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To cite this article: Guillaume Dalle, Camila Aloiso Alves, Pascal Clerc & Julien Le Breton (2025) A narrative approach for the management of low back pain in general practice: An in-depth patient interviews study, European Journal of General Practice, 31:1, 2522183, DOI: [10.1080/13814788.2025.2522183](https://doi.org/10.1080/13814788.2025.2522183)

To link to this article: <https://doi.org/10.1080/13814788.2025.2522183>



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Published online: 02 Jul 2025.



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RESEARCH ARTICLE



## A narrative approach for the management of low back pain in general practice: An in-depth patient interviews study

Guillaume Dalle<sup>a,b</sup>, Camila Aloiso Alves<sup>c,d</sup>, Pascal Clerc<sup>a,b,e,f</sup> and Julien Le Breton<sup>b,e,g,h</sup>

<sup>a</sup>Department of Family Medicine, Faculty of Health Sciences Simone Veil, University Versailles Saint-Quentin, Montigny le Bretonneux, France; <sup>b</sup>French Society of General Medicine (SFMG), Issy-les-Moulineaux, France; <sup>c</sup>Department of Health and Society, Faculty of Medicine of Petrópolis (FMP/UNIFASE/Brazil), Petrópolis, RJ, Brazil; <sup>d</sup>Expertise Research Center, University Sorbonne Paris Nord, Villetaneuse, France; <sup>e</sup>University Paris-Est Créteil Val de Marne, Inserm, IMRB, CEpiA, Créteil, France; <sup>f</sup>Multidisciplinary Health Group Philippe Marze, Les Mureaux, France; <sup>g</sup>Faculty of Health, Department of General Practice, University Paris-Est Créteil Val de Marne, Créteil, France; <sup>h</sup>University Health Center Salvador Allende, La Courneuve, France

### KEY MESSAGES

- A biographical approach revealed social factors influencing how individuals manage low back pain.
- Patients with low back pain fall into two main action profiles: the 'risk-taking' profile, where individuals find it difficult to change their habits, and the 'quest for meaning' profile, where individuals reflect on their lifestyle habits and self-functioning.
- Identifying a patient's profile can help physicians personalise care and improve treatment outcomes.

### ABSTRACT

**Background:** The broad range of definitions of low back pain (LBP) and the many associated risk factors on which management strategies are based do not seem to be relevant for general practitioners.

**Objectives:** Given the challenges of treating LBP and its impact on individuals' life, we aimed to explore the lived experiences of LBP patients to better understand their feelings, needs, and the internal and external resources they use for coping and treatment.

**Methods:** We used a comprehensive, qualitative, biographical approach to understand the patient's life events and the origins of these events in social life. First, each patient's life story was analysed individually to understand how they constructed their experiences. Then, a joint analysis identified common themes and overlapping patterns across different patient trajectories.

**Results:** We identified two main action profiles. The first ('risk-taking') reflected a desire for personal independence, where patients struggled to change their habits despite experiencing pain. In the second profile ('quest for meaning'), painful experiences led patients to reflect on their lifestyle and self-functioning, prompting adjustments in their daily habits.

**Conclusion:** A comprehensive approach to understanding the patients' behaviour in relation to their LBP can improve care strategies. General practitioners should consider not only the physical symptoms but also the patient's social and personal context, including relationships, living environment, work activity, limitations, and guiding values.

### ARTICLE HISTORY

Received 9 November 2023  
Revised 7 June 2025  
Accepted 10 June 2025

### KEYWORDS

Low back pain; patient experience; health behaviour; biographical approach; qualitative study

## Introduction

The management of patients suffering from chronic low back pain (LBP) has often yielded disappointing results. The broad range of LBP definitions [1–5] and the many associated risk factors [6–10] (which serve as the basis for management strategies) do not always appear relevant to general practitioners (GPs) and may also create

confusion for patients [11,12]. LBP is primarily a symptom (i.e., pain, without an identifiable organic cause), yet it is frequently used as a diagnosis to explain a patient's condition [13]. Given the lack of a single specific treatment, the biomedical approach to chronic LBP was redesigned in the 1990s, and for early-stage LBP, in recent years. The aim has been to adopt a broader

**CONTACT** Julien Le Breton [j.le.breton.com@gmail.com](mailto:j.le.breton.com@gmail.com) Centre de Santé Universitaire, 2 mail de l'Égalité, F-93120 La Courneuve, France.

