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Proceeding with caution: the medicalization of chronic back pain

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A Thesis

entitled

Proceeding with Caution: The Medicalization of Chronic Back Pain

by

Holly T. Renzhofer

Submitted to the Graduate Faculty as partial fulfillment of the requirements for the

Master of Arts Degree in Sociology

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The University of Toledo

August 2010
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An Abstract of

Proceeding with Caution: The Medicalization of Chronic Back Pain

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The main topic that was examined in this thesis was the partial medicalization of chronic back pain. Chronic back pain is becoming increasingly more common and in many cases it is a life-changing condition. Both traditional biomedical treatments and Contemporary and Alternative Medicine (CAM) can be used to treat lower chronic back pain, and there are both positive and negative aspects to both treatments, which have been noted in the literature review. However, the literature review has highlighted a gap in the literature, which the thesis seeks to address: the ways in which medicalization is only partially accomplished for some conditions, which are subjectively experienced, such as chronic back pain.

Although much of the literature on medicalization gives medicalization a negative connotation, it is sometimes necessary, and in fact is a vital part of the patient’s experience in order to receive appropriate care. This study will explore what happens if the patient’s chronic back pain is medicalized, partially medicalized, or not medicalized.
This study had two sets of findings. The first sets of findings are on the subject of biomedicine. The first finding is that patients are dissatisfied with the biomedical approach that leaves them over medicated, drug dependent or under the knife. Another finding is that when physicians are unable to make the patient better, the patient is accused of malingering, drug seeking or as having a mental/psychological issue. Additionally, medical treatment is only offered if there is a physical measure that justifies the pain.

The second set are on the subject of CAM. The first finding is that there is major problem: there is not as much consistency in CAM treatments as there is in biomedical treatments which may actually reduce the faith that people have in CAM. The second finding is that there is at least some distrust of CAM practitioners in both patients and physicians alike. Additionally, as a result of the partial medicalization of CAM, patients have to seek out and experiment with treatment on their own. As a result, patients are not getting their pain needs met in part because the two areas of treatment (biomedicine and CAM) don’t work in unison. All of these findings support the conclusion that chronic back pain is not fully medicalized. There is not a specialty that is stepping up to take over treatment other than surgery and when surgery isn’t indicated, the patient is on his or her own.
For my family, and friends. I could not have done it without your love, support and encouragement.
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List of Abbreviations

CAM …… Contemporary and Alternative Medicine
CLBP …… Chronic Lower Back Pain
FBSS……Failed Back Surgery Syndrome
IRB …… Institutional Review Board
PFNS …… Peripheral Nerve Field Stimulation
TENS …… Transcutaneous Electrical Nerve Stimulation
Chapter 1

Literature Review

1.1 Introduction

This thesis explores the medicalization process associated with chronic back pain, examines how people conceptualize the treatment of chronic back pain via a traditional biomedical approach and also via Complementary and Alternative Medicine, and explores how medicalization is just as much as social experience as a clinical one. These approaches are not necessarily opposites, and are often used in combination (Foltz et al 2005). However it cannot be denied that many people who adhere to a traditional biomedical approach regard alternative medicine with suspicion (Ernst 2009). There is a degree of wariness about Complementary and Alternative Medicine from some (but not all) medical practitioners: its scientific reliability and validity are sometimes questioned (Schneiderman 2000). What is particularly interesting, as far as this study is concerned, is that similar doubts are sometimes raised about the experience of chronic back pain. This thesis will focus on some of the broader power dynamics associated with the validation—or invalidation—of subjective, somatic pain. Its subjective and invisible nature raises suspicions that patients might be malingering, fraudulently claiming to have a disability which they do not really experience, or perhaps they are engaging in drug-seeking behavior. As a result, the traditional biomedical
model, with its emphasis on ‘scientific objectivity’, may have lingering suspicions over both Complementary and Alternative Medicine, and also the complaints of people with chronic back pain. This thesis explores the intersection of this ‘doubly suspicious’ combination: Complimentary and Alternative Medicine use among people with chronic back pain.

It will be suggested that medicalization is just as much as social experience as a clinical one. While the process of diagnosis and treatment may seem---from a standard medical viewpoint---to be neutral and value-free, medical sociologists stress that such clinical encounters are actually laden with power and subjective judgments – particularly when there is little ‘objective‘ evidence to verify symptoms, as is the case with chronic back pain. The veracity of somatic complaints is often questioned – particularly when the treatments may involve the prescription of opiod medications. Physicians, in this sense, become gatekeepers and arbiters of patient motivations – a social role which is often underestimated in the standard medical model (Weinstein 2001). Such social power, exercised by medical practitioners, is central to the process of medicalization – determining (to some degree) whose complaints are validated or invalidated, and which patients receive access to treatment (Purdy 2001). The ways in which patients interpret and respond to these judgments of medical practitioners is one of the central areas which this thesis will investigate.

Patients are not simply the recipients of a diagnosis. People with chronic pain, for instance, are driven by their somatic complaints to seek out the best treatment possible. This often means a search of various options – and this search is as much a social one as a medical one. They seek out information, try to find appropriate language for describing
their complaints, discuss their experiences with others, and in doing so they may query, challenge, validate or invalidate their medical treatment. As a result, some studies of pain from within the discipline of sociology have placed these actions by patients at the center of their analysis (Barker 2005). This thesis fits within such a patient-centered approach. It will not explore the perspectives of physicians, though they are obviously important to the process of medicalization. Other studies have done that – particularly those in the first wave of the literature on medicalization (Illich 1976 & Szasz 2007). Rather, this thesis identifies with more recent scholarship which highlights the importance of patient power in responding to the clinical encounter (Salter 2004).

1.2 Chronic Lower Back Pain

1.2.1 Defining Back Pain

Lower back pain can range in severity from background pain, mild pain, moderate pain, severe pain and hyper-severe pain (Borkan, Reis et al. 1995). In terms of symptoms, this means a person with lower back pain could simply experience back tension or back weakness, while others may experience unbearable pain that confines them to bed rest, or leaves them incapacitated and unable to move for weeks at a time. Pain can be felt as if it were burning, stabbing, or dull (though these words do not entirely capture the felt experience). Tingling, stiffness and numbness are also common and lower back pain is often radicular (radiating from the nerve root of the spinal cord to other places such as the leg) (Scholz, Mannion et al. 2009). Back pain can also cause sleep disturbances (Marin, Cyhan et al. 2006). Depression, anxiety and emotional distress

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1 There is a distinction between chronic back pain and chronic lower back pain. While the majority of respondents had chronic lower back pain, one responded did have chronic back pain in their upper back.
are common secondary effects of chronic back pain (Waddell, Main et al. 1984; Demyttenaere, Bruffaerts et al. 2007).

1.2.2 Importance of Back Pain as a Personal and Public Health Issue

Most back pain goes away within a 6-week period, but, for a small percentage of people, lifelong disabilities are associated with chronic back pain and affect both their capacity to work and their long-term quality of life (Santaguida 2009). Like many chronic conditions, this takes a long-term toll on an individual. Back pain is therefore a significant public health issue. Lower back pain in particular is an important factor in the lives of millions of people – data from the 2007 National Health Interview Service suggests that 25% of the US population experienced lower back pain during the three months prior to being interviewed (Pleis and Lucas, 2009). Freburger et al (2009) state that chronic lower back pain is the second leading cause of disability in the US and is estimated to cost the US economy between $100 and $200 billion. The estimated number of people with chronic back pain is increasing over time (Martin et al 2008). One estimate suggests that there was a 49% increase in the number of patients seeking outpatient treatment for such problems between 1997 and 2006 (Martin et al 2009). Given the growing number of people that are suffering from and seeking treatment for back pain, it is important to understand the treatment options and medical response to those options.
1.3 Biomedical Treatment for Back Pain

There are various biomedical treatments for back pain, such as back surgery, peripheral nerve field stimulation, transcutaneous electrical nerve stimulation, percutaneous neuromodulation therapy, direct stimulation of peripheral nerves, analgesics, and individual physiotherapy.

There are various types of back surgeries. According to Ragab and deShazo (2008) the best estimate of successful back surgeries are 60% or more, however, many are in fact not successful. In fact, there is something called failed back surgery syndrome (FBSS). According to Paicius, Bernstein, and Lempert-Cohen (2007), FBSS is “a condition that refers to patients with back pain with or without leg pain despite lumbar spine surgery, producing what is thought to be a mixed neuropathic and nociceptive pain syndrome” (p. 280). Ragab and deShazo (2008) estimate that there may be at least 80,000 “failed” back surgeries every year (p. 278). Success rates for back surgeries fall with each consecutive surgery: “30% after a second back surgery, 15% after the third, and to 5% after the fourth surgery” (p.272).

Peripheral nerve field stimulation (PNFS) “is becoming increasingly recognized as a safe, minimally invasive, and easily reversible treatment for a variety of chronic pain conditions” (Paicius et al. 2007: 279). In the study done by Paicius et al. (2007) “PNFS enabled patients to decrease their pain medication and increase their level of activity. The patients all reported reduction in pain as measured by visual analog scale scores and an improved quality of life” (p. 279). In fact Paicius et al. (2007) state “We conclude that

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2 Passing, entering or made by penetration through the skin” Merriam-Webster
PNFS is a safe and effective alternative treatment for patients with chronic low back pain, and should be considered in this population” (p. 279).

Paicius et al. also briefly mentions transcutaneous electrical nerve stimulation\(^3\) (TENS). Although TENS is used extensively to treat chronic low back pain, according to Paicius et al. (2007) it has not yet been supported by any controlled studies. On the other hand, percutaneous electrical nerve stimulation (PENS) “has demonstrated effectiveness in reducing pain as measured by visual analog scale (VAS) scores and in reducing intake of pain medications” (p. 280). Yet, this is not a long-term solution because of the numerous office visits it requires (Paicius et al. 2007).

