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Review Article (Meta-Analyses)

Lived Experiences of Older Adults With Chronic Low Back Pain and Implications on Their Daily Life: A Metasynthesis of Qualitative Research

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Abstract *Objective:* To synthesize and conceptualize the lived experiences of older adults with chronic low back pain (CLBP) by systematically reviewing qualitative studies.
Data Sources: CINAHL, PsycINFO, and PubMed were searched from their inception years (1961, 1967, and 1996, respectively) to September 2023 to identify qualitative studies on the lived experiences of older adults with CLBP.
Study Selection: Eligible qualitative studies included published journal article with qualitative design and analysis, and participants aged ≥65 years with chronic nonspecific low back pain (LBP) that lasted for over 3 months. Of 3669 citations screened, 17 studies met the inclusion criteria.
Data Extraction: Findings were analyzed using metasynthesis. Two reviewers independently conducted study selection and data extraction, and the methodological quality of each included study was assessed using the Consolidated Criteria for Reporting Qualitative Research framework.

List of abbreviations: CLBP, chronic low back pain; LBP, low back pain.

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Data Synthesis: Six themes emerged from the analysis: (1) perceived causes of CLBP; (2) interference with daily living; (3) family dynamics; (4) social life; (5) emotional responses to CLBP; and (6) coping strategies. Collectively, CLBP negatively affected older adults' personal, family, and social life to varying extents. Suboptimal LBP management could lead to negative emotions (eg, depression) and avoidance behaviors. Accepting and adapting to the presence of CLBP, along with a clear diagnosis of LBP, might promote self-management. Conversely, comorbidities and rumination might hinder self-management efforts.

Conclusions: Given that the acceptance (acknowledging and adapting to the pain) of CLBP improves self-management of pain in older adults, clinicians should pay attention to the concerns of older adults with CLBP, understand the negative effects of CLBP on them, and provide personalized education and management strategies to enhance their self-management and engagement in value-driven actions.

Low back pain (LBP) is highly prevalent among older adults aged ≥65 years,[1-4] with over 17 million experiencing episodes of LBP annually in the United States.[5] The reported global prevalence of LBP in older adults aged ≥60 years ranged from 21% to 75%.[6] Chronic LBP (CLBP) that lasts for at least 3 months[7,8] may occur in over 30% of community-dwelling older adults,[9] leading to physical disability,[10-12] psychological distress,[8,13] and suboptimal health-related quality of life.[3,8,14-17]

Compared with working-age adults, older individuals may face additional physical[8,13,17,18] and psychosocial[13] challenges when dealing with CLBP.[8,19,20] CLBP can hinder not only their ability to perform activities of daily living (eg, household chores or grocery shopping) but also contribute to accelerated cognitive decline[21] and an increased risk of falls.[22] Additionally, the high prevalence of comorbidities alongside persistent pain may lead to negative mood or depression, which is common in older adults.[9,23-27] Although older adults may have retired, they often have caregiving roles and household responsibilities toward their spouse and descendants, and the presence of CLBP may negatively affect their family dynamics.

Despite the significant impacts of CLBP on older adults, this population remains underrepresented in research.[28] Whereas quantitative studies provide valuable insights into the effects of CLBP on pain and function,[29] qualitative research captures older adults' feelings, nuanced thoughts, and reactions through interviews or observational data.[30] This approach is crucial for understanding behaviors and shaping tailored health care policies.[31]

Although there is an increasing number of qualitative studies investigating the lived experiences of older adults with CLBP, no systematic review has summarized the relevant findings. Qualitative metasynthesis is an emerging research method in the medical and rehabilitation field to analyze findings from multiple qualitative studies.[32-34] This approach identifies themes from various qualitative studies, compares, synthesizes, and draws conclusions based on qualitative evidence. By adopting qualitative metasynthesis to reanalyze primary data,[35] it provides a more comprehensive understanding on how CLBP affects the lived experiences of older adults, informing the development of policies and clinical guidelines.[31] Therefore, this study synthesizes and conceptualizes these experiences to answer 2 key questions: (1) What are the common themes emerging from qualitative studies on the effect of CLBP on older adults' daily activities and routines? and (2) How can these themes be structured into a conceptual framework to further illuminate the lived experiences of older adults with CLBP?

Methods

Protocol and registration

This review protocol was registered in PROSPERO (registration no. CRD42018091292) and was published elsewhere.[36] The reporting followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines.[37]

Search strategy

The search procedure was detailed in the published protocol.[36] A comprehensive search was conducted using PubMed, PsycINFO, and CINAHL from their inception years (1961, 1967, and 1996, respectively) to September 30, 2023. Keywords and medical subject headings related to qualitative research (such as anthropology, medical, focus groups, grounded theory, hermeneutics, qualitative research, interviews, narration, health services research, phenomenology), lived experience (such as, activities of daily living, life change events, activit*, ADL, "daily life," "everyday life," "life chang* event*," "self-care"), chronic nonspecific low back pain (such as low* back pain, radiculopathy, sciatica, "chronic LBP," CLBP, "chronic back pain," "chronic backache," "chronic lumbar pain," "chronic lumbosacral pain," "chronic spinal pain," "low* back pain," lumbago), and community-dwelling older adults (such as aged, retire*, elderl*, frail*, older*, geriatr*, "old* age") were used to identify relevant studies (supplemental appendix S1, available online only at http://www.archives-pmr.org/). Forward citation tracking was conducted using Scopus to identify potential publications that cited the included studies, whereas backward citation tracking was conducted by screening the reference lists of the included studies. The corresponding authors of the included studies were contacted by email to identify additional relevant papers.

