouldn’t use those phrases (mild, etc.)

(Physiotherapists)

GPs report they do use the term severe and are less likely to use mild or moderate. They sometimes establish severity on the basis of the degree to which the pain disables patients.

It’s obvious there are degrees. If somebody can’t move it obviously has to be severe. Mild... they come in and sit down and smile at you. That’s obviously the mild one.
...It’s the degree to which it disables them from their work and their leisure activity.

(GPs)

12.2.2 Mechanical back pain/ache
The general public have not come across the phrase but provide definitions.

They see it as related in some way to movement of your bones or spine rather than muscle or nerves.
To do with your actual bones, spinal as opposed to muscular.

(Female, C2DE, 20-39, no lbp)

I think of that as like a general back pain as the way your whole back itself works and everything and the whole movement of your back. The amount of problem you’ve got with your whole spine…and your general movement. The way it literally works.

(Male, C2DE, 20-39, with lbp)

Arising from some repetitive movement, probably at work.

I think that’s through your work, I think it’s like you’ve contributed to it if you’ve spent 20 years digging holes and stuff like that.

(Males, C2DE, 40-60, with lbp)

Some GPs concur with the general public thought that it is brought on by lifestyle; while one goes further and introduces the contrast with alternative causes of the lbp.

I think when I say mechanical I’m endowing it with some property that relates it to the mechanical bits of the back as opposed to …form some other origin, like you might get a back pain…if you had pleurisy.

(GP)

It is used by GPs if only because patients come across it with other HPs.

I do (use it) because it gets quoted; consultants’ letters come back; and physios, they say this patient’s got mechanical back pain and then you have to.

(GP)

Physiotherapists indicate it can be defined in terms of its opposite i.e. non-mechanical back pain which means pain form e.g. kidneys, which is not affected by movement.

They believe mechanical back pain/ache commonly changes with movement, position, etc.

It changes according to what you’re doing and where you are and what position you’re in.

…a non-mechanical back pain might be from some organ like a kidney for example where the pain would probably be constant and not affected by movement but it nevertheless manifests itself as back pain.

(Physiotherapists)

Most Chiropractors interviewed believe it is too technical a term for them to use.

Originating from a mechanical problem.

I wouldn’t use that term.

I think it’s more of a technical (term).

…I’d relate it to the origin of the problem. If they’ve got a sprain or a strain, it’s mechanical, I’d say is=t was a sprain or a strain.

(Chiropractors)

Osteopaths refrain from using it.

12.2.3 Muscle strain and sprain

Few members of the public have heard of either of these terms in the context of backs.

Not with backs. I mean if you’ve a sprain, turned an ankle and wrists.

(Male, C2DE, 20-39, with lbp)

And claim pulled is more common than sprained:
You don’t hear …muscle sprain. They say it’s a pulled muscle. It’s probably the same thing.

(Female, ABC1, 40-60, with lbp)

Sprain sounds like a more serious condition than strain, though again few know why that would be the case and many claim not to comprehend the difference.

If somebody told me they had a sprain as opposed to a strain I’d think it was worse but I don’t know.

(Male, ABC1, 20-39, no lbp)

Strain I would understand as pushing it and sprain I would understand that you’d pushed too far.
The damage is done.

(Females, ABC1, 40-60, with lbp)

Although members of the public claim to be unfamiliar with the terms in discussing back pain, HPs report that patients use the terms.
The patients use it. They say “I’ve strained my back”.
Pulled a muscle, a strain in the back.
And then we find there’s something more specific.

(Physiotherapists)

I tend to find that’s something (strain and sprain) that patients come in saying.
Rather than us saying it to them.

(Chiropractors)

Several GPs readily admit that they do not know the difference between strain and sprain and Osteopaths suggest they are not confident on this either. Most seem to agree with the public that a sprain is more severe than a strain.

I’ve never understood the difference really.
...Strain is something mild and sprain is just a stronger version of a sprain. It’s an enormous spectrum.

(GPs)

Well that’s (sprain) more colloquial so it means roughly the same thing (as strain).
Well usually they say sprains indicative of ligaments and strain is muscle.
...I use it out of complete ignorance.

(Osteopaths)

12.2.4 Sciatica
This is a phrase familiar to the general public.

Some specify a problem with the sciatic nerve (often that it is trapped) and a pain running down the back of the leg, though some respondents also believe it results in lbp.

It’s one nerve, it’s the sciatic nerve and I guess when that gets trapped...
...Back of your legs, all down to your toes, my mums suffers from sciatica.
...I though it was lower back and leg to be honest.

(Males, C2DE, 20-39, with lbp)

For others sciatica is simply a pain running down the leg.

It (the pain) goes all the way down the front or the back (of the leg).

(Females, ABC1, 40-60, with lbp)
HPs have come across patients who use *sciatica* to refer to any similar leg pain. And some who use it to describe any lbp.

