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Conceptions of pain among Somali women

Aim. This paper reports a study of a group of Somali mothers’ views on pain, the causes of pain, pain behaviour and pain treatment concerning themselves and their family members.

Background. Both the meaning of pain and pain behaviour are associated with values in a patient’s social and cultural context. Culture also provides models for how to treat and relieve pain. Several studies report a lack of cultural sensitivity and competence among healthcare professionals, resulting in lower quality of and less access to health care and pain treatment for minority groups. However, the majority of the scientific literature on pain and culture concerns adults in the United States of America.

Method. Focused conversational interviews were carried out with a convenience sample of nine Somalia women living in Sweden in order to describe and explore their conceptions of pain. Qualitative content analysis was conducted through meaning condensation. The data were collected in 2002–2003.

Findings. The women expressed a number of different ideas about definitions and causes of pain. Somalis, especially men, are expected to be stoic about pain. The women had different strategies for communicating about and relieving pain. Children from the ages of 6–8 years upwards were expected to control their pain expression. Respondents used both formal and informal care to relieve pain. For some of the women, consulting a psychologist was not a culturally acceptable way of seeking pain relief.

Conclusions. Nurses must strive for increased cultural competence and explore ways to make healthcare services sensitive to culturally diverse groups. Nurses have an educational role in educating parents and children about pain and the importance of sufficient pain relief. All healthcare providers should be aware of their own cultural values and the risk of stereotyping people.

Keywords: cultural competence, empirical research report, interviews, nursing, pain, pain behaviour, Somalian women

Introduction

A literature review by Bonham (2001) shows that disparities in pain treatment may result from difficulties with pain assessment and communication related to race and ethnicity. Caregivers, often nurses, will therefore need to explore ways to make traditional healthcare services culturally sensitive to Somalis, which is a relatively new challenge. As stated by the International Council of Nurses’ Code of Ethics for Nurses, Sect. 1 (International Council of Nurses 2000), ‘In providing
care, the nurse promotes an environment, in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected’.

In Sweden, a country of 9 million people, approximately 10% of the population are immigrants. The children of these immigrants have thus come to make up a significant proportion of the patients cared for in Swedish children’s hospitals. Women in the Somali subgroup, numbering around 22,000 (Statistics Sweden 2002), tend to have many children, which makes this subgroup frequent paediatric healthcare consumers. In this context, we know that pain behaviour is influenced by cultural and social factors, and that parents respond to their children’s pain in culturally acceptable ways (Bernstein & Pachter 2003).

Background

Pain perception in adults seems to be the same, irrespective of ethnic group, while pain tolerance can differ (Bonham 2001). Several authors emphasize the influence of cultural and social factors on patients’ pain behaviour and on pain management (Zborowski 1952, Bernstein & Pachter 2003, Helman 1994). The meaning of pain, as well as pain behaviour, is associated with values in patients’ social and cultural context. Culturally acceptable pain behaviour is learned from early childhood, through mechanisms such as modelling, explanations and instructions.

There have been only a few studies of children’s perceptions of pain and pain behaviour from cultural perspectives (Abu-Saad 1984a, 1984b). The majority of the scientific literature on pain and culture concerns adults in the United States of America (USA). There are two studies on this topic in Sweden (Sachs 1983, Löfvander 1997), but no research to date into parents’ conceptions of pain or pain in children from a cultural perspective. The Somali group in Sweden has not, to our knowledge, previously been studied with regard to conceptions of pain.

Many authors note that healthcare providers must be aware of ethnic variations (Helman 1994, Purnell & Paulanka 1998, Galanti 2000). They also warn against generalizations, which often lead to stereotyping. Galanti (2000) argues that stereotypes and generalizations function differently. Most knowledge is based on generalizations, which can serve as starting points, while stereotyping is classifying individuals and behaviour without proof of accuracy.

Cultural competence is an evolving process, leading to acceptance of differences and improved understanding, based on increased knowledge of social and cultural patterns (Webb & Sergison 2003). It also depends on self-reflection and increased self-awareness. Several studies report a lack of cultural sensitivity and competence among healthcare professionals, resulting in lower quality of and less access to healthcare and pain treatment for minority groups (Bonham 2001). Disadvantaged and minority populations must be prioritized and included in pain research (Craig & Pillai Riddell 2003); otherwise, there is a risk that we will have an inadequate knowledge base for appropriate and effective services.

The study

Aim

The aim of this study was to describe the conceptions of pain in a group of Somali women living in Sweden. We sought to illuminate the women’s views on pain, its causes, pain behaviour and pain treatment for themselves and their family members.

Design

A descriptive interview study was carried out with a convenience sample, and the data were collected in 2002–2003.

Participants

Focused conversational interviews were conducted with nine Somalia women, living in western Sweden. Since many Somali families do not migrate intact, the women often have increased responsibility for children and other family members in the diaspora (Mohamed 2001), and were therefore chosen as participants. Mothers can be assumed to be a relevant source of knowledge about children’s and other family members’ pain experiences. Three respondents were recruited when their children were patients in a children’s hospital where one of the authors (BF) works as a pain management nurse. Two were members of a Somali women’s network we had informed about the study. Three participants were recruited as friends or relatives of other respondents. The last respondent was something of a special case in that, in addition to being a Somali mother, she was also employed by her local municipality as a ‘cultural interpreter’; this meant that as well as being a traditional community interpreter she also had particularly good knowledge of both the Somali and Swedish cultures. This interview was conducted in order to obtain an insider’s view of the results of the first eight interviews, and to give the authors a deeper understanding of some statements of the respondents. This interview also aimed at strengthening the validity of the findings.

Inclusion criteria were that the woman had at least one child of her own, in relation to whom she had experiences of...
Swedish health care, and that she had enough knowledge of the Swedish language to maintain an ordinary conversation. The children were not patients at the hospital at the time of the interview, and none of the women had met us previously.

The ages of participants varied between 28 and 38 years. Three were single mothers. One was unemployed, one was a student, two were active in a Somali women’s network and the others had different occupations in the healthcare sector. Their backgrounds are shown in Table 1.

Data collection

Causes of pain, pain behaviour and how pain can be alleviated were the topic for the interviews. Open questions such as, ‘What does the word pain mean to you?’, ‘How do you show pain in your family?’ and ‘What do you do when your child is in pain?’ were used. The interviews were conducted by the first author (BF) and took place in the children’s hospital or at another venue chosen by the woman. The interviews lasted 60–90 minutes and were tape recorded.

Validity

With a view to strengthening the validity of the study we had four generally agreed upon criteria in mind: credibility, authenticity, criticality and integrity (Polit & Beck 2004). The interviews were transcribed verbatim and preliminarily analysed one by one during the data collection period. This meant that possible meanings and themes could be examined and validated during subsequent interviews to enhance authenticity and integrity. Credibility and criticality were also strengthened through the interview with the ‘cultural interpreter’, who confirmed and in some cases clarified the findings of the preliminary analysis. The findings are presented with appropriate quotations. The quotations were translated into English by the authors and checked by a professional translator.

Data analysis

A qualitative content analysis was conducted through meaning condensation (Kvale 1996). This entails an abridgement of the meanings expressed by interviewees into shorter statements. The analysis was conducted in accordance with the five steps described by Kvale:

- All interviews were transcribed verbatim and read by the researchers with the purpose of obtaining a sense of the whole.
- The meaning units expressed by the respondents were identified by the researchers.
- The themes in the findings were stated as simply as possible.
- The meaning units expressed were interrogated in terms of the aim of the study.
- The researchers summarized the themes of the interview in a descriptive statement.

Findings and discussion

Study limitations

We considered content analysis through meaning condensation a suitable method to use to describe the conceptions of pain in the study group. Although the findings provide illuminating data, the study also has some limitations. Since we sought to

<table>
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<tr>
<th>Participant number</th>
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<td>3</td>
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<td>Receptionist at a dentist’s surgery</td>
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<td>9</td>
<td>42</td>
<td>3</td>
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<td>Cultural interpreter</td>
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<td>Mean</td>
<td>31.4</td>
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explore the pain issues openly, the nature of the questions may sometimes have been too vague, and so the responses obtained sometimes lacked focus. This could explain, for instance, the difficulties of some participants in conceptualizing what they perceived pain to involve. The interviewees are probably not completely representative of Somali women living in Sweden, since they all spoke Swedish and most were employed or worked with different projects, indicating that they were well-integrated in Swedish society. In contrast, the unemployment rate among Somali women in Sweden is high, and many have poor knowledge of the Swedish language. This, and the limited number of interviewees, indicates that we must be cautious and not draw overly far-reaching conclusions. However, it is reasonable to transfer the findings to similar contexts in other Western societies.

