

Cultural aspects of pain: a study of Indian Asian Women in the UK

Running title: cultural aspects of pain

Stephanie Holt MSc

School of Health and Rehabilitation, Keele University, UK

Jackie Waterfield MSc EdD*

School of Health Sciences, Queen Margaret University, Edinburgh, UK

* Corresponding author jwaterfield@qmu.ac.uk

Acknowledgments: we would like to thank Kalpanaben Patel for acting as an interpreter, and Julius Sim for commenting on a draft of this paper.

Conflicts of interest: the authors have no conflicts of interest with regard to this paper.

Abstract

Objectives: Culture and ethnicity are acknowledged as important factors in the context of the biopsychosocial model. They may contribute to explaining the experience of pain, therapeutic encounters within health care, and the strategies that individuals use to cope with pain. This study explored these issues in a sample of Indian Asian women in the United Kingdom.

Methods: Based on a phenomenological approach, seventeen women participated in five semi-structured group interviews. Data were analysed using qualitative content analysis, so as to identify core themes and subthemes inductively from the data.

Results: Five themes were identified: meaning of pain; personal experience of pain; causes of pain; coping strategies; family and friends; experience of health care. Pain was conceptualized in both physical and mental terms, and its experience was explained largely in terms of functional consequences. The causes of pain offered suggested externalized beliefs, relating to events in participants' lives, rather than being expressed in biomedical terms. Alongside culture-specific therapies, the women spoke of coping strategies based on rest and activity. Although satisfaction with health care appeared to be high overall, problems due to communication – sometimes related to a language barrier – were voiced by some participants.

Conclusions: Greater attention to cultural aspects of the pain experience may assist health professionals in communicating with and managing patients with pain from ethnic minority backgrounds.

Introduction

Pain is a complex phenomenon, incorporating a wide range of physical, psychological and social factors (Main and Spanswick, 2000; Main et al., 2008). One such factor is culture and ethnicity (Morris, 1999; Helman, 2000; Cleland et al., 2005). The United Kingdom (UK) exemplifies a multicultural society; between 1993 and 2015 the foreign-born population in the UK rose from 3.8 million to around 8.7 million (Vargas-Silva and Rienzo, 2017). Consequently, UK society is made up of a number of ethnic subgroups, each with distinctive beliefs, values, and customs, and it is argued that healthcare practitioners (HCPs) should recognize how varying populations may conceptualize and experience pain differently (Cleland et al., 2005; Lovering, 2006; Berry, 2015).

Early studies by Zborowski (1952) and Zola (1966) were foundational in exploring the relationship of pain to culture and ethnicity. Zborowski (1952) noted that as generations of immigrants became more embedded within American culture they appeared to adopt more 'American' forms of behaviour and attitudes, except with respect to pain. This suggests that ethnic and cultural variations in beliefs and attitudes can also have a significant and longstanding influence, particularly when related to pain.

Allison et al's (2002) work in Manchester, UK, investigated self-reported musculoskeletal pain within four ethnic minority groups, and discovered that pain prevalence was slightly higher, and pain reported in multiple sites more common, than in the white population. More recently, Plesh et al. (2011) found that ethnic minority populations demonstrated an increase in comorbid pains by age when compared with Caucasians, with women demonstrating more variability in pain presentation across age and ethnicity than men. Similar findings are reported by Parmelee et al. (2012). Differences have also been observed between ethnic groups in pain-reducing behaviours (Hastie et al. 2005). The authors suggest that these behavioural responses to pain may reflect behaviour patterns based on cultural or other environmental influences that would have been acquired reasonably early on in life.

A UK study of people of African-Caribbean and South Asian origin (Rogers and Allison, 2004) reflected previous findings, with both of these populations reporting widespread pain more commonly than a general population sample from the same locality. Furthermore, while accounts of pain from the African Caribbean respondents mirrored the traditional Western medical model of psychogenic pain and more individualized coping strategies, such as 'thinking about something else', descriptions from South Asian participants tended to emphasise fragility and paralysis of the body. Some of the South Asian participants also appeared unable to separate pain located in particular parts of the body from wider social and personal concerns, and appeared reluctant to recognize the latter as 'depression' or psychological distress. In both groups, older respondents were more likely to have made use of home and lay remedies from their country of origin, and the authors report some evidence that this was passed on within families. Finally, in contrast to the African Caribbean respondents, South Asians were less likely to formulate individual coping strategies, and instead were more likely to refer to help from family members as a way of managing pain. It appears, therefore, that coping strategies can be shaped by ethnicity and culture through learning.

The South Asian community has been a particular focus of research, which has shown that South Asian people attend general practices more frequently than the white population (Atri et al., 1996; Balarajan et al., 1989; Njobvu et al., 1999). However, it is unclear whether this is due to differences in morbidity, or reflects different perceptions of illness (Njobvu et al., 1999). The pattern of consultation behaviour seen in the South Asian population has been further supported by the experiences of general practitioners (GPs), with reports that South Asian patients often consult recurrently with the same symptoms, presenting them as new, and that they present with more widespread pain (Patel et al., 2008), mirroring findings in the literature (Allison et al., 2002; Rogers and Allison, 2004). These non-specific presentations make diagnosis and management difficult, further complicated by communication problems when there is a language barrier (Patel et al., 2008, 2009).

