Psychosocial risks for low back pain: are these related to work?

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Abstract

Objectives—To examine whether psychosocial risks for low back pain, reported in previous studies, are specific to the working population or are more widely relevant.

Methods—A large population-based survey identified subjects free of low back pain, and obtained information on the degree of satisfaction with work (or not working) and the adequacy of income for their family’s needs. New episodes of consulting and non-consulting low back pain were identified prospectively over 12 months. The psychosocial risks for developing a new low back pain episode are examined in employed and non-employed groups separately.

Results—Dissatisfaction with work status doubled the risk of reporting a new low back pain episode in both the employed (odds ratio 2.0, 95% confidence intervals 1.2, 3.3) and non-employed (OR 2.0, 1.2, 3.1). Those perceiving their income as inadequate were at a threefold risk of consulting for this symptom regardless of their employment status (employed: OR 3.6, 1.8, 7.2; non-employed: OR 3.6, 1.4, 9.0).

Conclusion—Psychosocial factors pose similar risks for a new low back pain episode in workers and thenon-employed. This suggests that such influences may not be related solely to work but be a function of general aspects of life. The economic and individual impact of psychosocial interventions in the workplace, therefore, are likely to be limited unless account is taken of the influence of broader non-work related aspects.

Most people will experience pain in the lower back during their lifetime. However, the increase in sickness absenteeism and disability payments attributed to low back pain in working people has been hard to explain, especially given the contraction of heavy industry over recent years. One potential explanation is the association between psychosocial factors and low back pain identified in workplace-based studies. In a prospective population-based study, we have shown that psychosocial factors are more strongly associated with a new episode of low back pain in workers than mechanical stress at work, independent of psychological distress and social class.

The aim of this report is to examine if such psychosocial hazards for a new back pain episode are specific to those in work or are more widely relevant.

Methods

An initial postal survey of all adults (aged 18–75 years) registered with two general practices in south Manchester identified a cohort free of low back pain during the previous month. Information was obtained on past history of low back pain and current employment status. Two specific questions asked: Is the money coming in adequate for you and your family’s needs? How satisfied are you with your present job? (or non-employed status?). These questions have previously been included in a primary care-based study of social problems. Social class was derived from the last or current occupation, and a measure of psychological distress from the 12-item General Health Questionnaire.

This back pain free cohort was followed up over 12 months and two approaches used to capture all new episodes of low back pain. Firstly, the practice computers were monitored weekly to identify all those who consulted because of low back pain. Secondly, 12 months after the initial survey a further questionnaire was sent to those not consulting asking if they had experienced pain in the lower back during the past year.

The results, adjusted for sex and age (divided into four groups), are shown as odds ratios (OR) separately for the employed and non-employed. The control group for this analysis were those free of back pain throughout the follow up year. The results were also examined for potential confounders, namely past history of low back pain, GHQ score (in tertials), and social class.

Results

The baseline survey identified 2715 adults free of low back pain, of whom 1412 were employed full or part-time (47% male, mean (SD) age 38 (13) years), and 1303 non-employed (42% male, mean (SD) age 53 (19) years). Follow up
Table 1  Psychosocial risk for a new episode of low back pain (LBP): comparison of 12 months outcome in the employed and non-employed (adjusted for age group and sex)

