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The epidemiology of back pain and its relationship with depression, psychosis, anxiety, sleep disturbances, and stress sensitivity: Data from 43 low- and middle-income countries

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Submission to General Hospital Psychiatry

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Abstract (232/250)

Background

Back pain (BP) is a leading cause of global disability. However, population-based studies investigating its impact on mental health outcomes are lacking, particularly among low- and middle-income countries (LMICs). Thus, the primary aims of this study were to: (1) determine the epidemiology of BP in 43 LMICs; (2) explore the relationship between BP and mental health (depression spectrum, psychosis spectrum, anxiety, sleep disturbances and stress).

Methods

Data on 190,593 community-dwelling adults aged ≥ 18 years from the World Health Survey (WHS) 2002-2004 were analyzed. The presence of past-12 month psychotic symptoms and depression was established using questions from the Composite International Diagnostic Interview. Anxiety, sleep problems, stress sensitivity, and any BP or chronic BP (CBP) during the previous 30 days were also self-reported. Multivariable logistic regression analyses were undertaken.

Results

The overall prevalence of any BP and CBP were 35.1% and 6.9% respectively. Significant associations with any BP were observed for subsyndromal depression [OR (odds ratio)=2.21], brief depressive episode (OR=2.64), depressive episode (OR=2.88), psychosis diagnosis with symptoms (OR=2.05), anxiety (OR=2.12), sleep disturbance (OR=2.37) and

the continuous variable of stress sensitivity. Associations were generally more pronounced for Chronic BP.

Conclusion

Our data establish that BP is associated with elevated mental health comorbidity in LMICs. Integrated interventions that address back pain and mental health comorbidities might be an important next step to tackle this considerable burden.

Key words: Back pain, chronic back pain, mental health, mental illness, depression, psychosis, anxiety, sleep problems, stress sensitivity, low- and middle-income countries

Introduction

Lower back pain (LBP) is a leading cause of global disability, with a global point prevalence of 9.4% (95%CI=9.0 to 9.8%) (1). LBP ranked as the number one cause of disability among 291 conditions, and sixth in terms of overall burden in the Global Burden of Disease 2010 study (1, 2). Among Western populations, a plethora of evidence has demonstrated that back pain is associated with a range of deleterious consequences such as reduced quality of life, heightened risk of other physical health comorbidities and greatly increased health care costs (3-6). Given the rising prominence of the biopsychosocial model, a number of studies, largely focused on Western populations, have highlighted the important role of poor mental health as a risk factor for LBP (7) and as a consequence of a LBP episode (8).

To date, only a few large representative multinational studies have considered the mental health status of people with back pain, with a notable paucity in low- and middle-income countries (LMICs). However, there are indications that back pain is also highly prevalent in LMICs (9), where it is a source of substantial economic and health burden (10). Previously, one large-scale multinational study (11) using data from the World Mental Health Survey including 5 LMICs (Ukraine, Mexico, Colombia, Nigeria, South Africa) found that the presence of chronic back/neck pain is associated with 2.3, 2.2, and 1.6 times greater odds for mood disorders, anxiety disorders and alcohol abuse respectively.

While progress has been made in attempting to understand the mental health impact of back pain, a number of pertinent questions remain unanswered. First, while the relationship between back pain and mental health disorders (including depression, psychosis spectrum, anxiety and stress sensitivity) is equivocal, there are no studies exploring these associations thoroughly in LMICs. This is an important research gap given that the association between back pain and mental health symptoms or disorders in LMICs may differ from high-income settings, owing to factors such as suboptimal management of physical and

mental health conditions with limited availability of non-pharmacologic or pharmacologic treatments (12, 13). Second, as people in LMICs mostly rely on labor-demanding jobs in the informal sector with no job security or compensation for lost income, maintaining good mental and physical health is crucial for their livelihoods. Therefore, there is a need to elucidate the potential mental health burden among people with back pain in LMICs.

Thus, the aims of the current study were to: (1) Determine the epidemiology of back pain (any back pain and chronic back pain) in 43 LMICs; and (2) Explore the relationship between back pain and mental health (depression type, psychosis, anxiety, sleep problems, and stress sensitivity). Our hypothesis was that people with back pain would have worse mental health and this would be more pronounced among those with chronic back pain.

2. Methods

The World Health Survey (WHS) was a cross-sectional, community-based study undertaken in 2002-2004 in 70 countries worldwide. Single-stage random sampling and stratified multi-stage random cluster sampling were conducted in 10 and 60 countries respectively. Details of the survey have been provided elsewhere (<http://www.who.int/healthinfo/survey/en/>). Briefly, persons aged ≥ 18 years with a valid home address were eligible to participate. Each member of the household had equal probability of being selected with the use of Kish tables. The data were collected in all countries using the same questionnaire although some countries used a shorter version. The individual response rate (ratio of completed interviews among selected respondents after excluding ineligible respondents from the denominator) ranged from 63% (Israel) to 99% (Philippines) (15). Ethical approval to conduct this survey was obtained from ethical boards at each study site. Sampling weights were generated to adjust for non-response and the population distribution reported by the United Nations Statistical Division. Informed consent was obtained from all participants.