The relationship of ethnicity and culture to the experience and perception of pain is complex, and is under-researched, particularly in the UK. Therefore, the aim of this study was to more closely explore the perceptions of pain, coping and treatment within a particular ethnic group. Among foreign-born people residing in the UK, India is the second most common country of birth, after Poland (Vargas-Silva and Rienzo, 2017). The study sought to produce a deeper understanding of the perceptions of pain, coping and treatment within this particular group, and how these might be shaped by culture.

Research setting

Walsall, the setting for this study, is a large town within the West Midlands of the UK that has seen a significant increase in its level of ethnic diversity over the past decade, and more residents from a minority ethnic background than the average in England and Wales. The largest increase has been seen in people of Asian background, where Asian Indian remains the largest minority ethnic group, at 6.1% (Walsall Council, 2013).

Methods

This study adopted a phenomenological approach. Phenomenology seeks to understand the world as experienced by an individual or group of individuals, focusing on 'personal or shared meanings, as distinct from the objective physical world' (Finlay, 2011: 15). Within phenomenology there are both descriptive and interpretive approaches (Lopez and Willis, 2004), but we took a Heideggerian perspective within the interpretive tradition. This approach emphasizes the rich description that is found within everyday life, acknowledging that the narratives given by participants form their reality, and therefore the interpretive basis of understanding (Mackey, 2005).

Purposeful sampling was used (Emmel, 2013). The inclusion criteria were: women, aged 40–75 years of age, and of Indian Asian descent. The initial sample was achieved by approaching women's meeting groups, exercise groups, and women within the study interpreter's social circle. Those interested in being involved were given further information and invited along to a group interview. Further recruitment through snowball sampling was also used, a procedure whereby participants who

have already agreed to take part identify further potential participants (Atkinson and Flint, 2004), in this instance family and friends.

Data were collected through semi-structured small-group interviews. The small-group interview is similar to a focus group in that it involves more than one interviewee and is exploratory in nature (Morris, 2001; Polak and Green, 2016). However, it differs from a focus group in that each individual is given the opportunity to answer the same question, but is unlike a face-to-face questionnaire as it allows greater exploration and depth of an individual's response.

In line with recent guidance (Guest et al, 2017), it was expected that between 3 and 6 interview groups would likely identify most or all of the most prevalent themes, and the target number of groups was therefore in this range. Seventeen participants were thereby included in the study, in five interview groups of between three and five participants. An Indian Asian colleague was recruited to act as a translator, if required. Potential participants received detailed information about the study

The interviews were arranged at a mutually convenient time and place. As levels of English and literacy may be low among Indian women (Rudat, 1994), study information was therefore reiterated prior to interview in the participant's own language, and oral consent was obtained. Demographic data (age, country of birth, religion, first language, marital status, highest educational level and employment status) were recorded to help to contextualize the study and assist with making the findings transferable. The interviews took a semi-structured approach, with questioning based around topic areas including: understanding, interpretation, and personal experiences of pain; coping – including family and community support; and experiences of treatment (Appendix). The interview guide was drawn up by the researchers in relation to central concepts in the literature regarding culture and the subjective experience of pain. Each participant was asked the same questions. Interviews took place in the home of one or other of the participants, lasted approximately 45–60 minutes, and were audio-recorded and subsequently transcribed.

Data analysis was through qualitative content analysis (Graneheim and Lundman, 2004; Hsieh and Shannon, 2005). This was carried out following Braun and Clarke's (2006) six-step process, which involved coding, collating and analysing the data transcribed, then further organizing them into higher-order themes and subthemes, with data within themes then further analysed. The first group interview transcript was coded by both authors; thereafter the first author coded the transcripts and the analysis was discussed and agreed by both authors.

To minimize social desirability bias or other influences on disclosure (Richards and Schwartz, 2002), although the first author's health professional background was disclosed to participants, in other respects it was downplayed, and participants were recruited from the community rather than from a patient population (such that no participant had had any previous contact with the researchers within the healthcare system).

Rigour was maximized through a process of reflexivity that allowed the researchers to be transparent regarding the processes of collecting and analysing data and their own assumptions regarding the topic of enquiry. The potential impact of using an interpreter was also considered. It has been argued

that translating meaning literally from one language to another is impossible and may therefore require using different words from those spoken by the research participants (Temple and Edwards, 2002; Temple and Young, 2004). More important is to portray the concepts that are conveyed rather than the literal translation of the words spoken. The interpreter was therefore treated as a 'key informant' (Temple and Edwards, 2002: 6) with a reflexive approach that evaluated the interpreter's social location, values and beliefs, and her relationship with the researchers.