Selection of studies

Peer-reviewed studies were included if they: (1) were published in English, French, German, Spanish, Swedish, or Chinese; (2) involved qualitative research with a qualitative analysis; (3) recruited participants aged ≥65 years with chronic nonspecific LBP, defined as pain between the rib cage and the gluteal sulcus not extending beyond the knee[38] lasting for at least 3 months, and unrelated to osteoporosis, infection, tumor, fracture, cauda equina syndrome, or inflammatory disorders.[39] The international research team was able to screen articles and extract data in multiple languages. There were no limitations regarding the types of qualitative designs in the current metasynthesis based on the suggestion from studies discussing the methodology of metasynthesis.[33,40] Studies were excluded if: (1) they used mixed methods where qualitative data could not be extracted; (2) the data analysis lacked the necessary conceptual depth (ie, assessed as containing only nontranslatable second-order concepts)[41]; or conference abstracts or proceedings, theses, case reports, commentary, or gray literature.

A 2-stage screening approach was conducted. At the first stage, 2 independent reviewers (C.C. and E.C.) screened titles and abstracts to identify potential abstracts for full-text screening. Any between-reviewer disagreements were resolved through discussion. If disagreement persisted, the article under scrutiny was included for full-text screening. At the second stage, all selected full-text articles were retrieved. The full-text screening procedures were identical to the abstract screening procedure. Any disagreements were resolved through discussion. Unresolved disagreement was determined by a third reviewer (A.W.).

Data extraction and synthesis

This review used the approach of metasynthesis,[42] which is the most commonly used method in health services research for synthesizing qualitative research findings. Metasynthesis[42] is an interpretative form of knowledge synthesis that generates conceptual framework for health care practice and policy, rather than merely providing a description of knowledge findings. Our metasynthesis followed the principles outlined by Noblit and Hare.[42]

Relevant data from the included studies were extracted and summarized in a table to outline the characteristics of each study.[41] The data included study identifiers (the authors' names, publication year); and key categories for comparison: country of study, income level of the country, sample size, percentage of female participants, mean or median age of participants, study setting, study objectives, methodological approaches, key themes, theories, and quotations. Additionally, first-order and second-order constructs were extracted. The first-order construct[43] represents the experiences perceived by study participants, whereas the second-order construct refers to the researchers' interpretation of the first-order constructs. Two independent reviewers (C.C. and E.C.) analyzed the data and extracted the concepts that elucidated the data. If there was a discrepancy regarding the perceived second-order construct between the 2 reviewers, a third reviewer (A.W.) was consulted. The extracted second-order constructs were transferred to a synthesis matrix, which was used to analyze similarities and differences between studies included. Lines-of-argument synthesis was used to help interpret the concepts across studies to construct the main conceptual framework and synthesize the superordinate themes.[42]

Quality appraisal of the included studies

Two out of 3 reviewers (C.C., E.C., or A.W.) independently assessed the methodological quality of each included study using the 32-item Consolidated Criteria for Reporting Qualitative Research framework.[44] The Consolidated Criteria for Reporting Qualitative Research checklist assesses 3 domains (research team and reflexivity, study design, as well as analysis and findings) and the reporting of data. Any disagreements were resolved through discussion among the reviewers. The assessment framework did not exclude studies based on methodological quality because of the absence of predefined cutoff points or a consensus on the optimal approach for appraising qualitative literature.[45] It is important to note that 2 of the included papers were derived from the qualitative evaluation of the same cohort at different timepoints, and they were treated as distinct articles for quality appraisal.

Results

A total of 2571 records were identified through the electronic search (fig 1). After removing duplicates, 2493 abstracts remained for screening. Additionally, 1098 abstracts were identified through backward and forward citation tracking. Seventy-eight articles were retrieved for full-text screening. Seventeen studies were included in the metasynthesis. The reasons for exclusion included an inability to identify quotations from older adults, no involvement of older participants, lack of relevant quotations from older adults, only focusing on treatment results, quantitative research, or studies involving older adults without CLBP.

All the included studies collected their data through focus groups or individual interviews. A total of 106 older people (ranging from 1 to 25 participant(s) per study) from 9 countries/regions (ie, Australia, Chile, Ethiopia, Hong Kong, New Zealand, Nigeria, Switzerland, the United Kingdom, the United States) were involved. Fifteen studies were conducted in high-income countries, whereas 2 studies took place in lower-middle-income (Nigeria) and low-income (Ethiopia) countries. The qualitative approaches included: interpretative phenomenological analysis (n=4), thematic analysis (n=4), thematic content analysis (n=4), framework approach (n=3), phenomenology (n=2), and grounded theory (n=2). The characteristics of the included studies are summarized in table 1.