There is also percutaneous\(^4\) neuromodulation therapy, which is minimally invasive. In percutaneous neuromodulation “electrical stimulation is applied to the paraspinal peripheral nerves, appears to have only limited benefits” (Paicius et al. 2007: 280). This form of therapy also requires office visits for treatments one to two times a week, for several weeks (Paicius et al. 2007). Additionally, there is not documentation that proves sustained improvement” after treatment is ended (Paicius et al. 2007: 280).

Lastly, is a much more invasive procedure that involves the direct stimulation of peripheral nerves, which requires “open surgical dissection and placement of electrodes proximal to the painful segment of the exposed peripheral nerve, has had mixed results” (Paicius et al. 2007: 280).

Another form of treatment is that of analgesic medications, which include both opiate and nonopiate drugs. According to Paicius et al. (2007) these analgesic

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\(^3\) TENS is the electrical stimulation of the skin to relieve pain by interfering with the neural transmission of signals from underlying pain receptors” (Merriam-Webster 2010). More specifically transcutaneous is defined as passing, entering, or made penetration through skin” (Merriam-Webster 2010).

\(^4\) Percutaneous is effected or performed through the skin” (Merriam-Webster 2010).
medications “may be effective in alleviating pain, but have significant adverse effects and frequently contribute to the continued disability of individuals who require them for long-term use” (p.280).

The biomedical approaches to treating chronic back pain can be beneficial, however they do have some shortcomings. The shortcomings vary from the high cost of the treatments, to the low success rates, and the often invasive nature of the treatments. Perhaps, this is why many patients are turning to various alternatives.

1.4 The Costs of Biomedicine

Many people are choosing CAM as a result of the high costs of health care and malpractice rates in the United States. According to the National Coalition of Health Care (2009), “In 2008, health care spending in the United States reached $2.4 trillion, and was projected to reach $3.1 trillion in 2012.1 Health care spending is projected to reach $4.3 trillion by 2016”.” Additionally, “in 2008, the United States will spend 17 percent of its gross domestic product (GDP) on health care. It is projected that the percentage will reach 20 percent by 2017” (National Coalition of Health Care 2009). Whereas in Canada, at least 3.3 million Canadians sought treatment outside of conventional medicine, and they spent at least $1 billion which was not reimbursed by provincial health plans (Patterson, Arthur, Noesgaard, Caldwell, Vohra, Francoeur and Swinton 2008). Many people, with or without insurance may decide to explore alternatives such as CAM as a result of these rising health care costs.

Another issue to be taken into consideration is malpractice. Malpractice occurs in the United States a lot more often than people would like and with reports of doctors
amputating wrong limbs or doing risky surgeries, many people may decide to choose less invasive approaches such as CAM, and as stated previously the malpractice insurance for naturopathic doctors is much lower due to the rarity of litigation (Collinge 1996). Due to the cost of malpractice, some providers may be more likely to make referrals to or choose to practice CAM. Therefore, understanding these various social trends to seek CAM, helps place the importance of the history of health options for CLBP.

1.5 Contemporary and Alternative Medicine (CAM)

1.5.1 The History of CAM

According to Collinge (1996) naturopathic medicine dates back thousands of years to various ancient cultures. Therefore CAM is in a sense, the oldest medicine since “most medicine before this century was based essentially on natural substances and natural processes” (Collinge 1996: 96). CAM costs, practices and usage vary in different countries and cultures. In this literature however, we will focus on the United States and Canada.

1.5.2 The Cost of CAM in the United States

Collinge (1996) states that according to various studies, naturopathic office visits are about half as expensive as conventional medicine, and that estimate does not take into account savings that result from long-term preventative care. Generally speaking, CAM tends to be less expensive because of less emphasis on high-technology medical equipment, lower malpractice insurance costs and other market forces (Collinge 1996). Additionally, herbs that are often used in CAM are much less expensive than
pharmaceutical drugs used in conventional medicine. However, insurance coverage does vary for CAM treatments by policy and by state in the United States.

1.5.3 People Who Use CAM

According to the literature, certain people are more likely to use CAM than others. Meeker (2000) discusses a study that found that women tend to use CAM slightly more than men and that people in the age range of 35 to 49 years use CAM more than other age groups. CAM use was also associated with higher education and income levels” (p. 124). Meeker (2000) also discusses the Astin survey in which there were several variables that were predictive of CAM use in the previous year, including higher education levels, slightly poorer health status, a holistic orientation to health, and a personal transformation experience,” as well as specific health problems such as: chronic pain, anxiety and urinary tract and back problems (p. 124).

Additionally, according to Smith (2004):

Individuals choose CAM therapies because they more clearly reflected belief systems and philosophies, and not necessarily because they disagree with conventional treatments. The search for alternatives particular when there is inadequate or ineffective treatment, leads many individuals to CAM (p.176).

CAM therapies tend to have a more holistic approach to health, which includes a spiritual aspect because it includes not only the body but also the mind and soul. Thus, it can be concluded that those who use CAM are more likely to be spiritual as opposed to non-CAM users.

Since it is not mainstream CAM users may tend to have a higher education and income level because CAM requires a lot of research. Also, insurance companies generally do not cover the majority of CAM treatments and therapies, which can be very
expensive whether they are supplements, or actually going to a CAM practitioner. Simply having a personal transformation experience may also open some people up to CAM use. In addition, those who tend to use CAM often discover it while looking for alternative routes to health care for a problem they may have. Therefore, it is likely that CAM users tend to have specific health problems. For example, chronic pain and anxiety may be treated in CAM with yoga or meditation, urinary tract infections in CAM may be treated with cranberry pills, and back problems in CAM may be corrected through chiropractic care.

1.5.4   CAM’s Increasing Popularity

As stated previously, CAM is becoming popular in the United States and Europe (Meenan 2001: 38). Coulter & Willis (2007) also agree that CAM is becoming popular worldwide, and is a sort of “boom” (p.216). Generally CAM is more popular in first world countries, such as Great Britain, Australia, Canada, the United States, as well as other European States (Coulter & Willis 2007: 216).

CAM treatments take place outside of conventional medical settings, on an ad hoc basis and through individual providers rather than through an established or coordinated strategy. Likewise, in “developing” countries, the bulk of health treatments, especially amongst the larger poorer sections of their populations, have been (and always have been), folk remedies, probably because of the cost of conventional medicine (Coulter & Willis: 2007, 217).

Coulter & Willis (2007) mention that some caution may need to be taken because although the CAM boom more than likely exists, “the only slight reservation with this
otherwise solid evidence is that perhaps there is at least a certain extent to which the public have *always* been using CAM type treatments (then called ‘home’ or ‘folk’ remedies)” (p.217). However, I was unable to find any other literature that discussed developing countries.

### 1.6 CAM as a Treatment for Chronic Lower Back Pain

Various CAM treatments can be used to treat chronic lower back pain (CLBP), such as: back school, acupuncture, botanical medicine, massage, neuroflexotheraphy, and spinal manipulation.

In a recent trial, Cecchi, Molino-Lova, Chiti, Pasquini, and Gnocchi (2010) found that “back school included: group exercise, education/ergonomics, individual physiotherapy: exercise, passive mobilization and soft-tissue treatment” (p. 26). The back school model developed by Cecchi et al. (2010) was designed referring to the original Swedish model” (p. 28). Additionally the approach of individual physiotherapy was also used. Individual physiotherapy is also sometimes combined with individually tailored, active exercise, with passive or assisted mobilization or with manual treatment” (Cecchi, Molino-Lova et al. 2010). Additionally, there can be many variations within individual physiotherapy because various protocols and types of exercise can be use (Cecchi, Molino-Lova et al. 2010). Cecchi et al. (2010) concluded spinal manipulation provided better short and long-term functional, improvement and more pain relief in the follow-up than either back school or individual physiotherapy” (p.26).

According to van Tulder, Furlan, and Gagnier (2005) acupuncture is more effective than no treatment or sham treatment for CLBP but there are no difference in
effectiveness compared with other conventional therapies” (p. 648). However, the use of acupuncture as well as conventional therapies is more beneficial than simply the conventional therapies alone in terms of pain management (van Tulder et al., 2005).

Van Tulder et al. (2005) concluded that while “specific botanical medicine may be effective for acute episodes of non-specific CLBP in terms of short-term improvement in pain and functional status”, however, the trials did not assess long term efficacy (p. 648). However, it was noted that the trials that were done need to be reproduced.

In regards to massage as a treatment for CLBP, “there is moderate evidence showing that massage is more effective than sham treatment in reducing pain intensity and improving function” (van Tulder et al. 2005: 648). However, the effects of massage for CLBP are inconclusive in comparison with other treatments.

It was found that neuroflexotherapy seems to be more effective for non-specific CLBP than both sham treatment and standard care (van Tulder et al., 2005. However, “trials need to be replicated and results confirmed by other practitioners and research groups before recommending a broader usage” (van Tulder et al. 2005: 649).

Van Tulder et al. (2005) concluded “spinal manipulation had clinically and statistically significant benefits when compared with either sham manipulation or the group of therapies judged to be ineffective or even harmful” (p. 649). In fact, it was concluded that spinal manipulation was equally effective as other advocated therapies for

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5 According to van Tulder et al. (2005) “Neuroflexotherapy is a relatively new technique, used mainly in Spain by a small number of practitioners” and it is “characterized by the temporary implantation of a number of epidermal devices into trigger points in the back and into referred tender points in the ear” (p. 645). However, it is not to be confused with acupuncture because even though “both use puncture devices” there are “different zones of the skin” that are being stimulated by the devices (van Tulder et al. 2005: 646).
CLBP, such as analgesic, physical therapy, exercises and back school (van Tulder et al. 2005).

As past research has shown, both biomedicine and CAM are possible treatments for chronic back pain. However, there is another option for patients who are seeking treatment for their chronic back pain: both biomedicine and CAM being used together for treatment, some may argue a form of integrative medicine.

1.7 Biomedicine and CAM Used Together for Treatment

Some people are not only hesitant to use CAM by itself, but also as a supplement to biomedicine because of CAM’s reputation. That may be the result of the possible countermovement of CAM that is biomedicine itself (to Contemporary and Alternative Medicine in general).