Ethical approval

Ethical approval was obtained from Keele University Ethical Review Committee on 3rd September 2014.

Results

Participants' demographic and other characteristics are shown in Table 1.

Data analysis identified six main themes (with sub-themes in parentheses):

Meaning of pain (pain means pain; different types of pain; emotional pain; something is wrong)

Personal experience of pain (nature and location of own pain; physical consequences of pain; emotional aspects of pain)

Causes of pain (work; tiredness; stress; weather; food; age; medical causes; other beliefs)

Coping strategies (heat; massage, Indian remedies; food; painkillers; exercise; keeping busy; rest; barriers/demands)

Family and friends (reactions; help; no-one to help)

Experience of health care (contact with healthcare; good experiences; bad experiences; language barrier)

In this section, each theme will be presented alongside illustrative quotations and discussion within the context of the wider literature.

Each participant was allocated a number to maintain anonymity. Quotations indicated by 'P' represent the participant having conversed in the English language, whereas 'IP' represents the interpreter's translation of the participant's speech. The group interview from which a quotation is derived is denoted by 'GI'.

Meaning of pain

Most participants seemed unable to verbalize the meaning of 'pain' much beyond the word itself:

IP3: *Pain means just pain, too much pain, and it's all over the body, and that's all I understand.*

G11: 46–47

P9: *Pain is something hurting.*

G13: 45

Pain was conceptualized by some participants in both physical and mental terms:

P4 *I think there is different kinds of pain, sometimes body pain, and sometimes... somebody said something and it goes in your head I think that's painful as well. Thought pain, I think, it called thoughtful pain or something I think.*

G12: 80–82

IP5 *Pain means the mind almost goes there always, because there's pain there.*

G12: 98

The women appeared to relate to the immediate feeling of pain rather than its meaning, perhaps due to difficulty in verbalizing what pain might symbolize. One participant did, however, attempt to explain why pain might occur:

P12: *I think pain is, it's trying to tell you something, isn't it? When you have certain kind of pains, your body's trying to tell you that there's something wrong with you, and then you go to the doctor and tell him about it and – isn't it? – if we ignore the pain then it could get worse, it could get be too late, isn't it? That's what I think pain is. We tend to, you feel like someone is giving you a good bashing or something like that.*

G14: 83–88

Another participant suggested that pain can be felt emotionally as well as just physically:

P6: *Er [pause], there's all sorts of pain but you know, I think I can feel all the pain, like my family, all that's passed away I been crying and crying and that pain I hurt too much.*

G12: 106–108

Over the years, somatization – ‘the cultural patterning of psychological and social disorders into a language of distress of mainly physical symptoms and signs’ (Helman, 2000 p182) – has increasingly been reported within certain non-Western cultures, particularly amongst Asian and African populations (Kleinman, 1980; Fenton and Sadiq-Sangster, 1996; Kirmayer and Young, 1998; Parker et al, 2001). This is reflected in Rogers and Allison’s (2004) study, where South Asian respondents appeared unable to separate specific bodily pain from wider social and personal concerns, a belief that has also been found among GPs (Patel et al., 2008). However, the accounts in the current study would not support this view, as participants recognized psychological distress and expressed it as emotional rather than physical pain. Additionally, Fenton and Sadiq-Sangster (1996), who interviewed South Asian women in the UK, found that while the term ‘depression’ was not well recognized, the women did have a clear understanding of mental health and illness and an awareness of the relationship between physical and mental health. Furthermore, Bendelow (1993), interviewing men and women from mixed ethnic backgrounds, found that all participants either acknowledged or made reference to ‘emotional pain’ as a concept, with women more likely than men to acknowledge

emotional vulnerability. These findings reflect the accounts of 'emotional pain' within the current study (though this concept was only explored within one group interview).

Personal experience of pain

Fourteen participants reported experiencing some sort of pain, with seven (50%) of those reporting pain in more than one site. This accords with the reported high prevalence of widespread pain in ethnic minority groups, including Indian Asians (Allison et al., 2002; Rogers and Allison, 2004; Plesh et al. 2011).

Most participants reported physical consequences of pain, commonly relating to mobility and daily activities, particularly household duties.

IP1: I can only do one job at a time, when I do cooking for a while I just sit down. After cooking I get tired and I just sit down. If I can't do the continuous work, I have to sit down for 10 to 15 minutes, take a rest, and then I have to carry on. If I do that my leg is in terrible pain.

G11: 90–93

IP7: Whenever I have pain I am unable to walk properly, I was unable to sit properly, lie properly, so it's a really bad experience when I have pain.

G13: 37–38

Pain also gave rise to problems with concentration:

IP10: When you are in pain then your mind keeps going to the pain, to the affected area and then you can't concentrate your mind somewhere else.

G14: 163–164

One participant voiced a strong sense of helplessness in the face of pain:

IP3: I feel really bad, even though I feel that I am quite young and can't do much, so I feel helpless.