Quality appraisal

The comprehensiveness of reporting varied among the included studies, with scores ranging from 14 (44%) to 27 (84%) of the 32-item Consolidated Criteria for Reporting Qualitative Research checklist. Several of the included

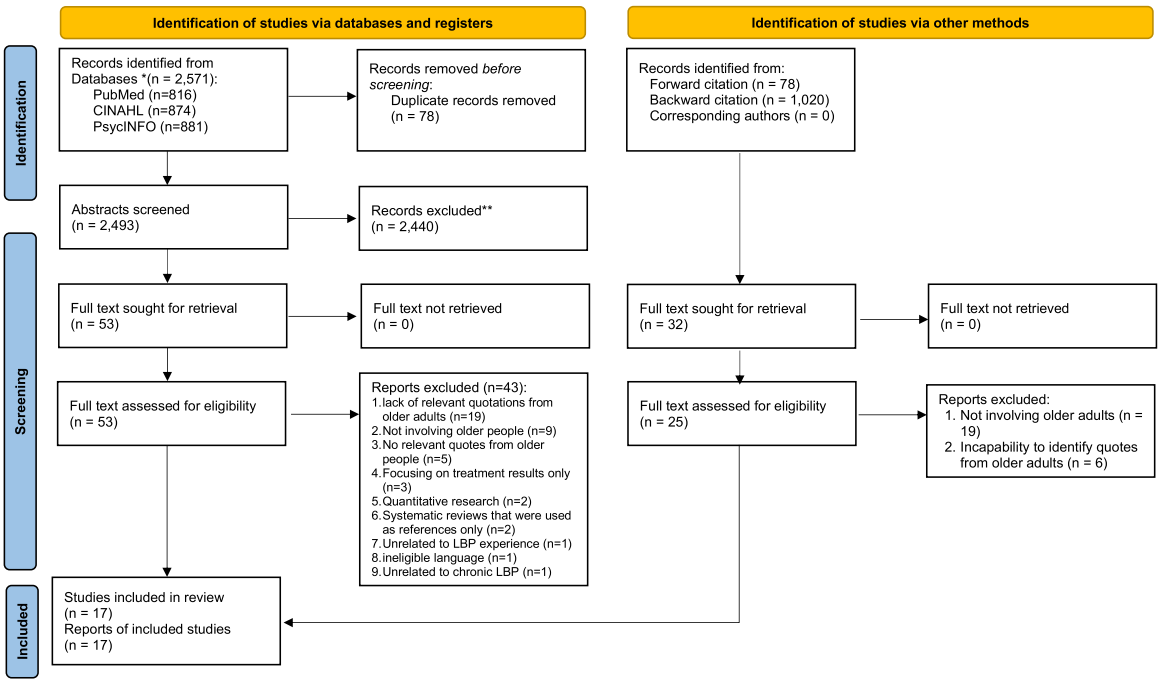

Fig 1 Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) flowchart of study selection process.

studies lacked reporting on items within the research team and reflexivity domain (eg, credentials, occupation, sex, or qualification of the interviewer). Two items, namely participant's knowledge of the interviewer, and interviewer characteristics (eg, bias or assumptions) were not reported in any of the included studies. However, all of the included studies provided information on the methodological orientation and theory, sampling methods, sample size, sample description, interview guide, repeated interviews, derivation of themes, consistency of data and findings, and clarity of major themes.

Superordinate themes

Six superordinate themes were synthesized from the reviewed studies (table 2).

Perceived causes of LBP

Attributing causes despite unexplainable origin

Nonspecific CLBP lacks an identifiable cause despite thorough medical examination.[63] However, older adults often attributed their pain to various factors,[46-48,50,51,60,61] such as previous work-related factors,[49,50] psychological distress,[50] inadequate access to treatment,[50] and spiritual beliefs.[51-60] Interestingly, 2 included studies revealed that older participants with CLBP actively sought legitimate reasons for their pain to gain trust from health care professionals and others.[60,61] Without a definitive cause, these individuals often experienced being medically and socially overlooked and struggled to be taken seriously.[20,62-67] They perceived that others did not acknowledge their invisible pain.[61] Therefore, they would attribute their pain to a "reason" or "story" beyond their control to legitimize it.[60,68]

Interference with daily living

Impairment of daily activities and function

Some included studies reported that CLBP significantly disrupted participants' ability to perform daily tasks and fulfill social roles.[46,48,50,53,57,62] Simple tasks, such as housework, carrying heavy objects, or driving became difficult, leading to increased reliance on others for assistance.[59] Some older individuals expressed frustration and distress over the loss of physical abilities because of spinal pain.[69] They considered the loss of functional performance in daily tasks as a significant challenge in maintaining family and social roles (see "Family dynamics" and "Social life" sections). This evoked a range of emotions (see "Emotional responses to CLBP" section) and led to the adoption of passive coping strategies (such as avoidance behaviors), and active strategies, such as accepting pain and modifying their lifestyle through careful task planning and necessary adjustments (see "Coping strategies" section).[53,59]

Family dynamics

Burdening family members

CLBP limited older individuals' ability to perform housework,[53] work,[50] and participate in family activities, such as outdoor events, or birthday celebrations.[57] This often led to reliance on family for daily tasks, finance support, and personal care (such as toileting),[53] straining family relationships.[47,49-51,53,57,62] The shift from caregiver to care receiver roles affected both older adults and their families.[47,51,53] For instance, one woman with CLBP struggled to transfer her husband from his wheelchair, altering her social role.[53] Many individuals were saddened by this shift, worried about negatively affecting their children's work and lives,[49,50] and feared becoming a "burden."[49,53,62] These concerns threatened their sense of self.[70-72] Some expressing thoughts such