Additionally, according to Goldner (2004) “counter movements also attempt to restrict the movement’s goals through scientific, not just political, strategies” and she briefly discusses what the National Council Against Health Fraud’s (NCAHF) goal is, as well as their viewpoint on acupuncture (p. 722). According to their website, “NCAHF is a private nonprofit, voluntary health agency that focuses upon health misinformation, fraud, and quackery as public health problems” (National Council Against Health Fraud 2009). In a news release on January 12, 2005, entitled “The Institute of Medicine ‘CAM‘ Committee Report: Stacked Deck of Advocates Want More,” which can be accessed on their website states “So-called ‘complementary and alternative medicine‘ is not medicine at all and is not evidence-based. It consists of everything from iridology (defining illness by the spots on the iris of the eye) to distant prayer therapy and dangerous chiropractic
neck manipulations that allegedly realign "energy flows" that have never been seen or measured” (National Council Against Health Fraud 2009).

The American Medical Association (AMA) could be considered a countermovement to the American Holistic Medical Association (AMHA). Goldner (2004) discusses how one respondent stated that the AMA [American Medical Association] and Western doctors are very threatened by naturopaths and alternative practitioners, ‘’because It’s their livelihood that is being threatened‘” (p.721). Goldner (2004) also states some alternative practitioners spoke of state laws restricting their practice, and more importantly, the knowledge that physicians can restrict us whenever they want’. One respondent said that traditional medicine, probably the AMA [American Medical Association]’, is behind legislation to increase the educational and training requirements for California hypnotherapists” (p.722).

Goldner (2004) also briefly mentions another countermovement called Quackbusters. She states that Quackbusters is another group that has questioned the safety and efficacy of CAM,” and was founded in 1969 by Dr. Stephen Barrett” (p. 722). He now operates the website quackwatch.org, as well as 21 other websites on special topics of interest that are related to disproving quackery on topics such as acupuncture, chiropractic care, etc. On quackwatch.org (2007), Dr. Stephen Barrett states that they are also closely affiliated with NCAHF. According to their mission statement, Quackwatch (2007) is a nonprofit corporation whose purpose is to combat health-related frauds, myths, fads, fallacies, and misconduct. Its primary focus is on quackery-related information that is difficult or impossible to get elsewhere.” Additionally, their activities include:

- Investigating questionable claims
- Answering inquiries about products and services
- Advising quackery victims
- Distributing reliable publications
- Debunking pseudoscientific claims
- Reporting illegal marketing
- Assisting or generating consumer-protection lawsuits
- Improving the quality of health information on the Internet
- Attacking misleading advertising on the Internet (Quackwatch 2007)

Thus, the counter-movements against CAM can have a negative effect on the public’s view of CAM. If the public has a negative or uneasy view of CAM, CAM itself is less likely to be medicalized which will directly influence patients who try to use CAM either by itself or as a supplement to biomedicine.

1.8 Summary

The main topic that will be examined in this thesis is the partial medicalization of chronic back pain. Chronic back pain is becoming increasingly more common and in many cases it is a life-changing condition. Both traditional biomedical treatments and CAM can be used to treat lower chronic back pain, and there are both positive and negative aspects to both treatments, which have previously been noted in the literature review. However, the literature review has highlighted a gap in the literature, which the thesis seeks to address: the ways in which medicalization is only partially accomplished for some conditions, which are subjectively experienced, such as chronic back pain.
Chapter 2

Theoretical Framework

The theory of medicalization provides the perfect framework for understanding the social response to lower chronic back pain and its treatment. It was suggested in Chapter One that medicalization is just as much of a social experience as it is a clinical one – this chapter will explain these dynamics in more detail. The "medicalization of everyday life" is, arguably, a characteristic of modern society (Lupton 2003; Rosenfeld and Faircloth 2006; Salanta and Santry 2006; Beck 2007; Conrad 2007; Szasz 2007; Miah and Rich 2008). According to Verweij (1999), "Zola introduced the term in order to call attention to the ongoing social processes in which the terms ‘illness’ and ‘health’ are made relevant for more and more aspects of everyday life" (p. 91).

Conrad defines medicalization as "a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders" (Conrad 1992). While the ‘medicalization thesis’ is sometimes interpreted differently by various authors---particularly those who focus on the causes of medicalization---there is general agreement that it refers to the process by which more and more aspects of regular life come to be understood in medicalized terms, or as medical phenomena (Williams and Calnan 1996). Yet some experiences – even some conditions that involve fairly large amounts of medical treatment – seem to be more
medicalized’ than others. There is no doubt, for instance, that broken bones require medical treatment, and are understood in fairly standard medical terms; but something which is subjectively experienced like a pain disorder may often be understood and interpreted differently (Greenhalgh 2001). There are considerable medical treatments available for chronic pain, ranging from surgery to pain medication, but that does not diminish the connection of pain with subjective emotions. Such emotional dimensions may be regarded as insufficiently ‘objective’ for a (narrow) biomedical approach.

It is fascinating to recognize that even though medical practitioners have the power to diagnose and treat various medical conditions, and to affirm the validity of complaints which might entitle a patient to government assistance, patients also play a central role in the process of medicalization. Patients are now researching their own problems and symptoms as well as possible solutions and options. They are also becoming proactive in their treatment options. In fact there is a “proven vitality and impressive vintage of self-help groups, and their apparently burgeoning numbers in the age of the internet, prompt us to recognize the analytical value of better mapping comparisons between self-help organizations and health activist mobilizations” (Landzelius 2006: 532). Such patient power is an increasing focus of medical sociology (Brown 2007). The internet is an influential tool in the world today, especially when it comes to information regarding health and healthcare. According to Ayantunde, Welch & Parsons (2007) “The use of the Internet as a source of health information has therefore become increasingly popular as many patients become aware of this option” and apparently a satisfying option as well (p. 460). In a study done by Ayantunde et al. (2007)
“ninety-five percent of respondents who had used the Internet for health information rated such information between average and excellent” (p. 459)

In a discussion by Barksy and Borus (1995), they discuss an example of a narrow biomedical approach towards subjective experiences of pain, which cautions against the medicalization of ‘normal’ human experiences:

Medical professionals should greet the process of medicalization with considerable caution and educate the public more about the normative presence of symptoms and bodily distress in healthy people (p.1931).

Given the important social role of medical practitioners as gatekeepers for a variety of governmental, medical and welfare entitlements, Barsky and Borus (1995) particularly stress the need for such –caution” when dealing with patients who present with somatic symptoms, in order to discourage patients from drug-seeking or other undesirable behaviors. Barskey & Borus (1995) suggest that patients may feel forced to express their "dis-ease" in more urgent and exaggerated terms in order to gain access to the physician” (p. 1931). In such cases, they argue that the patients should receive behavioral and educational interventions (as opposed to pain medication, referral to specialists, and other medical options).

Experienced from a patient’s perspective, this process may seem as though they are being treated as if they do not have a genuine medical condition. A patient may feel disbelieved, even as a hypochondriac, or they may not receive immediate treatment. This process of physicians –exercising caution” when dealing with patients who complain of chronic back pain – and the patient possibly experiencing a physician’s attitude as one of disbelief – might be called –partial medicalization”. This is the process which the thesis seeks to explore: physicians looking for ‘objective’ or additional evidence of a pain
disorder, patients feeling frustrated and disbelieved, and the process of medicalization operating only partially.

More specifically, this study also explores another dimension of the medicalization process – a dynamic called paramedicalization. Paramedicalization has been defined as “the trend of people setting more and more value on alternative medicine and different beliefs about wealth and health, which are not authorized by the medical science” (Wordiq 2010: 1). Wordiq (2010) states this process has gone on alongside with medicalization” and that “traditional or alternative medicines (especially the spiritualistic therapies) reach to ever greater scale of human activities - even to the time beyond birth and death. In that sense medicalization has much stricter borders” (p.1). Unfortunately, there does not seem to be much scholarly research regarding paramedicalization. By exploring the process of paramedicalization – which is clearly patient-driven – within the overall process of medicalization, this thesis is exploring previously unexplored practical and theoretical areas.

Potentially, a patient’s condition may deteriorate while the medical process of finding additional ‘objective’ evidence is undertaken. Whereas the ‘medicalization thesis’ suggests that more and more conditions are being treated as medical conditions, the experience of chronic back pain has not been smoothly or completely medicalized. Receiving a final diagnosis and appropriate treatment is still a problematic process for many patients; there is an apparent reluctance on the part of medical professionals to label a somatic experience as a medical one. The process of paramedicalization may therefore be seen as a form of patient power, or patient resistance to one form of medicalization – the medical model. When patients explore CAM, they open up another
avenue for medicalization. Their somatic complaints can be validated through CAM. Given the need for patients to have their subjective complaints validated, and the resistance (or inability) of the traditional medical model to legitimize many of these complaints, it is not surprising that patients exercise their power in such a way.

Verweij (1999) states that “Zola as well as DeSwann emphasize that medicalization processes should not be conceived as an intentional pursuit of power by the medical professions” (p. 92). Perhaps medicalization is not supposed to be seen as an intentional pursuit of power by the medical professions; however, the providers of care in the medical profession often do hold the power---the power of when, where and what type of medical treatment the patient will receive, depending on their diagnosis. Insurance companies often require a referral in order for a patient to receive services, that it is ‘medically necessary,’ or certain conditions being met. A patient relies on a physician to make a referral, to determine if something is medically necessary, or to allow a patient to meet those specific diagnostic conditions. Yet the power dynamic is still not unidirectional; patients with chronic pain may also visit many physicians in their search for legitimization (Barker, 2005).