Data from 69 countries were available. The data were nationally representative in all countries with the exception of China, Comoros, the Republic of Congo, Ivory Coast, India, and Russia. Countries without any sampling information (10 countries – Austria, Belgium, Denmark, Germany, Greece, Guatemala, Italy, Netherlands, Slovenia, UK) were excluded. Furthermore, 10 high-income countries (Finland, France, Ireland, Israel, Luxembourg, Norway, Portugal, Sweden, Spain, United Arab Emirates) were excluded as the focus was specifically on LMICs. Of the remaining countries, we further omitted 6 countries (Congo, Mali, Mexico, Slovakia, Swaziland, Turkey) as over 25% of the data on any back pain and chronic back pain was missing. Thus, the final sample included 190,593 individuals from 43 countries, which corresponded to 19 low-income and 24 middle-income countries according to the World Bank classification at the time of the survey (2003). Furthermore, according to

the United Nations' classification system (<http://unstats.un.org/unsd/methods/m49/m49regin.htm>), these countries corresponded to 17 countries in Africa (n=71,346), 5 in the Americas (n=23,986), 13 in Asia (n=81,633), and 8 in Europe (n=13,628).

2.1 Variables

2.1.1 Back pain

Participants were first asked "Have you experienced back pain (including disc problems) during the last 30 days?" with Y/N answer options. Those who answered affirmatively to this question were then asked "How many days did you have this back pain during the last 30 days?" We operationalized any back pain as those who answered 'yes' to the first question, and chronic back pain as those who claimed to have had back pain on all 30 days in the last 30 days.

2.1.2 Mental health conditions

2.1.2.1 Depression type

The severity of depressive symptoms was established based on the individual questions of the World Mental Health Survey version of the Mental Health Composite International Diagnostic Interview (CIDI), which assessed the duration and persistence of depressive symptoms in the past 12 months (16). Following the algorithms used in a previous WHS publication (17), four mutually exclusive groups were established based on the ICD-10 Diagnostic Criteria for Research (ICD-10-DCR) where criterion B referred to symptoms of depressed mood, loss of interest, and fatigability. The algorithms used to define the four groups were the following: (a) Depressive episode group: at least two criterion B symptoms together with a total of at least four depressive symptoms lasting two weeks most of the day

or all of the day. (b) Brief depressive episode group: same criteria as depressive episode above but not meeting the two-week duration criterion. (c) Subsyndromal depression: at least one criterion B symptom together with the total number of symptoms being three or less. The criteria of duration of at least two weeks and the presence of symptoms during most of the day had to be met. (d) No depressive disorder group: none of the above.

2.1.2.2 Psychosis

Participants were asked whether they had ever been diagnosed of having schizophrenia or psychosis. All participants, regardless of a psychosis diagnosis, were asked questions on positive psychotic symptoms which came from the CIDI 3.0 (16). This psychosis module has been reported to accord highly with clinician ratings (18). The hallucinations question excluded conditions associated with sleep-related states or substance use. Specifically, respondents were asked the following questions with answer options ‘yes’ or ‘no’:

During the last 12 months, have you experienced: (a) ‘A feeling something strange and unexplainable was going on that other people would find hard to believe?’ (delusional mood). (b) ‘A feeling that people were too interested in you or there was a plot to harm you?’ (delusions of reference and persecution). (c) ‘A feeling that your thoughts were being directly interfered or controlled by another person, or your mind was being taken over by strange forces?’ (delusions of control). (d) ‘An experience of seeing visions or hearing voices that others could not see or hear when you were not half asleep, dreaming or under the influence of alcohol or drugs?’ (hallucinations). Individuals who endorsed at least one of the four above-mentioned psychotic symptoms were considered to have psychotic symptoms. Based on information on psychosis diagnosis and psychotic symptoms, we created four mutually exclusive psychosis categories: (1) no symptoms and no diagnosis; (2) at least one symptom

and no diagnosis; (3) a diagnosis and no symptoms; and (4) at least one symptom with a diagnosis (19, 20).

2.1.2.3 Sleep problems

Sleep problems were assessed by the question “Overall in the last 30 days, how much of a problem did you have with sleeping, such as falling asleep, waking up frequently during the night or waking up too early in the morning?” with answer options none, mild, moderate, severe and extreme. Those who answered severe and extreme were considered to have sleep problems. This definition has been used in previous publications using the same survey question on sleep problems (21-23).

2.1.2.4 Anxiety

Anxiety was assessed by the question “Overall in the past 30 days, how much of a problem did you have with worry or anxiety?” Respondents could answer: none, mild, moderate, severe or extreme. In the current study those who answered severe and extreme were categorized as having anxiety (23, 24). Data for this variable was missing from Morocco.

