Biographical suspension and liminality of Self in accounts of severe sciatica

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Biographical suspension and liminality of Self in accounts of severe sciatica

Abstract

Sciatica is a common form of low back pain (LBP) that has been identified as distinct both in terms of the persistence and severity of symptoms. Little research has explored individual experiences of sciatica, and none focuses on individuals with the most severe, long-lasting symptoms who may experience the most profound impact. This paper addresses this gap through proposing a theoretical framework for understanding such experiences, that of biographical suspension as a form of liminality of Self. Twenty semi-structured interviews were conducted with individuals with severe sciatic symptoms between January 2016–March 2017, as part of the UK-based SCOPiC (Sciatica Outcomes in Primary Care) randomised controlled trial. Data were analysed thematically using the constant comparison method. The concept of ‘biographical suspension’, originally developed in LBP, emerged as one whereby individuals put life on-hold in the expectation of an eventual return to their former, pain-free selves. Deeper analysis extended this concept to a form of liminality, whereby individuals are caught between pre- and post-sickness selves, unable to fully identify with either. This liminality is underpinned by ongoing beliefs about sciatica as a temporary and fixable ‘injury’ rather than long-term ‘illness’, even among those with long-lasting symptoms. This led to a disjuncture between individuals’ ongoing pain beliefs and experiences, resulting in longer-term psychological impacts. Biographical suspension is further conceptualised as an experiential stage giving rise to four distinct short-term trajectories: i) symptom resolution leading individuals to occupy a clearly post-liminal state; ii) remaining in suspended liminality; iii) ongoing symptoms leading to a post-liminal state of resignation; iv) a state of being both between sickness and wellness, and straddling hope and fear; thus exemplifying differing states of liminality experienced over time. Findings have implications for the support provided in clinical settings to individuals who may struggle to self-manage due to sustained liminality of Self.

Key words: UK; sciatica; biographical suspension; liminality; illness experience; qualitative

1. Introduction

Sciatica is a common form of low back pain (LBP) characterised by pain radiating down the leg, particularly below the knee and into the foot, with various accompanying neurological features such as changes in sensation, reflex or muscle strength (Koes et al., 2007). Unlike LBP alone, sciatica more often has a clear 'biomedical' cause, most commonly disc prolapse compressing or irritating a spinal nerve root (Sanal, 2016). Sciatica is often experienced as an acute condition, with symptoms resolving in a matter of weeks, either naturally or through therapeutic intervention, e.g. physiotherapy. However, up to 30% of people will still experience pain after a year or more (Koes et al., 2007), and some may encounter recurrent episodes over time, thus representing a longer-term problem. Sciatica symptoms have been found to be particularly persistent and severe when compared with LBP alone, being associated with increased pain, disability, poor quality of life, and greater use of health resources (Boote et al., 2016; Konstantinou et al., 2013).

Despite its prevalence and impact on quality of life, there is a lack of qualitative research exploring experiences and management of sciatica, particularly when compared to the wealth of similar studies on LBP (see, for instance: Bunzli et al., 2013; ; De Souza & Frank, 2000; Sanders et al., 2015). Of the small number of papers on sciatica experience, most focus on views towards clinical care and services, or specific therapeutic interventions (Boote et al., 2016; Hofstede et al., 2013; Hopayian & Notley, 2014) To-date, only Ong et al. (2011) have explored in-depth individuals' beliefs about sciatica and its impact within the wider context of their lives. They argue that sciatica is distinctive from LBP and other forms of musculoskeletal pain from an experiential perspective in terms of its impact on individuals' everyday lives. However, Ong et al. (2011) identified individuals with sciatica from a broad sample of LBP patients, thereby including acute cases as well as those with more severe, long-lasting sciatica. Given the distinctiveness of sciatica that has been highlighted in terms

of severity and impact, we suggest there is a need to explore exclusively the experiences of those with the most severe cases of sciatica, that is, those with the highest pain severity and/or related psycho-social issues, and/or presence of particular clinical indicators. It is the views and experiences of this group of patients, for whom sciatica will likely have the most profound impact, that form the focus of this paper.

Whilst previous studies have taken largely descriptive approaches, we build on those findings through proposing a theoretical framework for understanding the experiences of individuals with severe sciatica. In doing this, we argue that experiences of sciatica can be considered as a form of 'biographical suspension' (Bunzli et al., 2013) – a concept developed from biographical disruption (Bury, 1982) and other related theories– which explains how individuals with non-specific LBP put life 'on-hold' in hope of a time when pain will resolve and they can return to what they consider to be the 'real me'. In contrast to biographical disruption in which individuals will usually, over time, begin to 'mobilise resources' (Bury, 1982) and incorporate their condition into a new sense of Self, those experiencing 'biographical suspension' do not move beyond the initial interruption caused by ill-health, not adapting to life with pain because of the belief that their condition is temporary. We extend this concept in relation to sciatica through conceptualising this suspension as indicating a form of liminality in relation to the individual's self-concept, whereby individuals find themselves stuck between their pre- and post-sickness Self, unable to fully connect/identify with either. The significance of this suspension is that it indicates individuals aligning with a short-term view of ill-health, which may be unproblematic for those whose sciatica symptoms resolve straightforwardly, but the uncertain prognosis of sciatica means that, for many, symptoms will be longer-term. Thus, whilst much of the medical sociology literature dichotomises experiences of acute and chronic or episodic conditions, the findings we present on biographical suspension and liminality extend previous work through elucidating experiences of a condition for which this distinction is less clear-

cut. Sciatic pain is on the one hand perceived by individuals as short-term and thus as requiring minimal if any adjustment to Self, yet on the other hand, can become chronic. Where this is problematic is when individuals' perceptions of pain as temporary and as something they can recover from persist over time despite them experiencing longer-term symptoms, resulting in an ongoing disjuncture between their pain beliefs and experience of pain. This, we will show, can lead to longer-term impacts on individuals' emotional and psychological wellbeing. Whilst building on our understanding of experiences of severe sciatica, findings may also have implications for understanding other conditions which have uncertain prognoses and are therefore not straightforwardly either 'acute' or chronic/ episodic.