Chronic back pain can be very disruptive in a person’s life. While the source of some pain can be identified, other pain is non-specific and presents significant challenges for physicians looking for objective evidence (Calnan, Wainwright et al. 2007). This makes pain “enigmatic in terms of diagnosis, pathophysiology, natural history and treatment” (Borkan, Reis et al. 1995). As a result, treating chronic back pain can be very frustrating for physicians and patients as no approach has been found to be definitive, efficient or effective (Borkan, Reis et al. 1995). While it is not specifically noted in past
studies on this topic, as the physician, or provider of care is trying to uncover the enigmatic pain, it is reasonable to suspect that the patient may become discouraged or restless. It is not surprising then, that patients may initiate a paramedicalization process in this context. Nevertheless, they may find themselves experiencing the ‘partial medicalization’ of their conditions in such circumstances. Partial medicalization, in this context, involves recognition of, and treatment for, the patient’s condition within CAM – but such treatments are often regarded with suspicion by the medical model. Partial medicalization is therefore another incredibly important social dynamic.

2.1 Partial Medicalization

This thesis examines whether the experience of chronic back pain is only ‘partially medicalized’ because of deep-seated questions that arise within a narrow biomedical paradigm about the validity of emotions and subjective evidence. Conrad, Mackie & Mehrotra (2010) recognize that medicalization is dimensional and on a continuum; there are degrees of medicalization from conditions that are thought to be minimally medicalized (e.g. sexual addiction or multiple chemical sensitivity disorder) to almost completely medicalized (e.g. childbirth or major depression). Once established, medicalized categories can be flexible, expanding or contracting (p. 1944).

Thus, this study is arguing that, on the medicalization continuum, back pain is only partially medicalized. Such partial medicalization may have profound social effects, such as forcing the people who experience such pain to bear the ‘burden of proof’ and to demonstrate conclusively that the pain is not ‘all in their heads’ but is instead a genuine, embodied experience. In attempting to find treatment for their pain, some patients may seek assistance through Complementary and Alternative Medicine. Some critics have
suggested that this is simply an extension of medicalization; Complementary and Alternative Medicine is, after all, still a form of medicine. Such an argument, however, ignores the fact that Complementary and Alternative Medicine is itself sometimes regarded as illegitimate within a narrow biomedical perspective. That is, it too is only partially accepted – and arguably, partially medicalized – since it too is subjected to a cautious and even disbelieving approach by some medical practitioners. One biomedical critic has described Complementary and Alternative Medicine as a “collective romantic fantasy” which relies on “the authority of theories -- preferably exotic, ancient, and magical” (Schneiderman 2003: 191). Thus, it is clear that the scientific, “medical” standing of Complementary and Alternative Medicine is not without question.

### 2.2 Importance of Medicalization

Medical sociologists have studied the process of medicalization for decades because they are interested in the ways in which certain social phenomena influence the experience of health and illness. Additionally, they are interested in the ways in which certain knowledges---such as the biomedical approach and also Complementary and Alternative Medicine---are recognized and institutionalized. Equally important, medical sociologists are interested in the experiences of patients and people with particular medical conditions such as back pain.

Medical sociologists seek to explore the ways in which social factors---including not only race, class, and gender, but also wider issues such as the social acceptance of a particular approach, or the stigma associated particular condition---influence the diagnosis and treatment of patients. It has been reported elsewhere that racial and ethnic
minorities are prescribed lower levels of opioid medications when they report subjective experiences of pain (Smedley, Stith & Nelson 2003). They not only experience the regular ‘suspicious’ attitudes of physicians about chronic pain, racist stereotypes mean that they experience even more social barriers in terms of ‘partial medicalization’. Again, the importance of a sociological analysis of such experiences is evident. Unfortunately, this thesis cannot explore all these social dimensions of medicalization and will therefore simply note that these factors may influence diagnosis and treatment. Instead, the thesis will focus on some of the broader power dynamics associated with the validation---or invalidation---of subjective, somatic pain.

Medicalization as a social process is important because of its power dynamics; the social consequences of labeling something as a legitimate medical condition are profound. In fact, Rhodes, McPhillips-Tangum, & Klenk (1999) conclude that “drawing on interviews from a study of chronic back pain patients' attitudes toward treatment, we argue that testing constitutes an important element in the legitimation of illness for these patients” (p. 1189). If a person with chronic back pain does not have what medicine regards as ‘legitimate pain,’ then that person will not be allocated a “sick role” that entitles them to avoid regular social and work obligations (Parsons 1951). However, if a person is allocated a sick role, then they may be eligible for sickness benefits, a disability pension, or workers’ compensation in some cases. Additionally when a person takes on the sick role, they have a social obligation to get well. However, if a person is unable to take on the sick role, they are expected to be healthy and do not get the social support that they need to recover. Clearly, the lack of legitimacy impedes the patient’s ability to function and manage their pain in a socially acceptable way.
Of course, the “sick role” is not automatically applied to everyone who complains about feeling unwell; some illnesses and experiences are more stigmatized than others and the benefits of the sick role do not necessarily flow evenly to every member of the population (Segall 1976). In fact, according to Conrad et al. (2010) “some observers have raised the concerns that medicalization is an over-expansion of medicine’s professional jurisdiction and is a mechanism by which the pharmaceutical industry can increase markets, thus contributing to rising health care costs” as well as concerns rising about “overmedicalization” and the burden of cost that is a result of it (p. 1943).

There is, nevertheless, a gap in the literature on medicalization – specifically, the case of conditions which are only “partially medicalized”. The literature on medicalization tends to disregard the challenges inside medicine of expanding medical categories. But this failure to explore “partial medicalization“ may lead to an over-estimation of the reach of medicine, and may under-estimate the challenges which some patients face in trying to have their conditions medically validated. Such validation is important because people with conditions that are only partially medicalized, such as chronic back pain, may not automatically receive the benefits of the sick role. How these people seek recognition of their condition, and treatment for it, is one of the key areas of investigation in this thesis.

This study explores how the possible “partial medicalization” of chronic back pain may interfere with patients’ ability to receive treatment, or may influence them to seek alternative treatments. Buijs, Lambeek, Koppenrade, Hooftman & Anema (2009) suggest that the healthcare system can pose enormous barriers for patients who are seeking
medical validation of their somatic complaints, and yet medicalization is vital for treatment. If one is waiting to receive treatment and the condition cannot be medicalized, the patient may struggle to receive care. Unfortunately for those patients who are waiting for their chronic back pain to be medicalized, it may never occur. Perhaps because “the neurobiology of chronic pain, including chronic back pain, is unknown” and in fact “structural imaging studies of the spine cannot explain all cases of chronic back pain”, some patients experience enormous difficulties in their search for pain relief (Grachev, Fredrickson, Apkarian 2000: 7). Such social dynamics will be explored further later in this thesis.

Chronic back pain can be medicalized to an extent. Grachev et al. (2000), suggests that “chronic back pain alters the human brain chemistry...these findings provide direct evidence of abnormal brain chemistry in chronic back pain, which may be useful in diagnosis and future development of more effective pharmacological treatments” (p. 7). When such physiological evidence can be given, such as in Grachev’s et. al. study, the medical model is able to operate more traditionally and the medicalization process operates more smoothly from the perspective of patients responding to the diagnosis. Thus, although much of the literature on medicalization gives medicalization a negative connotation, it is sometimes necessary, and in fact a vital part of the patient’s experience to receiving appropriate care. This study will explore what happens if the patient’s respondent’s chronic back pain is medicalized, partially medicalized, or not medicalized.
Chapter 3

Methods

Qualitative data were gathered through the use of interviews. Initially, the IRB approved the use of in-person interviews. An amendment was requested during the data gathering process because of numerous requests to do phone interviews. Since phone interviews were not initially approved, some of the people who made initial contact and were no-shows, or never called back could have been a result of the inconvenience of having to meet the interviewer at an agreed upon location. However, only two phone interviews were done after the amendment was approved. One was done because the interviewee went out of state until August and the other was done at the request/convenience of the interviewee.

In order to obtain access for interviews, snowball sampling was used as well as purposive sampling. The purposive sampling took place through the posting of flyers in various places on campus at the University of Toledo, posting a flyer in a local whole foods store, and posting a flyer at a local church (see Appendix B).

“Snowball sampling is a multistage technique. It begins with one or a few people or cases and spreads out on the basis of links to the initial cases.” (Neuman 2007: 144). Connections in the local community were used to begin the snowball sampling.
Using flyers to advertise the study in various places in the community was a purposive sampling device. The basic principle behind purposive sampling is to “get all possible cases that fit particular criteria, using various methods” (Neuman 2007: 141).

### 3.1 Demographic Information

For this study 22 interviews were conducted. Twelve of the people interviewed were woman, and ten were men. Six of the people interviewed were in the age bracket of 18 to 30. One person interviewed was in the 31 to 40 age bracket. Three people interviewed were in the 41 to 60 age bracket. One patient interviewed was in the 51-60 bracket and ten people interviewed were in the 61-70 age bracket. There was only one person in the 71 to 80 age bracket who was interviewed.

Twenty-one of the people interviewed identified themselves as being Caucasian. One man was Hispanic/Latino (non-white), although he seemed a bit confused as far as how he should describe himself, and then he settled on Hispanic/Latino. One woman, Anna, did state –I have a little Indian but I don’t know if I want to write that‖ while she was laughing. However, when asked to identify her race, she still identified herself as Caucasian. Interestingly enough, at the end of the interview, she brought out a picture of her grandmother who was a full-blooded Native American and told me that she had traced her family history all the way back to before the Trail of Tears (See Table 1).
Table 1: Sex by Age (N = 22)

<table>
<thead>
<tr>
<th>Age</th>
<th>Male n= 10</th>
<th>Female n= 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-30</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>31-40</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>41-50</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>51-60</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>61-70</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>71-80</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>81-90</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>91-100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>100+</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Thirteen of the interviews took place in people’s homes, either their own or a friend’s. Two interviews took place on campus at the University of Toledo; one in Carlson Library and one in the Student Union. Two interviews were done over the phone, another was done at a restaurant/bar and another was done at a local Tim Horton’s. Four interviews took place at the interviewee’s places of employment.

Of the 22 interviews, 17 were the result of snowball sampling and five were the result of purposive sampling.

It is possible that the few people who failed to show up to their scheduled interviews or failed to schedule an interview because chronic back pain is a very serious medical condition that is often not taken seriously by friends, family and the medical profession. In one interview with Marie, she actually stated that her teenage son did not believe that she was in pain even though she has had five back surgeries. Some of the patients who did not show to the interview, or failed to schedule may have had similar experiences.