2.1.2.5 Stress sensitivity

Stress sensitivity in the last month was assessed by two questions: “How often have you felt that you were unable to control the important things in your life?”; and “How often have you found that you could not cope with all the things that you had to do?” The answer options to these questions were: never (score=1), almost never (score=2), sometimes (score=3), fairly often (score=4), very often (score=5). The scores of the two questions were added to create a scale ranging from 2 to 10 (25). Brazil, Hungary, and Zimbabwe lacked information on stress sensitivity.

2.1.3 Control variables

Variables on sex, age, highest education achieved (no formal education, primary education, secondary or high school completed, or tertiary education completed), wealth, setting (rural or urban), smoking, and alcohol consumption were used as control variables. The selection of these variables was based on past literature (26). Principal component analysis based on 15-20 assets was performed to establish country-wise wealth quintiles. The question on smoking was 'Do you currently smoke any tobacco products such as cigarettes, cigars, or pipes?' with the answer options being 'daily', 'yes, but not daily', or 'no, not at all'. This variable was dichotomized into those who smoked regardless of frequency (i.e. daily or not daily) (current smokers) and those who do not smoke. Alcohol consumption was assessed by first asking the question 'Have you ever consumed a drink that contains alcohol (such as beer, wine, etc)?' Respondents who replied 'no' were considered lifetime abstainers. If the respondent replied affirmatively, then he/she was asked how many standard drinks of any alcoholic beverage he/she had on each day of the past 7 days. The number of days in the past week in which 4 (female) or 5 (male) drinks were consumed was calculated, and a total of 1-2 and ≥ 3 days in the past 7 days were considered infrequent and frequent heavy drinking respectively. All other respondents, apart from lifetime abstainers, were considered non-heavy drinkers (23).

2.2 Statistical analysis

The statistical analysis was performed with Stata 14.1 (Stata Corp LP, College station, Texas). The age- and sex-adjusted prevalence of any back pain and chronic back pain for each country was estimated by using the United Nations population pyramids for the year 2010 (<http://esa.un.org/wpp/Excel-Data/population.htm>) as the standard population. The difference in sample characteristics between those with and without any back pain or chronic

back pain was tested by Chi-squared tests and Student's *t*-tests for categorical and continuous variables respectively.

Multivariable logistic regression analysis was done to assess the association between mental health conditions (exposure variables) and back pain or chronic back pain (outcome variables). The mental health conditions examined were depression type, psychosis, anxiety, sleep problems, and stress sensitivity. These variables were included separately in the models. The models were adjusted for age, sex, education, wealth, setting, smoking, alcohol consumption, and country. We repeated the analysis stratifying by region for all mental health conditions with the exception of psychosis to assess whether the associations observed are consistent across geographical locations. We were unable to conduct region-wise analyses for psychosis since the prevalence of some categories of this variable was extremely low [e.g. diagnosis and no symptoms 0.49% (n=863)].

All variables were included in the models as categorical variables with the exception of age and stress sensitivity which were continuous variables. Adjustment for country was done by including dummy variables in the models, as in previous WHS publications (23, 29). Morocco was excluded from analyses on anxiety as it had no information on this variable. Furthermore, this was also the case for Brazil, Hungary, and Zimbabwe for the variable on stress sensitivity. The sample weighting and the complex study design were taken into account in all analyses. Results from the logistic regression models are presented as odds ratios (ORs) with 95% confidence intervals (CIs). The level of statistical significance was set at $p < 0.05$.

3. Results

The total sample included was 190,593 with the sample size of the countries ranging from 929 (Latvia) to 10,687 (India) (**Table 1**). The overall prevalence were 35.1% for any back pain and 6.9% for chronic back pain. The age- and sex-adjusted prevalence range for any back pain was 13.7% (China) to 57.1% (Nepal), with more than half of the population also having back pain in Bangladesh (53.1%) and Brazil (52.0%). For chronic back pain, the lowest prevalence was observed in Myanmar (0.6%), with the highest rates in Morocco (16.5%) and Nepal (16.4%) (**Table 1, Figure 1**). The mean (SD) age of the sample was 38.4 (16.0) years and 50.7% of the sample consisted of females (**Table 2**). Older age, female sex, lower levels of education and wealth, urban setting, current smoking, alcohol consumption, depression, psychosis, anxiety, sleep problems, and higher levels of stress sensitivity were all significantly associated with any back pain or chronic back pain, although urban setting was significant only for any back pain.

Table 1 and 2 here

Figure 1 here

Relationship between back pain and mental health

The prevalence of any back pain and chronic back pain by the 5 mental health conditions is illustrated in **Figure 2**. Compared to those who do not have that mental health condition, the prevalence of any back pain or chronic back pain was much higher for those who have any depression or psychosis type, anxiety, and sleep problems. For the stress sensitivity score, there was a linear increase in the prevalence of both forms of back pain with higher severity of stress sensitivity. The association between mental health conditions and both forms of back pain estimated by multivariable logistic regression is shown in **Table 3**. In the overall sample, compared to those without the mental health condition, all types of mental ailments were associated with a significant >2 times higher odds for any back pain. For stress sensitivity, a

one-unit increase in severity (range 2-10) was associated with 1.13 times higher odds for any back pain. Similar results were obtained for chronic back pain, with particularly high odds observed for depressive episode. The results of the region-wise analyses are presented in eTable 1 of the Webappendix. Results were similar across continents.

Figure 2 here

Table 3 here

4. Discussion

General findings

This large-scale study including 190,593 participants from 43 LMICs demonstrates that the overall prevalence of any back pain and chronic back pain were 35.1% and 6.9% respectively. The current study is the largest of its kind and contains several novel results. Our data suggest that both any back pain and chronic back pain are associated with an increased risk of depression and psychosis spectrum, sleep disorders, anxiety and stress sensitivity. Furthermore, these associations were similar across continents despite a large variation in the prevalence of back pain across regions.

The rate of chronic back pain at 6.9% in the current study is lower than the 18% (95% CI=14-24%) observed in a recent meta-analysis (9), which included 79 surveys from general adult populations, elderly general populations and workers from 28 LMICs. A possible reason might be that higher LBP rates were observed in the studies focusing solely on elderly general population and workers while the current study did not target these subpopulations specifically. Next to this, in the current study, we applied more strict criteria for chronic back pain, i.e. chronic back pain was defined as having had back pain on all 30 days in the last 30 days.

It is perhaps of little surprise that back pain is associated with depression, given the established bidirectional relationship in Western populations (7, 8, 30). However, very few studies have considered the relationship between the depression spectrum (i.e. subsyndromal depression and brief depressive episodes) and back pain. In fact, to the best of our knowledge, no representative multi-national study has considered this relationship between the depression spectrum and back pain. Our data clearly indicate that all types of depression are associated with increased odds of experiencing pain. Potential factors that may account for the high back pain and depression comorbidity cannot be determined from the available

data. One possible factor is the underlying shared pathophysiology, since both depression and pain facilitate modulation in the periaqueductal gray, amygdala, and hypothalamus regions (31, 32). Second, both pain and depression are associated with and exacerbated by social isolation and reduced physical activity (33, 34). In addition, genetics and in particular single nucleotide polymorphism in the NTRK3 gene may account for the pain and depression relationship (35). Within the context of some LMICs, the high prevalence of HIV and tuberculosis (36) may also account for both the depression (37) and back pain (38) observed in the current study.

There is a paucity of studies investigating subclinical psychosis and back pain in the literature. Previously, one study among people in North-America found that psychotic experiences were significantly associated with an increased risk of chronic pain (OR 1.94 (39). Another study found that psychotic-like experiences are associated with severe pain in LMICs (40). However, no study has yet to our knowledge demonstrated the heightened relationship between back pain and sub-clinical psychosis found here. Our study also found that psychotic disorder (including schizophrenia) with symptoms was associated with 2.05 and 2.68 times higher odds for back pain and chronic back pain respectively. Understanding the relationship between back pain and psychosis is important since both conditions are associated with a lower quality of life (41). Interestingly, while experimental pain research has demonstrated that pain sensitivity is reduced in people with schizophrenia including those who do not take medication (42), our results suggest this may not translate into lower pain prevalence in schizophrenia patients at the community level. The association between back pain and psychotic experiences may possibly be due to psychological distress arising from back pain (43).

Our data established that both back pain and chronic back pain were associated with approximately two-fold increase odds of anxiety. To our knowledge, the current data are the

first to establish this relationship in a multinational LMIC group. There are a number of factors that could account for this relationship. First, experiencing pain, can stimulate feelings of anxiety, which can increase one's sensitivity to pain (44). Moreover, both chronic pain and anxiety share common underlying neural, cognitive and behavioral processes (45). Previous literature has suggested a relationship between pain and sleep (46), however, a paucity of multinational data exists on this topic. One could propose that back pain and sleep could also exist in a bidirectional relationship.

Practical implications

The current data have important public health implications, in particular since the data were multi-national, population-based, and predominantly nationally representative, rather than from clinical settings or the workplace. Understanding and treating comorbid pain and mental health outcomes is essential since both pain and mental health outcomes are worse than when any one stands in isolation (47, 48). An important environmental barrier in the care of people with mental and physical health problems in LMICs is however the lack of integrated mental and medical services and the poorly developed community-based psychiatric services (49). Closer integration of primary and mental health care in these countries is needed, but without obscuring the responsibility for back pain and mental health assessment, prevention and management (50). We suggest that back pain assessment, prevention and management in people with mental disorders should in the first place be the responsibility of the main mental health professional, whilst screening for mental health symptoms in people with a presentation of back pain should be the responsibility of the main treating physician or physiotherapist. However, it should be acknowledged that many professionals providing care for people with mental health conditions do not ask about back pain and many professionals providing care for people with back pain do not screen for symptoms of mental health

conditions either because of a lack of consideration of this health care aspect, lack of time or lack of resources directly available to them (51). Therefore, there is a clear need to increase awareness of the importance of physical health needs of people with mental disorders among mental health providers and mental health needs of LBP patients in physical health providers in LMICs. Clinicians should be aware that some people presenting with back pain may actually be presenting with ‘masked depression’ (52) and this may provide an opportunity for the treating physician to identify and offer appropriate treatment to such individuals. In our results we found evidence that lower education status is associated with higher back pain and such individuals may be more likely to conduct more manual work and experience back pain and also masked depression. In addition to pharmacological interventions, treatment and management modalities for LBP include behavior and exercise therapy and lifestyle change, many of which are relatively low-cost to implement in primary care settings (53). However, most of what is known is based on studies executed in high-income settings (53). Context-specific trials and evaluations in LMICs therefore are urgently needed.

