Understanding the role of culture in pain: Māori practitioner perspectives relating to the experience of pain

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Abstract

Aims As there is growing interest in the role of cultural diversity within healthcare settings it is important to determine how culture can influence such things as pain. A person’s culture can impact not only how they perceive and experience pain but also how they interact with healthcare professionals and adhere to advice provided. To better assess and treat pain in different cultures the perspectives and experiences of that culture must be taken into consideration and therefore the present study was undertaken to better understand Māori perspectives of pain.

Methods Māori healthcare providers and kaumātua (tribal leaders/elders) were interviewed in order to gain insight into how pain was perceived and expressed by Māori with whom they had health-related interactions.

Results The interviews reflected themes consistent within the greater body of literature in that as with many cultures, Māori perceive pain as a multidimensional experience impacting them physically, psychologically, socially and spiritually.

Conclusions While our findings indicate that there is a commonality between cultures with regard to the experience of pain, it is valuable to understand a culture’s perceptions and experiences regarding pain before assessing and treating it as indicated in the findings from this study wherein cultural factors such as the role of the whānau (family) and the importance of the development of relationships with healthcare providers were points of emphasis in terms of ways to enhance Māori health.

It is widely accepted that pain is a multidimensional experience as it includes sensory, emotional, motivational, and social factors. An aspect of the social factor which can impact the experience of pain is culture as a person’s culture can play an essential role in how they perceive and respond to pain. While there has been interest in the role of cultural diversity within healthcare settings over the years, there is also growing interest in understanding the influence of race and ethnicity on the experience of pain.

Culture represents a significant force in shaping the values, beliefs, norms and practices of individuals including the way the person reacts to pain. Early studies looking at pain and culture have described how ethnic norms for pain behaviour can influence pain perception, interpretation and response. In addition to influencing the experience of pain, culture can influence the assessment and management of pain.

As culture can influence the perception and experience of pain, and hence the reporting and potentially the treatment of pain, it is important to be aware of cultural differences when working with patients from different ethnic backgrounds.
Māori perspectives of pain

According to Durie’s Māori model of health, *te whare tapa wha*, the dimensions of health include a spiritual aspect (te taha wairua), mental and emotional aspects (te taha hinengaro), family and community aspects (te taha whānau) and a physical aspect (te taha tinana). This is a holistic model with health dimensions represented by four supporting walls of a house.

The integrity of all four dimensions is required for a sound whole. This viewpoint is consistent with the widely accepted biopsychosocial view of health and wellness as well as with the multidimensional nature of the pain experience in that the different aspects of the person and their pain need to be taken into consideration when assessing and treating their pain.

As little has been published regarding Māori perspectives on pain it is not clear if the current measures and approaches to pain assessment and management are appropriate for this cultural group. A better understanding of Māori perspectives pertaining to the experience of pain would guide assessment and treatment approaches for this cultural group. By taking into account the distinct elements of the Māori culture with regard to the experience of pain, the present study was designed to be in accordance with the Treaty of Waitangi by holding to the principles of partnership, participation, and protection.

As a first step to understanding the Māori perspective of pain, we sought the views of Kaumātua (tribal leaders/elders) and Māori healthcare providers to gain insight into how pain is perceived and expressed within the Māori culture. Kaumātua are regarded as the tribal experts on most matters and therefore represent an essential source of information on the suitability of items for a culturally appropriate pain measure for Māori.

Methods

An important aspect of this research involved cultural consultation. Guidance from our cultural advisors and kaumātua was sought regarding Māori tikanga (customs and protocol) including issues such as language, protocol including rituals of encounter, perspectives on health, and assessing pain in Māori.

Qualitative interviews regarding Māori perspectives on pain

To investigate the experience of pain within the Māori culture, an in-depth ‘semi-structured’ interview format was employed as it has been shown to be useful in advancing cultural understandings of health among indigenous communities, including Māori.

The interviews sought to gain insight into how pain was perceived and expressed by those Māori with whom kaumātua and Māori healthcare providers had health-related interactions. Approval for this research was obtained from the University of Auckland Human Participants Ethics Committee.