The data collected were analyzed around themes. The majority of interviews were recorded. However, five interviews were not recorded due to either patient preference or

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6 Pseudonyms are used in place of the respondent’s real names to protect their identity.
technical difficulties with the digital audio recording device. The interviews were not transcribed, nor was any analysis software used.
Chapter 4

Results and Analysis

There were numerous subjective complaints made by patients during interviews with them. Below are five patients’ specific descriptions of their pain. It is important to note that all their descriptions of pain are very subjective and due to the nature of their pain, their chronic back pain was unable to be medicalized by biomedicine.

David, who is in his late 60s, describes his back pain as “it would be just annoying pain down the side of your leg or the fact that your leg would cramp up [in the car]…the pain worked its way up into the back where I would get up, you would feel it. Or if you were just calm, like sitting or lying, you would not feel it in the beginning but when you would move.”

Nicole, a student in her 20s, was originally told she was likely injured around age 15 while riding horses. However “there is not like one moment” or incident in which her back pain was caused and a doctor she recently went to at a regional clinic stated that “there is nothing wrong structurally that would be causing the pain that I have.”

Mary, who is in her 60s, was injured while transporting a patient at her job in a nursing home. She stated “the patient fell on top of me” and she was sent to a regular workmen’s comp doctor,” as well as to her family doctor and a chiropractor. However, her condition was never medicalized and since “there was nothing they could do,
[because] I did not have any disc fractures or anything that could surgically be corrected at that time, it was just a matter of waiting it out.” Perhaps the lack of medicalization in her chronic back pain was the reason why she did not win her Worker’s Compensation case.

Alfred, who has had chronic back pain for over 40 years, believes his chronic back pain initially developed due to his weight gain of 95 lbs after high school. He said “I think he [his family physician] thought it [his back pain] was more of a muscular thing.” He eventually quit going to the doctor all together because “it wasn’t doing anything.”

Matthew, who is in his 20s, described two different incidents. The first of which he stated that “I am not sure how I actually hurt it [his back] in the beginning, however it hurt before I actually ruptured my disc.” Before he ruptured his disc he went to the doctor once and “I think they thought I was pretty much faking it, they tried to tell me I had a strained muscle or something, and I knew it wasn’t. After that I knew they weren’t going to do anything so I just dealt with it.” Later on when he hurt it “at work after slipping on some ice” he went to his doctor who referred him to a specialist. Again, “at first they thought I just pulled a muscle again or something” however they ended up doing a MRI and found out he had ruptured a disc. However, once his back pain was medicalized he received proper treatment and his back pain was not longer questioned because it was considered to be valid.

It is also important to note that another common theme during the interviews was that respondents often did not remember when the pain initially began, or why it began which
makes their pain all the more subjective. When respondents could pin-point the exact cause of their pain, such as a fall or another incident that was immediately followed by a visit to an emergency room, their pain was more likely to be medicalized. It was those respondents who did not experience as much struggle within the system to get their pain to be legitimized.

4.1 Choice of Treatment

Out of the 22 interviews, only two respondents said they only use CAM to treat their chronic back pain. One of those two respondents who only use CAM to treat their chronic CLBP was Susan, who is in her 30s and works as a teacher. It may be interesting to note however that Susan‘s back pain just started approximately two months ago, and the chiropractic care is helping her pain.

The other respondent interviewed who only uses CAM was Matthew, who is a student. His back pain began about three years ago, which was around the time he was lifting a lot of objects at work. He tried massage therapy once, and stated that afterwards he —felt like a million bucks,‖ however he chose to self-treat through using various exercises and stretches that he researched on the internet. He said he had not seen a doctor in years because as he stated: —Why would I want to waste time and money when I could probably treat most things myself?‖ which is exactly what he did for his back pain.

Only five people only used biomedical treatments for the chronic back pain. David, a man in his late 60s, went to his family doctor and physical therapy. However, after a successful bout of physical therapy, his pain came back when he stopped doing the home exercises. He went back to see his family doctor, and at his doctor‘s suggestion he

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7 Pseudonyms are used throughout this thesis to protect the identity of those who were interviewed
lost a lot of weight and does home physical therapy exercises everyday and considers himself to be on a pain scale of 0-1, but his back is still not 100%.

Alfred, a man in his 60s, believes his chronic back pain was initially caused by his physically demanding job, as well as his weight gain after high school. He initially went to his family doctor/company doctor and received shots but stopped going shortly after because it didn’t come up with anything new the whole time, it was still hurting.” Additionally, while discussing the family/company doctor he stated that –He didn’t suggest exercising or anything—that I remember…When I just gave up, I just figured, well its not killing me, I’ll just live with it….” He also added: –Why take the shots if they are not fixing anything?” Thus, he has been living with his chronic back pain, as it progressively is getting worse for over 40 years now. This is particularly interesting because it relates to gender and healthcare seeking behavior. When asked about seeking other treatments such as those in CAM he actually stated that –with my bad attitude I have learned to live with it and I kept going.” In future studies it would be helpful to interview more men to see if actions/behaviors towards healthcare were similar.

However, there were fifteen people who used both CAM and biomedical treatments. This number includes one woman who used both biomedicine as well as an osteopath which could possibly be considered to be both CAM or biomedical depending on whom one talks to. During an interview with another respondent, he claimed that an osteopath was considered biomedicine, however the woman believed that it was considered to be CAM. However, it was categorized as CAM since the respondent interviewed stated that the osteopath did manipulation on her spine.
A common theme was present when discussing the treatment for chronic back pain in biomedicine. The treatment seems to consist of first doing x-rays, MRIs or CAT scans or as one respondent stated tests such as “walk like a crab”, then treating the pain through various means. Sometimes the use of painkillers whether taken orally or given through injections, were used (often through a pain management clinic), as well as surgery, and physical therapy.

The common treatment for chronic back pain in CAM seemed to consist almost entirely of chiropractic care. The chiropractic care consisted of x-rays (usually but not always), adjustments through the manipulation of the spine, hot pads and cold packs, the use of a TENS machine or other machines, sometimes the suggestion of using a back brace or a referral if necessary. However, other CAM treatments that were used are: acupuncture, counseling, massage therapy, a wellness doctor, an integrative medicine doctor (she has already scheduled a first appointment), osteopaths, a teacher of the Alexander technique, a practitioner of polarity therapy, and a woman who practices CAM and has her Ph.D.

There was a lot more variation in the types of CAM treatments used, compared to the types of treatments used in biomedicine. Many of the respondents interviewed sought out CAM themselves, which is an indicator of paramedicalization. Paramedicalization itself is a form of medicalization, and can be interpreted as one form of resistance to the partial medicalization of their subjective complaints.

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8 According to the American Society for the Alexander Technique (2010), with the technique you “learn to how to strip away the movement habits and tensions patterns at the root of your discomfort. You learn how to balance your own body and take charge of your own health. You learn how to sit, stand and move — with safety, efficiency and ease.”

9 Is “a holistic discipline that seeks to achieve physical and emotional health through a system of touch, diet, exercise, and self-awareness designed to balance energy flows in the body” (Merriam-Webster 2010).

10 The respondent knew that the woman had a Ph.D. but she was not sure what the Ph.D. was in, or what her title was.
One reason respondents may seek out CAM themselves could be that they have had a negative experience with biomedicine. One respondent, Rose, who had only used biomedicine, had problems with her sciatic nerve so she went to her doctor and received a shot. After she went home, she stated “I fell down six times before morning, so they told me to go to the hospital, they ran tests and three days later I had emergency back surgery.” She ended up herniating discs 2 & 3. She was upset because she as never told if she had any other options rather than surgery. She said that she was currently in the process of recovering from back surgery and told me that she was waiting until she got another CAT scan to check up on things. She stated “am not going to have another back surgery, I can tell you that, mm, mmm…” She also stated that she would have to look into some alternatives to relieve pain, other than surgery and told me that “They will never talk me to into back surgery again.” She said she “don’t want to end up paralyzed; I don’t want to end up with my kidneys shutting down.” She then proceeded to tell a story about her friend who ended up dying as a result of a complication.

Darla, a woman in her 60s, began her interview by listing off all of the biomedical procedures she had. She had four back surgeries. Some of her back surgeries were initially successful, until another episode of chronic back pain arose. Since Darla lives half the year in a different state, she saw an out of state doctor when her back pain returned. This doctor suggested back surgery. She said no, and sought a second opinion from her doctor. She stated “He just looked at me and said “It is a mess.” I mean, he didn’t say anything else” and suggested doing a myleogram.\textsuperscript{11}

At this point she was asked if she had ever used any CAM treatments and her response was: “Oh yea, I did them all. I went to acupuncture, I went to everything but the

\textsuperscript{11} “a radiograph of the spinal cord” (Merriam-Webster 2010).
chiropractor because he wouldn’t touch me” after he looked at her x-rays. She tried an acupuncturist after her fourth surgery and she went to them twice but it didn’t do anything to alleviate the pain. She also went to someone who did kinesiotape therapy, and you know, she like massaged and did all these electrical things” as well as supplements. She didn’t know what her title was, but she believed that she had her Ph.D. in something.” When asked if it worked she stated “Yeah it did. In fact I was walking when I left her place.” She mentioned walking various times throughout the interview and stated that she stopped seeing her because she could walk fine and then she went out of state for six months. After she came back she did see her one more. Walking seemed very important to her and was discussed various times throughout the interview, perhaps because she actually currently is using a walker. Later on in the interview she said that if she had her way she would continue going to her because she has tried all the drugs and they don’t work. However, with the economy the way it is, she is unable to.

Emily, who is in her 20s, has tried “pretty much everything” in regards to biomedicine. Additionally, she has tried acupuncture, massage therapy, a wellness doctor, counseling, and has an appointment coming up with an integrative medicine doctor. Another respondent, Elizabeth has tried both biomedical treatments and going to an osteopath. She stated that the osteopath did manipulation (which is what a Chiropractor usually does) and cortisone shots (usually done in biomedicine).