Definitions of pain

Most women had difficulties explaining the meaning and demarcation of the concept of pain. Some considered pain to be a physiological matter having nothing to do with emotions, while other described it as something ‘deeper’, involving both body and mind. Hurt or ache could come and go and did not need treatment to the same extent as pain:

Pain is worse than hurt and takes longer to be relieved.
Hurt is when you have some kind of injury, but pain...also has something to do with how you feel inside.

Callister et al. (2003) argue that there are similarities in the use of word descriptors for pain across cultural groups. The word **pain** characterizes the most severe pain; **hurt** is used for less severe discomfort, and **ache** is the least severe pain. This corresponds to the statements of the women in this study.

Causes of pain

Physical sources of pain mentioned by the women included childbirth, cuts and sores, infections or food poisoning, as well as allergies and fever. The explanation given by the ‘cultural interpreter’ was that the words for pain in Swedish and Somali do not overlap:

In the Somali language, the word for pain also covers discomfort and illness.

This may clarify why some women described fever or allergy as painful experiences. The Somali word **xanuun** means both pain and illness (Korshel 1995). It is important for healthcare providers to be aware of the fact that questions about pain can elicit broader answers than they might expect.

Only two women mentioned female circumcision, in spite of the fact that participants were requested to give examples of painful situations:

I’m thinking of when I was a little girl and was circumcised. It was really painful and the pain lasted for a long time.

The form of circumcision most commonly practised in Somalia is infibulation, which includes partial or total removal of the clitoris, labia minora and labia majora (Robleh 2001, Johansen 2002). Johansen (2002) points out that most Somali women do not talk about their experiences in connection with infibulation with other Somali women. Johansen found no explanation for this silence, but it may be that it is too difficult for them to acknowledge the memory, and perhaps there are no words that can really describe the experience. Several participants listed infection as a source of pain, and infection is a well-known and painful problem for infibulated women. Dirie and Lindblad (1992) reported that 39% of the Somali women in their study had experienced major complications after circumcision, most commonly infections, haemorrhage or urinary retention.

Emotional explanations such as sadness and worries, problems with children or discrimination were other sources of pain. The majority of women stated that stress and anger could be causes of physical pain in adults. According to Tiilikainen (2001), Somali women have started using the word **stress** more frequently as an explanatory model for pain and other illness. Stress is often perceived as a cause of pain in industrialized countries. Our impression, confirmed by the ‘cultural interpreter’, is that to talk about feelings and stress is culturally more acceptable than to talk about the psyche or body and soul, which may have connotations of mental illness. The terminology of stress and feelings would therefore be preferred when discussing symptoms that might have psychological causes.

Pain has been reported as one of the commonest complaints of Somali women living in Finland (Tiilikainen 2001). Tiilikainen stressed that health and illness can be defined as social processes. People interpret and respond to difficulties in living through the medium of the body. Pain can be a way of communicating suffering, even if the person is unaware that the pain is a psychosomatic expression for other problems.

Mothers’ knowledge of the psychosomatic dimensions of pain in children was limited. Only a few thought that there could be emotional causes of pain in children, although several had children who often had stomach pain, headache or other psychosomatic symptoms:

No, I do not believe that a child can have pain in the belly because the child doesn’t feel happy at the day nursery. It’s something they pretend, just because they want to stay home.
All women were familiar with traditional explanations of pain as the evil eye or evil spirits (jinns), but said they did not believe in them any more. Symptoms, which would have been interpreted as being caused by jinns in Somalia, can be interpreted in industrial countries as caused by stress or depression (Tiilikainen 2001).

Communicating about and tolerating pain

According to our interviewees, pain can be communicated through body language or by talking to a friend or family member. Resting is another way of communicating that one is in pain. Some of the women kept their pain inside for a long time before telling anyone about it. In most cases, they believed, women communicate pain more expressively than men. Crying and wailing are unaccepted ways of showing pain in the Somali culture:

There is no reason to exaggerate your pain. Everyone knows that childbirth is painful, and you are sort of ashamed of yourself if you cry, and the one who is there with you is ashamed as well. To cry is to be weak.

The women expressed a stoical attitude to pain, which is congruent with findings in other studies concerning attitudes to pain on the African continent (Sargent 1984, Johansen 2002). To moan and cry is to be weak, and since life contains a great deal of suffering you have to learn to control yourself and tolerate pain. The women considered pain a natural part of life, and said that religion can help a person to accept the pain: if Allah has given you the burden of pain, you have to bear it with dignity.