For individuals in the present study this temporary view of pain will be shown to result from a sustained view of sciatica as being an 'injury' leading to a symptom that has a clear explanation and that can be fixed, either naturally resolving or through treatment. It is the expectation that this 'injury' can be resolved that results in a lack of acceptance of pain as part of life which is central to the biographical suspension constructed in individuals' accounts. Furthermore, whilst biographical suspension has previously been conceptualised as a particular state of being, we extend its use through showing it to represent a distinct stage in sciatica experience that can give rise to a range of experiential trajectories through which individuals occupy differing states of liminality or post-liminality.

1.1 Illness experience and biographical concepts

Contemporary studies of illness experience continue to commonly draw on Bury's (1982) seminal concept of 'biographical disruption' (e.g. Lewis et al., 2015; Sanders et al., 2015; Trusson et al., 2016). Bury proposed that the onset of illness can result in a devastating impact on biography and

self-concept, marking a 'then' and 'now' divide between life before and after illness; with individuals needing to reformulate a new post-illness identity in light of this disruption.

It has since been argued, however, that illness need not be unexpected and devastating in the way Bury proposed, but can instead be anticipated and perceived as 'normal' (Williams, 2000); either as reinforcing prior elements of an individual's identity (Carricaburu & Pierret, 1995), or normalised in relation to age (Pound et al., 1998) or existing comorbidities (Faircloth et al., 2004). Others have argued that disruption caused by illness, and normalising of illness, need not be polar opposites and can be simultaneously constructed in individuals' accounts (Sanders et al., 2002). Scholars have also highlighted the perceived lack of agency in the original biographical disruption concept, which represents individuals as passive victims of illness. Subsequent research highlights the proactive strategies people use in their ongoing health maintenance (Sanders et al., 2015).

Additionally, the relevance of biographical disruption to conditions with non-linear trajectories has been explored. Sanders et al. (2015) argue that the nature of non-specific LBP means it requires a fluid, fluctuating process of adaptation and re-adaptation, as opposed to constituting a distinct disruptive event; a similar argument is put forward by Sanderson et al. (2011) in relation to rheumatoid arthritis.

Building on previous biographical research, Bunzli et al.'s (2013) concept of 'biographical suspension', outlined above, suggests individuals not accepting pain as a long-term part of life, and instead putting life 'on-hold' until their pain has resolved and their pre-illness Self can be restored. Biographical suspension was developed through a meta-synthesis of qualitative studies ($n=25$) reporting on experiences of non-specific low back pain (LBP), i.e. LBP which is not attributable to a

recognisable, known, specific pathology. The concept draws on Parson's (1951) classic notion of the 'sick role'. According to Parsons, an individual's occupation of the sick role allows them to be absolved from everyday responsibilities until the point at which sickness has passed and they are able take up normal roles once more. Key to successfully adopting the 'sick role' is the individual's acknowledgement that sickness is an undesirable state, and they therefore must recognise their obligation to try to get well again. Biographical suspension among those with LBP is characterised by a sense of diagnostic uncertainty and subsequent desire to seek legitimacy for their symptoms; these individuals can therefore be seen to be constantly striving to justify their occupancy of the 'sick role', as well as to prove their aspiration of getting better. Bunzli et al. (2013: 913) identified three elements of biographical suspension in relation to LBP: 'suspended wellness' (individuals ceasing normal activities in order to display themselves as 'ill' to others); 'suspended self' (maintaining that the ill self is not the 'real me'); and 'suspended future' (avoiding future planning due to an uncertain prognosis).

As alluded to above, biographical suspension provides a lens through which we explore experiences of sciatica in the present paper. However, whilst biographical suspension in LBP is driven by the individual's search for an explanation for their pain; conversely, for individuals with sciatica it is the fact that they *do* have a clear explanation – and, crucially, the beliefs attached to this explanation – that underpins biographical suspension. The representation of sciatica as a fixable 'injury' leads to heightened expectation of symptoms resolution, which we will argue has implications for self-management in the longer-term. Those with severe sciatica therefore do not actively strive to legitimise their occupancy of the 'sick role', but rather await the point at which they can vacate it. This, it will be shown, leaves them occupying a liminal position between pre- and post-sickness selves, as will be discussed further below.

1.2 Liminality

The concept of liminality originates from anthropological literature, as is defined by Turner (1967) as referring to individuals who fall 'betwixt and between' socially constructed categories seen to be normal. It is an ambiguous, often transitory state of being neither here nor there, neither one thing nor the other. Liminality is a diverse concept that has in recent years been applied to sociological studies of health and illness in several different ways. One conceptualisation is as a state in between illness and wellness – that of not being classified as 'ill', yet not seeing oneself as fully 'well'. This has been observed in studies of chronic fatigue syndrome (CFS) (Brown et al., 2017), kidney transplantation (Crowley-Matoka, 2005); and breast cancer treatment (Rees, 2017; Trusson et al., 2016), respectively. Trusson et al. report in relation to women's accounts post-breast cancer treatment that, 'an ongoing fear of recurrence combined with embodied changes prevented a return to 'normal' i.e. a pre-cancer state' (2016: 121). Little et al. (2008) go further still, proposing that liminality in relation to cancer experience is not only a stage experienced during diagnosis, treatment and post-treatment adaptation, but is a long-term existential state; an enduring phase of sustained liminality which may be life-long. In this conceptualisation, then, liminality arises from both embodied and symbolic changes. The body is now clinically free from disease, but the individual is changed both physically and emotionally by their experiences, resulting in an uncertain relational identity, or concept of Self, in terms of their health-status.