Biomedicine uses a limited approach to treating chronic back pain, whereas CAM seems to use a variety or approaches and techniques. Biomedicine has a sort of “standard” form of treatment that begins with trying to initially medicalize the chronic back pain through the use of x-rays, MRIs and CAT scans. However, if that does not
work then some physicians try to numb the pain through the use of prescription painkillers or shots. In some cases physicians immediately make referrals, perhaps in hope that another physician, usually a specialist can medicalize the chronic back pain. It seems as if the original physician (very often the respondent’s family doctor) cannot define the chronic back pain (i.e. medicalize it) then they do not even want to deal with, perhaps because they are not sure what to do.

In CAM, respondents often see a chiropractor first. Often when a respondent starts to explore the possibilities of CAM, they learn of other forms of treatment, which greatly increases the possible treatments they can receive. Additionally, as some respondents interviewed experienced, chiropractors often explored other options and tried various treatments on them.

Respondents’ views on the different approaches CAM used varied. It seemed that a lot of respondents were more satisfied with CAM treatments in general because of the holistic natural of CAM, as well as the willingness of CAM providers of care to not give up and to keep trying new things. There were mixed reactions on various types of treatments. Some respondents were extremely satisfied with their chiropractor and others simply felt as if it did not help. Only a few respondents tried acupuncture and all of them stated that it did not seem to help. However, the few respondents who did try massage therapy were satisfied, but considered it to only be a temporary solution, especially because of the cost.

It is also important to note that finances often influence respondents’ access to alternative approaches. Often respondents’ access to alternative approaches are limited since their conditions are not medicalized, or because CAM is only partially medicalized.
Since CAM is only partially medicalized, it may not be recognized as a legitimate approach, which may directly influence what insurance companies cover.

4.2 Nature of Back Pain

Many interviewees reported experiencing frustration as a result of the traditional medical model’s suspicion toward subjective complaints such as chronic back pain. As mentioned previously on page 18, physicians exercising caution while dealing with patients and the resulting attitude of disbelief from physicians is a form of partial medicalization (Barsky & Borus 1995). There are numerous ways the nature of back pain influences the treatment of respondents which include: prescribing prescription painkillers, how some providers of care respond to the subjective, invisible and often incurable nature of CLBP, the use of the pain scale, and how some physicians question their patients’ pain.

Prescription painkillers may be the first line of treatment and may have negative consequences for the patient. Benjamin, who is 70, had an initial injury in 1975, which he described as his “muscle, ligaments, and tendons” snapping. This landed him in the emergency room where he was told that he would never walk again. He then said he had “at least five doctors” prescribing various painkillers for him after the initial emergency room visit. He described a defining moment when he realized he was addicted to painkillers and he went to his family doctor. Even when he was taking the multiple painkillers he stated that his pain was still a 3 on a pain scale of 1-10. His doctor suggested he go to detox but he had his own method of cleansing his system. He tried physical therapy, and wore a back brace for at least 10 years. He stopped physical therapy
because "they told me I wasn't going to get any better" but if the pain got worse to come back. He can now do physical therapy at home and described physical therapy as "fantastic" after jokingly calling his physical therapist a physical "terrorist" because "he made me do things I swore I couldn't do." After he went through his own form of detox from his prescription painkillers which consisted of going to a nearby campground with his wife and a couple (one of whom was a nurse) and as he put it "I just swam and walked for seven days straight...because I didn't want them to know back then at 37 years old that "hey I am, this guy is a drug addict." He said that with the exception of occasional over the counter painkillers, "I am now just dealing with it." Chiropractic care is not an option because of the nature of his back pain.

What is interesting about Benjamin's story is that he also briefly touches on medicalization while discussing his drug addiction to prescription painkillers. He discussed how he did not want to go to a local rehabilitation center for fear of being labeled as a "drug addict" at such a young age and then have the stigma follow him through life. Thus, he made the choice to do his own form of detox.

The second issue with back pain is how some providers of care respond to the subjective, invisible and often incurable nature of CLBP. Marie, a woman in her 40s, was taken to the emergency room after she herniated a disc, while she was laughing at something at work. After herniating one disc, the two discs above and below the original herniated disc also herniated. She has had five back surgeries. According to her, the first surgeon "was a complete ass" and "he was egocentric[al]." While discussing her meeting with him after the first surgery, she paraphrased what he said: "I cured thousands of other people, I don't know what is wrong with you." Marie then stated "I think he basically
was like, I’ll give you another back surgery, I’ll charge you another $50,000. That is really how I felt.” She is still receiving “trigger shots” but stated that her last surgery “has worked so far.”

Emily, whose invisible and incurable chronic back pain has been a constant presence in her life described how she was treated at various doctor’s offices. She said “I am tired, and so exhausted from going to offices and dealing with these rude people.” On the other hand, “My chiropractor is fantastic and I am really so grateful that I found her. Uh, the surgeon is just an ass…he is just horrible, I have five minutes and I don’t know what is wrong.” She used to take Percocet up to three times a day with a dosage of four pills each time, but since it doesn’t do anything to alleviate the pain and she built up a tolerance to the drug she “kind of dropped all of them [the pills]” and doesn’t take anything anymore. Going to the chiropractor helps for about a day but she continues to go because her chiropractor “is so positive, and supportive and she has not given up. She is the one doctor that has not said to me, ‘I don’t know what else to do. I can’t help you.’” The chiropractor provides some relief, so she was most satisfied with that treatment. Emily even said that “If I have any problems, anything, I go to her and she will look it up and have an answer or a direction, or someone to talk to about it” thus “She keeps me going.”

She also said she felt most comfortable and trusted her chiropractor the most. When asked about her chiropractor she stated that “She’s the only one that helps with anything” and also that

she is the only one who is willing to look at the whole picture and look outside the box and if she needs to say you need to go to this other chiropractor because he might have something that’ll work, she is not afraid to say that. The other doctors are just focused on that one symptom in their area and that’s it. I’ve gone through so much of the traditional stuff….I’m looking at like DO’s, and alternative things and integrative medicine a lot more.
What is very interesting is that Emily’s pain is so incurable and subjective is that it was actually *suggested* that I look into the psychological aspect of my pain” and she said she currently goes to a counselor but she is not sure what exactly she is supposed to get out of the session and she said that I feel like I am wasting her time and mine.” Perhaps Emily is much more trusting and comfortable with her chiropractor because she believes Emily is in pain and tries to find solutions for her.

*Matthew*, who is in his 20s, stated that he has had various bouts with chronic back pain. The first bout was CLBP, he went to his family doctor and I think they thought I was faking it. They pretty much thought I was faking it. They tried telling me it was a strained muscle or something, and I knew it wasn’t. So after that I knew they weren’t going to do anything. So I just dealt with it.”

After a second episode of slipping on ice at work he first tried going to the chiropractor. He also went to the emergency room where they believed he had a strained muscle, and didn’t do any x-rays. He was given a shot of some painkillers. He stated that the painkillers from the shot never took effect.

After a few months of going to the chiropractor, and after going to the emergency room he went back to the same family doctor who actually thought he had a strained muscle again. Later when asked how he felt he was treated by his doctors, in regards to his family doctor he said I don’t know if they thought that I was just, I think they thought since I was younger that I shouldn’t be having ruptured discs and back problems like I was.” Later he stated that I think they were, thought I was just trying to get some medicine, ya know since I said my back hurt” they never outright said it but that is how
he felt since he kept telling him that it was more than just a strained muscle. Due to the subjective and invisible nature of his CLBP, his pain was questioned.

Fortunately, he requested he be referred to a specialist and he ended up being referred to a surgeon who did an MRI and discovered that he actually had a ruptured disc, thus medicalizing his pain. After that point, his pain was no longer questioned because his pain was then medicalized\textsuperscript{12}. A name could be attached to his pain, and his pain was no longer subjective or incurable because it could now be "seen." He ultimately ended up having a relatively successful back surgery. He said that it worked but later said that the surgery fixed the pain that was shooting down his leg and into his foot but he feels as if his CLBP is coming back perhaps because of some lifting at work.

Jennifer, a woman in her 20s who just received her Master’s degree, stated that her primary care physician may have questioned her pain —a little bit" simply because he had me do some of those tests and walk different ways and I wasn’t really reporting anything, so he was kind of a little bit mystified as to what it was, so I don’t know if he just thought, didn’t know what the heck was going on . It wasn’t like he said I wasn’t experiencing anything but he just couldn’t tell.

Thus, as a result of the invisible nature of Jennifer’s back pain, her pain was also questioned.

Nina, a woman in her 70s who has spinal stenosis, arthritis and degeneration between the "padding" in between her vertebrae in her back, said that the "second opinion" surgeon she went to see about hip surgery (which was also causing her CLBP) did not believe she should be having as much pain as she said she was. He said, "you need the hip surgery and you know, um, you are not going to get any relief without it. but he

\textsuperscript{12} See Chapter 2
couldn’t believe I was in as much pain as I was.” As she described: he “blew me off” and said to call when she was ready to make the appointment.

Emily also describes a case where her pain is considered to be incurable and subjective. She also stated that after she had her back surgery the pain management doctor prescribed her a large dose of painkillers. She took them for about six months then weaned herself off. After about a year her pain came back and she called the pain management doctor. It was then that the pain management doctor questioned her pain because she had not been to him consistently for a year so they were suspicious and accused me of selling it [the Percocet]…I had to do drugs tests I had to just do pill counts all those kinds of thing that, they said that because of my age and that I was not walking around in pain and whatever else they wanted me to do be doing it was reason for suspicion.”

The surgeon that performed surgery on her told her “it was all in my head” and said something to the effect of that I pushed him to do the surgery… this was of course after the fact after I had been to” the clinic and the doctor there said the surgery was unnecessary. Her surgeon’s only defense was that that she pushed him [to do the surgery] because I was so desperate for something to happen that he went ahead and did it.”

Elizabeth stated “I think they think that you exaggerate. I think they think that you are getting older what do you expect? That’s one they use a lot as you get older, and I knew, I knew that that type of pain was not [from getting older].”

James, a man in his 60s, sums up the nature of chronic back pain or as James put it “discomfort” when he said: “if they can’t cut ya, they don’t know what to do.”
Another tool that biomedicine uses that could cause frustration for the patients is the pain scale; it is a tool that doctors often use to gauge patients’ pain. Unfortunately, the pain scale is very subjective and therefore causes issues in treating patients. Four respondents interviewed actually discussed how they were asked what their pain was on a scale of one to ten and two of the respondents were outright told that there was no way that their back could be causing them that much pain. In fact, after George said his pain was a ten, his doctor responded: “a ten on the pain scale is dying.” George said that his pain was questioned “all of the time” and they thought he was imagining his pain.

One particular doctor stated that because the respondent was walking around, he clearly could not be experiencing a 10 on the pain scale. Other respondents felt as if their pain was being questioned, particularly if it the interaction involved pain medication of some sort, whether or not the respondent did not want to take any sort of pain medication.

There are numerous issues relating to diagnosing patients within biomedicine. Physicians are taught to quantify symptoms and unfortunately pain is not quantifiable. The pain scale of 1-10 is subjective and not reliable. One person’s pain could be a five on their scale, and the same amount of pain could be a ten on another person’s scale. There is not a reliable way to correctly and objectively measure pain. There is also a pressure to cure patients in biomedicine and if the physician does not see the problem, or cannot cure the problem there is a tendency to believe that the problem is nonexistent. When physicians believe the problem is not real they may believe that the patient is experiencing psychological issues, or they are exhibiting drug seeking behavior. Thus, chronic back pain is partially medicalized because if the problem can be seen in an x-ray or on an MRI the problem exists. If not, the problem is nonexistent.
4.3 Medicalization of Everyday Life

Additionally, the medicalization of everyday life influences the diagnosis and treatment of patients with chronic back pain in multiple ways. Insurance can sometimes influence what services a patient receives based on their diagnosis. For example, for a surgery to be covered, it may have to be considered medically necessary, and thus if exploratory surgery needs to be done then it may not be covered. Andrew, a man in his 40s, said that his surgeon did not know what was causing his chronic lower back pain, after doing an x-ray/MRI it could still not be pinpointed. After doing an exploratory surgery it was discovered that this particular respondent literally had a “broken back” or a small fracture, which was the cause of his pain. Interestingly enough, he had many doctors previously question if his pain was real. However, after his pain was medicalized and legitimized, doctors no longer questioned his pain.

4.4 CAM Suspect by Biomedicine

There were many in which respondents reported how their doctors did not fully endorse CAM. This suggests that CAM itself is only partially medicalized. Some physicians seemed to endorse CAM as a legitimate treatment option, and therefore makes CAM a legitimate form of medicalization; whereas other physicians viewed CAM suspiciously, which suggests partial medicalization.

Only one of the respondents interviewed said that his family doctor did mention a chiropractor in passing as an option to treat his chronic lower back pain. However, this particular respondent never chose to go to a chiropractor. This is the only instance in
which a biomedical treatment provider of the respondents interviewed that recommended or suggested any sort of CAM treatment.

Sometimes the respondents were referred to a pain management clinic, or physical therapy (both are biomedicine and medicalized). One respondent said her doctor “suggested” she see a counselor about her back pain because the doctor believed it may be helpful to look at the psychological aspects of back pain, and in fact the respondent told me during her interview that she believed her doctor thought that her back pain “may be all in her head.”

Two other respondents stated that their doctors were not necessarily against CAM. Mary stated that her family doctor “does not have a problem with chiropractic care, I mean she would like to be informed of what is going on to make a decision in each case.” In a similar instance, Darla could not remember if she did tell her doctor but she believes she did and she stated that he was okay with “anything he said that would help…anything to get off the drugs.” Thus, these two respondents’ physicians’ opinions of CAM end up legitimatising CAM as a form of medicalization.

However, in some instances physicians viewed CAM suspiciously which suggests partial medicalization. Nina, stated that her family doctor “flat out” said she did not approve of chiropractors and firmly believed that they “did more harm than good” and actually warned her of this. However, she continued to go to see the chiropractor. Anna, a schoolteacher in her 60s, who has scoliosis had to go to the emergency room after a “bully” at work pulled the chair out from under her and caused a nerve to become pinched, stated that her physical therapist was against to chiropractic care.
However, what was interesting is that some respondents did not believe it was necessary to state that they were also seeing a chiropractor, or as one respondent put it, they were not comfortable telling their physician at all. One could possibly conclude that this particular respondent refrained from doing so because they were afraid of what their doctor could say. Perhaps, some respondents sense that their doctors are suspicious of CAM. If a respondent is seeing a physician about their chronic back pain, one would assume that the physician initially asks what the respondent came in for, what they have done for it, if it worked, and so on.

One respondent said that they believed their doctor did not think that a chiropractor was a regular doctor and she felt that in fact her biomedical doctor(s) did not really care if she went to see a chiropractor as well because they could not do anything. Another respondent stated that her doctor simply brushed off the fact that she went to see a chiropractor and she felt that her doctor believed that a chiropractor was a non-entity.

However, there were some respondents such as Anna, Jennifer and James that expressed a fear of going to a chiropractor, perhaps due to the partial medicalization of CAM. Anna, when asked if she had ever gone to a chiropractor stated:

I have never done that, I have always been a little afraid of that. I, uh, a lot of people have say that they do it, but I have always just been a tad afraid of it…It’s just me, I just have never really felt real comfortable with it.

She also said she has heard stories where they cause more harm than good, and is a bit "iffy" on going to one but then she stated she was not sure, and thinks I would rather go to a physical therapist." Anna blatantly stated that she would rather go to physical therapy—a treatment which is already fully medicalized.
Jennifer, who has her Master's degree, stated that she started doing research on chiropractors and after reading articles and talking to people she would be hesitant to go to one. That is of particular interest because people who use CAM tend to have more education, and in Jennifer's case she only used biomedicine for her CLBP. Perhaps, it could be because her CLBP was basically corrected by physical therapy, and can be controlled by doing those exercises at home. However, she has also done research on acupuncture and massage therapy and said she would be interested in trying it if her problems worsened.

James has beliefs about chiropractic care that reflected the previously discussed Quackwatch.org when he stated that chiropractors “give you a line of bullshit that they can cure everything…they give me the heebie jeebies….they are all a bunch of crooks.” It seemed as if he was a bit more open to the person who did polarity therapy (which he described as “hands on healing” and was satisfied with it), but when describing all providers of care he stated: “they all have agendas” and are pushy. He stated he didn’t trust any providers of care because they all want to “operate, operate, operate.”

Elizabeth, stated that “osteopaths I think they are more open and willing to try stuff, I think they are more homeopathic than any other doctor, and I think they will try those routes before going into surgery” and she believes that at least when she was going to them (before they were more common in hospitals) “they would lead up to surgery instead of starting at surgery.” What is interesting is that Elizabeth is inadvertently discussing what it means to be an osteopath today. It seems as if she is unsure whether or not an osteopath is considered to be alternative anymore since they are now sometimes
more mainstreamed into hospitals and she is unsure if osteopaths are still as homeopathic as they once were.

Emily, who had been to many doctors previously, had back surgery done which actually worsened her condition. As a result she was unable to work at her previous job because she could not stand excessively (at work she was required to stand at least five hours a day) so she had to quit. According to Emily, doctors have done numerous tests to try to discover what the cause of her chronic back pain is, including testing for fibromyalgia. However, according to Emily, the doctors cannot find “anything structurally wrong with my back.” Another respondent had an x-ray done and the surgeon could not see why his back was causing him pain. If doctors are unable to diagnose, or specify why a particular respondent is in pain, it is more likely that their pain will be questioned, or there is not a medical ‘solution’ for their pain.

Many respondents choose to see their family doctor first and foremost, except in a few instances in which people I interviewed (three respondents) said that the first time they went for treatment was in an emergency room due to the pain escalating or an incident occurring. In all of my interviews, none of the respondents I spoke with said that their doctor recommended them going to a chiropractor.

4.5 Partially Medicalized?

The last question I hoped to answer is if chronic back pain is only "partially medicalized"? I found that the cause of chronic back pain varies and in some instances what is causing the pain cannot necessarily be defined or pin-pointed. However, in the case of Elizabeth mentioned earlier, she actually had a surgery because her doctor did put
a name to what was causing her pain (a slipped disc). This lack of a term or reason for the chronic back pain can be an issue for a respondent trying to receive services, or at the very least seek medical treatment to relieve some of the pain. What is interesting is that I found that the majority of respondents I interviewed had x-rays, an MRI or a CAT scan done on their back at some point. This was in order to diagnose or try to figure out where the pain was coming from or what it was being caused by. In fact, many of the respondents I interviewed had x-rays done at chiropractor’s offices.

Joseph, a student in his early 20s has been deployed overseas twice, believes he developed his chronic back pain while he was deployed overseas. As he waited until he was back into the United States to receive any sort of treatment. He was going to a chiropractor on a consistent basis but when he went off active duty it was no longer covered by his health insurance. He has new health insurance and maxed out his ability to go to the chiropractor and the VA clinic/hospital does not offer it. He is not sure what the cause of his back pain (he was the only respondent interviewed who defined their back pain as upper back pain) is and the doctors believe it may be degenerative but they have yet to actually ‘medicalize’ his chronic back pain. He stated that he now has to go to the VA hospital and they did x-rays, when asked if they did any treatments he stated “all that they want to do is give me pills.”

This may point to two larger problems in our society. The first being our reliance on pills in general, as well as issues with the care veterans receive. When asked about who the respondent trusted more, the chiropractor or the doctor at the VA clinic/hospital, Joseph said he trusted the Chiropractor more because “he actually cares” and that the doctors at the VA clinic and hospital “don’t want to do anything for me besides just give
me a bunch of pills. Which is fine because if I don't have them how am I supposed to
deal with the pain?” He also stated that he trusted the chiropractor more because — you'll
find that a lot of doctors at veteran’s hospitals and stuff are there because nobody else
wants to hire em, I think. Honestly. I mean, it is pretty ridiculous sometimes. They’re the
only place I can go that I need for free, or uh…” He is now going to the VA outpatient
clinic and they are still just giving him pills for not only his back, but also for his knee
problems.