Interview procedures

A purposeful sampling technique was used to recruit participants as it selects the most appropriate group (i.e. those involved with the topic) to provide ‘information-rich’ data on the phenomenon under study. For this study participants were recruited through our cultural advisors’ iwi (tribe) and their Māori healthcare networks. Participants were kaumātua and Māori healthcare providers who worked in a health-related role with Māori clients (e.g. hospitals, mental health settings and private clinics).

To take part in this study, participants were asked if they would be willing to be interviewed to explore the experience of pain within the Māori culture. On the advice of the cultural advisor, and at the request...
of the elders, group-format interviews were offered to kaumātua. The group-format was viewed as a cultural preference by some as it is commonly used on the marae (meeting house) and it provides opportunities for verification or disputation of views presented.

A semi-structured interview-guide was used to ensure that the range of topics relevant to the study objectives was covered in each interview. The interview-guide aided in framing questions to elicit the participants’ observations and experiences with Māori patients’ perceptions and beliefs pertaining to pain. Participants were asked to comment on the manner and format of assessing pain with Māori including whether English or te reo would be recommended. Interviews were on average 60 minutes long.

It should be noted that the type of interview conducted, group or individual, did not appear to negatively influence participation or discussion as individuals were able to choose which environment they were most comfortable taking part in. All participants consented to audio-recording of the interview.

Data analysis of qualitative interview

Audio recordings of the interviews were transcribed verbatim and the written transcripts constituted the raw data for qualitative analysis. Transcripts were analysed using purposeful constant comparative methodology. Comparisons of data collected from the groups were made using ‘data triangulation’, a form of convergent validation employed in qualitative research. The written transcripts were compared with the audio-recordings and notes taken at the time of the interviews. In some instances, verification of wording was obtained from a Māori advisor to ensure accuracy of transcription.

The constant comparative method (CCM) of qualitative data analysis was used. Accordingly three stages of comparison were conducted when generating analytical themes:

- Comparison within a single interview,
- Comparison between interviews within the same group, and
- Comparison of interviews between the two groups.

In the process of ‘open coding’, every passage of the interview was studied to determine the underlying intent or theme. Comparison of the codes used throughout a single interview determined the consistency of a theme. Judgment about saliency of themes was based upon either frequency of occurrence, emphasis of phrasing, or word choice.

The aim of the comparisons of the interviews within the same group (e.g. text of one kaumātua compared to that of another kaumātua) was to determine whether the content or themes were similar among groups, and between groups (e.g. between kaumātua and Māori healthcare providers) to determine the saliency of themes.

Results

Interview participant demographic characteristics

Of the 33 participants 23 (70%) were female and 10 (30%) were male. As expected, the kaumātua group was older (median age 72 years) than the Māori healthcare provider group (median age 38 years). The majority of kaumātua (65%) were fluent in te reo Māori, whereas the majority of Māori healthcare providers (86%) indicated basic te reo Māori competency. The demographic characteristics of the participants are presented in Table 1.
Table 1. Demographic characteristics of interview participants

<table>
<thead>
<tr>
<th>Variables</th>
<th>Kaumātua (individual, n=6)</th>
<th>Healthcare providers (n=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age – median (range)</td>
<td>65 yrs (59–81 yrs)</td>
<td>38 yrs (33–48 yrs)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5 (83%)</td>
<td>6 (86%)</td>
</tr>
<tr>
<td>Male</td>
<td>1 (17%)</td>
<td>1 (14%)</td>
</tr>
<tr>
<td>Fluency in te reo Māori</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic</td>
<td>1 (17%)</td>
<td>6 (86%)</td>
</tr>
<tr>
<td>Conversational</td>
<td>1 (17%)</td>
<td>1 (14%)</td>
</tr>
<tr>
<td>Fluent</td>
<td>4 (66%)</td>
<td>13 (65%)</td>
</tr>
</tbody>
</table>

Twenty kaumātua were interviewed in a group format. Six kaumātua and seven Māori healthcare providers were interviewed individually. All participants indentified themselves as being involved in a health-related role with Māori (see Table 2 for the categories participants chose to describe themselves). Additionally, all of the kaumātua (100%) were actively involved in their local marae and most (96%) were regular participants at the Kaumātua Advisory Group.