Study limitations and future research

Some study design limitations need to be considered. First of all, the cross-sectional design precludes any certainty about the direction of the relationship between back pain and mental health disorders. Although cross-sectional studies cannot determine whether mental health symptoms or disorders and back pain associations reflect causal links, a “dose-response” pattern with more back pain in mental disorders compared with milder mental health symptoms is at least consistent with a causal interpretation. It is important that future research attempts to understand the underlying explanatory factors of the relationships we observed. In addition, *In addition, the questions from the CIDI used for the diagnosis of depression have been used extensively in international settings while the CIDI has been validated against clinical*

reappraisals (54). However, convergent validity with the DSM-IV or DSM-V needs further assessment especially in LMICs. In addition, while our study assessed a number of mental health conditions, future research may also wish to consider atypical depression, anxious depression and bipolarity symptoms in relation to back pain. Another limitation is that the back pain questions were quite generic and future research may wish to consider more details regarding the history of symptoms and present back pain complains. Next, we were unable to conduct country-wise analyses as the sample size was too small in many of the countries. However, for the mental health outcomes for which region-wise analyses were possible, the associations with back pain were fairly consistent. Finally, we were unable to account for medication use in our analyses. Future research should therefore consider the impact of analgesic and psychotropic medication on the association between back pain and mental health outcomes.

In conclusion, our data show that both back pain and chronic pain are associated with increased odds of depression, psychosis (including psychotic-like experiences), anxiety, stress, and sleep disturbances. Clearly, future research is required to determine the directionality of the relationships we observed and to inform the development of effective treatments.

Conflict of interest

All authors declare they have no conflict of interest

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Table 1 Age- and sex- adjusted prevalence of any back pain and chronic back pain by country

Region	Country	Unweighted N	Any back pain % (SE)	Chronic back pain % (SE)	
Africa	Burkina Faso	4,948	29.5 (1.4)	4.1 (0.6)	
	Chad	4,870	44.8 (1.6)	8.7 (0.8)	
	Comoros	1,836	32.4 (1.8)	3.2 (0.5)	
	Ethiopia	5,089	25.3 (1.1)	4.1 (0.4)	
	Ghana	4,165	21.9 (0.9)	4.6 (0.4)	
	Ivory Coast	3,251	33.9 (1.6)	5.9 (0.8)	
	Kenya	4,640	27.1 (1.1)	5.1 (0.6)	
	Malawi	5,551	30.4 (1.1)	3.5 (0.5)	
	Mauritania	3,902	33.2 (1.4)	1.7 (0.4)	
	Mauritius	3,968	27.5 (1.4)	5.0 (0.6)	
	Morocco	5,000	45.8 (1.3)	16.5 (1.0)	
	Namibia	4,379	26.1 (1.0)	4.3 (0.6)	
	Senegal	3,461	26.8 (1.3)	3.9 (0.6)	
	South Africa	2,629	30.3 (1.4)	2.5 (0.5)	
	Tunisia	5,202	29.1 (1.0)	5.9 (0.5)	
	Zambia	4,165	25.6 (1.0)	2.3 (0.3)	
	Zimbabwe	4,290	28.1 (1.1)	3.4 (0.5)	
	Americas	Brazil	5,000	52.0 (0.8)	13.0 (0.6)
		Dominican Republic	5,027	22.7 (0.9)	3.0 (0.3)
Ecuador		5,675	28.9 (1.4)	4.3 (0.7)	
Paraguay		5,288	37.2 (0.9)	5.8 (0.4)	
Uruguay		2,996	23.8 (1.2)	3.9 (0.4)	
Asia	Bangladesh	5,942	53.1 (1.0)	10.9 (0.8)	
	China	3,994	13.7 (1.0)	2.6 (0.4)	
	Georgia	2,950	20.2 (1.3)	3.3 (0.5)	
	India	10,687	36.4 (1.7)	9.1 (0.8)	
	Kazakhstan	4,499	33.8 (1.3)	4.1 (0.5)	
	Laos	4,988	29.9 (0.9)	2.9 (0.3)	
	Malaysia	6,145	23.5 (0.8)	1.8 (0.2)	
	Myanmar	6,045	18.7 (1.2)	0.6 (0.1)	
	Nepal	8,820	57.1 (0.7)	16.4 (0.6)	
	Pakistan	6,501	26.3 (0.8)	7.3 (0.5)	
	Philippines	10,083	41.9 (1.1)	1.8 (0.2)	
	Sri Lanka	6,805	23.7 (1.1)	3.2 (0.4)	
	Vietnam	4,174	28.3 (1.9)	3.0 (0.6)	
Europe	Bosnia Herzegovina	1,031	34.2 (2.9)	8.6 (1.2)	
	Croatia	993	49.3 (2.2)	12.9 (1.4)	
	Czech Republic	949	47.5 (2.6)	13.3 (1.6)	
	Estonia	1,020	37.6 (2.1)	8.6 (1.0)	
	Hungary	1,419	40.0 (1.7)	12.7 (0.8)	
	Latvia	929	45.6 (2.4)	11.0 (1.3)	
	Russia	4,427	41.1 (2.1)	6.7 (0.9)	
	Ukraine	2,860	44.2 (1.8)	10.9 (0.9)	

