The contribution of qualitative approaches to musculoskeletal research

Tell me a story of who you are. And see who I am in the stories I am living

Oriah Mountain Dreamer, The Dance.

Through a number of editorials [1, 2] this journal has raised awareness of the need to understand people’s experiences of living with musculoskeletal pain and disability in order to provide effective care and support. Qualitative approaches are particularly suited to accessing the insider’s view of his or her social world because their prime focus is on the way experiences are given meaning with reference to people’s cultural and social contexts. A wide range of theoretical perspectives and methods can be adopted under the umbrella of qualitative research, but they commonly share particular strengths, namely by being interpretative in form, following a naturalistic paradigm (in contrast to the experiment), allowing multiple perspectives and complexity, and focusing on process [3]. Rather than getting lost in conceptual discussions, Silverman [4] proposes a pragmatic approach whereby the choice for qualitative research should be led by the type of problem to be researched, while recognizing the need to implement rigorous and critical standards that improve the robustness of the findings.

The questions within musculoskeletal research that can benefit from qualitative approaches are the following:

- How do people understand musculoskeletal pain and disability?
- How do they and their families live with musculoskeletal pain and disability?
- How does musculoskeletal pain affect people’s sense of self and identity?
- How do people manage their condition on a day-to-day basis?
- Why do they seek help (or not), and from whom?
- What interactions take place between clinicians and patients, and how are the processes and outcomes evaluated?

The increasing prevalence of musculoskeletal conditions [1] is a concern at the level of populations, but equally so at the level of the individual as people have to make sense of pain and discomfort. The fundamental problem of pain is that it constitutes a private experience and does not have a focus outside of the body [5]; expressing the sensation of pain therefore requires ‘translation’. Verbal expressions of pain depend on a repertory of words that are framed by culturally accepted concepts and ideas and, for example, Smith’s research [6] demonstrates that individual pain words—such as ‘throbbing’, ‘stabbing’, ‘gnawing’—change meaning depending on the context within which they are used. Other researchers [7] question the privileged position of the spoken word in Western culture, and contend that pain is expressed and communicated not only through verbal descriptions but also through metaphors and non-verbal means. They highlight the interplay between talk and gesture in which the body becomes a communicative instrument that can externalize pain, making it visible to the intended audience through, for instance, wincing or limping.

Musculoskeletal pain can be unpredictable or fluctuating, and in older people its interaction with other conditions leads to multiple illness trajectories. Thus, uncertainty is a major feature of musculoskeletal conditions and this has been seen to contribute to ‘biographical disruption’ of people’s lives [8]. In relation to osteoarthritis, Sanders and colleagues [9] use Bury’s concept to explore people’s accounts of their symptoms of osteoarthritis (OA) and the problems they encounter as a result. They then assess whether and how people experience these problems as disrupting their daily life and expectations. Importantly, they found that many people played down any symptoms or disruption because they considered OA to be a normal part of growing older, and thus they limited their demand for health-care.

One response to the biographical disruption caused by musculoskeletal conditions is to attempt to ‘repair’ one’s life through a process of ‘narrative reconstruction’ [10]. Research which uses a narrative approach can effectively highlight how people make sense of an illness and find a place for it in their lives, for example through drawing on personal resources [11], and also the particular difficulties in ‘remaking the future’ for conditions with an uncertain trajectory [12]. In addition, the narratives on the DIPEx website [13] are a powerful resource for researchers and practitioners aiming to understand the experience of living with the specific musculoskeletal conditions of rheumatoid arthritis and chronic pain.

The role of the immediate social network is important in enabling acceptance of and/or adaptation to musculoskeletal conditions and their consequences. Work and the family, in particular, are social arenas where identities may be lost or recreated, or new identities formed [14–17]. Musculoskeletal pain and disability are experienced not in isolation but within a range of social contexts, including the family, and understanding the experience of families is important [18, 19].

Qualitative studies on the demand for health-care reinforce the above findings and the often stoical attitude of, in particular, older people or those who have had ‘hard-earned lives’ [20]. This tendency to not consult is also related to a number of other factors, including the belief that no effective treatment exists or that the symptoms are not sufficiently severe [21]; that health professionals are perceived as not believing patients’ accounts of pain [22]; and the belief that conventional medicine and health-care have less to offer than complementary medicine [23].

The relationship between clinicians (especially doctors) and patients has been of key interest to qualitative researchers and many studies are applicable to musculoskeletal care. Rhodes and colleagues [22] draw attention to the complex interrelationship between the biomedical paradigm’s need to diagnose visible pathology and the private experience of pain. Chew-Graham and May [25] highlight the different models of back pain and its treatment used by patients and general practitioners, and the tensions caused by this discrepancy. Extending this work to include health professionals, such as physiotherapists, hospital specialists, chiropractors and osteopaths, Ong and Hooper [26] analyse the therapeutic processes that can lead to agreed outcomes, but also demonstrate that a discordant relationship can still deliver effective interventions. Lilrakn [27] discusses how the subjective nature of pain is juxtaposed with the medico-scientific model, again leading to tensions in mutual understanding. A comparison between general practitioner and patient perspectives on information requirements for low back pain examines the implications for clinical practice, namely that information should shift from being professional-driven to being more sensitive to patient experiences [28].
In terms of developing patient-defined outcomes, qualitative research has made an important contribution to devising sensitive tools. For example, the MYMOP (Measure Yourself Medical Outcome Profile) has been derived from interviews with patients about issues that they consider important in their illness experiences and the way in which they feel this could be most effectively studied [29]. Qualitative methods have also been employed to provide context and depth to epidemiological surveys, leading to more robust explanations of reported illness [30]. Studies have been carried out to include standardized survey-type questions in qualitative interview topic guides to act as triggers to stimulate detailed conversation on specific topics. It has been argued that in this way complex issues can be explored and a safer environment created to introduce sensitive subjects [31]. Qualitative research has also been valuable in evaluating policies relevant to musculoskeletal conditions, such as the Expert Patients Programme [32].

The contribution of qualitative approaches to musculoskeletal research is wide-ranging: in-depth studies have brought to the surface the complex experiences of living with pain and disability, and thus allow an understanding of how these are shaped by people’s social and cultural context. The study of therapeutic relationships demonstrates the different belief models that are employed by lay people and professionals. Only through understanding divergence can interactions be changed and improved, leading to more effective processes and outcomes. In terms of methodological advances, the interplay between quantitative and qualitative methods continues to be an area for further debate and development, but there is a significant number of studies that have shown the benefit that can be derived from adopting a broader array of methods. Understanding the complexity of living with musculoskeletal conditions can be achieved if research is carried out at the level of populations and groups as well as at the level of the individual and his or her social networks.

The authors have declared no conflicts of interest.

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References