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biopsychosocial model to better address this complex condition. Despite extensive literature on the topic, LBP remains challenging to treat. Applying the same standardised medical approach to all patients with LBP is likely inappropriate. Faced with the challenges and given the profound impact of LBP on individuals' lives, we hypothesised that exploring the patient's lived experience could offer deeper insights into their feelings, needs, and of how they utilise internal and external resources to manage their condition. A patient's experience is shaped over a lifetime, and understanding the disease trajectory and lessons learned could lead to a more effective and ethical approach to LBP management. By gaining insight into patients' experiences, the obstacles they face, and the constraints that shape their ability to act, we may develop a new LBP management strategy based on shared decision-making between patients and physicians.

To improve the quality of care, this study aimed to explore the biographical pathways of LBP patients, understand their representations of LBP, identify typologies of patient action profiles (i.e. recurring attitude in daily disease management), provide physicians with experience-based insights to improve care, and inform the adaptation of prevention strategies where relevant. By sharing knowledge derived from these patient perspectives, we can help practitioners develop more personalised care plans, ultimately reducing the risk of ineffective treatment. Our aim was to understand patients' lived experiences in managing LBP: how they perceive the course of treatment and practical recommendations, what knowledge they have acquired about acute LBP, and how they experience the expectations placed on them by healthcare professionals regarding LBP management.

## Methods

### Study design

We used a qualitative, comprehensive and biographical approach [14], in order to gain the health events experienced by patients from the onset of LBP symptoms and the resulting impacts on the social dimensions of their lives.

### Epistemological positioning of the narrative study

A narrative approach has enabled us to observe how patients relate their experiences in space and time, cope with their difficulties, integrate these difficulties into their life course and live through the changes induced by their illness [15].

### Recruitment and participants

The study population consisted of patients aged 18 and over, French-speaking, with chronic LBP invited by GPs in the Ile-de-France (greater Paris) region of France, which includes both urban and semirural environments. All the participating GPs were affiliated with a university for the supervision of trainee GPs. The GPs were contacted by e-mail or phone and invited to select patients who met these inclusion criteria. The patients who agreed to participate were called back in order to book a slot for an interview in their GP's practice, in a dedicated room.

### Data collection

A semi-structured interview guide was produced after identifying the main aspects linked to the management and experience of LBP in the literature (Table 1). This guide was structured with open-ended questions to allow patients to talk about their experience with their symptoms. Based on the content of their story, follow-up questions were asked to explore the following aspects in greater depth: onset and manifestation of symptoms, psychological and emotional impact, perceived causes and contributing factors, effects on personal and professional life, coping strategies, self-management and learning, knowledge gaps and expectations, messages for others, final reflections.

The patient interviews were conducted by the lead author (GD), trained by a psychosociologist (CAA), over the 6-month period from February to July 2019. Three pilot interviews were conducted, in order to test the relevance of the main questions. The interview guide was slightly adjusted after the pilot phase, and other patients were contacted. After the patient had given his/her verbal consent, the interview was recorded (using a dictaphone) and then transcribed. During the data collection phase, follow-up meetings were organised by the authors to reflect on the phenomena studied in relation to the data collected and the study objectives.

### Data analysis

Analysis was divided into two steps: first step, focused on the interpretation of each individual story; second step, focused on the analysis of all the stories in order to find the points of convergence and intersection between the different journeys and lived experiences, with regard to our aim of discovering a typology of patient action profiles.

In step 1, all interviews were transcribed, then each interview was individually interpreted. This work began

**Table 1.** Interview schedule.

Main questions	Sub-questions <sup>a</sup>
1) Can you tell me your story?	<ul style="list-style-type: none"> <li>• How and when were you informed about your condition?</li> <li>• How did the symptoms first present or manifest themselves?</li> <li>• What were your mental, psychological, and emotional reactions to the diagnosis?</li> <li>• What do you believe caused or contributed to your problems?</li> <li>• How has this condition affected your personal and professional life?</li> </ul>
2) What helped you? What enabled you to cope?	<ul style="list-style-type: none"> <li>• What have you put in place to cope? Comment?</li> <li>• What helped you? What treatment? What devices?</li> <li>• Who helped you? What meetings?</li> <li>• How is the relationship with your family and professional environment?</li> </ul>
3) What did this teach you?	<ul style="list-style-type: none"> <li>• What have you learned about yourself and your ability to manage the condition on your own?</li> <li>• What did you have to learn to do that you wouldn't have needed to learn if you hadn't been sick?</li> <li>• Tell me how you learned this.</li> <li>• What have you learned about how your body responds to the symptoms of your illness and to treatments?</li> <li>• How did you learn to push the limits? To take risks, to protect yourself?</li> <li>• How are you informed about how to position/defend/protect yourself in social and professional life?</li> </ul>
4) What knowledge might you lack to deal with your back problems? And what are your expectations regarding the care plan?	
5) Based on your experience, what knowledge and messages would you like to convey to other patients? To caregivers? To those around you? Based on everything we have just discussed and the research objective, do you have anything to add that we have not covered?	