G11: 67-68

The women's accounts indicate that pain is something that affects their day-to-day lives, limiting daily activities and demanding attention. Participants also described strong emotional impacts, such as feelings of unhappiness, anger and anxiety, connected to the pain experience. Wiech and Tracey (2009) propose that this can lead to long-lasting emotional disturbances, and research indicates that anxiety can also increase the amount of pain experienced (Fordyce and Steger, 1979; James and Hardardottir, 2002; McGowan et al., 1998). It may therefore be that higher levels of pain anxiety and attention contribute to the high levels of pain reporting and widespread pain noted elsewhere within this ethnic group (Allison et al., 2002; Rogers and Allison, 2004). It may also be that the pain anxiety and attention seen amongst the women in this study could partly be attributed to specific health beliefs, to be explored in the following themes.

Causes of pain

A number of different beliefs were held regarding causes of pain, with very few based on what would be seen as conventional biological reasoning. While some views were expressed in medical terms,

these were mostly repetitions of what individuals had been told by medical professionals. The women reported that not eating the right food, old age, and stress could cause pain, with an overlying belief that pain was often caused by hard work or tiredness.

IP3: *The hard work we are doing, that is why there is pain.*

G11: 95

P9: *Sometime if you work too much, you will suffer. Or if you don't sleep, you get stressed you will have a pain. Or not having enough sleep, or rest, if you don't have rest then you will suffer.*

G13: 65–67

IP16: *The pain sometimes comes when you are tired, or when you are not well, when you over-do it.*

G15: 60–61

This reflects Rogers and Allison's (2004) findings that ethnic minority groups often connected pain with their working lives, in addition to other aspects of lived experience and their personal and social environment. Generally, 'working hard' was considered a causative factor.

Another common belief was that UK weather – particularly cold and damp – exacerbates pain, with participants reporting that a hot climate would make them feel better, as indicated in a study of Pakistani people living in England and Pakistan (Hameed and Gibson, 1997).

It became apparent from the data that the women held quite externalized beliefs, whereby illness is ascribed to events or other external influences rather than to disorders of internal physiological function.

Coping strategies

Common self-help strategies included heat, massage, yoga, painkillers, and certain foods. In addition to painkillers, culture-specific strategies were reported, reflecting the findings of Rogers and Allison (2004) and Lovering (2006) that individuals are likely to use home and lay remedies from their country of origin.

IP6: *From India, an Ayurvedic doctor gave me some oil, I massage that oil and that goes in my bone and helps me. I have been told to eat aloe vera and some ladyfinger and some sort of yam as well because it's good for the lubrication of the bone. Aloe vera juice is good as well.*

G12: 254–258

A number of participants viewed exercise as a helpful strategy in the management of their pain, with yoga being particularly popular. Another strategy arising in the majority of groups was the idea of keeping busy:

IP11: *If I keep busy then my mind doesn't go to where the pain is, so I like to keep busy if I can.*

G14: 171–172

However, in contrast to exercise and focusing away from pain, which could be deemed active strategies, a predominant sub-theme was the belief that one should rest when in pain.

IP11: *If my body is in too much pain I would stop all the housework, stop whatever I was doing, then you need to rest.*

GI4:187–188

IP16: *If I'm in pain and I think I can't do anything then I'll just sit down and rest.*

GI5: 73

Others spoke of pacing – interspersing rest with activity – and related this to the idea that ‘you’ve got to listen to your body’ (IP10 GI4: 198). There was also an acknowledgment of the importance, and often the necessity, of continuing with life despite pain:

P17: *We women, like, we got a pain but still we carry on, it doesn't matter there's a pain there but we have to carry on in life.*

GI5: 49–50

IP16: *Even when I'm in pain I carry on because there is no one to help me.*

GI5: 113

A number of different coping strategies are utilized by these women, and in contrast to Rogers and Allison's (2004) findings, individualized strategies such as exercising and keeping busy did emerge. However, despite this, the coping strategies reported could be perceived to be a mixture of adaptive and maladaptive coping. As an overlying belief was that one should rest when pain is present, this would be considered a ‘passive’ coping strategy (Main et al. 2008; Oliveira et al. 2012; Tan et al. 2011), whereas pacing would be considered adaptive. Maladaptive coping has been linked to a more external locus of control (Main et al., 2008; Oliveira et al. 2012), while Tan et al. (2011) found that in the case of chronic pain, maladaptive coping seems to be related to poorer adjustment, associated with psychological distress and reduced function (Main et al., 2010; Tan et al. 2011), both of which have been recognized within this study as consequences of pain. Again, this could account, to some degree, for some of the higher levels of pain reporting and more widespread pain seen within this ethnic group.

The women perceived taking rest to be difficult, owing to daily demands and cultural expectations.