Table 2. Categories of interview participants

<table>
<thead>
<tr>
<th>Group affiliation</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaumātua</td>
<td>26</td>
</tr>
<tr>
<td>Allied health professional</td>
<td>1</td>
</tr>
<tr>
<td>Homeopath</td>
<td>1</td>
</tr>
<tr>
<td>Kaimahi (staff)</td>
<td>1</td>
</tr>
<tr>
<td>Nurse/midwife</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>1</td>
</tr>
<tr>
<td>Special needs paraprofessional</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
</tr>
</tbody>
</table>

Results of interviews

Several themes emerged from the interviews, with the same themes emerging from analysis of interviews from both the kaumātua and Māori healthcare providers’ interviews. Themes included: experiences of pain, pain as multidimensional, pain as a private experience, spiritual dimension, coping strategies including the complex role of whānau, and specific recommendations for assessment and treatment of pain.

Experiences of pain

When asked to describe pain issues and the experience of pain (e.g. key issues for Māori, pain behaviours observed with Māori patients, how Māori cope with/manage pain), both groups recounted experiences of supporting or caring for people with pain. Most kaumātua, unlike most of the Māori healthcare providers, also described pain
they had experienced themselves, and consequently they mentioned more personal coping strategies.

This difference in reporting is likely an artifact of the older age of the kaumātua group. Some healthcare providers prefaced their answer with a caveat that their opinion was influenced by clinical experience predominantly with Māori individuals experiencing either severe pain or who were not coping with their pain.

In describing pain and the pain experience, a number of descriptors were used to convey location (e.g. “back pain”, “leg pain”), emotion (e.g. “joyous pain”, “dreaded pain”), possession (e.g. “my pain”, “his pain”), temporal qualities (e.g. “continuous pain”, “lingering pain”), intensity (e.g. “a lot of pain”, “greatest pain”), and some less specific qualifiers (e.g. “another pain”, “that same pain”).

Table 3 provides a sample of the descriptors used by the participants during the interviews.

<table>
<thead>
<tr>
<th>Te reo Māori terms</th>
<th>Other terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>whakamā</td>
<td>intermittent</td>
</tr>
<tr>
<td>ngangana</td>
<td>a bit of</td>
</tr>
<tr>
<td>their wairua is sore</td>
<td>a really big</td>
</tr>
<tr>
<td>mamae</td>
<td>consistent</td>
</tr>
<tr>
<td></td>
<td>continuous</td>
</tr>
<tr>
<td></td>
<td>darkest</td>
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</tbody>
</table>

Table 3. Pain descriptors used by interview participants

Pain as a multidimensional human experience

Participants described mamae (i.e. Māori word for pain) in terms of being a complex multidimensional experience. Reference was made to the te whare tapa wha model of health in explaining the dimensions of pain. Differentiations between acute pain and chronic pain, as well as between physical pain and emotional or spiritual pain were made. Pain was frequently described in relation to an accompanying disease or medical condition (e.g. arthritis pain, cancer pain) and was personified as a demon (ngangana) preying upon the person’s life force.

With regard to the experience of pain, the universality of this experience was summed up by one of the kaumātua who stated: “What do you mean Māori pain? I’ve never heard of cultural pain. I thought pain was a human experience.” Similarly, a Māori healthcare provider commented that “I have worked with a number of Māori patients, and their whānau who have experienced pain, I can think of a group of words which are very much the common parlance, burning, stabbing, tearing, ripping, aching, and the pain might have a quality of being intermittent, pervasive, fluctuating or consistent in intensity, or building over certain periods, alleviated by some things and exacerbated by other things, and I can’t really think of anything particularly unusual that would differentiate Māori patients from non-Māori patients in the language that they used, and the English words that they’ve used.”
**Pain is private**

A common theme which emerged was that Māori were private people, who did not readily talk about their health worries. There were multiple descriptions of Māori enduring and or ignoring pain, with both positive and negative connotations. Pain and other health worries were regarded as private and only spoken of with close whānau. For some Maori there was shame (whakamā) associated with speaking of pain with outsiders.

The reasons given for the reluctance to disclose thoughts and feelings about pain were diverse. In some instances non-disclosure was seen as a positive coping strategy. Alternatively, ignoring pain was listed as a concern when it caused a delay in health-seeking behaviour. Explanations for delayed health-seeking behaviour included childhood memories and family stories of culturally insensitive healthcare, of perceived medical mismanagement, and of not wanting to be a burden. One kaumātua reported that seeing the negative consequences of such health-seeking delay was the impetus for becoming actively involved in health advocacy in the local community.