Table 1 Characteristics of included studies

Lead Author(s)	Country or Region	Country's Income Level	Country's Cultural Origin	Sample Size (% Female)	Methodological Approaches	Percentage of Older Adults in the Cohort and Their Age Range	Setting	Study Aims	Key Findings
Bourke et al[46]	Northeast of England, United Kingdom	High	English-speaking (Individualistic)	9 (44)	Grounded theory	44.4% (4/9), 67-73 (2M, 2F)	A private room at the recruitment site (National Health Service outpatient physical therapy department)	To identify the experience of CLBP self-management for patients attending outpatient physical therapy and assess how the experience of CLBP self-management changes over time	Six subthemes: (1) self-doubt, (2) coping day to day, (3) independent discovery, (4) developing resilience, (5) health care: opportunity and threat, and (6) living with pain differently. Conceptual model: "Fluctuating Uncertainty."
Chala et al[47]	Gondar, Ethiopia	Low	African-Islamic (Collectivist)	15 (47)	IPA	13.3% (2/15), 65-66 (1M, 1F)	Outpatient departments of the University of Gondar hospital in Gondar, Ethiopia	To explore the lived experience of people with CLBP in Ethiopia	Five main themes: (1) CLBP affects life on a day-to-day basis, (2) the invisibility of pain results in misunderstanding, misjudgment, and loneliness, (3) the cause of pain is a mystery, (4) the search for the cure is a quest, (5) each person has their ways of managing, coping, and living with pain.
De Souza and Frank[48]	United Kingdom	High	English-speaking (Individualistic)	11 (55)	Framework approach/ thematic content analysis	9.1% (1/11), 79 (F)	Home	To explore and describe the physical consequences of living day-to-day with CLBP and to document the "insider" accounts of how the pain affects on daily activities	Four themes: (1) sleep/rest, (2) mobility, (3) independence, and (4) leisure.
De Souza and Frank[49]	United Kingdom	High	English-speaking (Individualistic)	11 (55)	Framework approach/ thematic content analysis	9.1% (1/11), 79 (F)	Home	To investigate how individuals experience pain and its consequences for family life and work	Emergent themes were relationships with: (1) spouses and partners, (2) children/parents, (3) with other family and friends, and (4) work-related issues.
Horment-Lara et al[50]	Chile and South America	High	West and South Asia (Collectivist)	10 (100)	Thematic analysis	70.0% (7/10), 67-76 (all F)	Workplace	To explore the beliefs of women with nonspecific CLBP in terms of nature of symptoms, fears associated with pain, expectations for recovery, family, social and work-related limitations, and perceived self-efficacy	Participants described maladaptive beliefs about pain, leading to fearful attitudes and low expectations for recovery.
Igwesi-Chidobe et al[51]	Nigeria	Lower-middle	African-Islamic (Collectivist)	30 (50)	Thematic analysis using framework approach	6.7% (2/30), 67-69 (2F)	Home	To explore the experiences of people living with nonspecific CLBP in a rural Nigerian community	Themes showed that back pain beliefs were related to (1) manual labor/ deprivation, (2) infection/ degeneration, (3) spiritual/cultural beliefs, and (4) rural–urban divide.
May[52]	United Kingdom	High	English-speaking (Individualistic)	34 (59)	Framework analysis	23.5% (8/34), 65-77 (3M, 5F)	ND	To explore patients' perspective and attitudes about back pain and its management using an explorative qualitative approach	Themes: (1) the effects of back pain on their life; (2) perspectives about back pain; its management; (3) their involvement in its management; (4) what strategies they had for self-management; and (5) expectations about the episode of physiotherapy beforehand.

(*continued*)

Table 1 (*Continued*)

Lead Author(s)	Country or Region	Country's Income Level	Country's Cultural Origin	Sample Size (% Female)	Methodological Approaches	Percentage of Older Adults in the Cohort and Their Age Range	Setting	Study Aims	Key Findings
Schoeb et al[53]	Hong Kong SAR, China and Switzerland	High	Hong Kong SAR: Confucian (Collectivist); Switzerland: Protestant Europe (Individualistic)	25 (72)	Inductive thematic analysis	100% (25/25) 68-92 (7M, 18F)	Community centers, clinic	To illuminate older adults' experiences of living with CLBP and its implication on older adults' daily life in Western and Eastern cultures	Three themes on negative perceptions/experiences: (1) interferences of daily function, (2) pessimistic attitudes toward their conditions/prognosis, and (3) self-perceived burden related to families. Four themes on social roles: (1) maintaining their roles in families, (2) experiencing supports from family and friends, (3) being content despite LBP, and (4) enjoying social activities.
Schütze et al[54]	Australia	High	English-speaking (Individualistic)	15 (67)	IPA	20% (3/15), 65-76 (2M, 1F)	Home or clinic	To explore a nascent aspect of pain catastrophizing—metacognition—by documenting people's attitudes toward rumination and examining how these metacognitions might influence the course it takes	Documenting pain metacognitions revealed both positive and negative attitudes toward pain rumination. Both negative and positive metacognitions could fuel perseverative thinking. However, more nuanced negative metacognitions could help to end episodes of rumination by motivating the use of concrete problem-solving or active coping behaviors.
Snelgrove and Liossi[55]	United Kingdom	High	English-speaking (Individualistic)	10 (70)	IPA	20% (2/10), 66-76 (1M, 1F)	Home	To extend existing knowledge by providing a detailed and contextualized understanding of the meaning of CLBP for participants with long-standing experiences of chronic pain	Three themes: (1) maintaining integrity, (2) the crucial nature of the pain, and (3) managing the pain; that highlight participants' understanding of their pain within a biomedical framework.
Snelgrove et al[56]	United Kingdom	High	English-speaking (Individualistic)	10 (60)	IPA	20% (2/10), 66-76 (1M, 1F)	Home	To explore the "lived experiences" of patients with CLBP in the United Kingdom	A main challenge for participants was managing constant unchanging pain experiences and loss across all areas of their lives. Some participants held consistent biomedical understandings of CLBP, continued to focus on the physicality of their pain and adopt a narrow range of behavioral-focused coping strategies and maintained a strong loss orientation. It is proposed that these elements demonstrated embodied experiences and contributed to comprehensive enmeshment of self and pain with little re-establishment of any behavioral activity.