Liminality has also been drawn-upon to highlight the impact of illness and its treatments on other areas of identity, including gender. For instance, Navon and Morag (2004) found that for men with prostate cancer, undergoing hormonal therapy led to disruption in gender identities. On the one hand the men were able to regain certain elements of their masculinity, e.g. physical strength; yet at the same time lost others, e.g. in relation to their sexuality.

Furthermore, liminality has been used to explain the tension in reconciling pre- and post-illness selves upon the onset of illness. Birt et al. (2017) talk of the uncertain, liminal state individuals encounter when first diagnosed with dementia; unable to return to their premorbid state, but resisting the status of 'person with dementia'. They discuss how an individual's response to dementia onset can lead them to move into a post-liminal state of either 'passive' or 'active' citizenship.

In common with the conceptualisations outlined above, in this study liminality will be shown to relate to the precarious position of the individuals' notion of Self in the face of ill-health, or more accurately, in the face of a disrupted pain-free existence. However, rather than seeing themselves as being changed as a result of their pain, and subsequently unable to return to 'normal', for those with sciatica liminality is characterised by a *lack of* acknowledgement of a change in Self. The tension in the construction of Self arises precisely because individuals do not see their present pain-afflicted Self as reflecting the 'real me'. Furthermore, it will be shown that individuals with sciatica can experience different forms of liminality or post-liminality relating to the progression of their sciatica symptoms, and their responses to these diverse states.

2. Methods

2.1 Study context

The data presented here come from a qualitative study nested within the UK-based SCOPiC (SCiatica Outcomes in Primary Care) randomised controlled trial (RCT) which investigated the clinical and cost-effectiveness of 'stratified care' compared to non-stratified care for improving time to symptom resolution in patients with sciatica (Foster et al., 2017). Stratified care in this RCT involves subgrouping patients based on a combination of prognostic and clinical information. Each of three

subgroups is then matched to a particular care pathway. Patients in two of the subgroups are managed with physiotherapy interventions, and the third group is 'fast-tracked' for a Magnetic Resonance Imaging scan (MRI) and an appointment with a spinal specialist within a 4-week period from randomisation. Those in the 'fast track' pathway can be considered as having particularly severe symptoms of sciatica, as assessed based on a combination of clinical and prognostic information (see Foster et al. (2017) for further detail). The nested qualitative study focused on patients in this fast-track pathway, aiming to understand the views of these patients in the intervention arm of the trial about the acceptability and timeliness of treatment received (however, patients were not explicitly aware that this was a 'fast-track' pathway). The study also explored patients' experiences of living with sciatica and its impact on their lives, which forms the focus of the present paper. The views of clinicians were also explored and findings in relation to this will be published elsewhere in due course. The study received ethical approval from the National Research Ethics Service (NRES) Committee West Midlands - Solihull (17/03/15): Project Reference Number: 15/WM/0078.

2.2 Data collection

Individual semi-structured interviews were conducted with 20 patient participants in the 'fast-track' pathway, between January 2016–March 2017 in the Midlands of England. Participants were recruited by initial invitation letter and then via phone, having consented to contact as part of their participation in the RCT. Patients were purposively sampled to obtain a sample with diverse characteristics; based on treatment centre attended, and participant demographics, including age, gender, leg pain intensity, and response to treatment. Ten participants were male and ten female (average age: 52 years). The mean duration of sciatica symptoms for the current episode was approximately seven months at the point of interview. The average self-reported leg pain intensity measured at the 4-month follow-up point in the RCT was 5.3/10 (mode: 7) (See Appendix for

detailed breakdown of participant characteristics). Interviews were conducted after the 4-month follow-up point in the RCT.

Thirteen interviews were conducted at participants' homes; two in a room at the university; and five via telephone, in line with participants' preferences. Interviews ranged between 21 minutes and 1 hour 15 minutes in length (average: 48 minutes). All participants were given an information letter explaining the study prior to providing written informed consent (or audio-recorded consent in the case of telephone interviews). Interviews aimed to gain an in-depth understanding of participants' views and experiences. In the case of interviews which were shorter in length, participants tended to have a shorter symptom duration and/or had received less treatment as part of the RCT, resulting in less discussion of the acceptability of treatments. However, all participants talked in some depth about the impact of sciatica upon their lives. Topics covered in this regard included asking participants about their symptoms, effect of pain on activities of daily living, work, relationships and mood. Though a topic guide was used as an aide memoir, the interviewer retained flexibility to follow up on issues salient to participants, allowing aspects of the interviews to be participant-led. Early findings informed subsequent interviews, with the topic guide iteratively revised throughout the data-collection. Interviews were audio-recorded, transcribed, and anonymised.

2.3 Analysis

Data were analysed thematically using the constant comparison method (Glaser and Strauss, 1967), looking for connections within and across interviews, and across codes, highlighting data consistencies and variations. Anonymised transcripts were first systematically coded on a line-by-line basis by one of the authors BS with the aid of the software program Nvivo 10, in order to identify recurrent concepts inductively. Coding was reflexive and recursive, with codes being revisited in light

of the findings of subsequent data-collection. A random sample of five transcripts was independently coded by the other three authors to check for inter-coder reliability. Coders brought different disciplinary perspectives to the data (BS: medical sociology; BB: social gerontology; MA: academic general practice; KK: clinical academic physiotherapy and spinal expertise). The aim of independent coding was therefore to understand cross-disciplinary perspectives on the data and, through discussion, to come to an agreement on shared meanings and interpretations. It was thus deemed too simplistic to statistically calculate levels of agreement as a means of assessing reliability, and this was instead achieved in a more nuanced manner through detailed discussion. Analysis was an iterative process and data-collection continued until saturation was judged to have been reached, defined as 'informational redundancy' (Sandelowski, 2008) – the point at which additional data no longer offers new insights.

Five main themes were developed. Four of these relate directly to the objectives of the RCT vis-à-vis views on the fast-track care pathway: understanding of treatment; diagnosis and knowing the cause of symptoms; acceptability and experience of treatment received; and timeliness of treatment. However, the fifth theme, impact on life and sense of identity, appeared to stand alone in that its focus transcends the healthcare setting and participation in the RCT. The prominence of the theme across the dataset as a whole, and its salience within individual participants' accounts, are the reasons for the specific focus on this theme in the present paper. This theme was further explored within the context of existing theories of illness experience, with the aim of developing theoretical and conceptual insights through which to understand the experiences of these individuals. Data were considered from a social-constructionist perspective, seeing experiences not as neutral and observable, but as constructed, at least in part, through social interaction. Thus, whilst the authenticity of participants' views is not questioned, they are seen as being representations of experience, which are contextually-contingent (Riessman, 2003). As such, a reflexive approach was

taken, recognising the co-construction of meaning within interviews. For instance, the interviewer, BS was from a medical sociology background, which may have led to a greater orientation in interviews towards the social context in which pain is experienced, e.g. in relation to work and family roles.

3. Findings

3.1 Biography in a state of suspended liminality

All participants emphasised the extreme severity of their symptoms, including intense leg pain and restricted mobility, often leading to experiences of frustration and low mood. William (pseudonyms used to protect participants' identities) vividly articulated the intensity and perpetuity of his pain, and the extreme lengths he feels it could have pushed him to:

William: I can't describe the pain, that sort of pain where you want to throw up. You know when you were a child and you banged yourself, knocked yourself sick, it was like that but it didn't go off.

Interviewer: So it's just constant?

William: Constant, there was no relief from it and I've still got it now. With the pain I was in, some nights I was suicidal. If they'd put a gun at the side of the bed I'd have sooner shot myself.

(Aged 64, sciatica duration 9 months)

Such symptoms were reported as permeating all aspects of life, preventing individuals from going about their usual routines, or in some cases even leaving the house; clearly indicative of biographical disruption. However, the reported experiences of many individuals indicate biography as not just disrupted, but suspended altogether (Bunzli et al., 2013), with life put on-hold in the expectation of

getting better. John, a self-employed builder, had been unable to work or engage in valued activities since the onset of his sciatic pain:

John: Financially it's hit us massively. Health-wise, I'm not sleeping; I haven't been able to go to functions, go to the pub, I haven't done nothing like that. I haven't walked my dogs since August. So it's as if everything stopped August 12th. But I know all this will come back, I haven't got a gloomy outlook on that. It's just that waiting time. When you're sitting there in pain that time is a lot longer. And at times the house goes empty and you're sitting here on your own looking at the walls, and you can't go out, not that you don't want to go out, you can't go out... And frustration, that's the biggest one. When you can't do things, then you get frustrated, you can get bad tempered, you don't want to be, but it's only through the frustration that you can't do what you want to do. There're jobs that need to be done before the winter that you can't do. You can't cut that grass, you can't empty the pond, you can't clean your fish tank. These all need to be done at a certain time in a year. So you do get down, you do huff and puff a lot.

(Aged 42, sciatica duration 12 months)

Key to the biographical suspension constructed by John is that despite everything having 'stopped August 12th', i.e. the day of symptom onset, he expresses the expectation that there will be a point at which life will start up again, with his prior pain-free biography restored. This indicates a lack of acceptance of sciatic pain as a long-term part of life, which is particularly noteworthy given the lengthy duration of John's symptoms to-date. This in turn appears to contribute to significant emotional and psychological impacts, as John struggles to accept the physical limitations brought about by his symptoms, leading to 'frustration' that he is unable to undertake what he sees as important maintenance work on the house and garden; tasks he feels that he should be carrying out.

294

295 For John, putting life on-hold also meant refusing to accept an identity as someone afflicted by pain:

296 *I feel like an old man. And I'm not! I was fit, healthy, outgoing, doing everything,*
297 *coming home, doing jobs, do a full day's work and come home and do work at home,*
298 *I wouldn't sit down until it went dark.*

299

300 John endeavours to hold onto an identity as an active person in spite of this not fitting his present
301 reality; thus he argues that whilst he may feel 'old' at present, this is not who he really is. It can be
302 argued that the state of biographical suspension constructed here is one of liminality – John has
303 been removed from his preferred Self, but because he is waiting for this Self to return once his pain
304 is resolved, he is unwilling to accept a new post-sickness conception of Self; and is thus in a liminal
305 state between different selves.

306

307 Experiences of biographical suspension as a liminal state appeared rooted in beliefs about the nature
308 of sciatica. Participants commonly identified a specific trigger for symptom onset such as heavy
309 lifting. As a result sciatica was often referred to as an 'injury' and conceptualised as biomechanical in
310 nature; a view reinforced by results of the MRI scan undergone by almost all participants in the 'fast-
311 track' pathway, which potentially enabled them to see visually the cause of their pain, e.g. the
312 protruding disc. All of this appeared to contribute to expectations of a fast resolution of symptoms:

313 *Ruth: I was fully expecting to be, say, a fortnight from seeing my doctor, to the sciatica*
314 *clinic, and then I was expecting another two weeks from that to go for a scan. I fully*
315 *expected it all to be over in about a 3 month period. I did not expect it to be this long.*
316 *You expect the injury be mended, don't you, for want of a better phrase. Mentally it*
317 *grinds you down, you know. You expect for them to go, 'oh yes we've taken an x-ray,*

you've a ruptured disc, we'll bring you in next week, we'll have that ground down, couple of weeks then you'll be back at work.' That's what you expect.