*The patient uses that more than we do …
And they usually get it wrong as well because they think any leg pain is sciatica.
…and the doctors also get it wrong.*

(Physiotherapists)

*…they just think that sciatica is a posh word for backache. And then I explain it’s pressure on the sciatic nerve; and if they’re really clever I...*

(GP)

*You get lots of patients coming in saying I’ve got sciatica and the doctor’s basically said you’ve got pain down your leg therefore it’s sciatica, whereas the site of the nerve is actually specific to the back of the leg. So we have to explain to them they haven’t got sciatica, it’s something similar.*

(Osteopath)

A few Chiropractors use *sciatica*, like some of the general public, to mean pain down the leg.

*I think if people get pain down their leg it’s sciatica.
To me that’s what sciatica is. It just means a pain in their leg.*

(Chiropractor)

HPs claim not to use the phrase unless it has been accurately diagnosed.

*If it’s been medically diagnosed you’re on sound ground, but if they come out saying I’ve got sciatica because my mother in law...*

(GP)

GPs groups mentioned patients who are puzzled, even annoyed that their backs are being treated for pains in the leg.

*And they can get quite annoyed if you start focussing on the back and ask them questions about the back because they thinking I didn’t come to you with my back, my back’s ok, it’s this pain that runs down here.*

(GP)

**12.2.5 Radiated**

Most of the general public define radiated along similar lines, sometimes using their hands to indicate fanning or spreading out:

*It starts in one place and spreads.*

(Male, C2DE, 40-60, with lbp)

*Spreads from somewhere else.*

(Male, ABC1, 20-39, no lbp)

But it was inaccurately guessed at by a few:

*Somebody who’s just dropped a bomb.
Glow in the dark.
Radiation isn’t it?*

(Males, C2DE, 20-40, with lbp)

Physiotherapists use the term radiated pain though sometimes with explanation.

*Yes (I use it) you tell them when you bang your funny bone you get a pain in your little finger.*
I think they accept that quite well. (Physiotherapists)

Osteopaths believe they have clearer alternatives to radiated.
I tend to use referred rather than radiated.
Most people understand it (radiated). Sometimes people look at you and you say “Does the pain travel?”
I end up using that (travel) much more because you don’t have to be constantly, every day going through the same “No what I mean is”. So you keep it down to a nice lay language, it saves time. (Osteopaths)

As do some Chiropractors
...not radiated, what would I say?
Travelling.
Transferred. (Chiropractors)

12.2.6 Muscle imbalance
The public describe this phrase in terms of one muscle/side of the body being bigger or stronger than another; though again this definition does not come from any prior experience of having heard the term used.

One muscle’s bigger than the other.
One of them’s wasted away and the other one’s working double time. (Males, C2DE, 40-60, with lbp)

...walking a bit funny because you’ve got a pain in your back. And the muscles have been working a bit differently. (Female, C2DE, 20-39, no lbp)

Neither Osteopaths nor GPs claim to use the term with patients.
It doesn’t mean anything.
...And you don’t even know that it’s true. (GPs)

Some Physiotherapists and Chiropractors do use it though the latter believe it demands further explanation and with a 3d model.
I do use muscle imbalance. Often to explain the joint can be compromised by a difference in the balance of the muscles either side of them.
...there is always a model to demonstrate...the visual thing. (Chiropractors)

The muscles on one side don’t match the other for example....some are stronger than others so when you walk when you move you don’t have an equal distribution of power and movement. (Physiotherapist)

12.2.7 Nerve root pain
Spontaneously, the context for understanding this phrase is with teeth.
Teeth. (Female, ABC1, 40-60, with lbp)
And especially painful
  Ooh I don’t like the sound of that.  
(Male, C2DE, 20-39, with lbp)

It can also suggest sciatica to several.

This phrase is used by HPs; often with the aid of a diagram and further explanation.

(We’d use) a prop.
Yes just say that’s the nerve root and that’s something pressing on...
Make them understand why they’re in pain.

(Osteopaths)

You have to explain it.
...With a spine (model) you can actually see the nerve roots on the spine.

(Physiotherapists)

It is an option on some GPs proforma for back pain clinic and so is used to that extent, though only some use it with patients since it requires detailed explanation.
...we have this proforma for our back pain clinic; funnily that’s one of the questions nerve root pain, question mark. But it’s not a term I use to patients.
I think I might do.
...You’d have to explain is. It depends on the patient.

(GPs)

12.2.8 Disc – slipped, prolapsed, herniated, ruptured
Slipped disc is a commonly heard and used term, though few of the general public can define it or know what it means beyond damage to the spine, which is really painful. It is seen as a relatively common cause of lbp.

...My mum had a slipped disc
That’s more common isn’t it (than ruptured)?
I’ve had a slipped disc.

(Females, ABC1, 40-60, with lbp)

That’s one that’s fallen out of place isn’t it? Well to me anyway.

(Male, C2DE, 40-60, with lbp)

The general public perceive that treatment is available and that it can require surgery. Some respondents claimed a slipped disc usually required surgery.

Painful.
Operation.
But fixable.