Abbreviation: SE standard error

All age- and sex-adjusted weighted estimates were calculated using the United Nations population pyramids for the year 2010.

Table 2 Sample characteristics (overall and by any back pain or chronic back pain)

Characteristics	Overall	Any back pain		P-value	Chronic back pain		P-value
		No	Yes		No	Yes	
Age (years) Mean (SD)	38.4 (16.0)	35.9 (15.3)	43.1 (16.2)	<0.0001	37.5 (15.7)	48.7 (15.8)	<0.0001
Sex							
Male	49.3	53.9	40.9	<0.0001	50.6	33.4	<0.0001
Female	50.7	46.1	59.1		49.4	66.6	
Education							
No formal	28.0	25.5	31.9	<0.0001	26.7	41.7	<0.0001
<Primary	32.3	31.9	33.2		32.6	30.1	
Secondary completed	29.8	31.8	26.6		30.5	21.9	
Tertiary completed	9.8	10.7	8.3		10.1	6.3	
Wealth							
Poorest	20.1	19.1	22.2	<0.0001	19.9	23.9	<0.0001
Poorer	20.0	19.1	21.3		19.7	22.0	
Middle	19.9	19.8	20.2		19.9	20.3	
Richer	20.0	20.4	19.2		20.2	17.3	
Richest	20.0	21.7	17.1		20.3	16.5	
Setting							
Rural	58.8	59.6	56.9	0.0002	58.9	56.8	0.0969
Urban	41.2	40.4	43.1		41.1	43.2	
Current smoking	26.7	24.8	30.1		26.4	30.6	
Alcohol consumption							
Lifetime abstainer	67.4	70.3	61.8	<0.0001	67.7	63.0	<0.0001
Non-heavy	27.6	24.9	33.0		27.2	33.9	
Infrequent heavy	3.8	3.7	4.0		3.9	2.3	
Frequent heavy	1.1	1.1	1.2		1.1	0.8	
Depression type							
No depression	87.8	92.5	77.6	<0.0001	89.1	64.4	<0.0001
Subsyndromal depression	2.5	1.8	4.1		2.3	7.1	
Brief depressive episode	2.9	1.8	5.2		2.7	6.0	
Depressive episode	6.8	3.9	13.1		5.9	22.5	
Psychosis							
Symptom (-) Diagnosis (-)	84.7	88.8	76.9	<0.0001	85.5	72.8	<0.0001
Symptom (+) Diagnosis (-)	14.2	10.4	21.4		13.5	24.8	
Symptom (-) Diagnosis (+)	0.5	0.3	0.8		0.5	0.8	
Symptom (+) Diagnosis (+)	0.6	0.4	0.9		0.5	1.7	
Anxiety^a	12.0	8.2	19.2	<0.0001	10.8	29.3	<0.0001
Sleep problems	8.0	4.3	14.9	<0.0001	6.8	24.3	<0.0001
Stress sensitivity^b Mean (SD)	4.9 (2.2)	4.7 (2.2)	5.5 (2.2)	<0.0001	4.9 (2.2)	5.9 (2.2)	<0.0001

Abbreviation: SD standard deviation

Data are weighted column (%) unless otherwise stated.

^aMorocco is not included.^bBrazil, Hungary, and Zimbabwe are not included. The stress sensitivity score ranges from 2-10 with higher scores indicating higher levels of stress sensitivity.

Table 3 The association between mental health conditions and any back pain or chronic back pain estimated by multivariable logistic regression

		Any back pain		Chronic back pain	
		OR	95%CI	OR	95%CI
Depression type	No depression	1.00		1.00	
	Subsyndromal depression	2.21**	[1.91,2.54]	2.89**	[2.36,3.56]
	Brief depressive episode	2.64**	[2.33,2.99]	2.06**	[1.73,2.46]
	Depressive episode	2.88**	[2.63,3.17]	3.12**	[2.76,3.52]
Psychosis	Symptom (-) Diagnosis (-)	1.00		1.00	
	Symptom (+) Diagnosis (-)	2.01**	[1.88,2.16]	1.72*	[1.54,1.92]
	Symptom (-) Diagnosis (+)	2.51**	[1.87,3.39]	1.62*	[1.08,2.43]
	Symptom (+) Diagnosis (+)	2.05**	[1.64,2.57]	2.68**	[1.93,3.73]
Anxiety ^a	Yes vs. No	2.12**	[1.96,2.29]	2.45**	[2.19,2.74]
Sleep problems	Yes vs. No	2.37**	[2.19,2.57]	2.38**	[2.13,2.65]
Stress sensitivity ^b	(per unit increase)	1.13**	[1.12,1.15]	1.15**	[1.13,1.18]