(Aged 67, sciatica duration 8 months)

Ruth's language-use appears to minimise the complexity of the condition, whilst also placing the burden of responsibility for resolving her pain firmly on clinical intervention. The fact that Ruth's initial expectations about her pain were unfulfilled and she has instead gone on to experience persistent long-term symptoms has seemingly resulted in an ongoing psychological impact: 'mentally it grinds you down'.

Mark expressed a similar view of sciatica as a temporary and curable 'injury' which he too feels *should* have been resolved at a much earlier stage:

Now that is going to be the best part of nearly 12 months of an injury to cure. And I think that's too long a time for the type of injury I've got. I've seen car crash victims come back better and quicker.

(Aged 44, sciatica duration 12 months)

What appears significant in relation to both Ruth and Mark is that their view of sciatica as resulting from a temporary and fixable 'injury' appears to have become an ongoing narrative, ingrained over time; despite this being contrary to their experiences of long-term symptoms. This sustained narrative of the temporariness of pain appears key to their lack of acceptance of pain as part of life, underpinning the biographical suspension experienced, and in turn leading to considerable frustration.

341

342 For some participants, the suspension of certain aspects of life was particularly salient. Judy
343 highlights the significance of her inability to work:

344 *I love my job working with the children [as an early years practitioner working with*
345 *under 5s]. The thought of not being able to ever go back is soul destroying. I can't*
346 *think of that, I just hope that doesn't happen. I've got to get back to work, for*
347 *everybody...I'm just hoping to God this nerve block [injection] works. It's all fingers*
348 *crossed, hold breath and just hope. I'm praying it works. If it doesn't, I don't know*
349 *what I'm going to do.*

350 *(Aged 44, sciatica duration 9 months)*

351 Whilst, above, John expressed an expectation of a return to his former, pain-free self, Judy's extract
352 indicates more so desperate hope for a return to life before the sciatic pain. She, too, has not
353 accepted pain as part of life, in part due to the weight of the loss she would feel were she not able to
354 return to work, i.e. for her it is just too terrible to contemplate. Additionally, and crucially, the
355 availability of forthcoming treatment gives Judy legitimate hope of a return to her pre-morbid state.
356 Judy can thus also be seen to occupy a liminal state between a preferred, pre-sickness Self, and her
357 present Self which she cannot bear to accept.

358

359 Judy's extract highlights another significant factor reinforcing participants' beliefs about the
360 potential for recovery from sciatica, which is the fact that in many cases sciatica will fully resolve.
361 This is due to the range of viable treatment options potentially available to individuals, including
362 surgery in some cases. This means that the hope of a return to the former, pain-free Self is not an
363 unrealistic prospect, even for those like Judy who have a lengthy symptom durations.

364

3.2 Biographical suspension as an experiential stage

The data suggest that ‘biographical suspension’ (Bunzli et al., 2013) can represent a distinct stage through which individuals pass. Four short-term trajectories of experience are highlighted as following on from biographical suspension; each of which give rise to differing states of liminality or post-liminality. These are labelled as follows: suspension lifted; remaining in suspension; resigned to symptoms; and partial symptom resolution, pre-sickness self partly restored.

- i. *Suspension lifted* – A quarter of the participants did, after some months, experience a complete (or near complete) resolution of symptoms. As a result, biographical suspension gave way to biographical reinstatement (Sanderson et al., 2011), with the pre-sickness Self restored and life resuming as normal:

Harriet: It was really intense pain. I couldn't even sit in the chair, I had to carry a hot water bottle with me all the time and heat it up and put it at my back and it was very, very painful. I think the pain lasted for about three months, and as mysteriously as the pain appeared is as mysteriously as it vanished. I just am still puzzled as to how can it just mysteriously vanish like that. I am very happy about that, very, very happy. Everything is fine now. It's gone and I can get on with life; it's not an experience that I would want to repeat.

(Aged 36, sciatica resolved at 3 months)

Harriet's description of her pain as having ‘mysteriously vanished’ does not appear to align as easily with the narrative identified earlier relating to the expectation of sciatica being ‘fixed’ or ‘mended’; however, her ‘puzzled’ reaction to the resolution of her symptoms appears to relate more to the

suddenness with which her pain disappeared rather than necessarily her expectations about the temporariness of pain. Significantly, she represents the pain experience as something that has now past and is behind her, suggesting she has now moved into clearly post-liminal state. Her assertion that 'everything is fine now' and she can 'get on with life' indicates that these experiences have not resulted in any long-term changes and, as such, her former pain-free Self can be successfully reinstated.

Whilst in most cases the ‘suspension lifted’ trajectory indicates a complete return to normal activities, a notable exception was Gary, who, despite no longer experiencing pain, reported having accepted clinical advice to seek a less physically demanding job:

Gary: They recommended I stop working as a roofer now.

Interviewer: Permanently?

Gary: Permanently, yeah.

Interviewer: How do you feel about that?