(Females, C2DE, 20-39, no lbp)

There is a fairly widespread perception that a slipped disc is permanently weakened and can go again at any time.

The general public have little awareness of any of the other terms, though some claim a familiarity with prolapsed believing it probably means collapsed. It is also described as having dropped. No one is confident in their definition.

That’s half a slipped disc isn’t it?
As opposed to the disc coming out a little bit, is it a lot or dropped. Does that mean the disc’s actually dropped? (Females, C2DE, 20-39, no lbp)

Herniated suggests a hernia – though it is unclear whether this comparison is considered helpful.

I’ve heard of hernia but not herniated disc.
...that’s swollen, when the disc has got bigger or something, like a hernia. (Males, C2DE, 20-39, with lbp)

Ruptured sounds as if it has burst – and consequently most painful, least easily mended and most worrying to the majority.

(Ruptured) ...has just burst or broken or whatever. Don’t know what they do.
...There’s nothing they can do. That’s it. Once it’s started to go it can’t be repaired. (Females, ABC1, 40-60, with lbp)

GPs agree ruptured can sound serious and would therefore not use it with patients.
It sounds severe, doesn’t it? (GP)

At least one respondent did not find it illuminating to differentiate the conditions and use specific terms
Why not put them all together and say “disc’s shot”, at the end of the day. (Male, C2DE, 240-60, with lbp)

HPs with the exception of GPs avoid using slipped though patients introduce it.
I say there’s no such thing as a slipped disc.
It usually requires an explanation then. (Osteopaths)

(Slipped is) misleading.
I usually ask them where they’ve slipped to. It’s a bit facetious. (Physiotherapists)

There was reluctance from across the sample of HPs to use very specific terms such as herniated without a clear diagnosis. Again time and care are believed to be required if technical/medical terms are introduced to patients.

Its too confusing, hernias, it would just confuse patients.
...And you wouldn’t use it unless you’ve had an MRI scan that says herniated, unless you want to explain the surgical procedure to them for the next half an hour and write it down. (GPs)

I think we use them all but differently to a lot of other healthcare professionals. We’d only use them when we’d got a diagnosis of them. More often than not I’m explaining about discs because they’ve been told they’ve got a disc problem without any evidence...I wouldn’t go in to specifics until there is evidence that they had. (Osteopath)

It depends what it is exactly. There are different types of disc lesion and usually the MRI will show exactly what type it is and you pick the term that is most appropriate. (Physiotherapist)
Patient friendly alternatives such as bulging disc are preferred and used.

Bulging is probably favourite.
It sounds less medical.  

(Chiropractors)

I perhaps try to be kind by telling patients whatever they have that there’s a slight bulge on the disc really. I think that’s a more kind term than saying it’s ruptured or it’s burst that sound more aggressive.  

(Physiotherapist)

I use bulge
Bulge a lot, yes definitely.
...Well they understand what that means.  

(Osteopaths)

Visual references such as jam doughnuts, soft centre sweets and water filled balloons are found helpful by some HPs to illustrate various disc conditions.

(For prolapsed) I just have a water filled balloon that I use and I just put it between my hands and I say this is what it is and I squeeze it and then make it bulge out of one side and I say that’s what happens.  

(Osteopath)

I talk about jam doughnuts, personally.  

(Chiropractor)

12.2.9 Facet joint
This is one of the phrases, of which there are only a few, which respondents did not attempt to define.

They had certainly never come across it.

I’m not even going to guess.  

(Female, C2DE, 20-39, no lbp)

No verbal definition was offered by HPs either, with the exception of one Physiotherapist who had found it useful to describe the facet joints to patients as their ‘wings’.

...I say vertebrae have got wings where one joins the other – they’re your facet joints.
They can understand wings. I’ve always go the spine that I show them but they like that.  

(Physiotherapist)

All discussion of facets joints with patients required the use of visual aids.

(We uses facet joint) only with the aid of a prop.
...need some photographs and charts and things.  

(Osteopaths)

I would personally show the spine.  

(Chiropractor)

12.2.10 Alignment and posture
Respondents claim familiarity with both alignment and posture. They see a relationship between alignment and lbp; several had heard health professionals use it.

They’re all in line.
The vertebrae.  

(Females, C2DE, 20-39, no lbp)
Your spine should be in a certain alignment and if it’s out of alignment then it’s a problem.

Alignment and posture are seen as linked.

I think of your posture.
...You just think of your back nice and straight basically.

There was suggestion in the general public groups that posture predominantly relates to sitting – and sitting up straight. In fact, in all of the groups respondents ‘sat up’ when they heard the term.

The way you walk, the way you sit.
Posture’s your sitting isn’t it?
...Not slouching.

‘Bad’ posture and back pain were seen as closely interlinked.

If you haven’t got the correct posture it causes the back pain.
And if you’ve got back pain you’ve got bad posture.

Posture is used by Osteopaths with patients and often in preference to alignment.

I don’t use alignment....it is useful for us to talk to each other ...if something’s out of alignment, (patients) think “OK it must be off to one side”, but it’s not...
Osteopaths do use posture more than alignment because I tend to think of things in terms of movement or not movement more than actual alignment because what is normal alignment; there is such a wide variation.
... (Posture is) the best position for that person’s body.

Posture is a concept, which patients think, they understand but which actually requires detailed explanation for individual patients, according to Physiotherapists interviewed.

When you say posture everyone goes (respondent sits up very straight).
...an awful lot of people think they’ve got good posture and they’re not aware that they’ve got terrible posture. This is where you really do need you cameras...
I always go though (an explanation of) normal posture with every back patient...

12.2.11 Spondylitis

A few in our sample of members of the public recognised Spondilytis, though insight was limited.

That’s what you get down your neck.

Curvature of the spine.

Most respondents had not heard the term and declined to define it.

HPs defined it as wear and tear or a degenerative condition of the spine, though the Physiotherapist group pointed out that this was in fact spondylosis rather than spondylitis; and...
Just keep in mind that spondylitis is an inflammatory condition by definition. …They understand that it’s inflamed and it’s sore and it’s painful. And they tend to understand that more than spondylosis.

(Physiotherapists)

Chiropractors would tend not to introduce the term.

Not unless they specifically come in about it.

(Chiropractor)

12.2.12 Stenosis
Similarly, the general public did not feel able even to hazard guesses as to the meaning of stenosis.

Never heard of it.

(Male, C2DE, 20-39, with lbp)

It sounded worrying for some.

It is understood by HPs as a narrowing or shortening of the spinal canal and recognised as a precise medical term which they would use only after positive diagnosis or a strong indication that it is present.

Narrowing of the spinal canal.
If you’ve got symptoms that would indicate spinal stenosis you might …mention the possibility.

(Chiropractors)

Unless you know, you’ve got a positive diagnosis …no point in suggesting that until you’ve got positive proof.

(Physiotherapist)

Discussing the term with patients is helped with visual aids though it is rarely discussed because it is a fairly uncommon condition.

I mainly draw pictures and who them other x-rays and diagrams.

(Physiotherapist)

12.3 Terms, which the public seem to understand as intended.

12.3.1 Muscle spasm
The general public comprehend this term easily. Some have first had experience of it.

Involuntary contraction.
...Back cramp kind of thing.

(Males, ABC1, 20-39, no lbp)

I get that.
...cramp in bed and you (try to) leap out of bed and you can’t get up.

(Males, C2DE, 40-60, with lbp)

GPs and Chiropractors both use the term and find that patients understand it.

A patient comes “Oh, I’ve got muscle spasm. That’s one they tend to use quite frequently.”
(Other words sometimes used for spasm are) ‘tightness’, ‘tension’.  

12.3.2 Sensation
This term is readily understood by the general public.  
...physical feeling.  

And a familiar phrase used by HPs  
*If it would be what the doctor said to you. “So explain the sensation you feel”.*  

Some HPs do in fact use *sensation* and as understood by the public. Others prefer the term *feeling*.  

*In the notes I put down…sensation NAD, but I wouldn’t actually use it for the patient.*  
*…I say feeling because they don’t understand the word sensation.*  

HPs point out that they find themselves using the term to refer to the absence of sensation/feeling e.g. numbness, lack of normal sensation.  

*In a sense it’s the negative that you’re looking at.*  

*Or as part of the neurological test, whether the patient has normal sensation, you usually compare one leg with the other. That’s the context I would use sensation.*  

12.3.3 Manipulation and mobilisation
The general public, even those without any experience of low back pain, recognise that *manipulation* is a ‘treatment’.  

*It’s what a chiropractor would do.*  
*Or a physio*  
*Movements*  
*Pushing you, moving you.*  
*Them moving you without you moving you is being manipulated.*  

*Hands on.*  
*Yes.*  
*Kneading.*  

*Chiropractor I think of straightaway.*  
*And physio as well.*  
*Just putting in place what’s not in place…*  
*…hand on type of thing.*  

*Mobilisation is less easy to define in detail but is seen to be about ‘moving’.*  
*I would look at that as an improvement word. That that’s something to help with being more mobile.*  

*Coming out of paralysis…*
...to get it moving again.  
(Males, ABC1, 20-39, no lbp)

Keep moving.  
(Female, C2DE, 20-39, no lbp)

Like getting somebody up out of bed when they’ve been in bed getting them up and moving again.  
(Male, C2DE, 20-39, with lbp)

Osteopaths use manipulation as a term, which does not alarm but needs explaining. They also talk about the different forms of manipulation, which they use, on patients.

I try to demystify that sometimes by saying just using the hands to work on the body.  
I think some of us…call it soft tissue manipulation.  
...really I guess all it means is moving things around…But some people would say, the profession would be thinking HVTs.  
(Osteopaths)

Similarly, mobilisation, for Osteopaths means:  
Again moving things, moving a joint around.  
(Osteopath)

Chiropractors prefer the term adjustment to manipulation, with at least one believing adjustment is more appropriate because more specific to their profession.