Abbreviation: OR odds ratio; CI confidence interval

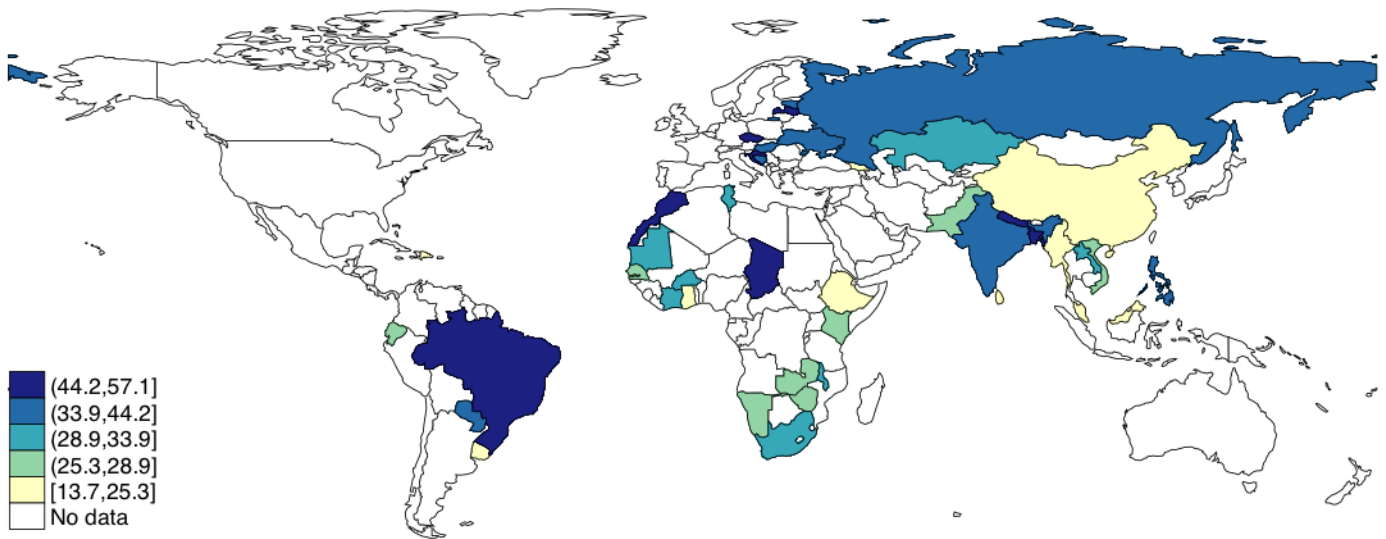
The mental health conditions were included separately in the models. All models are adjusted for age, sex, education, wealth, setting (rural or urban), smoking, alcohol consumption, and country.

^aMorocco is not included.

^bBrazil, Hungary, and Zimbabwe are not included. The stress sensitivity score ranges from 2-10 with higher scores indicating higher levels of stress sensitivity.