IP11: *Sometimes even if I am in pain I will carry on because someone needs to finish the work, obviously house work.*

P12: *Yeah, it's your job isn't it, if you've got a job then you carry on.*

GI4: 194–196

P15: *we're always very busy you know and we never make time for ourselves. You know we're always looking after the family. That's our culture you know, we've always been brought up you know, things are changing now, I think the younger generation like the men help the women more, but like still in our generation you know they don't, we're still expected to be in the kitchen, still, you know no matter what we still have to look after the family.*

GI5: 238–243

In Indian culture, while the role of women can vary with socioeconomic, generational or educational level, they are often expected to maintain a role that comprises dutiful wife, obedient daughter-in-law,

and loving mother, and family needs are seen to supersede those of the individual (Choudry, 2001; Ibrahim et al., 1997). As the expectation is to prioritize one's own health below taking care of family, women may feel unable to take time out from these duties even when unwell.

However, if these women do not feel able to control their level of activity, this would reduce their sense of control over pain. Main et al. (2010) state that beliefs about the degree to which pain can be controlled are strong determinants of adjustment to pain or the development of disability, with the potential to mediate the influence of pain and depression. This could therefore be a strong barrier to recovery or effective self-management.

Family and friends

The majority of respondents acknowledged that help was available from family members if required, reflective of Indian culture, in which family solidarity and mutual dependence are encouraged (Choudry, 2001). However, several respondents reported either not receiving enough help, or help not always being available due to others being busy:

IP3: *No one helps, everyone is busy, they do their work. You have to suffer on your own, and you have to do it.*

GI1: 110-111

IP7: *Generally, when I am in pain I take painkillers and have a rest. Everybody can't help every day, they have their own life as well.*

GI3: 132-133

Similarly, there was a perceived need to be self-reliant in the face of pain:

IP8: *I am very blessed by God that I don't need that kind of help at the moment. Friends and family will listen to you one day, second day, but then not every day though. You need to help yourself.*

GI3: 134-136

Participants also believed that they would be perceived as complaining:

Interviewer: *Okay, and how about other people, how might they react to you if you were in pain? So family or friends?*

P17: *Well we get some people they say oh you getting old, oh you're old. I say we're not old, I don't know why, you know like [they say that].*

P15: *They can be supportive but then again...*

P17: *They can be supportive yeah.*

P15: *....But then again it's just like oh she's just complaining again [laughs].*

P17: *Yeah.*

P15: *We get a lot of that don't we you know.*

P16: *Moaning all the time.*

P15: *Yeah you're always moaning about this and that, this is aching, that's aching, but that happens to me, it's just a sign of old age [laughs].*

GI5:100-111

For some participants, a cultural perception that women should continue with their household duties and caring responsibilities regardless made them reluctant to ask for help.

IP16: *The children do say to me that you are a worried person and you get stressed. They do help. I don't like anybody helping me though, I'm a very independent person.*

G15: 119–120

One participant referred to the loss of support of friends and extended family back in India, reflecting Choudhry's (2001) study of the effects of resettlement in south Asian women.

Experience of healthcare

The majority of respondents seemed to have faith in their GP, reflecting high levels of GP consultation behaviour seen within this ethnic group (Atri et al., 1996; Balarajan et al., 1989; Njobvu et al., 1999). Most participants were also happy with the treatment and care they had received within the broader healthcare system. Clear communication from HCPs was valued, and bad experiences were related to not being listened to or receiving a misdiagnosis. There were also reports of a 'language barrier' due to a lack of interpreting support.

IP11: *there is no Gujarati doctor so they will say well Hindi is the nearest one... I feel helpless, nobody came to help me, I can't speak English and I feel helpless because I couldn't explain.*

G14: 96–97,104–105

Language and cultural differences may cause misunderstandings in 20% of consultations (Roberts et al., 2005). This, combined with reported difficulties in clarifying and diagnosing symptoms (Patel et al., 2008, 2009), and preconceived ideas that healthcare professionals may hold, particularly in regard to somatization (Patel et al., 2008), may generate misconceptions or inappropriate assumptions, leading to a poor patient experience.

Discussion

This study aimed to explore the relationship between ethnicity and the pain experience, an area that is still poorly understood. A number of important themes emerged, which may allow a better understanding of the perceptions of Indian Asian women in relation to pain, and how these views may be shaped by ethnicity and culture.

The biopsychosocial model of pain proposes that a combination of factors can influence the individual pain experience, including ethnicity and culture (Edwards et al., 2005; Main and Spanswick, 2000; Main et al., 2008). Previous research has identified that ethnic minority groups report a high prevalence of pain, and more widespread pain (Allison et al., 2002; Plesh et al., 2011; Rogers and Allison, 2004), and demonstrate a variation in coping strategies (Edwards et al., 2005; Hastie et al., 2005; Jordan et al., 1998; Rogers and Allison, 2004; Tan et al., 2005). South Asian populations have also been shown to consult their GP more frequently than the general population (Atri et al., 1996;

Balarajan et al., 1989; Njobvu et al., 1999). However, it is not fully understood why these differences are present, and how they may relate to ethnicity or culture.

The use of an interpreter within this study allowed inclusion of participants who otherwise would not have been able to take part, which may have misrepresented the population to be studied. However, it may have influenced the findings. Through the process of translation of speech by the interpreter, and further from the third to first person by the researcher during transcription, it is difficult to know whether the participants' original thoughts and feelings have been truly represented. As it has been deemed more important to portray the concepts that are conveyed rather than the literal translation of the words spoken (Temple and Edwards, 2002; Temple and Young, 2004), it is hoped that this is what has been achieved within this study.

This was a small study, which included participants only from a specific area within the UK. It would be interesting to expand the study to other areas of the UK, or carry out a similar study with men of the same ethnicity, or to focus on younger participants, who may have become more embedded within UK culture.

These findings have implications within healthcare, as it has been highlighted that difficulties in the consultation process exist owing to a combination of practitioner preconceptions, problems with clarification and diagnosis, and a language barrier, potentially leading to a poor experience for both patient and healthcare professional. Reflecting upon the findings, suggestions for improving the consultation experience and patient outcomes might include: allowing more time for explanation; ensuring the patient is heard, and that expectations are discussed; making use of professional interpreters where required; placing a focus on patient education, particularly in regard to challenging externalized beliefs; promoting adaptive coping strategies and discouraging maladaptive ones; and finally being aware of, and further exploring, patients' perceived barriers to recovery and how these might be overcome.

Conclusion

This study revealed a number of interesting findings. The understanding of pain evinced by the participants was not framed in conventional biological terms, and reflected a more externalized belief system (Young, 1986). Participants identified both physical and emotional consequences of pain, with some evidence of pain anxiety and increased attention to pain, and a number of coping strategies were reported. There was a perception of daily demands related to the cultural expectations of women within this ethnic group, and this was viewed as a barrier to recovery or self-management. Finally, while the majority of women reported good experiences within healthcare, poor experiences encompassed situations where participants did not feel listened to, or cases where a language barrier was experienced.

References

- Allison, T.R., Symmons, D.P.M., Brammah, T., Haynes, P., Rogers, A., Roxby, M., & Urwin, M. (2002). Musculoskeletal pain is more generalised among people from ethnic minorities than among white people in Greater Manchester. *Annals of the Rheumatic Diseases*, 61(2), 151–6.
- Atkinson, R., & Flint, J. (2004). Snowball sampling. In M.S. Lewis-Beck, A. Bryman & Liao T.F. (Eds.), *The SAGE encyclopedia of social science research methods. Volume 3*, (pp 1043–1044). Thousand Oaks, CA: Sage
- Atri, J., Falshaw, M., Livingstone, A., & Robson, J. (1996). Fair shares in health care? Ethnic and socioeconomic influences on recording of preventative care in selected inner London general practices. *British Medical Journal*, 312(7031), 614–617.
- Balarajan, R., Yuen, P., & Soni Raleigh, V. (1989). Ethnic differences in general practitioner consultations. *British Medical Journal*, 299(6705), 958–960.
- Bendelow, G. (1993). Pain perceptions, emotions and gender. *Sociology of Health & Illness*, 15(3), 273–294.
- Berry, M. (2015). Ethnicity, culture and pain: can an anthropological perspective aid clinical practice? *Pain and Rehabilitation*, 39, 29–34
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2), 77–101.
- Choudhry, U.K. (2001). Uprooting and resettlement experiences of South Asian immigrant women. *Western Journal of Nursing Research* 23(4), 376–393.
- Cleland, J.A., Palmer, J.A., & Venzke, J.W. (2005). Ethnic differences in pain perception. *Physical Therapy Reviews* 10(2), 113–122.
- Edwards, R.R., Moric, M., Husfeldt, B., Buvanendran, A., & Ivankovich, O. (2005). Ethnic similarities and differences in the chronic pain experience: a comparison of African American, Hispanic, and white patients. *Pain Medicine* 6(1), 88–98.
- Emmel, N. (2013). *Sampling and choosing cases in qualitative research: A realist approach*. London: Sage.

Fenton, S., & Sadiq-Sangster, A. (1996). Culture, relativism and the expression of mental distress: South Asian women in Britain. *Sociology of Health and Illness* 18(10), 66–85.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. Chichester: Wiley-Blackwell.

Fordyce, W.E., & Steger, J.C. (1979). Chronic pain. In O.F. Pomerleau & J.P. Brady (Eds.), *Behavioral medicine: Theory and practice* (pp. 125–153). Baltimore, MD: Williams & Wilkins.

Graneheim, U.H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today* 24(20), 105–112.

Guest, G., Namey, E., & McKenna, K. (2017). How many focus groups are enough? Building an evidence base for nonprobability sample sizes. *Field Methods* 29(1), 3–22.

Hameed, K., & Gibson, T. (1997). A comparison of the prevalence of rheumatoid arthritis and other rheumatic diseases amongst Pakistanis living in England and Pakistan. *British Journal of Rheumatology* 36(7), 781–785.