Physiotherapists tend to use techniques, which are mobilisations rather than manipulations with specific meaning.

...we use...again generalising here very much, grade four techniques which are more mobilisations rather than manipulations.  
They’re not high velocity.  
(Physiotherapists)

And:

...mobilisation (implies) that the physiotherapist is doing the movement that will increase the range of movement. But mobilisation more generally would include exercises.  
Self assisted.  
(Physiotherapists)

12.3.4 Soft tissue technique
The public are familiar with this phrase only in part but are quick to offer definitions.

I’ve never heard of that…I’ve heard the words but not ... phrase.  
(Male, C2DE, 20-39, with lbp)

Sounds like massage.  
(Male, C2DE, 40-60, with lbp)

I’ve heard of soft tissue injuries, I’ve never heard of soft tissue techniques.  
...Massage.  
(Males, ABC1, 20-39, no lbp)

Physiotherapists use the phrase and have to explain the different tissues and that this is only one of many techniques.  
It’s a broad term, it encompasses a number of different things but it’s a technical word I use.
It’s really the mobilisation of tendon or muscle tissue. …Well quite a few of my patients don’t know what soft tissues are so I then have to explain what they are as well.

(Physiotherapists)

Osteopaths favour massage with patients; and Chiropractors mention using muscles and trigger points as alternatives.

We tend to just say massage; they understand that better, to patients.
Yeah and we say soft tissue to each other...

(Osteopaths)

12.3.5 Rehabilitation
The general public from across the sample largely agreed on a definition of this familiar phrase with regard to backs.

Trying to get back to normality

(Male, C2DE, 20-39, with lbp)

Well it’s the recuperation. It heals.

(Female, ABC1, 40-60, with lbp)

Someone’s getting you back to where you were.

(Male, C2DE, 40-60, with lbp)

It can suggest to some that the lbp is particularly serious.

But it also sounds very positive to the public.

That sounds good because there’s …light at the end of the tunnel.
...You’re on the road to recovery.

(Males, ABC1, 20-39, no lbp).

Both Physiotherapists and Osteopaths use this term. It is seen as positive and forward looking.

(We use rehabilitation) because it is forward looking...
...Restoring normality hopefully.

(Physiotherapists)

Osteopaths report it usually part of the discussion of a longer than average process i.e. after pain and at the activity phase.

I use it in the context of a treatment plan normally.
...I tend to use it after the acute phase, once the pain has gone it’s then that the treatment switches from being a pain relieving treatment or a resolving treatment to advising on rehabilitation exercises and getting them back...into activity.

(Osteopaths)
12.4. Understanding of procedures

12.4.1 X-rays
The immediate response from the general public was that X-rays show bones and damage to them. And that the spaces between vertebrae would also show up.

An x-ray is more for bones.  
(Male, C2DE, 20-39, with lbp)

Several of the general public believe an x-ray would also show slipped discs, inflammation, etc. While a few go on to suggest they show muscles since they believe hearts show up in x-rays and they are muscles.

I think you do see inflammation on an X-ray....  
Because on X-rays they put them up the light and say see this shadow here. Well that wouldn’t be bone would it because that’s where they pick up cancer and everything?  
(Females, ABC1, 40-60, with lbp)

HPs report that x-rays essentially show the condition of bones and joint spaces. But some HPs mentioned how it is important to tell patients that x-rays are used to rule out certain diagnoses i.e. used for what they don’t show; and to manage their expectations.

Mainly bone tissue and joint spaces. And the spaces between bones demonstrate something but they rarely show problems with muscles, tendons, ligaments.  
...it’s important to tell the patient what the x-ray will not show.  
I tell patients that x-rays often tell us what you haven’t got. That that’s ruled out probably 50% of the possible causes of your problem. It can be very helpful in ruining things out.  
(Physiotherapists)

Bones.  
...Sometimes you have to explain to them what you can see and what you can’t because they sometimes think that that might be enough.  
(Chiropractor)

12.4.2 MRIs
Clear to the majority of the general public sample that MRIs show everything within the body including e.g. muscles, nerves.

A few respondents believe an MRI is a brain scan.  
That’s a brain scan.  
(Female, ABC1, 40-60, with lbp)

I thought it was brain...  
It’s everything.  
(Males, ABC1, 20-39, no lbp)

In one group MRIs were associated with cancer. 
...MRI in connection with cancer.  
Yes I think it’s more serious if you’re told you’ve got to have an MRI.  
(Females, C2DE, 20-39, no lbp)
In the discussion with Osteopaths a high regard for MRIs was mentioned, though it too requires explaining to patients.

_Well I usually say it’s (MRI) the gold standard in scans. It’ll tell you everything that you need to know that will be beneficial to us to be able to diagnose a condition._

(Osteopath)

But:

_I usually tell them isn’t a scan, it’s not treatment, it’s literally just a step towards treatment._

(Osteopath)

12.4.3 Reflexes checked
For the general public having reflexes checked is done:
• Simply to see if reflexes are working!
• To make sure everything is working i.e. muscles and nerves together.
• Or that the nervous system is working properly.