Gary: *Yeah, I don't mind. It keeps me out of the cold. A career change won't do me any harm.*

(Aged 28; sciatica resolved at 5 months)

Whilst this would seem to indicate sciatica as having had a significant long-term impact, Gary minimises the significance of this change. It may be that Gary's job as a roofer does not represent a key part of his identity, and therefore for him leaving this job does not signal a departure from his pre-sickness Self. Gary thus appears able to emerge into a clearly post-liminal state despite the lasting impact of sciatica.

412 ii. *Remaining in suspension* – At the time of interview five participants appeared to be still
413 experiencing biographical suspension, awaiting a return to ‘normal’ life, and thus still occupied a
414 state of liminality between pre- and post-sickness selves, as discussed above. In a few cases,
415 such as Judy (described earlier), they were still awaiting further treatment.

416

417 iii. *Resigned to symptoms* – For two participants, their pain had not improved and they faced the
418 same limitations to their lives as during biographical suspension, the difference being that they
419 now appeared resigned to living with pain and no longer held out hope of symptom resolution:

420 *Margaret: I have come to terms with it now that I’ve just got to live with it, no one*
421 *can do anything for me. That’s what it is, that’s what I do, struggle*
422 *through. The days go on and that’s it...They [healthcare professionals]*
423 *can’t do anything for me so I don’t bother any more. I just have to live*
424 *with it... I just be careful what I’m doing and restrict myself. I’d love to*
425 *be able to go and do what I used to do in the garden and things. You’ve*
426 *gone from an active person to... I don’t know what. And where I live*
427 *here at the moment, if it’s icy, I daren’t go out because from that*
428 *position to the car, I’ve got nothing to hold on to. That’s even more*
429 *restriction if the weather is bad. You feel housebound and I think*
430 *depression comes in with it then, that you can’t get out and do your*
431 *normal everyday things.*

432 *[Aged 62, sciatica duration 7 months]*

433 Whilst Margaret appears to have entered a post-liminal state, with life no longer suspended, this
434 extract is characterised more by resignation and hopelessness than a sense of positive acceptance.
435 She expresses a significant sense of ‘loss’ of her prior Self (Charmaz, 1982) resulting from the
436 physical restrictions imposed by her sciatica, and emphasises the emotional toll of at times feeling

437 'housebound' due to her restricted mobility. The magnitude of the losses Margaret has suffered
438 results in her struggling to clearly articulate a coherent sense of her present Self: 'you've gone from
439 an active person to...I don't know what'. Margaret's current episode of sciatica was the latest in a
440 number of recurrences experienced over several years and her resignation may therefore be a
441 reaction not only to her present symptoms, but to a lengthy history of sciatica negatively affecting
442 her life.

443

444 iv. *Partial symptom resolution, pre-sickness self partly restored* – For eight of those interviewed,
445 treatment (e.g. analgesics; physiotherapy; spinal injections) had led to improvement in
446 symptoms to the point of being liveable and tolerable. They were thus able to resume valued
447 activities and move beyond the state of biographical suspension; and thus beyond the initial
448 state of liminality. For Siobhan, having had physiotherapy she was able to return to work and
449 other daily activities; however, some symptoms persisted:

450 *Siobhan: I've still got it but I am keeping it at bay doing these exercises.*

451 *Interviewer: So the physio's been effective then?*

452 *Siobhan: Oh it's helped, yes. But if I miss doing it I can feel it. It's still there,*
453 *definitely. Some days it's worse than others, like a bit of a dull ache,*
454 *but it's tolerable now. It's bearable I would say...workwise now, it's*
455 *not stopping me doing anything.*

456 *(Aged 45, sciatica duration 5 months)*

457 However, whilst individuals talked of being able to regain elements of their pre-sickness selves,
458 there was also a sense that residual symptoms had resulted in a change to their lives, and, for some,
459 an inability to reinstate certain valued elements of Self:

Geoff: I was off work for three and a half months. See it was a driving job. You're sitting down a lot plus you're lifting and everything, I couldn't have done it. But now I'm back at work...and I've started going back to the gym, just started working my legs, squatting on the machine. Before I was a very active, strong person... but now I'm limited to what I can do. I see all these people doing things in the gym and I'm thinking, 'I used to be able to do that, I used to be able to do that'. The normal things you do now I've got it in mind that I can't do that. I never thought in my lifetime I'd be saying to someone, 'I can't lift that because I've got a bad back.'

(Aged 55, sciatica duration 6 months)

Geoff here struggles to come to terms with the bodily restrictions he still experiences; particularly the loss of physical strength meaning that he cannot exert himself at the gym as he once did. For Geoff, physical strength appears an important aspect of Self, and he represents these bodily restrictions as signalling a significant disjuncture between his pre-pain Self and current Self; as highlighted through his assertion that prior to pain onset he never would have imagined being the kind of person who would experience such physical limitations.

For some individuals in this trajectory, having experienced some improvement in symptoms, there was still hope of further progress:

Mike: One person said he had it and it cleared up, and he's 10 years older than me. So if it can clear up in his body and he's 10 years older it could possibly clear up in me...if that disc will shrink back it will move away from the nerve that it's pressing against.

(Aged 46, sciatica duration 6 months)

Mike draws on anecdotal evidence, rationalising that his younger age compared to another man whose sciatica resolved, could make this an even more likely outcome for himself. Echoing findings above, Mike also draws on the view of sciatica as biomechanical and fixable, speculating that his body could fix itself without further medical intervention – thus again demonstrating sustained beliefs that appear to minimise the complexity of the condition.

However, the accounts of individuals in this trajectory also highlight a fear of severe symptoms returning. Arthur talks of ongoing fear as a constant presence that has changed his outlook on life:

There's things I'm wary about now. Life has changed. Before I'd just pick something up, now I've got to be mindful how I'm bending over, how I'm turning. I'm fearful of it going again. Your life as you used to know it ain't the same, because your mind is mindful what could happen. You're always thinking about it. Always.