<sup>a</sup>The sub-questions were asked to delve deeper into the main questions based on the content of the participants' responses.

with two moments of reading, which enabled us to identify the way in which each patient had constructed his or her story through the different forms of discourse, the recurring motifs in the narrative, and the patterns of action constructed [14], showing how each patient had articulated and integrated the illness into his or her life and biographical construction process. In addition, a chronological timeline was constructed with the most significant elements evoked in each story, the phases through which the patients passed, in connection with the treatments and interventions proposed during the care project. These timelines were used to create an inventory of the experiences that make up each patient's journey, thus enriching the interpretation.

The analysis phase (step 2) focused on the collective dimension of patients' experiences.

At the end of this work, we were able to understand how each patient lived through the experiences surrounding the disease and developed learning and ways of acting depending on how they integrated and articulated the disease in their biographical trajectory. This made it possible to identify main patient action profiles defined as a recurrent attitude observed in the patient's relationship with to the disease, situations, and events, and the way in which patients act, react and manage their everyday life with the disease).

## Results

We interviewed 13 patients with LBP (4 men and 9 women; mean age: 52; age range: 25 to 73) (Table 2), with an average mean duration of 52 min (range: 44 to 67). The interviewees came from various socioprofessional categories and included workers, managers, retail workers, farmers, employees, and retirees.

**Table 2.** Characteristics of the participants.

Patient	Gender	Age	Professional background	Duration of the LBP
1	Male	60	Butcher/Electrician/Road maintenance worker	1–2 years
2	Female	25	Nursing assistant	< 6 months
3	Female	54	Receptionist/Childcare/Job seeker	< 6 months
4	Male	68	Maintenance worker/Firefighter/Retired	> 2 years
5	Female	68	Nursing assistant/Retired	6–12 months
6	Female	73	School catering/Retired	> 2 years
7	Male	33	Aeronautical mechanic	1–2 years
8	Female	47	Farmer	> 2 years
9	Female	42	Nursing assistant	< 6 months
10	Female	51	Specialised territorial agent for nursery schools	< 6 months
11	Male	52	Plumber/Heating technician	< 6 months
12	Female	44	Accounting manager	> 2 years
13	Female	60	Order picker	> 2 years

### Patient action profiles

The patients' biographical experience revealed different ways of coping with disease, depending on the relationship between the lived events on one hand and the personal characteristics, perceptions, and the patient support network on the other hand. Our analysis of all the pathways revealed two main patient action profiles (Table 3).

### Dealing with the disease through a pattern of risk-taking

#### Features

In this first action profiles, the patients sought to reconcile their work options with their personal interests or skills. They tried to find ways to stay at work and continue their everyday activities but did not consider the changes possibly imposed by the disease. LBP had not led to transformations in the patients' lifestyles and the way they dealt with LBP at work: 'So, that's it,