Additionally, he also briefly discussed how he was treated at a naval hospital during a
previous incident where he was bit by a brown recluse spider. The doctors did not believe
he was in as much pain as he said he was and he ended up having an infection in his
blood as a result and had to have emergency back surgery (not where his pain is currently
though).

Another example was that of Elizabeth. Elizabeth, a woman in her 60s, went to a
—second orthopedic doctor,” who did an x-ray. He told her she had a disc that was
slipped, but the previous —orthopedic doctor” had not caught it because the disc had
slipped in instead of out like usually occurs. As a result it was pinching a nerve and he
stated — if you don’t have the surgery to relieve that then you can be paralyzed” then she
said — Sd thought mmm, should I or shouldn’t I? I knew what other people had gone
through, but I thought he put a name on something that was actually physically there. So I
had the surgery.” She believed the surgery corrected a problem she didn’t know she had,
because she was still in pain and after going to numerous types of different doctors four
years after her original surgery she is still in pain. What is very interesting is that
Elizabeth discussed how, as a result of a name being put on her CLBP, or her back pain being medicalized, she ended up having a surgery.

Mary, a woman in her 60s, discussed two different episodes of chronic back pain. The first was the result of an injury obtained while on the job. She simply went to a chiropractor because the biomedical doctors stated there was nothing they could do, because she didn’t have any uh, disc fractures or anything that could surgically be corrected at that time, and it as just a matter of waiting it out, and the adjustments would provide the pain relief and whatnot.” During this time when biomedical treatments could not be used, she also had to go see a doctor for her workmen’s compensation. She expressed extreme distaste for going to this doctor and described it numerous times as “like I was being rubber-stamped” because he was just doing his job and that was it, there were no frills on any of it.” Mary explicitly states that there wasn’t anything that could be surgically fixed, and nothing that could be ‘defined‘ or ‘named‘ and thus medicalized. Therefore, she was forced to ‘wait it out.’ She later told me she did not win her case at Worker’s Compensation, and it could be a result of a lack of medicalization of her back pain. If she would have fractured a disc, or something of that nature then perhaps her pain would have been legitimized and would have resulted in winning her worker’s compensation case.

For her current episode of chronic back pain, she discussed how her orthopedic surgeon basically told her that whatever hurts her back now, as a result of the weakened area from her injury is incurable, and that she should take precautions. She also works out and does a sort of self treatment through various exercises and stretches. However, since
her surgeon believes that particular area of her back will always be weak, and there isn’t really anything he can do about it, it is very subjective.

One respondent interviewed, Marie, expressed how she really “loved” the physician assistant she went to at pain management because “she never blamed me and thought it was just in my mind.” She said that doctors have not questioned her pain, but named her son as not believing she was in as much pain as she said she was in. Thus, people in the general community also may have a problem with legitimizing pain unless that pain is fully medicalized.
Chapter 5

Conclusion

The main topic that was examined in this thesis was the partial medicalization of chronic back pain. Chronic back pain is becoming increasingly more common and in many cases it is a life-changing condition. Both traditional biomedical treatments and CAM can be used to treat lower chronic back pain, and there are both positive and negative aspects to both treatments, which have previously been noted in the literature review. However, the literature review has highlighted a gap in the literature, which this thesis seeks to address: the ways in which medicalization is only partially accomplished for some conditions, which are subjectively experienced, such as chronic back pain. Chronic back pain can be medicalized to an extent such as in Grachev et al.’s (2000) study, where it is suggested that “chronic back pain alters the human brain chemistry...these findings provide direct evidence of abnormal brain chemistry in chronic back pain, which may be useful in diagnosis and future development of more effective pharmacological treatments” (p. 7). When such physiological evidence can be given, such as in Grachev’s et. al. (2000) study, the medical model is able to operate more traditionally and the medicalization process operates more smoothly from the perspective of respondents helping with the diagnosis. Thus, although much of the literature on medicalization gives medicalization a negative connotation, it is sometimes
necessary, and in fact a vital part of the respondent’s experience to receiving appropriate care.

This study explored what happens when the respondent’s chronic back pain is medicalized, partially medicalized, or not medicalized. This study had six findings regarding both biomedicine and CAM. The first finding is that respondents are dissatisfied with the biomedical approach that leaves them over medicated, drug dependent or “under the knife.” Another finding is that when physicians are unable to make the respondent better, the respondent is accused of malingering, drug seeking or as having a mental/psychological issue. Additionally, medical treatment is only offered if there is a physical measure that justifies the pain.

One finding in regards to CAM is that there is a major problem present--that there is not as much consistency in CAM treatments as there is in biomedical treatments, which may actually reduce the faith that people have in CAM because a sort of “standard” of treatment is not present. There is also at least some distrust of CAM practitioners in both respondents and physicians alike. Additionally, as a result of the partial medicalization of CAM, respondents have to seek out and experiment with treatment on their own. As a result, respondents are not getting their pain needs met in part because the two areas of treatment (biomedicine and CAM) don’t work in unison. All of these findings support that chronic back pain is not fully medicalized. There is not a specialty that is stepping up to take over treatment other than surgery and when surgery isn’t indicated, then the respondent is on his or her own.

There are, however, some limitations to this study such as: not asking respondents’ education levels and diversity in race and ethnicity. In future studies, it would be helpful
to ask the respondents about their level of education, in order to better identify the subpopulations that tend to use CAM. As discussed in the literature review, users of CAM tend to have a higher education level. Additionally, in future studies, it would be helpful to have a more diverse patient group in order to determine if one’s race or ethnicity influences their healthcare decisions since CAM was mostly developed in non-Western areas. In this study, patients were asked to identify their race/ethnicity and 95% of the patients identified as Caucasian. White patients may have more access to CAM because they tend to have more resources in general.

Another limitation of the study is the study was initially developed with the intention of interviewing providers of care to get their opinion on the partial medicalization of chronic back pain. However, due to time constraints, these interviews could not be scheduled. It would be beneficial to interview providers of care, both biomedicine and CAM alike, in order to get the “full story” or to at least identify what their “plan of action” is when a patient initially comes to see them about chronic back pain.

The findings of this study will be beneficial to both patients and providers. It may encourage patients to look at alternative methods of treatment, as well as help patients realize they are not alone in their struggle of having a condition that is only partially medicalized and often questioned. The study may help providers of care realize how painful and stressful it is for patients to struggle while trying to receive appropriate treatment without having their pain questioned or being treated as if their pain is ‘suspicious.’ Overall, the findings of this study should be seen as ‘eye-opening’ to both patients and providers of care alike. Discussing and learning about what it is like to be in
the other person’s position can be helpful for patients to more clearly express their pain, as they are aware of the possibility of being looked at with suspicion, as well as the providers of care acknowledging the possibility of how harmful partial medicalization is in this instance.

This thesis also contributes to the theoretical study of medicalization through its focus on partial medicalization and paramedicalization. As previously discussed in the literature review, partial medicalization and paramedicalization are both topics that are under researched, perhaps because paramedicalization consists of patients questioning biomedicine through the placement of value on alternative medicine and different beliefs about wealth and health, which are not authorized by the medical science” (Wordiq 2010: 1). Additionally, this thesis can make a contribution to the development of a patient-centered methodological approach to medicalization, an area that was previously under researched.

Despite the limitations of this study, this study has clearly identified six ways in which chronic back pain is only partially medicalized. The first is that paramedicalization simply exists to fill a void. The second piece of evidence that chronic back pain is only partially medicalized is the attitude of disbelief that providers of care (particularly those in biomedicine) express when patients have chronic back pain. Another way is that many patients seek out CAM after biomedicine fails. The fourth way is that many physicians do not fully endorse, or are suspicious of CAM. The physician’s inability to plan a course of treatment when they are unable to diagnosis a patient’s condition is another way in which chronic back pain is only partially medicalized. The final way in which chronic back pain
is fully medicalized is that medical treatment is often only offered when the patient has a
diagnosis and their treatment is thus medicalized.
References


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Appendix A

Interview Questions

Questions used to guide the interview (varied according to which treatment the respondent used):

1. Do you prefer Contemporary and Alternative Medicine (CAM) or biomedical treatments?
   a. If you use CAM how did you first hear about CAM?

2. How were you treated in each setting?

3. Is your pain being managed correctly?

4. How did you feel after treatment?

5. Why or why not did you continue treatment?

6. Which treatment were you more satisfied with?

7. What kind of provider of care did you feel more comfortable with?

8. What kind of provider of care did you trust more?

9. Have you ever had an experience where a provider of care did not believe that you were in as much pain as you said you were in?
10. Do you think that your doctor gets mad at you, or would get mad at you, If you used a chiropractor too?

11. Do you think that seeing a chiropractor would make you have to keep going to him or her forever?

12. Are you afraid that if you go to a chiropractor you may have negative side effects (i.e. paralysis)?

13. How did you learn about CAM?

14. Have you ever been referred to a psychologist or psychiatrist for pain treatment?

15. Are you employed?

16. Do you have health insurance?

17. Does your health insurance cover CAM treatments?
   a. Which CAM treatments do they cover?

18. Are you making choices for your healthcare that are influenced by money or health insurance coverage?

**Demographic Information**

**Sex**

☐ Male
☐ Female

**Age**

☐ 18-30
☐ 31-40
☐ 41-50
☐ 51-60
☐ 61-70
☐ 71-80
☐ 81-90
☐ 91-100
☐ 100+

**Race/Ethnicity**

☐ Caucasian
☐ African Americans
☐ Hispanic/Latino (Non-White)
☐ Asian/Pacific Islander
☐ Multiracial
Appendix B

Flyer

Do you experience chronic lower back pain?

Would you be willing to share your story with a University of Toledo Graduate Student?

If so please contact Holly at: Holly.Renzhofer@utoledo.edu or (419) 351-6274