(Aged 53, sciatica duration 10 months)

Thus, for individuals within this fourth experiential trajectory, they are no longer 'sick' in the sense of being in extreme pain, but residual symptoms mean they are also not fully 'well'; and therefore whilst able to reinstate elements of their pre-sickness selves, other aspects may still elude them. They still retain hope of further improvement or a potential cure for their sciatica, yet are also fearful of the worst pain returning. They have moved beyond biographical suspension and normal life has to some extent resumed; but they have not moved into a clearly post-liminal state, as will be discussed further below.

4. Discussion

It has been shown that individuals with severe sciatica experience 'biographical suspension' (Bunzli et al., 2013), with life put 'on-hold' whilst they wait for a return to their former, pain-free Self, i.e. the 'real me'. We have extended this concept from its original use in LBP through considering biographical suspension as indicating a state of liminality in relation to Self. Furthermore, we identified different experiential trajectories which lead to some individuals moving into a post-liminal state, whilst others remain in a state of liminality following biographical suspension.

Key to the biographical suspension constructed is that individuals were shown to be unwilling to accept pain as part of life, or to adapt their self-concept in light of their pain - thus suspending Self. This differs from Bunzli et al.'s (2013) findings in relation to LBP, in which suspension of Self is rooted in diagnostic uncertainty, with individuals seeking an explanation for their pain. For those with sciatica, rather it is their pain beliefs and the way pain is conceptualised that drives the suspension of Self. The combination of a clear 'trigger' causing the onset of pain, an obvious explanation for the pain (for example, disc prolapse), and availability of viable treatment options, all support many participants' views of sciatica as fixable – as an 'injury' they can recover from rather than perpetual 'illness'.

This injury-illness consequence distinction that is implicit in the accounts can be further clarified through contrast with findings elsewhere in the sociological literature. Whilst it is highlighted in the literature that individuals respond to illness onset in diverse ways (see earlier discussion), adaptation to long-term illness often involves the individual initially mourning the loss of their former Self in facing a new life with illness (Charmaz, 1983). Over time, they may reconfigure their self-concept, having come to terms with an altered reality (Asbring, 2001; Birt et al., 2017; Bury, 1982). This process does not appear to fit with the sense-making of individuals with sciatica in this study. Conceptualising sciatica as an 'injury' with a clear explanation and likely to improve over time and

with treatment means the reconfiguration of Self that may be required in the case of long-term illness is deemed unnecessary. Such beliefs instead resonate with Frank's (1995) classic 'restitution narrative', identified as characterising the way in which some people talk about ill-health, which follows the script of: 'yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again' (1995: 75). The significance of this, however, is that Frank's 'restitution narrative' has been more commonly associated with acute sickness, which clearly does not fit with the experiences of many of our participants who have ongoing symptoms. For these individuals the conceptualisation of pain as attributed to an 'injury', with the expectation of resolution, may therefore in fact be an unhelpful one, as this results in a disjuncture between their perceptions of symptoms as temporary and short-term, and their actual experience of symptoms. We have shown above how this can lead to sustained biographical suspension and liminality over a lengthy period, resulting frustration, distress and low mood as the individual's pain persists, and crucially, so does their lack of acceptance, and lack of adaptation to it.

Liminality, as it relates to biographical suspension can also be further unpacked. As highlighted earlier, liminality has often been used to explain perceptions of an uncertain position between 'sickness' and 'wellness' (Crowley-Matoka, 2005; Trusson et al., 2016). When sciatica is at its most severe, this kind of liminality has less relevance; individuals clearly occupy the 'sick role' (Parsons, 1951) and identify as such. Rather it is liminality in self-concept resulting from lack of acceptance of the permanence of pain that is salient to biographical suspension. The person the individual is whilst sick is not who they wish to identify as, and they do not foresee a future Self as someone living with sciatica, yet at the same time they are unable to align with the preferred, 'real' Self. They are therefore stuck between different conceptions of Self, not fully identifying with either.

The different short-term experiential trajectories identified as leading from biographical suspension can each be seen to indicate a differing state of liminality or post-liminality. Whilst it was highlighted above that some participants were still in a liminal state of biographical suspension when interviewed, others had entered a clearly post-liminal state as a result of their symptoms having resolved. These individuals had achieved the desired 'restitution' highlighted in Frank's (1995) 'restitution narrative'. For these individuals, experiences of sciatica were relatively acute, and they emerged untouched by sickness, their prior Self and biography 'reinstated' (Sanderson et al., 2011). For others, however, emerging from biographical suspension appeared less straightforward. For the two individuals identified as resigned to their symptoms, they too occupied a post-liminal state, but rather than experiencing biographical reinstatement, they were unable to reconcile their pre-sickness identities. The construction of post-liminal identities instead focused around the negative impact of pain upon their lives and a lack of hope. These individuals appeared to no longer adopt the view that sciatica symptoms can be resolved, and now accepted symptoms as indicating long-term 'illness'. However, there was little evidence in their accounts of positive adjustment, as has been observed in relation to some individuals living with other long-term conditions, e.g. fibromyalgia (Asbring, 2001); metastatic breast cancer (Lewis et al., 2015); inflammatory bowel disease (Saunders, 2017). Thus, for these individuals, accepting their sciatic pain did not appear to equate to incorporating it within a new conception of Self.