**Table 3.** Two main patient action profiles.

	Dealing with disease: risk-taking	The quest for meaning and progressive exploration of the disease
Features	<ul style="list-style-type: none"> <li>• Low back pain does not mark the beginning of a new life, i.e. no change in the personal or professional lifestyle of patients before and after the pain</li> <li>• Cope with his/her pain at work, maintaining his/her activities despite the known risks</li> <li>• Perception of low back pain by the patient who is poorly represented in society</li> <li>• Strong/stubborn/impulsive character</li> <li>• Beyond its limits</li> <li>• Relies on circumstances</li> </ul>	<ul style="list-style-type: none"> <li>• Progression: exploration of situations and progressive construction</li> <li>• Search for meanings in his/her pain</li> <li>• Listens to his/her body and its pain</li> <li>• Anxious character trait, search for answers</li> </ul>
Consequences in daily life	<ul style="list-style-type: none"> <li>• Neglect</li> <li>• Lack of adaptation, keeps the same action pattern, the same risky behaviour</li> <li>• No questioning of actions</li> <li>• Enters a care pathway when pain is no longer tolerated and leads to incapacity/handicap</li> <li>• Hardly verbalises his/her complaints</li> </ul>	<ul style="list-style-type: none"> <li>• Development of adaptation strategies in professional and/or personal life</li> <li>• Avoidance of painful situations</li> </ul>
Impact on treatment monitoring	<ul style="list-style-type: none"> <li>• Palliative treatment (to alleviate pain)</li> <li>• Difficulties in complying with treatments</li> <li>• Non-compliance with the advice given</li> <li>• No questioning of professional practices</li> <li>• Not sensitive to prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Enters the care pathway easily and personal investment (proactive)</li> <li>• Better compliance with treatments</li> <li>• Explores situations by experiencing care via different media, outside the care pathway</li> <li>• Asks those around you (care advice, human help)</li> <li>• Development of non-drug strategies to reduce pain (physical activity, muscle strengthening, etc.)</li> <li>• Receptive to prevention advice (secondary prevention)</li> <li>• Feels invested in having to disseminate prevention advice to those around them (primary prevention)</li> </ul>

*we're going to change jobs, we're going to change lives, we're going change ... (in an ironic tone). [...] But I like doing that so... It won't prevent me from living my life. [...] Because it's my life it's like that, it's like that! As long as we hold on, we will hold on' (Patient #8).*

The patients stated that work had become a highly important element in their lives. In order not to interrupt their work activities or lose their job because of LBP, they preferred to maintain their daily activities to the detriment of their health. This coping strategy was reinforced by strong character traits: *'So, he told me: "Don't go back to work". But... stubborn! (laughs) [...] So I went back to work, and the same day it happened again' (patient #5).* These personal characteristics appeared to prompt patients to trigger a self-maintenance dynamic by repeating harmful habits acquired before symptom onset and the LBP diagnosis. The patients sought to 'push through' the pain and maintain their previous professional and non-professional activities, despite the risks.

Despite the strategies implemented to maintain activities and continue the previous rhythm of life, living with pain was mentioned as an element that marked the patient's daily life: *'We already felt that it was pulling a little then we continued to do what we didn't have the right to do then at some point it doesn't pass anymore. [...] I always go over the limit' (Patient #8).*

Another relevant aspect concerned ageing and the perception of a decrease in the ability to bear the

LBP-related pain: *'Well, we are getting old, huh?! We support pain a little less huh! [...] Because it is true that as we get old, we are still doing the same job huh! And in the end, it... It goes on, it continues and at the end we are in too much pain' (Patient #4).*

Ageing and the persistence of the problem appeared to be two elements that prompted patients to link the LBP to their circumstances. So, the patients placed themselves in a position of 'seeing it coming' without thinking about their past actions and the present and future impacts: *'Because it's my life, it's like that, it's like that! As much as we hold, we will hold and afterwards there will be a surgery, and there we go!' (Patient #8).*

The patients' devaluation of their symptoms and the representation of LBP as an event of minor importance to society (with no visible signs) help us to understand their relationship with health professionals and the continuity of care in their daily lives: *'Well, my back hurts [...] Yeah, it's nothing. For me it's nothing. [...] We won't cry for a bobo huh!' (Patient #13).*

### **Consequences in daily life**

The patients' life stories show that this profile had several consequences: (i) persistence of pain during maintenance of the same activities: *'We were in pain, good bah... We kept the pain for three, four days and then boom! It happened and then presto! We started again!' (Patient #4);* (ii) neglect or lack of consideration for the pain, without questioning previous past

actions: *'We feel that it pulls behind, that it is close to get stuck but hey we continue to live like that day in, day out'* (Patient #8); and (iii) a decision to seek medical care only when the pain became unbearable or caused disability: *'I very rarely go to doctor. [...] I really go when I'm at the end of my tether'* (Patient #13).