_Isn’t that your muscles and your nerves?...your nerves are functioning._

(Female, ABC1, 40-60 with lbp)

And for health professionals:

_I would talk about the basic neurological testing but to the patient – checking the function of the nervous system._

(Chiropractor)

It shows if there’s any neurological involvement.

(Physiotherapist)

12.5 Comprehension of medications

12.5.1 Anti-inflammatories
Most familiar to general public are _anti-inflammatories_ with widespread understanding of the name and purpose of the medication.

_Take the swelling down._

(Female, ABC1, 40-60 years, with lbp)

However, an element of concern about taking anti-inflammatories entered some discussions.

_But it does give you a false sense of security. If you take anti-inflammatories you don’t then feel pain, which means you could start doing activities, which would cause even more pain. So they’re not always the best option._

(Female, C2DE, 20-39, no lbp)

GPs report that an _anti-inflammatory_

_Reduces swelling_

_Patients know that it does_

_Say to them it’s more than a painkiller._

(GPs)

12.5.2 Analgesics
The general public largely do not recognise _analgesics_ as a term, though they know it is a form of medication. They are much more familiar with the term _painkillers_ which co-respondents introduce to define _analgesics._

_I’ve heard of the word analgesic._

_I’ve heard it as well._
…I don’t know (what they are).  
(Females, ABC1, 40-60 with lbp)

…I’m going to prescribe you some painkillers; they don’t say I’m going to prescribe you analgesics.  
(Females, C2DE, 20-39, no lbp)

No pain.  
(Chiropractor)

12.5.3 Anti-depressants
In the context of back pain, anti-depressants are understood by the general public as perhaps only helpful when back pain is making patients feel depressed or stressed.

I don’t know, probably do nothing because they’re supposed to cure your thing in the mind aren’t they. anti-depressants, they’re supposed to make you happy. But they’re not painkillers are they?  
(Male, C2DE, 20-39, with lbp)

Makes you happy about having the back pain.  
(Male, ABC1, 20-39, no lbp)

It was rare in discussions for any in this sample to volunteer the idea that anti-depressants might be prescribed as a muscle relaxant.

Personally I would get depressed because of the illness…anti-depressants because they’re down in themselves.  
It does relax you as well.  
(Females, C2DE, 20-39, no lbp)

If prescribed anti-depressants for back pain most of the public report that they would be puzzled at best and probably alarmed.

HPs recognise which of these terms are familiar to patients and which not e.g. GPs use the term painkillers rather than analgesics and would explain why they were prescribing an anti-depressant. i.e.

• To make the pain bearable.
• To relax them.
• Anti-depressants need explaining to patients because in response to being prescribed them, patients say they are not depressed.

There was a hint that the use of anti-depressants as a muscle relaxant is not always salient to some HPs.
The findings of the study show that messages from bodies such as the NHS are rated as credible and trustworthy. The source of interventions was shown to matter. Government or commercial sources were regarded with scepticism and even anger. Given the size of the economic burden of back pain, the Government is understandably keen to reduce back pain costs but explaining this to the public in an acceptable way is obviously difficult. Members of the public in this study would prefer the message to solely be a health care one rather than a political or economic one. Health care sourced messages are perceived as more sympathetic in tone than Government ones. Adverts mentioning return to work were perceived negatively. It is known that back pain sufferers fear the reality of their back pain being questioned and the participants in this study too voiced concern that the key message of the proposed campaign, namely to keep active, might contribute to this problem. Employers may doubt the legitimacy and severity of back pain if people keep active. Since back pain usually carries no visible signs of disability, the back pain sufferer’s inability to carry out certain activities is often used to demonstrate proof of suffering. The need to be believed by society may conflict with the advice to return to normal activities. When work was included in the stimulus material this conflict was voiced. This research indicates that the appropriateness of the source of health care messages needs to be ensured prior to delivery.

Participants valued the use of media to inform them about health care and all groups felt that the suggested back pain campaign would be worthwhile. The research supports the findings of Steinbrook and the opinion of Johnson regarding the importance of the media to inform the public. Participants did not seem to feel over-bombarded with health care messages and approved of their use. They were generally open to progress in medical care. Health care messages that seemed to be contradictory were not considered helpful; apparent contradictions and reasons for change need to be explained. There was also doubt expressed whether the health professions did actually agree with the key messages, since some participants recounted experiences to the contrary.

One of the problems this study highlighted was how people defined whether or not they had experienced back pain. The recruiter and the recruitment questionnaire specifically asked participants whether they had ever had back pain. Additionally, after the first supposedly non-back pain group, where it became evident that some of this group actually had experienced back pain, all subsequent non-back pain group participants were telephoned by the recruiter to ask again whether or not they had ever had any back pain. Yet, as Table 2 demonstrates, some of these participants later said they had had back pain. The groups revealed reasons for this discrepancy. Some participants thought back ache or injury is not the same as back pain. It may be worth future research studies which rely on the self report of back pain, asking respondents whether they have ever experienced back pain, back ache or back injury rather than just back pain or the true prevalence may be underestimated.

It was highlighted that clinicians need to be aware that patients / members of the public may interpret language differently and recognise the importance of checking how intended messages are understood by their target audience. In this instance, even though the key message of keeping active was generally acceptable to participants, the use of the phrase ‘gentle exercise’ was misinterpreted. Since attitudes and beliefs are relevant to recovery and return to work message rejection is a serious issue. The earlier study in Australia acknowledges that unexpected or possibly unwanted effects of their campaign were not measured and highlighted the need for future qualitative research in this area. This study illustrates the importance of research taking place in the developmental stages of campaigns to minimise or prevent the occurrence of unwanted effects and to explore the possible impact of these effects.
In conclusion, although the relationship between health care professionals and the media can be an uneasy one, participants in this study generally valued and trusted health care messages if they were sourced by the NHS. Issues regarding the language and tone of the messages were raised. The meaning, understanding and acceptability of mass media campaign health care messages needs to be explored with the target audience prior to implementation. A closer collaboration between health care professionals and the public is advocated to achieve valuable, effective media campaigns.
14. REFERENCES


### APPENDIX A

The Sampling Frame for the Study.

<table>
<thead>
<tr>
<th>Number in Group</th>
<th>Gender</th>
<th>Age</th>
<th>SEG¹</th>
<th>Back pain?</th>
<th>Location</th>
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<td>40-60</td>
<td>ABC1</td>
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* Due to the low turnout rates initially in these groups, further groups were held to ensure the sampling frame was sufficiently representative. For ease of understanding these results have been combined.

¹ Socio Economic Group
INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE.

Please answer every question, unless the instructions tell you to do something else.

Most of the questions can be answered by simply putting a tick in a box (next to the answer which is appropriate).

If you have any questions about how to fill in the questionnaire please ask Margaret for help.

When you have finished please check that you have answered all the appropriate questions. Please return the questionnaire to Margaret.

Thank you very much for your help with this research project.

SECTION A. These questions are to find out if you have ever had back pain and, if so, to tell us about it.
1. Have you ever had back pain?

(Please tick one box only)

Yes………………… (continue with question 2)

No………………… (Please return this questionnaire to Margaret)

2. Do you have back pain today?

(Please tick one box only)

Yes………………… (continue with question 3)

No………………… (continue with question 4)

3. How long have you had this episode of back pain?

(Please tick one box only)

0-7 days………………………………………

8-14 days……………………………………

15 days – 1 month…………………………

More than one month-2 months…………

More than two months-3 months………..

More than 3 months………………………

(Please continue with question 4)

4. How many episodes of back pain lasting more than 24 hours have you had in your life?

One episode only…………………………

…
A few episodes (two or three)………………

Quite a lot (less than a total of ten)……………

Lots (more than ten)………………………

*(Please continue with question 5)*

5. Have you ever been to see any health professional about your back pain?

Yes……………….. *(continue with question 6 )*

No………………… *(continue with question 7 )*  

6. Which health professionals have you seen?

*(Please place a tick in the box next to a health professional if you have ever seen them about your back pain)*

Acupuncturist……………

Chiropractor……………

GP………………………

Osteopath………………

Physiotherapist…………

Other……………………

*(If ‘other’ please write who you have seen in the space below)*

……………………………………………………………………..

7. On average, how would you describe your back pain?
Mild………………………□
Discomforting………………□
Horrible……………………□
Excruciating………………□

(Please continue with question 8)

8. In general, would you say your health is?

(Please tick one box only)

Excellent…………□
Very good………□
Good…………□
Fair…………□
Poor…………□

SECTION B. These are questions to provide us with some important general information. Please complete all the questions in this section.

7. Are you male or female?

(Please tick one box only) □
Male………………..

Female……………..

(Please continue with question 8)

8. How old are you?
Under 21.........
21-30.............
31-40.............
41-50.............
51-60.............

Thank you for your time and help in completing this questionnaire.
APPENDIX C

LOW BACK PAIN MEDIA PROJECT –
QUESTIONNAIRE RESPONSES
Lbp sufferers

All respondents below claim to have had low back pain.

Total sample is 32 respondents.

Numbers for each group are:

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<th>Urban Devon Men</th>
<th>Rural Devon Men</th>
<th>Rural Peterborough Men (1)</th>
<th>Rural Peterborough Men (2)</th>
<th>Oxford men</th>
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</table>

1. Have you ever had back pain?
   Yes…………..all

2. Do you have back pain today?

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<th>Urban Devon Men</th>
<th>Rural Devon Men</th>
<th>Rural Peterborough Men (1)</th>
<th>Rural Peterborough Men (2)</th>
<th>Oxford men</th>
<th>Peterborough women</th>
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3. How long have you had this episode of back pain?

<table>
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<th>0-7 days</th>
<th>8-14 days</th>
<th>15 days-1 month</th>
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Five respondents who did not that day suffer from low back pain mistakenly went on to answer Q3.

4. How many episodes of back pain lasting more than 24 hours have you had in your life?

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<th>Urban Devon Men</th>
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5. Have you ever been to see any health professional about your back pain?

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<thead>
<tr>
<th></th>
<th>Urban Devon Men</th>
<th>Rural Devon Men</th>
<th>Rural Peterborough Women (1)</th>
<th>Rural Peterborough Women (2)</th>
<th>Oxford men</th>
<th>Peterb. women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>24</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

6. Which health professionals have you seen?

<table>
<thead>
<tr>
<th></th>
<th>Urban Devon Men</th>
<th>Rural Devon Men</th>
<th>Rural Peterborough Women (1)</th>
<th>Rural Peterborough Women (2)</th>
<th>Oxford men</th>
<th>Peterb. women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncturist</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>GP</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Osteopath</td>
<td>3</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
<td>4</td>
<td></td>
<td>2</td>
<td></td>
<td>5</td>
<td>12</td>
</tr>
</tbody>
</table>

7. On average, how would you describe your back pain?

<table>
<thead>
<tr>
<th></th>
<th>Urban Devon Men</th>
<th>Rural Devon Men</th>
<th>Rural Peterborough Women (1)</th>
<th>Rural Peterborough Women (2)</th>
<th>Oxford men</th>
<th>Peterb. women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>
### 8. In general, would you say your health is?

<table>
<thead>
<tr>
<th></th>
<th>Urban Devon Men</th>
<th>Rural Devon Men</th>
<th>Rural Peterborough Women (1)</th>
<th>Rural Peterborough women (2)</th>
<th>Oxford men</th>
<th>Peterb. women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Very good</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Good</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Fair</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Poor</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

### Are you male or female?

<table>
<thead>
<tr>
<th></th>
<th>Urban Devon Men</th>
<th>Rural Devon Men</th>
<th>Rural Peterborough Women (1)</th>
<th>Rural Peterborough women (2)</th>
<th>Oxford men</th>
<th>Peterb. women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>3</td>
<td>6</td>
<td></td>
<td>8</td>
<td></td>
<td>17</td>
</tr>
</tbody>
</table>

### How old are you?

<table>
<thead>
<tr>
<th></th>
<th>Urban Devon Men</th>
<th>Rural Devon Men</th>
<th>Rural Peterborough Women (1)</th>
<th>Rural Peterborough women (2)</th>
<th>Oxford men</th>
<th>Peterb. women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>31-40</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>41-50</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>51-60</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>
## APPENDIX D

**Diagram to Illustrate the Discussion Flow Guide for the Focus Groups.**

<table>
<thead>
<tr>
<th>Introduction and warm up, asking about mass media campaigns that respondents recall. Aim: to provoke spontaneous comments regarding the impact and effectiveness of health care mass media interventions and to introduce the group to discussing advertising</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use stimulus material (rotated order) to explore the different media and their individual strengths and weakness:</td>
</tr>
<tr>
<td>Explore ads for: level of comprehension, message interpretation, perceived acceptability/appeal, relevance, motivating power, memorability, tone of voice,</td>
</tr>
<tr>
<td>Explore the aptness and trustworthiness in the authority and credibility of the various potential sources of the intervention (e.g. Government, NHS, various professions)</td>
</tr>
<tr>
<td>Explore the perceived value of using mass media campaigns</td>
</tr>
<tr>
<td>NB. These points are not necessarily in order; they were explored flexibly as they arose in discussion.</td>
</tr>
<tr>
<td>Identify and explore individual preferences for 1. Mode of media (e.g. television, radio, press etc). 2. Most preferred advert. 3. How the individual advertisements could be improved.</td>
</tr>
<tr>
<td>Discuss whether a mass media campaign to promote the self-management of low back pain would be useful and whether one should be implemented. If so, discuss how to get key messages over most effectively.</td>
</tr>
</tbody>
</table>
### APPENDIX E

**Back Pain Characteristics of the Study Participants**

<table>
<thead>
<tr>
<th>Questions asked (n =)</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Group 4</th>
<th>Group 5</th>
<th>Group 6</th>
<th>Group 7</th>
<th>Group 8</th>
<th>Group 9</th>
<th>Group 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had back pain? Yes</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td>3</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Do you have back pain today? Yes</td>
<td>2</td>
<td>N/A</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>N/A</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>How many episodes of back pain lasting more than 24 hours have you had in your life? None</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A few (less than 10)</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lots (more than 10)</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been to see any health professional about your back pain? Yes</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key:** Since some members of the non back pain groups answered that they had experienced back pain, all groups are included in this table. Some responses are missing, therefore not all columns add up to the total number of participants.  
1. five respondents who said they did not have back pain today still answered this question.  
2. some respondents have seen more than one professional