(*continued*)

Table 1 (*Continued*)

Lead Author(s)	Country or Region	Country's Income Level	Country's Cultural Origin	Sample Size (% Female)	Methodological Approaches	Percentage of Older Adults in the Cohort and Their Age Range	Setting	Study Aims	Key Findings
Stensland and Sanders[57]	Midwest United States	High	English-speaking (Individualistic)	21 (62)	Phenomenology	100% (21/21), 66-83 (8M, 13F)	Mostly home	To understand older adults' lived CLBP experience	Under the main theme "It has changed my whole life," results are reflected in 6 subthemes: (1) pain damages sense of self, (2) trapped in a body that does not work anymore, (3) me, my partner, and my pain, (4) pain complicates family relationships, (5) painfully employed, and (6) feeling socially and recreationally repressed.
Stensland and Sanders[58]	Midwest United States	High	English-speaking (Individualistic)	21 (62)	Phenomenology	100% (21/21), 66-83 (8M, 13F)	Mostly home	To understand older adults' lived CLBP experience	Under the main theme "living a life full of pain," results are reflected in 4 existential subthemes: (1) Corporeality: the pain is relentless and constantly monitored, (2) Temporality: to live with pain is to live by pacing day and night, (3) Relationality: pain creates limits that can be tested or obeyed, and (4) Spatiality: manipulating the space around me to accommodate the pain.
Strong and Large[59]	Auckland, New Zealand	High	English-speaking (Individualistic)	15 (73)	Thematic content analysis	20% (3/15), 65-75 (3F)	ND	To explore the coping construct held by individuals with CLBP	Analysis indicated the desirability, if not need, for a somatic focus, the reliance on higher order cognitive strategies for planful action, and the use of a varied repertoire of coping strategies.
Toye and Barker[60]	United Kingdom	High	English-speaking (Individualistic)	20 (65)	Grounded theory	10% (2/20), 66-67 (2F)	Home	To explore how patients with persistent unexplained pain interpret and use the biopsychosocial model	Patients battled through several dialectic tensions in an attempt to legitimize their pain: (1) patients wanted a medical diagnosis but also recognized that psychosocial factors contributed to their pain; (2) although the outward appearance of pain was important to legitimacy, it was also important not to appear "too ill"; (3) meeting others with unexplained pain reinforced credibility, but patients also described how they were not "like the others"; and (4) although holding on to one's self was important, patients also described an acceptance of loss.

(*continued*)

Table 1 (*Continued*)

Lead Author(s)	Country or Region	Country's Income Level	Country's Cultural Origin	Sample Size (% Female)	Methodological Approaches	Percentage of Older Adults in the Cohort and Their Age Range	Setting	Study Aims	Key Findings
Vroman et al[61]	Northeast New England States, United States of America	High	English-speaking (Individualistic)	133 (ND)	Thematic content analysis	ND, 0.8% (1/133), 80 (1F)	Health care facilities (eg, physical therapy, occupational health or ambulatory medical centers, chiropractic or osteopathic clinics)	To examine the broader experience (acute as well chronic) of LBP in the community	Two themes: (1) the challenges to the authenticity of LBP and (2) the consequences of living with LBP, which had 2 threads: the disruption of life due to physical limitations, and the emotional distress incurred.
Wong et al[62]	Hong Kong SAR, China	High	Confucian (Collectivist)	15 (100)	Thematic analysis	ND, 13/15 (86.7%) aged >71 y	On a university campus or in an elderly community center	To investigate the experiences, challenges, concerns, and coping strategies of older women with CLBP in Hong Kong	Five themes: (1) physical effects of CLBP on daily life; (2) psychological influences of CLBP; (3) management of CLBP; (4) family support; and (5) social activities and support.

Abbreviations: F, Female; IPA, interpretative phenomenological analysis; M, Male; ND, no datum(a); SAR, Special Administrative Region.

as "it would be better if I die."[53] Conversely, some received support from family members, ranging from companionship and assistance with daily care to professional support and overall help with daily tasks,[49,53,62] although some found it insufficient or unhelpful.[62]

Social life

Altered social circle

Some included studies found that certain older adults with CLBP received increased social support from friends[48,53] and enjoyed social activities.[53,62] However, other studies highlighted that CLBP hindered social activities, leading to feelings of isolation.[57,62] CLBP-related limitations prevented older adults from participating in previously enjoyed activities, such as dining with friends, evoking negative emotions such as sadness. One individual described giving up hobbies and social gatherings as "traumatic"[57] whereas another experienced "turning into nothing" because of reduced social interactions.[57]

Emotional responses to CLBP

Older adults with CLBP sometimes received increased social support and engaged in activities such as dining out and volunteering, which helped reduce loneliness and improve mood.[73,74] However, CLBP also led to negative emotions, including fear, worry, worthlessness, and hopelessness[47,51,53-55,57,62,69] because of its effect on their physical and social abilities.

Fear and worry for the future

Older adults expressed concerns about the future[57,62] because of persistent pain and the lack of a definitive cure.[64] One participant reported by Schoeb et al[53] shared, "I am worried because many people said it can't be cured. It's hard to cure it at my age." Another said, "I always have back pain, so that's what I am ending up being worried about."[53] Concerns included the prognosis and potential consequences of CLBP, such as fears of falling, losing confidence, severe disability, dependence, or loss of autonomy.[57,62] As one participant reflected, "I am worried that I may not be able to walk anymore."[62]

Diminishing the self to a minimal, nonperson status

Older adults with CLBP experienced a psychological threat to their personal identity described as an "assault on the self,"[75] as described in studies.[47,54,55,57,62,69] This led to feelings of sadness, depression, and worthlessness, with individuals perceiving themselves as "nonpersons." Reduced activity levels to negative self-perceptions contributed to this diminished self-worth. One participant said, "I just view myself as more of an old man than I would have if I didn't have the back pain, I guess. It makes me feel older, and maybe less fun, less active, things that I can't do and you know, I realize when you get older there's — you can't do the things you did when you were younger, but there's things that I wish I could probably do or I worry about doing."[57] Feelings of isolation contribute to a profound sense of loneliness: "There is nothing as bad as living with this pain; it makes you feel inferior to others, to your friends and

Table 2 Themes and subthemes

Themes	Subthemes	Supporting Studies
Perceived causes of CLBP	Attributing causes despite unexplainable origin	De Souza and Frank[48]; Horment-Lara et al[50]; Igwesi-Chidobe et al[51]; Toye and Barker[60]; Vroman et al[61]
Interference with daily living	Impairment of daily activities and function	Bourke et al[46]; De Souza and Frank[48]; Horment-Lara et al[50]; Schoeb et al[53]; Stensland and Sanders[57]; Strong and Large[59]; Wong et al[62]
Family dynamics	Burdening family members	Chala et al[47]; De Souza and Frank[49]; Horment-Lara et al[50]; Igwesi-Chidobe et al[51]; Schoeb et al[53]; Stensland and Sanders[57]; Wong et al[62]
Social life	Altered social circle	De Souza and Frank[48]; Schoeb et al[53]; Stensland and Sanders[57]; Wong et al[62]
Emotional responses to CLBP	Fear and worry for the future	Stensland and Sanders[57]; Wong et al[62]
	Diminishing the self to a minimal, nonperson status	Chala et al[47]; Schütze et al[54]; Snelgrove and Liossi[55]; Snelgrove et al[56]; Stensland and Sanders[57] Wong et al[62]
	Despair because of long-term suffering	Igwesi-Chidobe et al[51]; Snelgrove et al[56]; Wong et al[62]
Coping strategies	Avoidance and withdrawal	Chala et al[47]; Horment-Lara et al[50]; Igwesi-Chidobe et al[51]
	Acknowledging and adapting to the pain (acceptance)	Horment-Lara et al[50]; May[52]; Schoeb et al[53]; Wong et al[62]
	Active strategies	Chala et al[47]; Horment-Lara et al[50]; Igwesi-Chidobe et al[51]; May[52]; Schoeb et al[53]; Stensland and Sanders[58]; Strong and Large[59]; Wong et al[62]
	Positive attitudes	Bourke et al[46]; Horment-Lara et al[50]; Stensland and Sanders[58]

neighbors. I see them go to a market without any problem and I don't have a choice but to stay at home. That makes me feel sad and think less of myself.".[47] The difficulty in curing CLBP added to the distress, with one individual describing it as a "misery-go-round".[54]

Despair from long-term suffering

Older adults with CLBP often express pessimism and a negative outlook on their condition.[51,62,69] Many feel powerless, as one participant noted, "I sit here and watch the people go by,"[69] while enduring persistent pain he believed "it will stay with me for the rest of my life."[62] One participant described CLBP as "a living death" and expressed a preference for death over continued suffering, indicating a state of "suicidal ideation."[51]

Coping strategies

Avoidance and withdrawal

Some older adults with CLBP coped by avoiding and withdrawing from conversations and activities with others.[47,50,51] They preferred solitude over engaging with family or others, and avoided discussion about their condition with those who did not understand ("When people ask me how I was doing, I always say 'I am fine'").[47] Additionally, they avoided bothering family members,[47,50,51] saying things like, "I already had my fun, and now I'd rather stay home and not bother anyone. I try to avoid it at all costs."[50] However, some increased their activity levels to escape distressing thoughts by "evading self."[51]

Acknowledging and adapting to the pain (acceptance)

Some participants acknowledged and coped with CLBP through acceptance.[50,52,53,62] They recognized the pain and associated thoughts but did not let them dominate their lives.[60,76] Wong et al[62] revealed individuals expressed acceptance, saying "I am not depressed now; it has been there for many years, and I have accepted it." Instead of worrying about future implications, they focused on the present. Horment-Lara et al[50] reported a participant stating, "I don't think about it at all. I live minute to minute, day to day. I sometimes plan ahead for a week or maybe 2, but no more than that."

Active strategies

Conversely, some older adults adopted various active coping strategies, such as searching for the right doctor or effective treatments, exercise, employing religious strategies, practicing pacing, manipulating spaces, and cultivating positive beliefs.[47,50-53,58,59,62]

Positive attitudes

Additionally, some older adults demonstrated optimism and high level of self-efficacy, which originated from previous successes, learning from others' experiences, belief in their own abilities, or external motivations.[46,50,58] These individuals actively set challenging goals, pushed their limits, and engaged in acts of service.

Discussion

As far as we know, this is the first qualitative metasynthesis to summarize the lived experiences of older adults with CLBP. Six superordinate themes were identified: perceived causes of LBP, interference with daily living, family dynamics, social life, emotional responses to CLBP, and coping strategies.

Similarities and differences in experiences between working-age and older adults

Our review identified some themes (eg, effect on self, relationships with others, and various coping strategies) that are very similar to those reported in prior metasyntheses of qualitative research involving younger individuals with CLBP (table 3).[56,77,78] Similar to working-age individuals, older adults experienced impaired physical functioning, negative emotions, and social isolation. Some adopt disabled behaviors to conform to the sick role,[40,56,79] whereas others used passive or active coping strategies to manage CLBP.[80] These similarities suggest that the effects of CLBP and responses to it are consistent across all ages.

Similar to working-age adults with CLBP,[56,77,78] some older adults engage in behaviors to validate their pain and gain trust from health care professionals and others. This behavior may stem from the uncertainty and invisibility of CLBP, which can lead to perceived stigma in clinical and social settings.[64,65,81-84] Similar experiences have been reported in people with multiple sclerosis and fibromyalgia.[85,86] In order to establish their credibility as genuinely ill, they seek a diagnosis and treatment to be believed and cared by others.[87]

Adequate support from family and friends assists both working-age and older adults with CLBP in managing the challenges and psychological distress associated with their condition.[73] Social support has the potential to alleviate perceived pain by mitigating the effects of stressors and enhancing an individual's coping ability.[88,89] However, the initial support from family members may diminish over time, particularly in the absence of a clear diagnosis or explanation for the pain.[56] Therefore, it is essential to involve family members or caregivers in clinical consultations to educate both older adults with CLBP and their families about the nature of CLBP and explore individualized treatment options together.[71,90]

Compared with working-age adults,[56,77,78] older adults experience the effect of CLBP on their family dynamics differently. Notably, older adults are primarily concerned with how CLBP affects their caregiving roles[47,51,53] and the fear of becoming a burden to the families.[49,53,62,84] In contrast, working-age adults worry more about career implications and financial dependence.[77,78] These differences reflect their life stage differences. After retirement, older adults often take on caregiving roles, especially for spouses with chronic illness,[91] and aim to support rather than burden their families. Conversely, working-age adults focus on careers and roles as breadwinners, leading to distinct effects of CLBP on their family roles.

Although CLBP can lead to social withdrawal in both working-age and older adults,[56,57,62] its effects can be more

Table 3 Comparison between systematic reviews of working-age adults with our review for older adults with CLBP

Aspects	Working-Age Adults Review 1 (MacNeela et al[78])	Working-Age Adults Review 2 (Bunzli et al[77])	Our review on Older Adults
Perceived causes of CLBP	Not discussed	The psychosocial effect of the nature of CLBP -Omnipresence of pain -Fluctuating/unpredictable	Perceived causes of CLBP -Attributing causes despite unexplainable origin
Interference with daily living	Not discussed	The psychosocial effect of the nature of CLBP -Life disruption -Other physical symptoms	Interference with daily living -Impairment of daily activities and function
Family dynamics	A disempowering effect on all levels -Family strain -Loss of job and lack of money		Family dynamics -Burdening family members
Social life	A disempowering effect on all levels -Social withdrawal	The psychosocial effect of the nature of CLBP -Life disruption (change in social roles) CLBP as a socially mediated experience -Stigma -Establishing credibility	Social life -Altered social circle
Emotional response	The undermining influence of pain -Discomfort, distress and loss -Worry and fear for the future A disempowering effect on all levels -Hopelessness -An oppressive intrusion on the self	The psychosocial effect of the nature of CLBP -Psychological	Negative emotional responses -Fear and worry for the future -Diminishing the self to a minimal, nonperson status -Despair for long-term suffering
Coping strategies	Learning to live with pain -Coming to terms with pain -Self-management practices -Attitudes to collaboration	Coping with CLBP -Acceptance -Coping strategies	Coping strategies -Avoidance and withdrawal -Acknowledging and adapting to the pain (acceptance) -Active strategies -Positive attitudes

severe in older adults, especially those with multiple comorbidities. Research shows that social isolation and loneliness (subjective feeling of being alone) in older adults increase the risk of cardiovascular diseases,[92] anorexia,[93] sarcopenia,[93] accelerated functional decline,[94] depressive symptoms,[95] cognitive decline,[96] Alzheimer's disease,[96] and even death.[97] These health issues further reduce independence and increase the need for residential care. Therefore, social workers and family members should be vigilant about social isolation in older adults with CLBP and intervene early.

Unique considerations for older adults with CLBP

CLBP and depression are prevalent among older adults, with many experiencing both simultaneously.[23] Studies have demonstrated a significant association between CLBP and depression.[9,24,25] CLBP may lead to depression in older adults because of the indeterminate nature of the pain, its effect on mobility and social roles, and a pessimistic outlook on the prognosis of CLBP and life in general.[51,62,69] If untreated, depression can impede recovery and worsen disability in these individuals.[23,26] Many older adults with comorbid CLBP and depression also exhibit pain catastrophizing, low pain self-efficacy, high anxiety levels, and fear avoidance behavior.[98] Clinicians should routinely screen high-risk individuals using validated self-reported questionnaires (eg, Patient Health Questionnaire) and provide early referrals for psychological interventions.[23,26]

Unlike working-age adults, comorbidity is common among older adults. Certain comorbidity (eg, sleep deprivation or depression) or multimorbidity are associated with higher

LBP intensity or poor prognosis.[99-101] However, CLBP is often overlooked and undertreated in older adults when it coexists with other comorbidities (eg, diabetes and hypertension).[8,102] Both CLBP and comorbidities (eg, cardiopulmonary diseases) can negatively affect mobility and function, potentially creating a vicious cycle of physical deterioration and pain. Therefore, clinicians should be attentive to older individuals with both CLBP and comorbidities.

Influences of socioeconomic status, health care systems, and cultures and religions beliefs on older adults with CLBP

The studies included in our review, conducted across different continents, allow for a comparison of how socioeconomic status, health care systems, and cultural and religious beliefs influence the experiences of older adults with CLBP. Regardless of socioeconomic status, individuals with CLBP face similar negative effects on their physical and psychological well-being, as well as their family and social roles. Many seek a diagnosis and cure, adopting coping strategies that very based on personality, culture, or religion. Wealthier individuals often achieve better health outcomes because of superior health literacy, resources, and health care options, which significantly affect health disparities.[103] Different health care systems also affect treatment choices for CLBP. For instance, Hong Kong and Chile offer both public and private health care systems,[50,53] whereas Switzerland's decentralized health care system mandates residents to purchase health insurance from private providers, under strict government regulation.[53] Therefore, Hong Kong and Chile residents can choose their care based on financial and insurance situations.

Additionally, cultural and religious beliefs significantly shape older adults' views on health and illness.[104-109] In Hong Kong, Confucian culture promotes multigeneration coresidency, providing family support but also potential conflicts.[53] Nigerians emphasize family interdependence, viewing unsupportive family members as adversaries.[51] Conversely, Swiss older adults tend to be more independent, relying on a broader social circle for support.[53] Religious beliefs also influence health-seeking behaviors. For instance, older adults in Gondar use "holy water" as a traditional remedy for CLBP,[47] reflecting a reliance on nonevidence-based practices rooted in their spiritual beliefs. In rural Nigeria, illness is often viewed as a discord between humanity and God, with an expectation of a pain-free existence.[51] These beliefs highlight the complex interplay between spirituality, cultural values, and health perceptions among older adults worldwide. Clinicians and policymakers should consider cultural and religious beliefs when treating patients and developing health care policies.

CLBP management in older adults

Considering the unique physical and psychosocial challenges faced by older adults with CLBP, it is necessary to modify effective treatments originally designed for working-age adults[110,111] and increase their accessibility to older adults with CLBP.[8] The treatment modification may involve adjusting frequency, intensity, and content complexity of interventions before applying them to older adults. Likewise, websites or mobile applications developed for working-age adults with LBP[112-114] can be adapted to meet the specific needs of older individuals. For example, incorporating larger fonts, touchscreen functionality, and video instructions can enhance accessibility and usability for older adults to effectively self-manage their LBP. Future research should evaluate the effectiveness of tailored LBP interventions that specifically address the needs of older adults.

There is a paradigm shift toward self-management of chronic conditions, including CLBP, instead of relying solely on clinician-led management.[115] Successful management of CLBP involves empowering older individuals to self-manage their LBP and engage in meaningful activities.[116] Acceptance of CLBP[117] and receiving a definitive diagnosis have been shown to promote self-management in this population.[60,61] Health care professionals should demonstrate patience, use motivational interviewing, actively listen, and encourage older adults to seek help and use self-management strategies.[115] Motivational interviewing[115,118] can help clinicians identify facilitators and barriers to self-management and promote behavioral changes. Establishing a trusting relationship and providing proper education on self-management skills can increase older adults' motivation to self-manage CLBP. Further, involving caregivers in the consultation and education process can create a supportive network for older people with CLBP.

Study limitations

The current metasynthesis possesses several strengths. First, its protocol was registered in PROSPERO and published, ensuring transparency and accountability. Second, it followed standard procedures for screening, data extraction, and risk of bias evaluation. Third, the reporting of this review adhered to the Preferred Reporting Items for Systematic reviews and Meta-Analyses guidelines.

Although the inclusion of a small set of diverse studies may not be generalizable, it offers a glimpse into the breadth of conditions and contexts affecting older adults with CLBP globally. This review also has some limitations. First, the inclusion of only 1 study from Africa, Asia, and Australia limits the representativeness of the findings to those regions. Future qualitative studies conducted in those regions are warranted to better understand the cultural or health care system influences. Second, alternative interpretations of our findings are possible as qualitative research is undertaken within interpretive paradigm. The process of grouping themes from different studies required in-depth reading and could introduce subjectivity, despite involving 3 reviewers. Third, gray literature was excluded, potentially resulting in the omission of some concerns expressed by older adults. Future qualitative research could consider soliciting older adults' opinions about their health condition through social media platforms.[119]

Conclusions

This qualitative metasynthesis establishes a baseline understanding of the themes surrounding the effects of CLBP on older adults' daily activities and lived experiences. Six identified themes highlight the unique challenges they face,

including the perceived causes of LBP, interference with daily activities, family dynamics, social life, emotional responses to CLBP, and coping strategies. The findings highlight commonalities such as disruptions to routines, emotional burdens, and coping mechanisms, while acknowledging the influence of cultural and health care system contexts. Health care professionals play a crucial role in empowering older individuals to accept and self-manage CLBP through active listening and proper education, and involving caregivers in treatment plans. Future research should delve into pain experiences among a broader spectrum of older adults, encompassing populations not covered in the current metasynthesis. This could involve region-specific studies in underrepresented areas such as Africa, Asia, and Australia, so as to explore the unique characteristics and tailor the interventions more effectively to comprehensively address CLBP in older adults.

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CC and EC were responsible for acquisition of data. AW was responsible for supervision and the final approval of the version to be published. And they were responsible for analysis of data and drafting the manuscript. AW, VS, EO, DC, and JL were responsible for interpretation of data. AW and VS were responsible for the conception and design of the study, and funding acquisition. All authors contributed to the review, revising it critically for important intellectual content. All the authors finally approved the manuscript.

Data statements

No data was used for the research described in the article.

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