### Impact on treatment monitoring

This action profile had an impact on treatments: (i) poor adherence *'No because it's happened twice, he prescribes it [a lumbar support belt], I wear it for two days and then I stop'* (Patient #8); (ii) a tendency to self-medicate: *'I take my paracetamol [...] when it's not very painful, codeine when it starts to increase and when I don't want it anymore I go to see the osteopath'* (Patient #13); (iii) non-compliance with health professionals' advice on preventing the recurrence of pain: *'It's not possible so I go against what he also gives me as prescriptions, in addition to everyday life advices. [...] It's because I don't do what THEY ask me to do'* (Patient #8); (iv) a quest for ways of alleviating the pain and maintaining activities: *'We have tables and so I massaged my back on the table. [...] When I was in pain and I couldn't move, I had to work so I had to find an immediate solution. [...] And suddenly I was leaning on it and that relieved me'* (Patient #13); (v) little consideration to prevention and the resumption of old habits at the end of a pain attack: *'When you learn before with when you bend down you have to bend your knees, all that, when you don't have back pain, you don't do it, huh'* (Patient #8).

### The quest for meaning and progressive exploration of the disease

#### Features

The second action profile that emerged from the participants' life stories highlighted the need to understand the aetiology and mechanisms of pain: *'Already to understand better what a herniated disc is [...] It made me allowed to understand how it works'* (Patient #7). However, this quest for meaning has been shown to be associated with the triggering of anxiety states. This is an element that marked the patients' narrative: *'I had an anxiety-provoking state but not about pain. Really tell me how I'm going to manage because...'* (Patient #2).

The deep pain experienced was considered to be a learning event in which strategies were sought, tested and implemented: *'...during my pregnancy, I also changed my mattress because I thought that it might come from that, so [...] we bought a memory foam mattress'* (Patient #2). The patient tested new treatments and sought to learn, in order to better understand the

disease and better manage life with the disease: *'Keeping observing myself, I know what I can do and what I won't be able to do. [...] No, I also learned a lot by myself...'* (Patient #9).

### Consequences in daily life

This action profile resulted in the application of an adaptive coping strategy to the patient's personal and professional lives, in order to avoid painful situations: *'Gradually, I changed my way of doing things. For sport, for my general well-being, little by little, and I had a period when I really felt better, in fact'* (Patient #12).

### Impact on treatment monitoring

The elements that characterised this action profile influence the treatment of LBP in several ways. The first aspect concerned the patient's involvement in and commitment to the treatment process: *'I'm trying to do everything I can to feel better! [...] I found a general practitioner, who works in [city name], who did a thesis about the back, which therefore deals with patients with back problems and which created a school dedicated to the back pain'* (Patient #9).

The second aspect concerned better compliance with the treatments recommended by healthcare professionals: *'The doctor told me that I needed to strengthen my back a little bit. [...] Because it will help to no longer have this lumbago. So, I'm going to... I'm going to do some sport'* (Patient #11). With regard to regular physical activity, the patients reported that muscle strengthening exercises and reduce need for medication symbolised a possibility of being less dependent on medication: *'I don't want any medications, so I have to find an alternative [...] After that, a few years later, I tried to do some sport. [...] It was absolutely essential to strengthen my lower back, my abs to hurt myself less and less often.'* (Patient #10).

The third aspect referred to experimentation with complementary and alternative treatments: *'She advised me to do acupuncture. [...] Also, to do orthopaedic soles because I was wobbly. [...] So, I made the soles, I did acupuncture, and at the same time the acupuncturist doctor did mesotherapy'* (Patient #9).

Activating support network in seeking help or advice appeared to be further aspect related to treatments: *'I tried several things from friends or colleagues' advice who had been relieved well I tried that too huh!'* (Patient #12).

This set of factors had positive influences on the patients' care trajectory and was reflected in the patients' use of pain prevention practices: *'I try a maximum of... To do what we learned in training'* (Patient #7).

The adoption and development of knowledge about LBP led patients to share their experiences with relatives, in order to help the latter avoid developing this health problem: *'So I give good advice to my daughter to avoid being in my situation later'* (Patient #3). We found that as the patient went through these pain episodes, the learning process developed via a reflexive interaction between experiments and a quest for recovery: *'I started doing sport and I saw the benefits right away. [...] We worked with abdominal crunches, and I think this may have also contributed to weight loss and also continuing to feel better on my back'* (Patient #12).

## Discussion

Our data on how each patient experienced LBP allowed us to identify two main action profiles. The first profile (risk-taking) reflected a desire for personal independence, where the patient 'copes' with LBP without altering their lifestyle (despite the pain) and finds it difficult to change their habits. The priority for these patients is to maintain the habits they had before the onset of LBP. As a result, they often move back and forth along the care pathway. For the GP, the challenge lies in not underestimating the significance and severity of LBP, especially when the patient rarely voices their complaints or even neglects them. The key issue is helping the patient recognise the potential seriousness of the condition, including the risk of progressive worsening, and the preventive measures that should be taken. The GP will need to apply tools from motivational interviewing to support the patient in making the necessary changes.

In the second action profile (quest for meaning), anxiety and curiosity about the pain led the patient to question their lifestyle, habits and their daily activities. The experience of pain and limitations seemed to encourage the patient's active involvement in the care process, sparking a learning process and motivating changes in certain life habits. As a result, these patients became more aware of the benefits of regular physical activity and adopting proper postures. Their lived experiences, the knowledge gained from those experiences, concerns about the condition, interactions with health professionals, and advice from family members all contributed to shaping a new pattern of actions in the patients' life stories.

## Strengths and limitations

To the best of our knowledge, this is the first study to explore the biographical pathways of LBP patients to identify social factors influencing how they manage

their condition. This approach seeks to capture patients' experiences and the constraints that determine their ability to act, in order to gain a more comprehensive understanding of the complexity of each patient's pathway. This approach mobilises the life story by inviting the participant to tell his or her story, organising it diachronically and chronologically. It enables access to the knowledge, explanations and meanings that each patient constructs as a function of the events shaped by their disease. This provided a deeper understanding in the patients' mental representations of their illness and health, their environment and their educational needs. A semi-structured biographical interview proved to be the most suitable method for initiating field research on how the patients' life course with the disease had been built, compared to other methods like focus groups [16]. The use of a two-step method (interpretation and analysis) enhanced the validity of our findings, as well as the credibility, stability and reliability of the researchers' interpretations.

However, our study has some limitations. Based on our results, we cannot determine whether there is a natural transition from one action profile to another or if each study participant maintained the same profile over time. These profiles should be seen as general trends influenced by individual life contexts, emerging from a hermeneutic approach that deepens our understanding of patients' life paths. They are not fixed and may evolve as patients gain new experiences and knowledge. Additionally, the translation of patient quotes from French to English may have led to slight nuances being lost.

## Comparison to existing literature

Although numerous risk factors for LBP have been identified [8,17], studies suggest that GPs are more influenced by their patients' life history and concerns [18] than by medical guidelines [19]. This indicates that the concept 'risk factors' is context-dependent and may sometimes be inappropriate or even misleading in the diagnosis and management of LBP. Qualitative studies have shown that patients assess their satisfaction with LBP management based on two key aspects: care structure (access, waiting times, consultation duration, and financial, administrative and bureaucratic costs) and care process (including the caregiver's personal and professional attitudes, the quality of information provided, and the patient's engagement in their care plan, treatment, outcomes, and follow-up) [20–22].

Our findings suggest that patients' narratives and care trajectories contain key factors that can help physicians better understand the manifestation of LBP.

These elements should be integrated into a contextual diagnosis, allowing GPs to distinguish between different action profiles and tailor their interactions accordingly. For GPS, the challenge is twofold: for some patients, it involves raising awareness and helping them recognise important health-related behaviours; for others, it requires providing positive reinforcement, support, and, when necessary, correcting misconceptions or mistakes to ensure better health outcomes. A key priority is identifying patients in the 'risk-taking' profile, as they often require more time and effort to improve care management. From this perspective, the patient should be seen as a multifaceted individual interacting with their environment, rather than merely someone with a disease. This shift in approach can help strengthen the physician-patient relationship [23–25]. Managing LBP may also be facilitated by understanding how patients adapt and defend themselves against pain, incorporating person-centered care [18] and lifelong learning [26] principles into treatment strategies. Future research should explore how clinical diagnoses interact with the action profiles identified in this study. Our results suggest that action profiles are not strictly determined by the type or severity of the condition (e.g., herniated disc vs. no herniated disc) but are also shaped by patients' psychological, behavioural, and adaptive responses to LBP. A deeper understanding of this interplay could lead to improved prevention and treatment strategies, fostering more personalised approaches to LBP management.

## Conclusion

Our analysis of the life courses of patients with LBP revealed two distinct behavioural profiles: 'risk-taking and' and 'quest for meaning'. Caregivers should adopt a listening attitude and recognise the disease experience as an integral part of patient education and assessment. Moving away from standardised, one-size-fits-all approaches will allow for more personalised and effective LBP management.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

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