<table>
<thead>
<tr>
<th>Baseline employment status</th>
<th>No LBP Controls</th>
<th>Non-consulting LBP</th>
<th>Consulting LBP</th>
<th>Non-consulting LBP</th>
<th>Consulting LBP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases OR (95% CI)</td>
<td>Cases OR (95% CI)</td>
<td>Cases OR (95% CI)</td>
<td>Cases OR (95% CI)</td>
<td>Cases OR (95% CI)</td>
</tr>
<tr>
<td>Satisfied</td>
<td>356</td>
<td>131 1.0</td>
<td>35 1.0</td>
<td>282</td>
<td>96 1.0</td>
</tr>
<tr>
<td>Slightly dissatisfied</td>
<td>113</td>
<td>83 1.7 (1.2, 2.4)</td>
<td>23 1.8 (1.0, 3.1)</td>
<td>102</td>
<td>58 1.6 (1.2, 2.4)</td>
</tr>
<tr>
<td>Severely dissatisfied</td>
<td>39</td>
<td>28 2.0 (1.2, 3.3)</td>
<td>3 0.8 (0.2, 2.7)</td>
<td>82</td>
<td>60 2.0 (1.2, 3.1)</td>
</tr>
<tr>
<td>Perceived adequacy of income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate</td>
<td>203</td>
<td>131 1.0</td>
<td>24 1.0</td>
<td>165</td>
<td>81 1.0</td>
</tr>
<tr>
<td>Slightly inadequate</td>
<td>181</td>
<td>81 1.0 (0.7, 1.4)</td>
<td>21 1.5 (0.8, 2.7)</td>
<td>178</td>
<td>67 0.8 (0.5, 1.2)</td>
</tr>
<tr>
<td>Severely inadequate</td>
<td>57</td>
<td>33 1.3 (0.8, 2.1)</td>
<td>16 3.6 (1.8, 7.2)</td>
<td>149</td>
<td>83 1.1 (0.7, 1.6)</td>
</tr>
</tbody>
</table>

*95% Confidence intervals  †All subjects not currently in part-time or full time employed.

In common with other population studies, non-responders to the initial survey were younger and more likely to be male. Their overall consultation rate during the following year was marginally lower (6%) than that of responders (7%). The study design enabled data from the initial survey to be compared for responders and non-responders to the 12 month follow up survey. Non-responders to this were younger, and significantly more likely to smoke and have higher GHQ scores than responders. However, the validity of the results would only be affected if any systematic bias, should it exist, effected the association between the risk factors and low back pain in employed persons differently from that in the non-employed.

The difference between the one year cumulative episode incidence of low back pain reported in the follow up study (32%), and the cumulative consultation rate (approximately 4%) clearly illustrates that most people with a new back pain episode do not consult their general practitioner because of this—only about one in seven choose to do so. This confirms the results of previous studies and suggests that the association between low back pain and primary care consultation is not direct, but mediated by other factors.

It could be argued that workers with lower incomes are more likely to consult their general practitioner to obtain the sickness certification necessary for state benefits. However, similar risks in the non-employed make this explanation unlikely. Perception of income as inadequate might not reflect actual income, but be a more subtle indicator of a propensity to consult, possibly mediated by somatising behaviour. Disatisfaction with your situation might be more directly related to back symptoms, regardless of employment status. This is in line with Waddell’s comment that low back pain in workers is confounded by the high prevalence of this symptom in the general population, and suggests that the dominance of psychosocial risks of low back pain, compared with risks relating to physical activities at work, might be a function of subjects’ dissatisfaction with life in general.

Most reports of back pain in workers refer to the economic impact of the exponential rise in disability payments and absenteeism caused by low back pain. Our results suggest that, while psychosocial intervention in the workplace...
might reduce the economic costs to society of back pain, these effects would be limited if no account is taken of the influence of broader non-work related aspects. Moreover, for the individual, such interventions are unlikely to impact on the overall experience of back pain and consultation behaviour.

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Unusual and memorable

Series editor: Gary D Wright

A 29 year old women presented with painful stiff fingers on her left hand. The pain was associated with intermittent swelling and limitation of motion of her digits. She was otherwise well with no history of psoriasis or other joint problems. On examination there was diffuse bony swelling of the second and third fingers of her left hand with a reduced range of movement. The overlying skin was shiny and erythematous (fig 1). Radiographs of the hands revealed endosteal hyperostosis of the second and third metacarpals (fig 2 ). Scintigraphy showed an increased accumulation of radionuclide in these areas (fig 3).

Melorheostosis is a rare bone disorder.1 It usually presents with joint pain, intermittent swelling, and muscle contractures below the age of 20 years but may occur as late as the fourth or fifth decades. The disease is usually limited to a single limb, in which one or more bones may be affected. The lower limbs are more commonly affected than the upper limbs. Radiographic appearances are highly characteristic. Osseous excrescences extend along the length of the bone and may be associated with endosteal hyperostosis partially or completely obliterating the medullary cavity. Soft tissue calcification and ossification occurs frequently. The cause of melorheostosis is unknown although investigations have indicated possible associations with neurofibromatosis, tuberous sclerosis, hypophosphataemic rickets, and haemangiomas.2


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