For those identified as being in the fourth experiential trajectory a partial resolution of symptoms meant elements of normal life had returned, but owing to symptoms still experienced they were not able to return fully to their pre-sickness Self. Additionally, these participants reported feeling emotionally changed by their experience of sciatica due to a fear of a recurrence or worsening of symptoms. This points to a different kind of liminality, one showing clear similarities with the liminality observed in individuals who had undergone breast cancer treatment (Rees, 2017; Trusson

et al., 2016) and kidney transplantation (Crowley-Matoka, 2005). Therefore, whilst central to the experience of biographical suspension is that change in Self is *not* acknowledged, individuals in this fourth experiential trajectory *do* acknowledge a change in Self. However, this change does not necessarily indicate a new reconfiguration of Self that incorporates their pain, and despite accepting some symptoms as now being part of life, they still held out hope of future improvement or a possible cure. Acceptance of symptoms therefore does not extend to accepting their permanence, suggesting these participants are still holding onto the conception of sciatica as a problem that can improve and go away; they still did not perceive it as a long-term 'illness'. Thus, despite moving beyond biographical suspension, with elements of normal life resuming, there is still a sense in which these individuals remain in a state of liminality – both between sickness and wellness, and between pre- and post-sickness selves. However, liminality of Self now relates not to a lack of acceptance of Self as having changed due to ill-health, but, conversely, an explicit acknowledgement that it has. This shift to a subtly different form of liminality supports Brown et al.'s (2017) finding, in relation to myalgic encephalomyelitis (ME) and chronic fatigue syndrome, that individuals can experience different forms of liminality at different points in the sickness trajectory. Of course, what we do not know is whether the individuals in the present study may begin to accommodate sciatica within a new conception of Self further down the line; or alternatively whether they will continue to be caught in a state of 'enduring liminality' (Little et al., 1998).

These findings could have implications for the clinical management of patients. In managing musculoskeletal conditions clinicians have been found to place great importance on making a concrete diagnosis, both to direct management and to reassure the patient (Saunders et al., 2016). However, our findings suggest that for patients with severe sciatica, conversely, having a clear explanation for the pain can lead to negative impacts on self-management due to the sustained beliefs formed about the condition, i.e. as temporary and fixable. It is therefore vital that as well as

identifying the cause of pain, healthcare professionals take the time to address the uncertain course of the condition and its variable impact, and the psychological and emotional toll this can have on patients. In particular, understanding the disjuncture between patients' ongoing beliefs about 'temporary' pain and experiences of protracted pain, and how this can lead to patients struggling to form a coherent sense of Self, can be key in supporting those patients for whom there may be no early resolution or effective treatment intervention. This support can be provided through discussing from the outset the variability in prognosis, together with the evidence-based interventions available, and as the condition progresses paying particular attention to addressing patients' ongoing beliefs and expectations about their pain. If necessary, this may include working towards realigning these expectations in the context of existing evidence. Such an approach can enhance resilience in individual patients, support a sense of control and self-efficacy, and strengthen the trust essential to a therapeutic relationship.

Limitations

Interviewing participants at a single time point can only ever offer a snap-shot of individuals' experiences at that particular juncture; and we are not therefore able to discern how these different trajectories progressed over time. Future research in this area could usefully explore experiences of these individuals longitudinally in an attempt to understand this further.

It is also important to note that whilst individuals' accounts have been conceptualised as exemplifying different experiential trajectories, this is not intended to undermine the individuality and uniqueness of participants' respective stories; but represents an attempt to propose a theoretical framework for better understanding these individuals' experiences.

5. Conclusion

This paper is the first to explore in-depth the lived experiences of individuals with the most severe sciatic symptoms. We have argued that accounts display biographical suspension, considered as a state of liminality, which is underpinned by perceptions of sciatica as a pain problem resulting from an injury, which has a solution. The concept of biographical suspension was also extended through being considered as a distinct stage that can give rise to different short-term experiential trajectories. Whilst some individuals remained in a state of suspended liminality at the time of interview, others had emerged into a clearly post-liminal state. However, for some, their emergence from a liminal state of biographical suspension gave way to a subtly different form of liminality, exemplifying how individuals can experience different forms of liminality at different points in the sickness trajectory. As proposed above, enabling healthcare professionals to recognise those patients experiencing biographical suspension and liminality of Self could aid the management of these patients in clinical settings, which could, in turn, help patients with their overall ability to self-manage and be better prepared to continue with their normal life as much as possible in the face of the uncertainty experienced during periods of biographical suspension.

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Appendix: Table of participant characteristics

Age	Sex	Occupation type	Current Episode duration in months (at interview)	Leg pain intensity over past 2 weeks (at 4 month follow-up)	Symptoms at 4-month follow-up compared to baseline
53	M	Compliance director	7-10	4/10	Better
62	F	Unemployed due to sciatica	5-6	9/10	Worse
44	M	Assistant manager	9-12	7/10	Same
64	M	Retired	7-10	9/10	Much worse
49	F	Pottery worker	7-10	7/10	Same
36	F	Radiographer	Resolved at 3 months	0/10	Completely recovered
60	F	Dining hall assistant	Resolved at 3 months	3/10	Better
42	M	Builder	9-12	10/10	Much worse
44	F	Early years practitioner	7-10	7/10	Same
57	M	Pottery worker	5-6	4/10	Better
66	M	Ambulance driver	6-8	3/10	Better
86	F	Retired	Resolved at 4 months	2/10	Much better
45	F	Data claims manager	5-6	7/10	Better

67	F	Unpaid carer	7-10	7/10	Same
55	M	Machine driver	5-6	2/10	Better
69	F	Retired	11-16	6/10	Better
67	M	Office manager	Resolved at 3 months	2/10	Much better
70	F	Retired	5-6	6/10	Better
46	M	Police service staff	5-6	5/10	Better
28	M	Left skilled labour job due to sciatica	Resolved at 5 months	1/10	Completely recovered

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