To communicate and explain the symptom of pain to nurses and doctors is problematic if a patient cannot speak Swedish or English:

The doctor didn’t understand what I meant, and the interpreter couldn’t explain it either.

A majority of participants were of the opinion that Somali women are very strong and can endure more pain than Somali men. They said that women do their work even when they are in pain:

I can tell you, Somali women know what pain is. You know we are circumcised, some of us have been raped and there has been a war in Somalia for many years. Somali women are very strong and we can stand a lot.

Women are stronger than men. Even if we are in pain we take care of the children and our home, but the man lies down on the bed and says, ‘I’m in pain and I can’t do anything’.

Although they thought that women could stand more pain than men, they also believed that men waited longer than women before seeking medical care. In Somalia, cultural patterns emphasize the value of endurance, and its history has given rise to a social pattern that glorifies and rewards aggression, bravery, courage, strength and toughness – traits associated with the ‘macho’ male (Keynan 2001).

Participants working in the healthcare sector stated that Swedes complain more about their pain than Somalis. Swedes are encouraged to be stoical about pain (Löfander 1997), but they apparently have different ways, culturally unacceptable to Somalis, of communicating their pain. To withdraw when in pain is behaviour seldom seen among Somalis, but has been shown to be a coping strategy used by people in Northern Europe (Zborowski 1952, Zola 1966). The culture in African societies is collectivist, while that in Sweden and most Western industrialized societies is individualistic (Triandis 2001). People from collectivist cultures are more interdependent within their in-groups (family, tribe or nation), and are especially concerned with relationships. The needs of the group or family are given priority to over the needs of the individual. To withdraw from the group when in pain, or because of other problems, is not a common strategy for people from collectivist cultures. In return, the group is expected to help and support the individual who is in need of help (Triandis 1994).

Mothers expected their children to control their expressions of pain in connection with procedural pain from the age of 6–8 years, although some of them also said that one has to respect the emotions of the child. Girls are expected to be more emotional about pain than boys, and boys learn from an early age to be stoic about pain:

I was frying potatoes in oil and some of the oil splashed on his hand, but he said, ‘Mama it doesn’t hurt’. But I know it hurts. He wanted to show me that he is not a baby anymore. He is seven years old.

To relieve pain

Informal care and traditional methods

Some women would read from the Koran when they were in pain, believing that to rest can relieve pain, as well as to be with others or to talk to someone. To have family members close by is important when in pain:

We don’t like loneliness. We are not like Swedes. You need help from others when you are ill, so we want to be with friends and family members when we are ill or in pain.
All interviewees knew about traditional methods of relieving pain, such as red-hot needles and herbs, and a few had their own experiences of practical use:

I cried at first and tried to run away, but my father grabbed me. They took the red-hot needle and pricked my belly for four or five times, and at once I felt much better and then I fell asleep. Next morning I woke up early and the pain was gone. I had recovered.

A few women had grown up in cities, and they said that traditional methods were more common in the countryside because of less access to medical care. Others said that people turn to traditional methods when Western medicine fails, or when they cannot afford to seek medical care. None used traditional methods in Sweden.

Formal care
Although the women expressed a stoical attitude to pain, analgesics were highly valued and requested. A few women were dissatisfied with Swedish health care and experienced discrimination because of their race and religion. The language and use of interpreters were other difficulties. This is congruent with the findings reported by Herrel et al. (2004) about Somali women in Minnesota, USA, where many respondents thought that interpreters were not competent in medical terminology. They also expressed negative opinions about the care they received from nursing staff in particular.

To consult a psychologist is not a culturally accepted way to relieve pain among Somali women, according to our participants. Some expressed hesitation about psychological help and said that it was better to talk to close friends or family members or to rely on Allah. Most said that Somali people often associate the word psychology with mental illness:

We are Muslims, and when we are ill or in pain we read from the Koran. We are not familiar with psychologists. I never saw a psychologist’s nameplate in Somalia. Most Somalis think that psychologists are for mentally ill people.

Relieving children’s pain
The pain associated with a blood test was not considered dangerous, is of short duration, and should therefore be tolerated by the child. Children were not regarded as needing topical anaesthesia such as EMLA cream (eutectic mixture of lidocaine 2.5% and prilocaine 2.5%) when taking blood for tests after about 6–8 years of age. Children under 3 years of age were regarded as not understanding what was going to happen and therefore were not candidates for EMLA cream, according to a few mothers. Some emphasized that it is important to let the child choose if they want EMLA cream or not, while others felt that this should be decided by the mother:

EMLA cream is good, but since it must be applied to the skin for at least one and a half hours it is too long to wait. In my opinion it is the mother, and not the child, who decides if the child can have EMLA cream or not, but if the nurse says it is necessary I do as she tells me.