Another consequence of this reticence to talk openly about pain was the difficulty in having open debate among the community on certain sensitive topics such as euthanasia which was raised in the context of intractable pain in terminal illness. Fundamental to discussions about matters such as death, and indeed for any aspect of life according to the Māori interviewed, was the spiritual dimension.

Generational as well as gender differences in expression of pain were reported. Among the kaumātua, there was recognition that a pattern of ignoring pain was less useful with advancing age. Elderly Māori were reportedly less likely to report pain or to seek medical attention for their pain. Additionally, males were reportedly less responsive to symptoms such as pain than females.

**Role of whānau (extended family)**

All participants had provided care or support for Māori experiencing pain. Most participants described personal experiences of providing whānau support for close family members (e.g. spouse, sibling, cousin, niece, nephew, or grandparent) through the final stages of terminal illness involving intractable pain. Several participants recounted filling this role on two or three occasions. In addition to the importance of caring for their unwell whānau member, the importance of looking after the carer(s) was raised.

Regarding the role of whānau in relation to pain, a variety of important issues were raised. The dynamic tension of having whānau support on the one hand and of being overwhelmed with the number of visitors on the other was presented.

Another issue was the tension between the desire to be private and not burden others with one’s pain or health worries (i.e. not call on whānau support) versus the value of whānau support. Most participants commented on the importance of providing whānau support, but expressed reticence in notifying whānau when unwell.

An interesting interpretation presented was that this behaviour (i.e. of not accessing whānau support or of feeling guilty about seeking whānau support) was regarded as
selfish. It was recommended that responsibility to whānau could be viewed as motivation for adherence to treatment recommendations including pain management.

There was also recognition of the disparity between the ‘ideal’ availability of whānau to provide support and the ‘real’ experience of complex family situations where actual support was not so readily available with family members living considerable distances away (including overseas).

**Whānau as advocate**

Several of the participants described the role of whānau as health advocate and asserted its importance for those elderly Māori who were reluctant to disclose their health worries in doctor-patient interactions as these settings were often found to be inhospitable or insensitive of cultural practices. The role of the health advocate was to negotiate these health encounters on behalf of individuals from their whānau or hapu (wider community) who were experiencing pain. It was acknowledged that those members of the community who had family members with medical training were at an advantage in negotiating such encounters.

**Participants’ recommendations**

**Pain measure**—The possibility of developing a pain measure incorporating Māori perspectives was discussed and endorsed by kaumātua and Māori healthcare workers. To improve the appropriateness and usefulness of such a measure, the following recommendations were made:

- Incorporate visual aids (e.g. pictures, diagrams),
- Use clear simple language,
- Incorporate Māori models of health (e.g. te whare tapa wha model),
- Ensure the measure is valid,
- Ensure treatment matches identified target,
- Ensure the measure is sensitive to clinical change (i.e. able to measure meaningful progress), and
- Develop different versions for different settings and different populations (e.g. paediatric and adult versions).

With regard to whether such a pain measure should be in English and/or te reo participants commented that the majority of New Zealand Māori were not fluent in te reo Māori, but were fluent in English and would therefore not find a te reo Māori version helpful. However, it was suggested that incorporating Māori words on charts visible in treatment could be beneficial.

Emphasis was placed on the quality of the healthcare relationship (i.e. culturally appropriate rituals of encounter). Other recommendations from participants were for auditing current practices of pain management within health services to ensure the general standard of practice was at a high standard and to provide standardised pain management training to all medical personnel.

**Trust is earned**—Enhancement of Māori health in relation to the quality of the relationship between the healthcare provider and the Māori client was discussed. It
was suggested that this needs to be a negotiated encounter with rapport and trust earned through awareness of, and adherence to, cultural practices.

Recommendations for culturally-appropriate practice, which would be applicable for any health encounter not just for pain management, included:

- Taking time to listen,
- Not undermining client/whānau resourcefulness and initiative,
- Do not overwhelm,
- Involve whānau in treatment,
- Use whānau or a cultural advisor nominated by the client,
- Seek permission to express less tidy or sensitive aspects,
- Avoid barriers in seating arrangement in relation to client/whānau,
- Have transparent systems,
- Acknowledge constraints of time/place,
- Know some basic te reo Māori,
- When possible use visual aids to explain procedures,
- Engage with Māori networks,
- Know and use cultural advisors, and
- Express humble curiosity.