Hastie, B.A., Riley, J.L., & Fillingim R.B. (2005). Ethnic differences and responses to pain in healthy young adults. *Pain Medicine* 6(1), 61–71.

Helman, C.G. (2000). *Culture, health and illness* (4th edn). Oxford: Butterworth-Heinemann.

Hsieh, H.F., & Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research* 15, 1277–1288.

Ibrahim, F., Ohnishi, H., & Sandhu, D.S. (1997). Asian American identity development: a culturally specific model for South Asian Americans. *Journal of Multicultural Counselling and Development* 25(10), 34–46.

James, J., & Hardardottir, D. (2002). Influence of attention focus and trait anxiety on tolerance of acute pain. *British Journal of Health Psychology* 7(2), 149–162.

Jordan, M.S., Lumley, M.A., & Leisen, J.C.C. (1998). The relationships of cognitive coping and pain control beliefs to pain and adjustment among African-American and Caucasian women with rheumatoid arthritis. *Arthritis Care and Research* 11(2), 80–88.

Kirmayer, L.J., & Young, A. (1998). Culture and somatization: clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine* 60(4), 420–430.

- Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine and psychiatry*. Berkeley, CA: University of California Press.
- Lopez, K.A., & Willis, D.G. (2004). Descriptive versus interpretive phenomenology: their contributions to nursing knowledge. *Qualitative Health Research* 14(5), 726–735.
- Lovering, S. (2006). Cultural attitudes and beliefs about pain. *Journal of Transcultural Nursing* 17(4), 389–395.
- Mackey, S. (2005). Phenomenological nursing research: methodological insights derived from Heidegger's interpretive phenomenology. *International Journal of Nursing Studies* 42(2), 179–186.
- Main, C.J., & Spanswick, C.C. (2000). Models of pain. In C.J. Main & C.C. Spanswick. (Eds.), *Pain management: An interdisciplinary approach*, (pp. 1–18). London: Churchill Livingstone
- Main, C.J., Sullivan, M.J.L., & Watson, P. (2008). *Pain management: Practical applications of the biopsychosocial perspective in clinical and occupational settings* (2nd ed.). London: Elsevier.
- Main, C.J., Foster, N., & Buchbinder, R. (2010). How important are back pain beliefs and expectations for satisfactory recovery from back pain? *Best Practice & Research Clinical Rheumatology* 24(2), 205–217.
- McGowan, L.P.A., Clark-Carter, D.D., & Pitts, M.K. (1998). Chronic pelvic pain: a meta-analytic review. *Psychology and Health* 13(5), 937–951.
- Morris, D.B. (1999). Sociocultural and religious meaning of pain. In R.J. Gatchel & D.C. Turk (Eds.), *Psychosocial factors in pain: Critical perspectives*, (pp. 118–131). New York, NY: Guilford Press.
- Morris, S.M. (2001). Joint and individual interviewing in the context of cancer. *Qualitative Health Research*, 11(4), 553–567.
- Njobvu, P., Hunt, I., Pope, D., & Macfarlane, G. (1999). Pain amongst ethnic minority groups of South Asian origin in the United Kingdom: a review. *Rheumatology* 38(12), 1184–1187.
- Oliveira, T.H., Oliveira, V.C., Melo, R.C., Melo, R.M., Freitas, A.E., & Ferreira, P.H. (2012). Patients in treatment for chronic low back pain have higher externalised beliefs: a cross-sectional study. *Revista Brasileira de Fisioterapia* 16(1), 35–39.
- Parker, G., Gladstone, G., & Chee, K.T. (2001) Depression in the planet's largest ethnic group: the Chinese. *American Journal of Psychiatry* 158(6), 857–864.

Parmelee, P.A., Harralson, T.L., McPherron, J.A., DeCoster, J., & Schumacher, H.R. (2012). Pain, disability and depression in osteoarthritis: effects of race and sex. *Journal of Aging and Health* 24(1), 168–187.

Patel, S., Peacock, S.M., McKinley, R.K., Clark-Carter, D., & Watson, P.J. (2008). GPs' experiences of managing chronic pain in a South Asian community – a qualitative study of the consultation process. *Family Practice* 25(2), 71–77.

Patel, S., Peacock, S.M., McKinley, R.K., Clark-Carter, D., & Watson, P.J. (2009). GPs' perceptions of the service needs of South Asian people with chronic pain: a qualitative enquiry. *Journal of Health Psychology* 14(7), 909–918.

Plesh, O., Adams, R.N., & Gansky, S.A. (2011). Racial/ethnic and gender prevalences in reported common pains in a national sample. *Journal of Orofacial Pain* 25(1), 25–31.

Polak, L., & Green, J. (2016). Using joint interviews to add analytic value. *Qualitative Health Research*, 26(12), 1638–1648.

Richards, H.M., & Schwartz, L.J. (2002). Ethics of qualitative research: are there any special issues for health services research? *Family Practice* 19(2), 135–139.