In Sweden EMLA cream is often used as topical anaesthesia in connection with venepuncture for children of all ages. Since the cream has to be applied 11/2 hours before the procedure can be carried out, some mothers were not motivated to use it. Information about children’s psychological and physiological reactions to pain and the benefits of adequate analgesia might change their attitudes.

To these women, to endure procedural pain is to be brave and strong, which is regarded as important, especially for boys. In her paper about the Bariba tribe in Nigeria, Sargent (1984) described how children from 6 years of age were expected to endure severe pain. A study by Kankkunen et al. (2003) has shown that some Finnish parents expect their children, especially boys, to learn to tolerate postoperative pain and to a certain extent to cope with pain by themselves. These ideas were more common among Finnish fathers than mothers, and were found in a minority of the respondents. According to the researchers, these findings might reflect Finnish culture where, like that of Somali, pain tolerance is highly valued. It might also illustrate gender differences all around the world, where men and boys are expected to be more stoical about pain than women.

When a child is hurt and in pain, the mother tries to stay calm, which is regarded as very important. First of all, she has to clean the sore and decide if the injury is severe. If not, the child is encouraged to go on playing. It is important to the mother to tell the child that the injury is not dangerous and that the pain will disappear in a while:

The fact that the mother tells the child that the pain is not serious, and nothing to worry about, can relieve the pain in a way.

Distraction was not a major strategy for relieving pain in children for the majority of the mothers. In the Somali culture, distraction and comfort often seem to be left to siblings:

Maybe you kiss or cuddle small children, younger than five or six years of age, or the big brother or sister does. A sister about 12 years old is often like a mother.

Somali mothers often have many children. They are busy with cleaning, making food and all sort of things, so Somali children have to learn to help their mothers from an early age and to take care of their siblings as well.

In his classic study, Zborowski (1952) stated that each culture has its own language of pain, which was also shown
in our study. Culture plays an important role in attitudes toward pain, its definition and how to communicate about, tolerate and relieve it.

Conclusion

We have described the conceptions of pain in a group of Somali women living in Sweden, showing that their views about the causes of pain and pain behaviour are culturally based.

Somali women often experienced difficulties in expressing their problems. This seemed to remain true even when an interpreter was involved. Another area about which the women seemed to have difficulty talking and describing their suffering was female circumcision. A support group for Somali women could be a good forum for discussion and reciprocal support for women who want to talk more about such experiences. However, nurses must improve their cultural competence to be able to interpret and understand both body language and verbal communication in order to comprehend the needs of patients from culturally diverse groups.

A number of our respondents were unfamiliar with the idea, often used as an explanatory model in Western societies, that there could be psychological or emotional causes of a child’s pain. Adequate information about children’s pain should be provided to parents. Nurses have a pedagogical task in educating parents about the causes of pain and the importance of sufficient pain relief. In paediatric care we should, if possible, avoid exposing children to painful procedures or treatments without pain relief. Special attention should, therefore, also be paid to cultural attitudes and parents’ expectations of boys’ higher pain tolerance.

The family is a source of support and pain relief for Somalis. This should be respected by nurses, who could encourage patients to have family members close by during a stay in hospital.

Several authors have emphasized the risk of stereotyping (Helman 1994, Purnell & Paulanka 1998, Craig & Pillai Riddell 2003). There is often greater variability within a group than between groups. Women in this study were quite well integrated into Swedish society. They had learned Swedish and were trying to understand the values and societal patterns in their new country. It is important to call attention to the differences within an ethnic group such as Somalis, where individuals are in a process of acculturation into the mainstream culture.

Empirical studies relating to ethnic groups and their experiences and perceptions of pain can contribute to greater cultural competence for healthcare providers, and to more sensitive pain management for culturally diverse groups. Craig and Pillai Riddell (2003) argue that there are several critical moments in research on cultural minority groups, e.g. how to define the population of interest, and that some representatives of a minority group might identify themselves more as members of the mainstream culture. Researchers must also bear in mind how their own cultural values and beliefs influence their research design and their interpretation of the findings.

Author contributions

BF was responsible for the study conception and design and drafting of the manuscript. BF performed the data collection and data analysis. OS made critical revisions to the paper. OS supervised the study.

References

Issues and innovations in nursing practice