*p<0.05, ** p<0.001

(a) Any back pain



(b) Chronic back pain

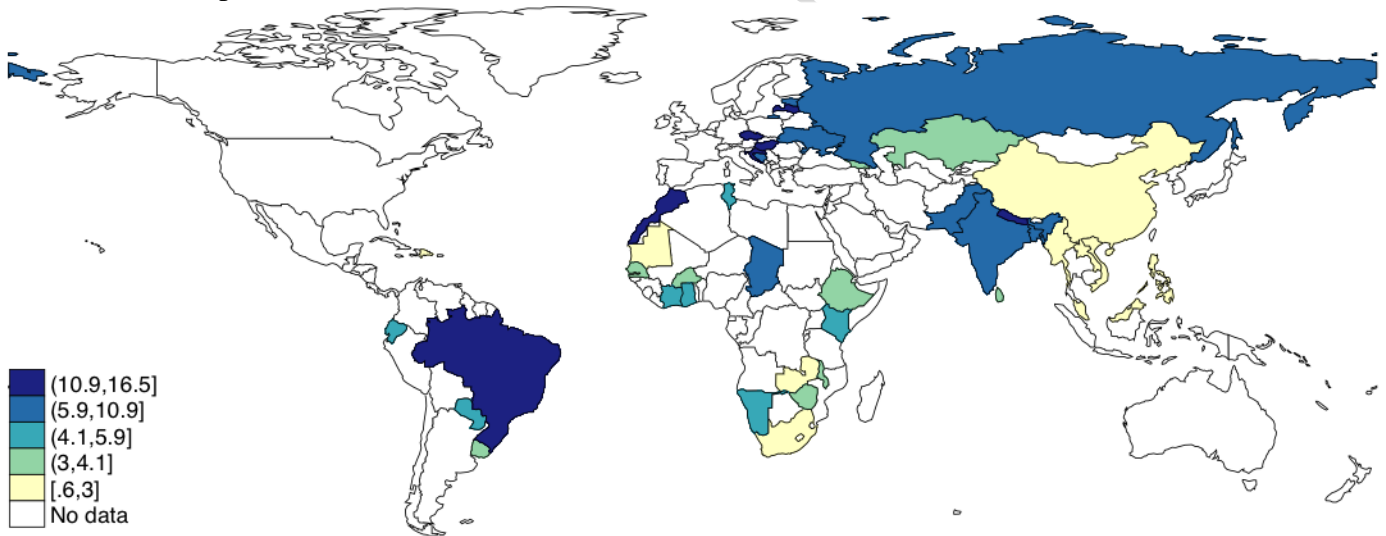


Figure 1 The age- and sex-adjusted prevalence of (a) any back pain and (b) chronic back pain. All age- and sex-adjusted weighted estimates were calculated using the United Nations population pyramids for the year 2010.

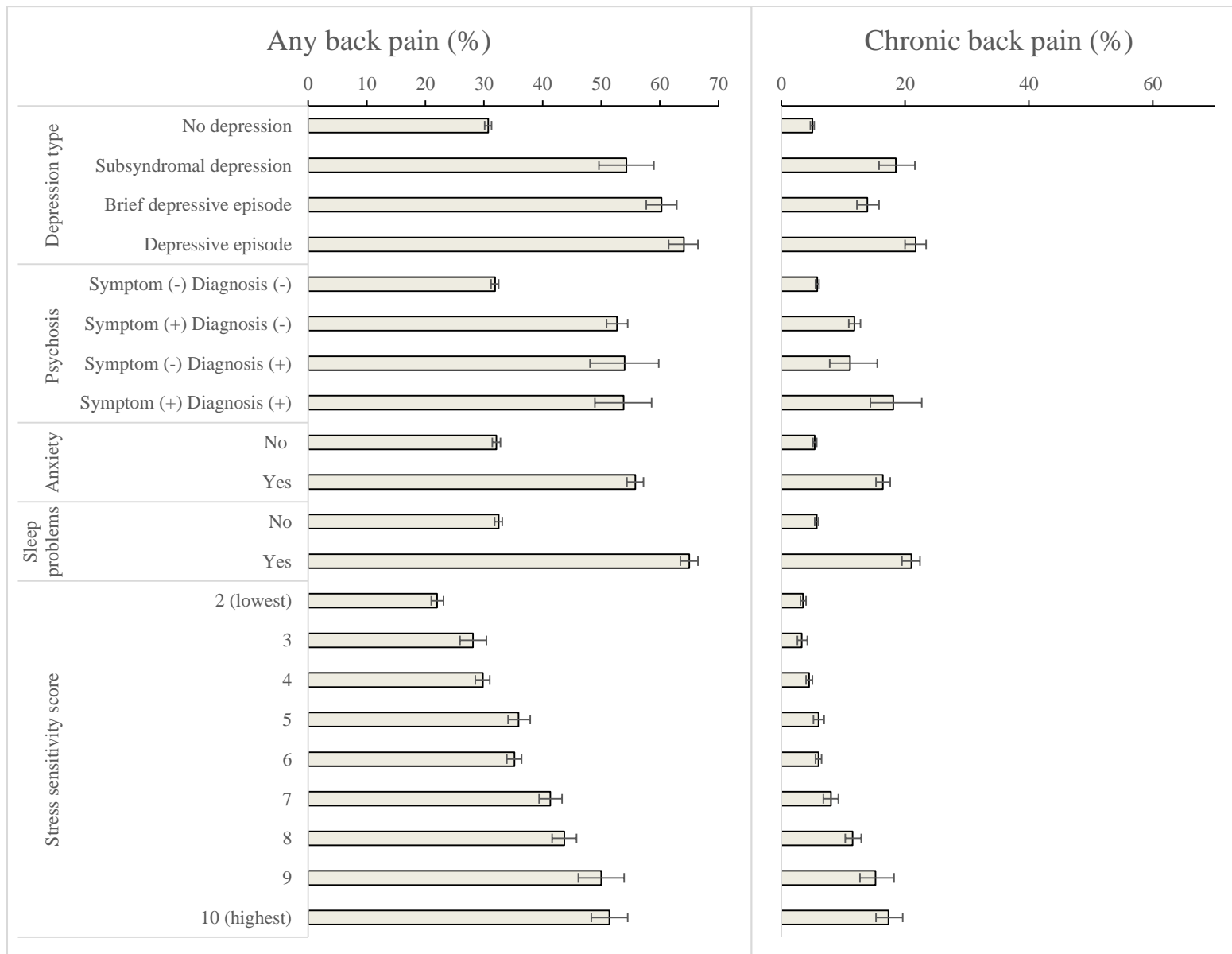


Figure 2 Prevalence of any back pain and chronic back pain by mental health conditions
 Estimates are based on weighted sample. Bars denote 95% confidence intervals.

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