Vargas-Silva, C. & Rienzo, C. (2017). *Migrants in the UK: An Overview*. The Migration Observatory, University of Oxford: Oxford [online] Available at: <http://www.migrationobservatory.ox.ac.uk/resources/briefings/migrants-in-the-uk-an-overview/> [Accessed 28/09/2017].

Roberts, C., Moss, B., Wass, V., Sarangi, S., & Jones, R. (2005). Misunderstandings: a qualitative study of primary care consultations in multilingual settings, and educational implications. *Medical Education* 39(5), 465–475.

Rogers, A., & Allison, T. (2004). What if my back breaks? Making sense of musculoskeletal pain among South Asian and African-Caribbean people in the North West of England. *Journal of Psychosomatic Research* 57(1), 79–87.

Rudat, K. (1994). *Black and Minority Ethnic Groups in England: Health and Lifestyles*. Health Education Authority: London.

Tan, G., Jensen, M.P., Thornby, J., Anderson, K.O. (2005). Ethnicity, control appraisal, coping, and adjustment to chronic pain among black and white Americans. *Pain Medicine* 6(1), 18–28.

Tan, G., Teo, I., Anderson, K.O., & Jensen, M.P. (2011). Adaptive versus maladaptive coping and beliefs and their relation to chronic pain adjustment. *Clinical Journal of Pain* 27(9), 769–774.

Temple, B., & Edwards, R. (2002). Interpreters/translators and cross-language research: reflexivity and border crossings. *International Journal of Qualitative Methods* 1(2), 1–12.

Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research* 4(2), 161–178.

Walsall Council (2013) *2011 Census Reports: Key Statistics for Walsall: Borough Summary*. Walsall: Walsall Council [online] Available at: http://cms.walsall.gov.uk/2011_census [Accessed 17/02/2015].

Wiech, K., & Tracey, I. (2009). The influence of negative emotions on pain: behavioral effects and neural mechanisms. *NeuroImage* 47(3), 987–994.

Young, A. (1986). Internalising and externalising medical belief systems: an Ethiopian example. In C. Curren & M. Stacey (Eds), *Concepts of health, illness and disease: A comparative perspective*, (pp. 139–160). Leamington Spa: Berg.

Zborowski, M. (1952). Cultural components in response to pain. *Journal of Social Issues* 8(4), 16–30.

Zola, I.K. (1966), Culture and symptoms – an analysis of patients' presenting complaints. *American Sociological Review* 31(5), 615–630.

Table 1. Participant information

Participant number	Group interview	Age	Country of birth	First language	Religion	Marital Status	Highest educational level	Employment status	Pain location
1	1	47	India	Gujarati	Hindu	Married	Secondary school	Housewife	Left side trunk, back, leg, head, feet, ankles
2	1	58	Kenya	Gujarati / English	Hindu	Married	Primary school	Housewife	None
3	1	47	India	Gujarati	Hindu	Widow	Secondary school	Self-employed – shop owner	Whole body
4	2	44	India	Gujarati	Hindu	Married	University	Employed – supervisor NHS	Right knee, ankles
5	2	55	Uganda	Gujarati	Hindu	Married	Secondary school	Housewife	Knees
6	2	64	India	Gujarati	Hindu	Married	Secondary school	Housewife	None
7	3	75	India	Punjabi	Sikh	Married	None	Housewife	Low back, legs, shoulders
8	3	75	Burma	Punjabi	Sikh	Married	Secondary school	Housewife	Knees
9	3	63	India	Punjabi	Hindu	Married	Secondary school	Housewife	Posterior left knee
10	4	72	India	Gujarati	Hindu	Married	Primary school	Retired – machine operator	None
11	4	72	India	Gujarati	Hindu	Widow	Primary school	Retired – machine operator	Right shoulder, knees
12	4	52	Fiji Islands	Gujarati	Hindu	Married	Secondary school	Employed – teaching assistant	None
13	4	60	Kenya	Punjabi / English	Hindu	Married	Secondary school	Housewife	Heartburn

14	4	66	India	Gujarati	Hindu	Married	Secondary school	Housewife	Right knee
15	5	41	England	English	Hindu	Married	College	Employed – administration officer	Left thoracic spine, side
16	5	70	India	Gujarati	Hindu	Married	Primary school	Housewife	Shoulders, low back
17	5	44	India	Gujarati	Hindu	Married	College	Employed – lunchtime supervisor	Right shoulder, low back, left knee

APPENDIX – INTERVIEW GUIDE

Opening question: Have you ever been unwell in the past? Or have you known a friend or relative to be unwell?

Transitional question: Did this experience include any pain? Have you ever experienced any pain? Or have you known a friend or relative who has experienced pain?

Main questions:

What does the word pain mean to you?

What kind of things might cause pain?

How do you think being in pain might make you feel?

How might you cope with it? What might you do to help yourself?

Anything you should avoid?

How do you think others would react if you were in pain?

Would you seek treatment? If so what type?

Have you had any previous experience of having treatment for pain? What did you try? Did it help?