Discussion

The findings of this study illustrate that, as with many cultures, Māori perceive pain as a multidimensional experience impacting them physically, psychologically, socially and spiritually. These findings are consistent with those found in many other cultures, suggesting that assessing and treating pain from a multidimensional perspective would be appropriate within the Māori culture and that consideration of Māori langue and cultural concepts (e.g. inclusion of whānau, developing trust in healthcare relationships, using the te whare tapa wha model) would be valuable in the assessment and treatment of Māori clients.

The presence of pain, its significance, cause, and purpose have been the basis of speculation and study in cultures over time. Cultural groups have sought meanings for pain and have incorporated their conceptualisation of pain within their language and discourse. As stated by Morris18 “Pain is as elemental as fire or ice. Like love, it belongs to the most basic human experiences that make us who we are.” As exemplified by comments in this study’s interviews, pain is a universal human experience.

While findings from qualitative studies cannot be generalised beyond the study sample, they provide useful insight into the nature of the topic under investigation. In this instance Māori perspectives of pain generated from this study’s interviews with Kaumātua and Māori healthcare providers reflect themes consistent within the greater body of literature. For example, the finding of the multidimensional experience of pain is consistent with previous studies exploring the applicability of the McGill Pain Questionnaire for use in other languages and cultures, in that the dimensions of human pain, independent of the language used, can best be described as encompassing
a range of sensory-discriminative, cognitive-evaluative, and motivational-affective dimensions.1,19

Similarly, the role of whānau described in this study aligns with the body of research on the important role the family plays in the health of its members, an area which has gained prominence within pain research in terms of the role of the family in the onset and maintenance of pain.20-23 With regard to pain treatments, the efficacy of partner-guided or family-guided pain management protocols have been demonstrated for chronic pain due to arthritis22 and cancer.23

In a recent overview of research on psychological aspects of persistent pain, Keefe et al.23 regarded the social dimension as a relatively untapped area of research, and recommended more research examining how psychological factors relate to the broader social context of persistent pain.

The importance of spirituality in the conceptualisation of health and pain as found in this study was consistent with a growing body of literature on the relationship between spiritual commitments and health outcomes. In an article on the impact of spirituality on quality of life, Baker24 described how spirituality as a variable in scientific study had evolved over the years, and cited research guides for the inclusion of spirituality within health research. Additionally, several articles in the Journal of the American Medical Association highlighted the role of the spiritual dimension in healthcare, providing evidence of its inclusion in medical training and providing guidelines for incorporating spiritual dimensions within an initial intake interview.25-29

Koenig26 recommended acknowledging spirituality within health not for the purpose of addressing spiritual issues, but rather to identify how patients cope with their illness or pain, the types of support systems available to them in the community, and any strongly held beliefs which might influence medical care.

Within the context of pain, Morris28 contended that religious discussions of pain and suffering provide a reference to the importance of the meaning of the suffering, an emphasis on the spiritual dimension of human experiences, and an acknowledgement that suffering is more than just a private matter but involves others in a sociocultural context.

In a recent review of spirituality in health literature, Unruh, Versnel and Kerr29 found diverse definitions of spirituality which they categorised as sacred (construed in relation to a higher being), secular (without reference to a higher being), or religious (participation with an identifiable group of people that is organised around a spiritual goal). Unruh et al.29 recommended clearly separating the spirituality construct from related psychological constructs, and respecting the spiritual views of a client (whether secular, sacred, or religious), while providing healthcare in a manner which does not violate the client’s spiritual needs.

Conclusion—Clearly pain is a multidimensional and universal experience and while this means there is a commonality between cultures with regard to the experience of pain, it is valuable to understand a culture’s perceptions and experiences regarding pain before assessing and treating it.
Our findings demonstrate that while commonly used and widely accepted approaches to the assessment and treatment of pain are appropriate to use when working with Māori pain patients, it would be beneficial to include the additional items/approaches indicated by the participants in this study (e.g. role of whānau, trust between client and provider) when working with Māori pain patients in order to improve understanding and treatment of their pain.

The findings from this study therefore provide a useful framework for exploring Māori perceptions of pain within a Māori pain population which could be explored in future research.

Competing interests: None.

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References:


