EMIC PERSPECTIVES OF BODILY PAIN

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EMIC PERSPECTIVES OF BODILY PAIN

ABSRTACT

The sensation of bodily pain has neither cultural nor social boundaries. However, pain perceptions and the ways of dealing with pain do have social and cultural boundaries. At least in part, human responses to pain are learned and are shaped by various socio-cultural factors. It was the goal of this project to explore cultural variations in how physical pain is interpreted and treated by a group of both American and Indian women. Demographics of the two study groups were restricted by the following criteria: participants were female, between the ages of 30 and 60, at least a second-generation born citizen of their respective countries, and had attained the highest level of post-secondary education necessary to teach in the collegiate setting. Both groups were interviewed using an identical set of questions. Questions considered aspects of religion, familial roles, education, and treatment patterns in regards to management of bodily pain. This study suggests the ways in which familial support was utilized in the pain process; attitudes, treatment patterns in the use of allopathic, Western medicine and the role of education all greatly contribute to defining these individuals' experiences with physical pain.

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INTRODUCTION

The sensation of pain is a seemingly limitless phenomenon. It manifests itself at both visceral and psychological levels. It is not bound by cultural or social factors, and it has occupied discourse spanning the course of history. Pain is at the core of the human experience.

Though the sensation of pain is undoubtedly universal, the experience of pain is not. Pain perceptions and the ways of dealing with pain have definite social and cultural boundaries. At least in part, human responses to pain, or the way a person reacts to and interprets it, are learned. It is the culture-specific messages and meanings associated with the sensation that have the ability to reshape an individual's experience, thus affecting the perception and management of pain.

This paper examines two cultures' emic observations of bodily pain. Interviewees in the study were female college professors from India and the United States. Research questions included the following topics: expressiveness while in pain, familial support behaviors, attitude, and treatment patterns to relieve pain (i.e. use of natural remedies, indigenous health care systems, use of allopathic medical systems, attitudes towards prescription drugs), religious/spirituality factors, effects of education, and meanings associated with pain (such as is pain "good" or "bad"). Differences and similarities between the two groups of data were compared and discussed.

Research on such social perceptions is important for several reasons. The commonplace nature of pain makes it a topic worthy of discussion. Many individuals report finding no relief from pain, even with treatments; the more information contributed to the present body of knowledge, the more likely pain can be dealt with effectively. Furthermore, many of the previous studies focusing upon bodily pain have been medical studies, which often have the potential to dismiss the actual person in pain. These factors make the study of pain among different social backgrounds an appropriate one for the field of medical anthropology.

LITERATURE REVIEW

The study of pain is not an easy undertaking because pain is a subjective experience, an "inner experience" in which even those closest to the sufferer cannot fully share (Kleinman et al 1992:5). Pain cannot be consistently measured nor objectively quantified. Because it is commonplace and nonfatal, pain has the potential to be invisible (Morris 1991:66). It is for these reasons that pain studies ultimately face issues related to the lack of a comprehensive and holistic approach.

To further complicate matters, much of the information about pain that comes to us is from the medical community. Such information centers on explaining the existence of pain and the ways of immediately treating it (Encandela 1993:784). In this view, the perception of the pain experience is

quantified largely in terms of somatic sensations and is limited in its consideration of concomitant factors. Medical scientific study places an emphasis on repeatable experiments, achieved through quantitative research methods. This manner of research and its physiological focus poses the risk of actually leaving the individual and his or her emotions and expectations out of the pain process. When pain is viewed in limiting terms such as hidden tissue damage requiring drugs, surgeries and referrals, a possible result is that there is little regard given to a person's social and cultural environment.

In addition to potentially leaving the actual person out of the pain experience, modern medicine also threatens to commodify the body by essentially allocating "worth" to its parts: "like other commodities in our postmodern capitalist world, (the body) is defined by its potential for generating capital" (Low 1994:476). Modern medicine views the body as a machine in which parts can break and can ultimately be repaired or even replaced. With a perspective such as this, it should be no surprise that the medical field is a multi-billion dollar industry; this is an industry in which personal expenditures and corporate profits are increasing by the year (U.S. Census Bureau 2005:99-101).

For studies to be limited solely to the medical realm would ultimately mean a failure to consider many components of the subjective pain experience. When this happens, "pain threatens to become entirely meaningless" (Morris 1991:77). It is crucial to understand that pain does

indeed encompass a great variety of meanings, some of which can directly affect its perceived outcome. For example, Kodiath notes how cultures that find meaning in their pain show “markedly less suffering [compared to] those who find pain to be meaningless” (Callister 2003:209).

Furthermore, in many instances the modern medical approach prevents effective care for the patient seeking relief from pain. As long as the cultural backgrounds of both patients and providers lack relevant consideration, expensive treatment programs will essentially remain ineffective (Bates 1996:145). Bates provides an example of such inappropriate care. In one study, several nurses (many of whom were Caucasian and native New Englanders) exhibited judgmental behaviors towards expressive Hispanic patients; they admitted to seeing the patients’ expressiveness as an “over-reaction” and would sometimes ignore their pained cries for help and relief. This judgment was clearly related to these nurses’ own cultural backgrounds (Bates 1998:276). This demonstrates how pain that can be “absolute private certainty to the sufferer” has the potential to become “absolute public doubt to the observer” (Kleinman 1992:5).

It is for this reason that the social sciences, and specifically medical anthropology, must embrace the study of pain. With their focus on the qualitative data, social scientists have the power to put the culture back into the study of pain. As keen observers of everyday experience and cultural categories, anthropologists are drawn to pain in order to understand how the

bodily experience itself is influenced by meanings, relationships and institutions (Kleinman 1992:7). Medical anthropology realizes that patterns are not isolated, but are integrated into a complex network of beliefs and values that are part of the culture of each society.

Explorations in the topic of bodily pain do exist within the field, but studies are limited. There is an agreement that more research is needed in order to build upon the current body of knowledge regarding cultural influences on both acute and chronic pain (Callister 2003:209, Encandela 1993:783).

The first large scale study focusing on cultural variations in pain was done by Mark Zborowski. In the 1950's he interviewed and observed patients at the Veteran's Hospital in Bronx, New York. His groundbreaking work specifically focused on finding cultural congruencies in pain related behaviors between the varied patients within his study. Zborowski concluded Jews and Italians tended to be uninhibited and expressive in their pain responses, whereas Irish and Old Americans tended to hide their pain, avoid company, and engage in strategies of silence and denial (Zborowski 1969:239).

Zborowski's study is special in that it was one of the first and largest of its kind. It also showed pain as "not only a neurological or psychological experience" but also as "a cultural one" (Encandela 1993:783). Zborowski's work, however, is laden with one-dimensionality. He is often criticized for creating "cardboard characters instead of describing real people" (Kleinman

et al 1992:2) and performing erroneous acts of ethnic stereotyping. Nevertheless, Zborowski's studies did open the door for future studies on pain as a culturally unique experience.

Another example of such studies is found in work by Ohnuki-Tierney. His study concentrated on individuals within contemporary Japan and the ways in which they analyzed and treated pain based on where it was located in their body and how it was related to traditional, sacred symbolism concerning that location (Encandela 1993:785). For example, "abdominal pain may indicate a spiritual imbalance which must be attended to, since the abdomen is thought to be the seat of the soul among many Japanese" (Encandela 1993:785).

Maryann Bates and W. Thomas Edwards found certain cultural variations in their studies of chronic pain. Research was conducted at the Pain Control Center in Worcester, Massachusetts. Their methodology combined both quantitative and qualitative strategies. Among their findings were that Hispanic groups tend to have the highest mean of pain intensity, the greatest interference with work and social activities, the highest degree of emotional and psychological stress, and the highest pain expressiveness (Bates 1998:273).

Among the Chinese, pain and illness are often considered to be caused by an imbalance among the organs or body systems. In Zibin Guo's recent work done with an elderly Chinese population in Flushing, New York,

he found that these imbalances emically manifest themselves in different ways. Imbalances vary by degree and can often be categorized into three forms: *xiao mao bing* (small problem), *dai mao bing* (big problem) and *bu dai bu xiao de mao bing* (problems between small and big) (Guo 2000:106). Guo's research demonstrated how people individually classify specific painful conditions through a variety of descriptions, but a general conclusion was that these problems were often a result of aging (2000:103-105)

In another study, Nayak et al (2000:135-151) performed pain research on male and female college students from the United States and from India. Using a "Pain Behavior Questionnaire" and a cold-pressor test, they found Indians, both male and female, to have a much higher pain tolerance than the United States participants. Furthermore, they found the Indian sample believed the overt expression of pain is significantly less acceptable than the comparable American group.

The factors mentioned in these studies cannot be viewed as having a predictable or specific relationship to the patient's response to pain. There is no agreement about definite causes and effects. However, these factors often seem to be *associated* with similarities and differences in reactions to the pain experience and acceptance of pain treatments (Meinhart 1983:90).

As emphasized above, pain responses are learned. In one example, Morris states the following in regards to crying about pain:

> We very soon replace our earliest natural responses to pain with carefully calibrated understandings about how much crying is

> permitted, about when and where you can cry, about who can cry and for what reasons. The truth is that we learn almost everything we know about pain, including the need to deny it and to smother it in silence. [Morris 1991:72]

So whereas the actual site of pain pathology may be precisely the same in individuals, the likely course of pain may be quite different among them. These factors are dependent upon the meaning of the pain, the life world of the sick person, and his or her relationship to family, health-care and disability systems, and the resources available to treat pain (Kleinman 1992:10). People learn these factors in social communities, where conventional ways of interpreting, expressing, and responding to pain are acquired. "People with similar learning experiences are likely to show similar pain perception, expression, and response patterns" (Bates 1996:138). It logically follows that people with dissimilar learning experiences would therefore show different patterns.

"The differences between groups is not positive or negative in itself – it is simply a different reality, which should be evaluated from an emic perspective and not through the cultural lens of the outside provider or researcher" (Bates 1996:139). Therefore, it is the intention of this paper to examine these various emic perspectives regarding bodily pain.

One way to approach discovering these perspectives is by using anthropologist Arthur Kleinman's theory of "explanatory models (EM)." "Explanatory models are held by patients and practitioners in all health care systems. They offer explanations of sickness and treatment to guide choices

among available therapies and therapists and to cast personal and social meaning on the experience of sickness" (Kleinman 1980:105).

First, to understand ways in which EMs can differ, distinction must be drawn between the terms disease and illness. *Disease* refers to a "malfunctioning of biological and/or psychological processes" (Kleinman 1980:72). This is the term largely used by professional practitioners. It is viewed as being acquired individually and expressed at the cellular level (such as defective immune system, susceptibility to particular microbes and toxins, failure to follow good health practices, etc.) (Felker 1983:361).

Illness refers to the "psychosocial experience and meaning of perceived disease" (Kleinman 1980:72) and is the term associated with lay folk. Illness derives its meaning from the personal, social and cultural reactions to a disease. There are five major factors that EMs use to establish meaning for illness episodes. They are: etiology; time and mode of onset of symptoms; pathophysiology; course of sickness (including both degree of severity and type of sick role—acute, chronic, impaired, etc); and treatment (Kleinman 1980:105). Again, the responses to these factors are direct products of one's ethnicity, social class, education and so on.

Symptoms of an illness are constructed socially and are "saturated with specific meanings" (Kleinman 1980:77), which ultimately forms the overall notion of illness. The cultural shaping of symptoms may sometimes be minimal, and so these symptoms may look the same from a cross-cultural

comparison. But often they do differ significantly – in meaning and experience. This is essentially the uniqueness of illness as opposed to the more static notion of disease.

Taking the concept of disease and illness into the next level leads to explanatory models. Practitioners' EMs are based upon how they understand and treat sickness. Patients' EMs are how they make sense of the illness they are experiencing and how they choose and evaluate particular treatments. It is the patient's EM which is of primary interest here; this paper seeks to explore differences regarding Indian and American beliefs in relation to bodily pain. In order to properly understand this EM, one must examine the various social, political, cultural and environmental factors which shape a patient's beliefs regarding the condition.

Kleinman does emphasize disease and illness are not separate entities; they are a "complex set of interrelations" (Kleinman 1980:79). Furthermore, how the practitioner's EM and patient's EM interact offers a more "precise analysis of problems in clinical communication" (Kleinman 1980:105). This is why studies of pain cannot be limited to just the medicalization of the sensation or to the practitioner's EM.

Following are salient points which might contribute to the explanatory models of the women included in this study.

DEVELOPMENT OF RESEARCH QUESTIONS AND HYPOTHESES

Pain and Gender

The first and probably most obvious factor about the participants in the study is that they are women. This gender makes for a particularly interesting study in regards to health and the body. In many cultures, wome have traditionally been caregivers and herbalists, healers and midwives. Much of their identity has centered upon these roles. However, in today's modern medical climate, women use the health care system more than men - including more doctor visits and use of prescription drugs (U.S. Census Bureau 2005:102).

Some studies indicate that gender affects the pain response. Women typically feel a greater intensity of pain and tend to express their discomforts and stresses associated with the pain more openly than men (Cepeda 2003:1464-1468, Encandela 1993:785, Nayak et al 2000: 141, UPI News Track 2005). In another study researchers found women not only express pain more openly, but that both males and females deem an overt pain response to be much more appropriate in females rather than males (Nayak et al 2000:141).

"It may be that women express pain more freely, merely because they are more familiar with it and come to expect it as an inevitable part of life" (Encandela 1993:786). This conclusion is drawn because women are

unquestionably confronted with issues such as menstruation, childbirth, birth control, abortion and menopause. The associated meanings assigned to these pains differ between cultures.

Indian gender studies have largely focused upon issues targeting unequal access to resources; lower life expectancy at birth as compared to males; maternal health and immunization and the effects of education in less developed countries (See Dyches 1996, Kutty 1989; Kynch 1983; MacCormack 1988; Navaneetham 2002; Pande 2003; Paolisso 1995; Ravindran 1998; Wickrama 2002; and Yadava 1994). A serious lacuna exists in research involving Indian women and the specifics of pain. One study by Nayak et al (2000) did compare college students' (both Indian and American, male and female) responses to pain. They found Indian women had a higher pain tolerance, reported less suffering and thought the overt expression of pain less acceptable than their American counterparts.

Given these factors, it is predicted both groups of women will express pain, but that the Indian women will do so less.

Pain as a Solitary and Social Phenomenon

> We are probably never more alone than when severe pain invades us….The isolation of pain is undeniable. Yet it is thus especially important to recognize that pain is also always deeply social. The pain we feel has in large part been constructed and shaped by the culture from which we now feel excluded or cut off. [Morris 1991:38]

India is a patrilineal society; postmarital residence patterns typically follow that of patrilocality. It is assumed the Indian women will reach out for comfort and support from the family which surrounds them.

America is a highly individualistic society; it is assumed these will women will more commonly depend on themselves rather than others. Present patterns of neolocality and unconnectedness with extended families will further amplify this response.

Pain Management

India has its own indigenous care system called Ayurveda, which focuses on a holistic and natural approach to health. It is assumed the women will utilize this system. Considering the foundations of Ayurvedic therapies are derived from local plants, these women will incorporate herbal remedies and concoctions of their own to help alleviate painful symptoms. Additionally, because India is in a period of rapid urbanization, it seems likely that college educated women will increasingly incorporate allopathic care as the trends continue to progress in this direction.

The opposite is assumed for the American women. With the rising costs of insurance, medical bills and prescription drugs (U.S. Census Bureau 2005:99-101), these women will be seeking an alternative. As members of a society moving towards post-industrialization, they will more frequently utilize

natural, herbal and home remedies, thus seeking to place the control of their individual health within their own hands.

Also worthy of noting: in one study, only 38 percent of women interviewed reported trusting their doctors' advice (Crook 1995:112). It is speculated that the women in the present study, armed with education and critical reasoning, may follow this trend and instead opt for outside sources of information. One source will be to utilize a more Eastern, holistic approach to health.

Pain and Religion

People often turn to religion in times of trouble, such as during pain and serious illness. Its role in such times has both personal and social implications. On a personal level, one may seek peace and acceptance through prayer and other means of spiritual connectedness. On a social level, active participation offers a supportive network. Assistance can range from family and friends' prayers and blessings to help with the routines of everyday life, such as cooking hot meals, a ride to the hospital, or offering to lend a hand with paying bills or doing laundry. While these functions can occur through a variety of means, participation in religion is often a channel utilized by many.

Some studies even show there is a direct link between spirituality and health. Research performed by Duke University's Center for the Study of

Religion/Spirituality and Health have found several positive results when the two are connected. It was found that people who regularly attend church are hospitalized less often than people who never or rarely participate in church services. Furthermore, people who pray and read the Bible have lower blood pressure on average. People who attend religious services tend to have stronger immune systems than their less-religious counterparts (Williams-Tracy 2000:19).

Whether additional studies can verify these physiological findings, it is indisputable that most regions of the world have a form of religion. Furthermore, religions are often inseparable from health, healing and sickness (Kinsley 1996:1). It is hypothesized religious and spiritual factors will affect the way in which they approach pain.

India is a country saturated in religion. Statistically Tamil Nadu, the Indian state where this research was performed, breaks down into 88.7 percent Hindu, 5.7 percent Christian and 5.5 percent Muslim (CIA World Factbook 2006). However, India is truly a pluralistic society in regards to religion (Sherinian 2002:239); sometimes the lines of the various religions are rather indistinct. Hinduism especially has a pervasive way of seeping into the other religions. With corner-side shines of various sizes on nearly every block, one can hardly turn around without being reminded of the relationship of the Indian people with spiritual divinities.

Hinduism itself is a very sensual religion and its practice is very involved. Worship consists of literally going to “see” (darśan) the deity; ritual offerings (pūjā) consist of flowers, food, cloth, incense, *kunkum* powder, water and honey (Eck 1998:3, 35, 39). These ritualistic traditions and other aspects of Hinduism also have a place within Christianity (Meibohm 2002:66).

In regard to health and pain, certain gods and goddesses protect or harm accordingly. For example, in one case study, an Indian woman suffering from breast cancer felt she had acquired the condition because she failed to pray to Goddess Durga (the killer of all evil and demons) on her wedding night (Thatte-Bhat 2003:154). Furthermore, pain has great significance within religions. In Hinduism suffering permits one to escape this life cycle and be reborn into another where there is a lessened experience of pain (Vertosick 2000:276). Christianity emphasizes that all pain has a purpose. To what extent these Indian women will worship is unknown; however, their religion will undoubtedly play a significant role when experiencing pain.

In America there is an assumption that scientists and other educated individuals, such as the women in this study, are not religious. Data suggests, however, that the rate of religiosity is actually positive when correlated with educational attainment (Stark et al 1996:435, Sherkat 1998:1103). Stark et al additionally note that “although surveys do show scientists, professors and graduate students are less religious that the overall

population, the estimated differences are small, on the order of a few percentage points" and longitudinal data show this difference predates entry into higher education institutions (1996:435). Based on this data, it is hypothesized that religiosity will not be affected by education, and this may play a role in the American women's pain alleviation process.

Pain and Education/Work

In India the majority of women's work is low-pay, low-status, manual work (Devi 1983:698). However, the status of women is improving in some circles. "Education, urbanization and the influx of Western influences through the mass media and other routes have brought changes" (Andrade 1999:66). This directly influences health care practices and personal attitudes. One study compared the perceived well being of working versus non-working Indian women. While both groups reported poorer self-health than that of their husbands, the working women expressed more confidence in coping with illness in comparison to the non-working women (Andrade 1999:72). Another study indicates employment leads to higher concept of self (Bali 1998:73). Due to the dual power of having an education and being employed, these women's health will likely benefit.

A similar result is anticipated for the American women. "The recent work in medical sociology suggests that for women, work outside the home of any sort, but in particular professional work, contributes to mental and

physical health" (DelVecchio Good 1992:51). But DelVecchio has developed a model based on some of her individual studies she coins the "work→stress→ill-health" model (DelVecchio Good 1992:70). Pressures and stress from the professional world may likely take their tolls on health for both groups of women, but the overall result of education will be positive.

PRIMARY RESEARCH QUESTIONS AND HYPOTHESES

In short, the specific hypotheses for this research are as follows:

Due to the paternalistic and collectivistic nature of Indian society, the Indian women in this sample will turn to their nuclear families in times of pain but will be less vocal about their pain. They will use herbal remedies for treatment; utilize their indigenous Ayurvedic care system, but as a result of higher education, will also incorporate Western, allopathic care. Given the cultural trend of religious saturation, religion will play a significant role in the pain alleviation process.

The American women in this study, as members of a highly individualistic society, will not express the desire to turn to others for support and will take health matters into their own hands. As a result of education, the American women will markedly look more towards the East for inspiration in health treatments to keep them well (i.e. use of herbal remedies, incorporation of various Eastern indigenous care systems). Religion will also play a role in the pain alleviation process.

METHODOLOGY

Data used for this study was collected at two intervals over the course of a year and a half. Initial data collection was performed during summer 2004 on a scholastic trip to Tamil Nadu, India. The cross-cultural comparison data was collected during winter 2006 in Chattanooga, Tennessee

India Data Collection.

During a six week trip to India in 2004, the researcher conducted one-on-one, semi-structured interviews with five participants. Interviewees were all female and ranged from 31 to 57 years old. Each woman possessed a high level of education (minimum of a Master's degree in their respective fields). All participants were professors of an all female, Christian college.

These particular demographics were chosen for two reasons. First, matters of convenience dictated the decision. Though India is a multilingual society and much of its population speaks English (due to a great diversity in language, English is actually considered India's national language), barriers are still omnipresent. The professors in the study are fluent in English and actually teach many of their classes in the language. Also, the collegiate campus setting offered a high concentration of participants willing to be interviewed on relatively short notice. Secondly, female university teachers are in the extreme minority, thus their perspectives are of great interest.

Though southern India boasts the largest concentration of women's work participants across the cardinal regions in the country (Devi 1983:684), the total number of female professors is comparatively small. According to the 1971 Census of India, female university teachers comprised 0.46 percent of the women's total workforce (Devi 1983:691). This specific percentage of female professors could not be found within the most recent Indian census data. Yet based on other information regarding the Indian woman's work force (Census of India 2001), it can be extrapolated that these numbers have likely remained low. Therefore, the answers these respondents provided would undoubtedly be of significance.

As mentioned previously, interviews were semi-structured in nature, meaning the interviews were lent a discussional tone but adhered to a set interview guide. This was due largely to the tight schedules of the interviewees: efficient use of time was essential. Topics and specific open-ended questions were pulled from the Sunrise Model developed by prominent nursing theorist Madeleine Leininger (Tomey 2002:501-518). This ethnonursing guide covers topics aimed to provide holistic, culture-specific care and reflects issues pertinent to the researcher's academic field of study at the time. Specific domains of inquiry included issues like kinship, social factors, religiousness, spirituality, professional life, and generic care beliefs, amongst others. The way these topics specifically related to bodily pain was discussed in depth. Though the initial study was motivated by interests in

nursing at the time, all inquiries reflect a congruency derived from medical anthropological training.

Interviews were conducted on a one-on-one basis. The researcher felt this interview technique, as opposed to the focus group format utilized in later research, would be more effective given certain Indian cultural factors. While a focus group might not have been impossible with women in India, the technique had not been advised. There has been previous research discussing difficulties regarding Indian women's' unwillingness to openly communicate about certain health issues when in the presence of others. For example, Jayashree Thatte-Bhat has performed breast cancer research/awareness in India and found certain health topics to be taboo amongst Indian women (2003:145). Not wanting to place the women in a potentially uncomfortable environment, the one-on-one interviews were favored. These interviews were tape recorded, transcribed and made ready for text analysis.

United States Data Collection

In early 2006 the researcher sent an e-mail requesting interview volunteers via the University of Tennessee at Chattanooga's faculty electronic mail network. Based on the preset participant selection criteria, six individuals were selected for the study.

Similar to the Indian participants, the six participants selected in Chattanooga were all female and ranged between 33 and 60 years old. They were all United States born, professors at a public university and possessed an education minimum of a doctorate degree.

The interview technique initially planned was one-on-one interviews, like those done in India. However, after further review, it was decided a one-time focus group would be more beneficial due to the noted openness of Americanized women (Nayak et al 2000:145). It was believed the "sharing and comparing" of a group discussion (Morgan 1998:12) would facilitate a more active, engaging and informative session. In order to achieve a pertinent cross-cultural comparison, the same qualitative research questions used in the India data collection were discussed.

The two and a half hour event was video recorded, transcribed and made ready for text analysis. Participants were also asked to complete a short demographic survey consisting primarily of nominal variables such as race, religion and marital status.

References to interviewees are presented in a codified format for sake of confidentiality. Please refer to Table 1 and Table 2 for a quick review of their demographic information.

Table 1. Indian Interviewee Demographics

ID Code	Age	Religious Affiliation	Marital Status	Children	Professional Discipline
I1	31	Hindu	Married	Yes	Economics
I2	39	Catholic	Married	Yes	Economics
I3	42	Hindu	Married	Yes	Zoology
I4	56	Hindu	Married	No	Economics
I5	57	Hindu	Married	Yes	Physics

Table 2. American Interviewee Demographics

ID Code	Age	Religious Affiliation	Marital Status	Children	Professional Discipline
A1	33	Protestant	Married	Yes	English
A2	52	Agnostic/atheist	Married	No	Geology
A3	54	Catholic	Married	Yes	Dietetics
A4	55	Agnostic/atheist	Married	Yes	Communications
A5	59	Protestant	Married	Yes	English
A6	60	Agnostic/atheist	Married	No	English

RESULTS

As previously emphasized, pain is not limited to the visceral realm. It infiltrates many aspects of one's life. The interview questions reflect the nature of such all-encompassing characteristics; they centered upon a variety of topics.

Familial Support and Pain Expressiveness

The ways in which people seek support and help from others may hold messages about the society at large. However, the ways in which individuals express or suppress pain can determine ways and timeframes in which those supportive individuals are looked to for comfort.

I1, the youngest of the Indian interviewees, says she is quick to say when she is hurt and will immediately turn to her mother and ask for help and comfort. As an interesting comparison, I1 shared a story about a recent accident involving her mother. The mother had been working in the kitchen and received a "big burn" on her hand. "And she didn't tell us anything! She didn't even apply cold water or anything - she just continued doing her work." Several days later the family noticed the sore, the skin now peeling, oozing and close to infection. Upon noticing this, I1 and her family bought some healing ointment and helped make sure the mother applied it regularly. When asked, I1 believes her mother is quiet about her pain because her mother "does not want to disturb her work." Though the mother does not explicitly state she needs help, and in fact does not voice her concern at all, her family still offers help in times of pain.

I5 often turns first to her husband and children: "They are comforting and concerned but also bring cheer. They are very conscious of my health." Then she will call her mother if necessary. If she is suffering from acute pain,

she may lose her temper, shout out and “make things difficult for others.” Generally, she tries “to be cool, not to disturb others and hopefully forget the pain.”

I5 often finds she is a source of comfort for others when they are feeling pained and sick[1]. She tries to “hide” her feelings from them. “Ordinarily I would be very upset but I would try not to show it to them. I try to raise good spirits, saying ‘You will get better soon!’ I think the patient has to be happy, has to remain optimistic that they will come up very soon. That kind of feeling we have to impart to them.”

I2 seeks comfort from her husband - “he’s the pampering kind!” But when in pain, she tends to “talk less and smile less,” and tries to continue on with her necessary duties without calling attention to herself. But her husband can normally make out that she is in pain because her “face would reveal it.”

I3 also turns to her husband in times of great pain and when she needs assistance. She claims, “Yelling doesn’t come impulsively to me” and tends to keep to herself in times of pain, but knows her husband will be there for her when she needs him.

I4 was the only one of the women to say she turns to her brother and sisters’ families in times of pain. “I am more affectionate with them than with

[1] Please note here, both the Indian women and the American women often associated the sensation of bodily pain with being sick or suffering from an illness. “Pain” was not limited in its strictest, most singular sense and therefore came to be associated with a variety of conditions (as is the true nature of pain).

my husband's family. Because many things happened at our time of marriage, I hate that family." Though she typically is not quick to voice it, she does not like to be alone when in pain; she likes to accept help from others and desires the company of her "affectionate people." In turn, she helps her brother and sisters' families when they are in pain. "I give all sorts of financial support, moral support, everything I do. Even my brother's house, I will be there and do things."

Table 3. Desired Family Member for Comfort

Indian Response	Frequency
Mother	1
Husband and children, then mother	1
Husband	2
Brothers and sisters	1

American Response	Frequency
Prefers to be alone	4
Desires husband's physical presence and touch	1
Prefers to be alone initially, then desires sympathy from husband and/or eldest daughter	1

The American responses to these same questions were decidedly different from their Indian counterparts. Overwhelmingly, the American women choose to be alone when experiencing symptoms of pain and ill health. Along with wanting to be alone, there is a trend not to discuss the pain.

A6 spoke of how “you have to be tough.” She attributes this attitude to the influences of modernist American literature, such as Hemingway. “Part of the code of ethics is you suffer in silence, you don’t whine, you don’t talk a lot about your problems and your pain.” She has also found that others’ experiences with pain have contributed to her desires in keeping silent. She grew up hearing the older women in her family complaining about their pain. She did not want to be like that and decided she was not going to talk about her pain or her health. “I don’t want to bore others.”

A6 also explains, “The sick role in our family is filled already.” Her husband has a variety of health issues, including diabetes, heart issues, an artificial heart valve, amongst others. She feels there is no room for her to complain, especially when he is the one suffering such a great deal.

A1 relates to this: both her husband and sister have painful health issues, and she feels her pain is not much when compared to theirs. Additionally, she grew up in a family of doctors who simply would not give her attention over trivial pain matters, and so she learned to not say much and keep these sensations to herself. A1 believes much of this has to do with our culture not being an empathetic one. “We’re just not aware of other bodies; we don’t know how to be sympathetic.” Furthermore, she feels our culture puts limits on “acceptable pain:” if it is past that point, no one wants to hear it.

A2 simply wants to be alone, but somehow her mother is aware of these times of sickness and will reach out to her. “I’m not the type of person

who likes to be pampered or coddled. I just want you to leave me the hell alone until I get well, and she'll call!" She prefers to be alone because she has realized that if she gives herself that time, she is able to get well more quickly.

A5 experiences pain on a daily basis, but she prefers to not mention it. "I have decided who wants to hear about something that is going on all the time? I hate the whining, and so I just don't mention it." She knows that she can turn to her husband and he would support her "110 percent." Yet she struggles to find a balance when wanting to tell someone she does not feel well, because she worries to whom she can tell that and furthermore what that person is suppose to do with the information.

A4 offers a very sharp contrast. She thinks "all pain is existential" and "it's okay to share it a little bit." "That's what we're here for." In times of pain and sickness, A4 literally reaches out to her husband. She believes in the power of simply touching someone. Not only does she want to be touched, but she wants to touch others in response to their not feeling well.

A3 incorporates aspects of each of these sentiments. She will turn to someone depending on whether she "gets sympathy" from them. This role is usually played by her husband. As her oldest child has matured, she often turns to her for comfort also. But A3 claims that she sometimes does not want to be touched or have companionship when in pain. This is particularly the case when her day has been chaotic and she needs it to be quiet and

alone. "Then after I have that time, that moment, I would like contact." A3 admits to being reserved about expressing her pain. Like A1 she attributes that to part of American culture: "You just aren't supposed to say much."

Health Care Practices and Patterns of Management

Use of Herbal Remedies

Every one of the Indian women said they use herbal remedies at the first sign of pain and illness. Some of these remedies are made at home, using fresh picked leaves, roots or flowers which may then be combined with water, oils, honey or sometimes "palm candy." (Palm candy is a product from the palm tree and Tamil Nadu is one of India's primary states of harvesting. It is high in B vitamins, minerals and protein. Palm candy can be taken by itself, mixed with water, milk or herbs.) If not made at home, herbal remedies will be bought at one of the many corner-side drug stands. These remedies may be taken internally or used externally, as in rubbing oils over the stomach.

At this point both I1 and I5 mentioned the importance of certain foods in keeping one well and "to avoid going to the doctor." Foods mentioned were limes for vitamin C, greens, leafy vegetables, dates and starchy material to relieve/prevent constipation.

Etic observations imply the women all believe there is efficacy in these treatments. Emic statements support this; I5 stated she has "lots of faith in it" and I4 said that she finds the herbs usually work.

Table 4. Use of Herbal Remedies/Nutritional Supplements

Indian Response	Frequency
Yes	5
No	0

American Response	Frequency
Yes	2
No	4

The American women were more hesitant to use supplements. None of them make remedies in their home like the Indian women. Only two admit to purchasing them for times of sickness or for preventative maintenance of physical problems.

A6 uses MSM/Chondroitin and Calcium for her knee problems, as was suggested by her medical doctor. She also uses zinc lozenges when she has a cold.

A4 uses all "the old tried and trues." These include vitamin C, oil of oregano, homeopathic remedies, amongst others. A4 has utilized such remedies all of her life. Her mother was a nurse who "hated doctors" and decided to raise her children naturally. A4 has continued this throughout her life. When she gave birth to her son in 1976 she brought to the hospital with her a typed sheet of all the things the doctors and nurses were not allowed to do to her and it "absolutely floored them." She went home two hours after giving birth.

A4 believes the following about natural, self-treatments: "It requires you to stay in touch with yourself, or otherwise you can't do it. Because then

you have to give yourself over to a caretaker. And I didn't like that. I'm too independent. I wanted to figure out how I could manage it myself."

A1 does not use herbal remedies but would like to know more about such treatments. Her sister, a botanist, has been helping inform her by giving her various literature. But she believes herbs have the potential to be poisonous to the body, just like other drugs and so when she is not feeling well she focuses on cleansing her body. She drinks a lot of water and refrains from eating "anything yucky" such as meat.

A2 states she is already on so much medication for her asthma that she does not want to take anything more. "It already looks like I'm a walking drugstore." She focuses on getting rest and sleeping as much as possible: "I can usually nip things in the bud like that."

A3 and A5 do not take such remedies primarily because of a lack of trust. A5 does not have much knowledge about herbs herself and does not trust the people who sell them: "I don't know why we should put our trust in them any more than some people are saying we can't trust doctors!"

A3 does not trust the herbal remedies because they are not regulated by the federal government and believes she has found no empirical evidence suggesting they actually work. She thinks they can be toxic to the body. She does try several "home remedies" such as gargling with salt water or eating chicken soup. She notes that her professional background as a dietician has helped her know how and what to treat.

Use of Pharmaceutical Pain Killers

Most of the Indian women approve of taking pharmaceutical pain killers if the doctor has prescribed them. I5 was the only to say she will not take pain killers, even if prescribed by a doctor. “They are very powerful. I think in the long run it reduces my capacity to bear pain and then I will have to go to the higher dose. I would rather suffer.”

I1 will take them because by the time she has gone to the doctor, the pain is at its maximum. She is very cautious however and makes sure to ask many questions, such as any side effects, duration they should be taken, and so forth.

I2, I3 and I4 will take them according to doctor’s instructions. I3 added, there are times she has been “particularly thankful” for them because of the relief they gave her.

Table 5. Use of Pharmaceutical Pain Killers

Indian Response	Frequency
Avoids even when prescribed	1
Will use and is thankful for them	1
Will use if no relief is derived from other sources	1
Will use if MD prescribes	2

American Response	Frequency
Avoids all together	2
Tries to avoid, or will minimize dosage	3
Will not hesitate to use	1

A4 and A1 will not take drugs to relieve pain. A1 adds that she is too skeptical of the pharmaceutical companies and does not trust them.

A2, A3 and A6 will take them, but they do have limits. A2 made the comment that she is a "firm believer in better living through chemistry" but when recently prescribed Oxycotin for her pain, she threw it away. "There is a certain level."

A5 will take them, adding, "They have made my life better."

Indigenous Care, Allopathic Doctors and "How Long Before Visits?"

India has its own indigenous care system, Ayurveda. Only one of the women uses it. I5 will go to an allopathic doctor but only after trying to remedy the pain on her own first. Within about a week, if nothing has helped, then she will go to the doctor. But she has found "sometimes there is no healing in the allopathy." So she uses Ayurveda as an alternative. Several years prior she had experienced tremendous pain as she was suffering from kidney stones. The allopathic suggestion was invasive surgery. Instead she opted for the Ayurvedic remedy which, through her drinking various herbal concoctions three times a day for forty days, gave her relief from the pain and dissolved the stones.

Table 6. Indian Use of Indigenous Care

Indian Response	Frequency
Does NOT use	4
Does use	1

The other Indian women only go to the allopathic doctor. When asked about Ayurvedic medicine I1 said, “No, no, no. We don’t go to that type of doctor.” She initially tries to cure it at home and then goes to an allopathic doctor within 2-3 days. I2 typically waits a week before going to an allopathic doctor. I3 also waits about a week. She does not use Ayurveda because “there are so many practitioners” and she “doesn’t know who to trust.” I4 waits about ten days before going to an allopathic doctor for pain. If it is a continuing fever she will go much sooner, in two to three days. I4 does not use Ayurveda because she fears “the problem may be intensified.” I4 does however practice yoga for successful alleviation of chronic back pain.

Table 7. Utilization of Medical Doctor at First Sign of Pain/Illness

Indian Response	Frequency
Typically waits 2-3 days	1
Typically waits one week	3
Typically waits 10 days	1

American Response	Frequency
Waits until last possible moment/ Only goes if condition is serious	5
Only goes to gynecologist for routine check-ups	1

All of the American women express a hesitancy to go to the doctor. They only go if it is a dire emergency and usually wait until the last possible moment. All of the women express a dislike for male doctors; they all see female physicians (except for A4 who has a male doctor but usually is seen by his physician’s assistant, who is female). There were also frustrations over

traveling doctors, their practice partners, the increased rate of nurse practitioners doing the doctors job, male doctors assuming female patients do not know anything and so forth.

A1, the youngest of the interviewees, states she does not go to the doctor except for routine gynecological exams. She is “fed up with the system.”

Religion and Spirituality

The Indian women consisted of four Hindus and one Christian. When it came to religious practices used to alleviate pain, all of the Indian women state they prayed. For all except one, this was the greatest extent to which they went in regards to incorporating their religion. I4 responded in saying, “I do have the faith. I pray god will help me in relieving the pain. I pray this will be cured and the medicine will work. But I don’t do much ritual.” This was the general consensus amongst the women.

Only I1, a Hindu and the youngest of the women, claims to make special offerings or promises. She stated, “If it (the pain/sickness) is very big we will just pray and then afterwards we’ll make promises and do some offerings. But we do not do big promises; we may walk to the temple, and there we may give some offerings to the poor people.”

Table 8. Role of Religion/Spirituality in Pain Alleviation Process

Indian Responses	Frequency
Prays	4
Prays, also makes promises and does offerings	1

American Responses	Frequency
Is confused	1
Religious: prays for others and self	1
Religious: prays for others, but not for self	1
Spiritually aware, concentrates on awareness of self/pain	1
Does not need an outside power, acknowledges power of own mind over pain or anything	2

The American women had varying responses. They ranged from not knowing and being "confused," to finding great peace and consolation within their beliefs, to having no belief in religion and spirituality. These sentiments carry into how they incorporate or do not incorporate religion into the pain relief process.

A1 was the one to state, "I'm very confused." She was raised Protestant but went to a Catholic school. She married a Catholic man who "doesn't really know. He just has the guilt of being Catholic." A1 also has an older sister who is a pagan and a botanist by profession. Her sister places a great deal of belief into "the earth giving you what you need" in regards to health, healing and pain alleviation. A1 finds her sister's spiritual beliefs in the natural world have come to influence her a great deal and A1 strives to do things naturally. Then she retorted by saying, "Sometimes I don't know what

that means anymore, what ‘doing things natural’ means.” So her confusion exists at many levels.

A3 on the other hand is quite firm in her beliefs. She was born and raised in Louisiana, where “if you weren’t Catholic you were foreign.” When she came to Tennessee to attend college, a state in which Catholics simply “weren’t around,” she was forced to decide exactly what role she wanted her religion to play. She said, “At that point I decided I did believe in my faith and it gave me a connection between my past life (in Louisiana) and present life.”

A3 definitely believes in the power of prayer. This power is not in the context of actually creating healing, but instead “rests on the power of meditation” and the ability to create a “different balance” within her life. She finds that it takes the pressure off her, and allows her to let go of the pains and stresses she experiences. She finds that it “actually helps,” particularly in dealing with something like physical pain. A3 also wears various Catholic medals which help her “get through the day.”

A5 is Methodist. She states that she is at a life stage in which she has been thinking a lot about God and religion. She states there is a power which she does not completely understand, but she attributes that power to God. She has come to conclude that God is within her and she cannot do it by herself. A5 questions God, but she does not blame him for her pain. She does not pray for herself when she is in pain either: “I pray for other people more than for myself. I mean, if I get a bad headache, I’m not praying, ‘O,

God, take this away!' If I see somebody else sick, I would want that other person to feel better." A5 believes that this notion of God being present within her is a "Hindu thing, more Eastern."

The remaining respondents, A2, A4 and A6, consider themselves to be either agnostic or atheist. They differ, however, within their specific beliefs.

A4 places a strong emphasis on the differences between religiousness and spirituality. She was brought up in the Catholic Church, but has grown to believe religion "has INSTITUTION written all on it, and (has) a bunch of people involved in it, but it doesn't have much to do with God." She finds solace within being spiritual, which to her, is "just being aware." It is a way of tapping into one's own personal power, which is no different from "the power of whatever, a god." She believes, "It's an illusion, it's a Western idea that they (individual power and God's power) are separate. Just to me, to be in the moment, to be aware, that's probably the closest I get to spiritually trying to heal myself. To me, there's no difference. It's not like I have to do some rituals and get into a religious frame of mind. Just awareness."

A2 is similar to A4 in regards to the power of the mind. She said, "I don't feel like I need an outside power, I feel like I can do this for myself." To exemplify the power of the mind over the sensation of pain, A2 shared an experience that she rarely shares with others: Doing fieldwork in Australia a few years prior, she fire walked. She told herself, "I know you can do this! I know your mind can do this for you!" And it worked for her.

A6 considers herself to be a “secular humanist.” She agrees with A4 that religion is nothing more than an institution, but she states she doesn’t understand those who claim to be spiritual. She believes spirituality is nothing more than an emotion. She agrees with A2 and A4 in that the power of the mind is great, and this is often how she too handles pain.

Education

I1 believes education results in getting a, “Good job, good salary - monetary improvement is one vital link to a better health and a peaceful life.”

For I2, having an education has given her the power to make critical decisions. “It helps me decide the pros and cons of postponing medical treatment. I know what is good for my diet and what is not. I am able to understand the treatment/procedure outlined by the physicians.”

I3 incorporates aspects of both I1 and I2. “It helps us make a distinction between healthy and unhealthy; sanitary and unsanitary; nutritious and non-nutritious; infective and non-infective. And it gives one money which contributes to staying fit.”

I5 believes education has benefited her health greatly. It has brought her out of the home and given her necessary knowledge. “Being educated, I became aware of so many things. I can make better control of my habits, my environment. Another thing, working with a group of people here, outside the home, it helps a lot. We get lots of input and at the same time we are able to

share our difficulties and get to know a lot of information. But on the whole it makes everything healthier. It's not only money: it's moving with others and sharing things with others."

[data from I4 is lacking]

Table 9. Effects of Education on Staying Well/Becoming Ill

Indian Responses	Frequency
Results in a higher income which is essential for good health	2
Education has made her aware, able to connect with others because it has brought her outside the home	1
Is able to make critical decisions	2

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American Responses	Frequency
Research capabilities lead to greater understanding/better control of personal health	6
Finds personality has been shaped by stoic literary characters	1
Education obtainment has led to reluctance to show pain/ allow body to give into sickness because might interfere with career goals	4

All of the American women stated knowing how to do research has led to a greater understanding and control of health. Many do research before even going to the doctor, which can often take the doctor by surprise.

A2 notes, "Knowledge makes me feel powerful. If I don't know something, I can learn it. And I don't feel like people should treat me like I don't know, which is a thing a lot of women doctors don't do and I think a lot

of male doctors do. Often I'm able to offer an alternative to what the doctor suggests and a lot of people are threatened by that, but I think it's a strength."

A6 feels like the process of obtaining education and the ideas which she was exposed to at such a "crucial age" have largely shaped who she is, what she believes and her values. "My attitudes about pain were formed in large part by the kind of things I was reading when I was in high school and college…reading works about stoic literary characters."

Several of the women believe education and their professional position have led to a reluctance to show pain and prohibit their bodies from actually experiencing sickness. A3 noted, "I sometimes wonder too if the pain issues have more to do with being a woman, employed full time, striving to get a PhD, not wanting to look weak and unable to do the job…. We do have to be stronger. Do we have to work harder with our PhDs compared to the men with PhDs? We've grown up in an age where women did not work full time. We're breaking a mold…Primarily in our fields we have been the leaders. Are we afraid to show pain because they might interfere with our career goals?"

A5 admits that in thirty-five years of teaching, she has missed "*maybe* five or six days." She said the following: "For years I used to get sick at the end of the fall. 'Well, it's December! It's time to get sick!' Because I make myself go- 'got to, got to, got to get this done.' Then by the time December comes, I allow myself, it's my gift to myself that I will now just let down and allow the disease to take over for a few days. It's become a family joke, 'Oh,

it's December. Time for Mom to get sick!'…But I think this is internal, that it's just me."

The other women also expressed "pressures" such as this. A6 commented, "Short of death, I drag myself in. I can't remember the last time I missed a class."

A2 notes, "If I don't teach my class, I feel like I'm letting my students down." A2 mentioned earlier in the interview she had bronchitis in the previous fall semester, though she did not realize it at the time. She did not miss class while sick. "I went for six weeks with bronchitis until one day I just couldn't breath. And I went to the doctor and I had a collapsed lung, and I had had a collapsed lung for a week! I was just like, how long was I going to wait?"

A1 and A4 admit that while they do not like to "let their students down" by missing class, unlike the other women, they will miss if it is necessary. A4 noted she will miss "even if it's just a cold with a fever." These two women find that if they give themselves time, sometimes "just that one day," they will get well much more quickly and be over it.

Assigning Meaning to Pain: "Is pain good or bad?"

The Indian responses to this question were rather split down the middle. Both I1 and I3 think of pain as purely a negative thing. They do not like to experience it and would rather it simply go away.

I2 and I4 see both positive and negative messages within the meaning of pain. I2 states that when she has headaches and feels any other pain she does not enjoy it and so thinks it is bad in that sense. However, it makes her realize other things, and thus she can derive a positive meaning from the presence of pain. “But it also makes me think that I need to go slow, take some time off, rest…and in that sense, I think pain serves as a monitor…like the engine heating up and needing a coolant. If I think of pain in that context, I feel that pain is normal and that my body functions normally.”

Similarly, I4 realizes that pain “gives us lessons about the people around us” and sees this to be positive. She goes on to state, “I don’t like pain,” and so therefore she recognizes a negative effect.

I5 simply sees pain to be good. “Pain is good because it brings you closer to God, closer to your family and you don’t want to try to walk on top of others—you realize your weaknesses. And I also know pain is an indicator of something more serious in our body. If there is no pain, we may not take care of it.”

Table 10. The Meaning of Pain: “Good or Bad?”

Indian Responses	Frequency
Bad	2
Good	1
Both good and bad	1

American Responses	Frequency
Does not know	1
Good	1
Both good and bad	4

There were a couple inconsistencies with the Americans responses. However, they overwhelmingly think of pain as both a good and a bad thing.

A1 is not quite sure what to think. She has come to believe that accepting pain is part of the American experience. She reminisced for when she was young and would experience pain and hurt; her father would tell her that she was just “putting in her dues, that you had to put in your dues.” She states, “I think that comes from part of his growing up, where you have to struggle in order to be happy and so some pain is part of life. I don’t know what I feel about that yet.”

A2 believes that pain is good because “it keeps you from going too far, hurting yourself.” Along these same lines A3 notes that pain indicates there is a deeper problem, and therefore it is important not dilute the pain and mask the problem. A3 goes on to state that when pain interferes with life and productively functioning, then “it’s not good.”

A4, A5 and A6 agree that pain is a combination of positive and negative effects. A4 feels that pain is similar to life; they both are simply what they are. “It’s pain and it’s not pain.” A5 finds true value within the “lessons” pain teaches, while A6 notes that one has to “look at the effects of pain, and not pain itself.”

DISCUSSION

Pain is not easy to evaluate. It is highly subjective, and personal experiences will have an influence on how individuals express and experience their pain. But symptoms of an illness *are* socially and culturally constructed. The explanatory models created by such views “are embedded in larger cognitive systems, which in turn are anchored in particular cultural and social structural arrangements” (Kleinman 1980:105). By analyzing the contributing factors, as expressed through an emic perspective, attempts can be made to better understand the way in which beliefs about pain are formulated (See Figure 1). Furthermore, we can expand our understanding of human cultural systems and experiences through comparative analysis.

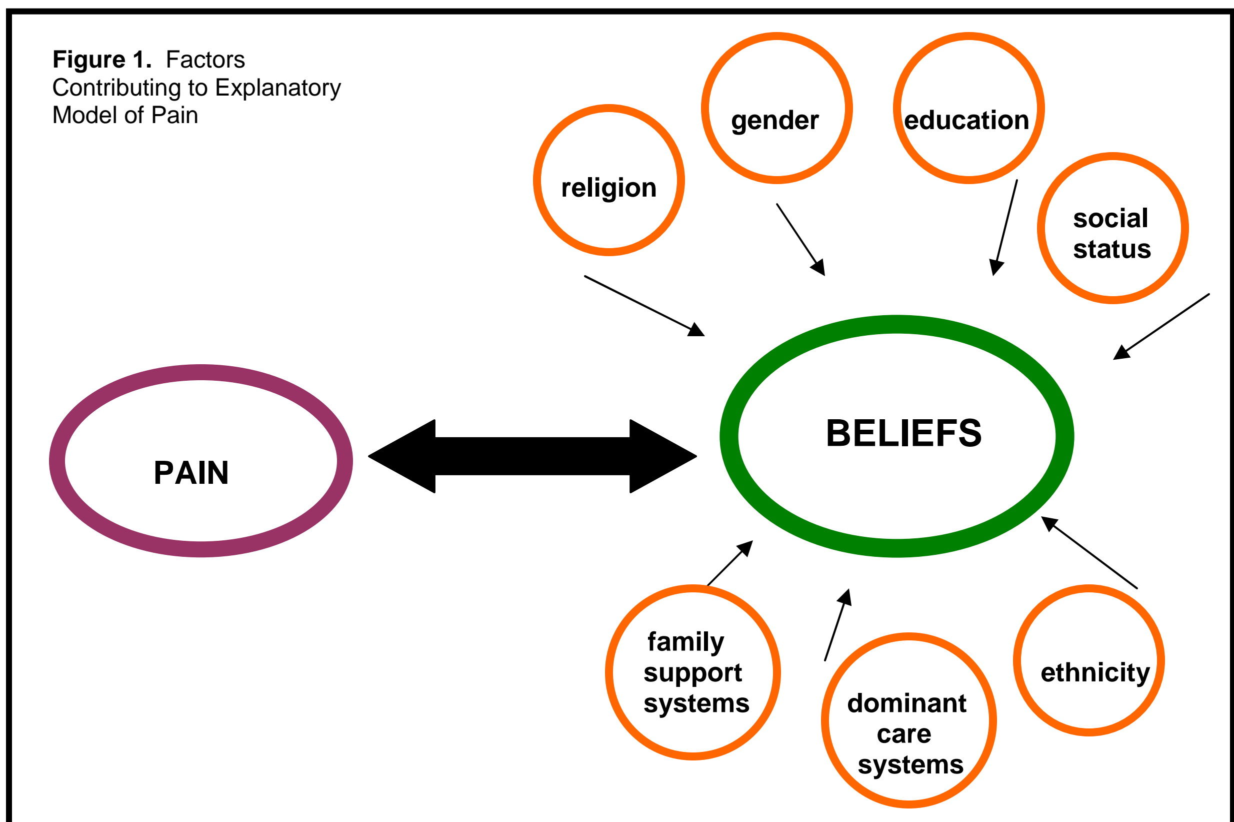

Figure 1. Factors Contributing to Explanatory Model of Pain

As expected, many of the Indian women say they do tend to keep their expressions of pain more to themselves. Only the youngest, I1, stated she would overtly express her pain. It is likely this factor could be attributed to her age or possibly infringes upon the type of relationship she has with her mother. Throughout the interview she continually made references to her mother. In one example, when asked to share a personal experience with pain, I1 reported a recent occurrence involving a "big burn" on her mother's hand. Not surprisingly, I1 turns to her mother for help and comfort when she is in pain.

Three of the five women said they turn first to their husbands when in pain. Given that India is a paternalistic society in which men have historically been the financial providers and source of authority, this is not a surprising factor and was partly expected. I4 mentioned how she "hates" her husband's family; this would logically explain why she does not turn to them in times seeking comfort. She turns to her brothers and sisters instead.

Comparatively, the American women in the study exemplified the individualistic nature of its society, as expected. All except one mentioned the desire to be alone when in pain. They also expressed a tendency to not outwardly verbalize the sensation, which was not anticipated. This is interesting because American society was not necessarily always this way. Only within the past century, with the rapid rise of industrialization, have

Americans opted for less dependence upon family; prior to that such cooperation was crucial to survival of the family unit, for they financially, and consequently socially, depended on one another. As India moves into a more and more industrialized state, it will be interesting to chart how the utilization of family support systems change.

In accordance with the research hypothesis, the Indian women in the study do use herbal remedies to treat pain. For each of them, this was the first action taken when illness would ensue. However, quite surprising to the researcher and in opposition to the formulated hypothesis, only one of the women reported using the ethnomedical tradition, Ayurveda. Ayurvedic clinics are quite common in India; it seems as if there is one within every block. Perhaps this is where the problem lies. One of the women alluded to this concern, stating there are so many practitioners; she simply does not know whom to trust.

The disregard for Ayurveda could also be seen as a logical trend of industrialization; encompassed within this shift, a situation is often seen in which elderly wisdom no longer applies and there is a general disregard for tradition. Another result is that a personalistic theory of disease is often dropped for a naturalistic, meaning impersonal, theory: for example, instead of illness being a result of an invading spirit, it is then considered as a foreign biological pathogen invading the body, suppressing the Helper T-Cells, etc.

These Indian women all use allopathic care. Likely as a result of education, they realize the power and weight of the medical system's emphasis on empirical knowledge. Furthermore, visits to an allopathic doctor may be accompanied with a sense of social prestige: these women have the various resources needed to seek this type of care. It would have been interesting to inquire about health seeking behaviors over the life course, for it is likely they have not always had such resources available to them.

Given the studies on current attitudes about the state of America's health-care system, it was hypothesized the American women's responses would mirror these sentiments, and as a result, they would be seeking alternative healing therapies. Education, in regards to the actual knowledge attained and also openness to new ideas, was speculated to be a guiding factor in such decisions. While there was indeed evidence of great dissatisfaction with the system, ranging from male doctors to pharmaceutical companies, only two of the women use herbal or vitamin supplements. This number does represent a third of the sample, a relevant percentage; however, it was the level of distrust from the other participants that was so greatly unexpected.

It seems as though education had the inverse effect of that which was anticipated; several participants noted there simply was not enough scientific data to prove the validity of herbal supplementation. Again, this seems to be a result of industrialization. It was assumed post-industrial ideals might have

taken root and information coming from other culture's health systems might have been utilized but apparently were not.

Hypotheses regarding religion were also refuted. It was anticipated that the study's Indian women would be greatly involved in their religion, both in a spiritual and physical plane: performing ritual, making offerings, giving prayers. I1 admitted to doing these things when experiencing pain and sickness, but the others said they only prayed. The original hypothesis was developed partially by etic observations while in the country and partially upon the scholarly religious literature. The primary point in coming to the hypothesis is that Hinduism, a very sensual religion which emphasizes ritual, is the majority religion and therefore influential and has certain elements which have been incorporated into the other theological institutions. Perhaps instead of Hinduism seeping its way into other religions, it worked in the opposite direction. These women did teach at a Christian college. It is possible the tenants of Christianity altered the ways in which the Hindus worshipped, thus the sole emphasis on prayer.

Another possibility is based upon education. Often religion can be used as an impetus for logically arranging certain theories of disease causation, such as soul loss, object intrusion, spirit intrusion, disease sorcery or breach of taboo. But education leads to more plausible rationale and often a naturalistic (impersonal) theory of disease. So while these women find

great comfort in prayer, the more elaborate rituals associated with ridding the body of pain, were simply not incorporated.

The American religion hypothesis was based upon studies by Stark and Sherkat. Their work dismisses the negative effect of education on religion, stating the correlations are actually positive. This positive correlation was not overwhelmingly seen in this particular data. Two women did consider themselves religious; one was "confused" and three were agnostic/atheist. What is particularly interesting here and worthy of noting were the amount of references made to incorporation of aspects of eastern religions. From concepts such as God being within the individual, to using prayer as meditation, to the power of the individual mind, four individuals made such references. It is possible this is where some of the post-industrial idealism (which was expected to be seen with the use of herbal remedies but was not) may come in. Their education about other religions has allowed them to break free and partially look beyond what their own culture has taught them.

Finally, education has been a pivotal factor in shaping pain beliefs and practices for both groups of women. It affects their social class, economic status and religious practices (Furthermore, history has shown that when education standards have been raised collectively within a country, revolutionary changes ensue.)

For the Indian women of the study, the most salient factors center upon money; the ability to make "educated" decisions; and for one woman, a

reciprocation of health knowledge with her co-workers. The importance placed on economics supports the concept of having the resources to incorporate allopathic care as mentioned above. Overwhelmingly, all of the responses regarded education as a positive force affecting health.

All of the study's American women noted education's most positive result has been in the ability to effectively research. However, the majority of the respondents noted education has actually led to a suppression of pain and not taking care of the body. These comments were highly unanticipated. The women stated that the pressures of their occupation, coupled with the fact they are women, leads to such attitudes and actions. There are fears of seeming weak, incompetent, and letting students down. To reiterate, the notion of their gender largely comes into play regarding these sentiments. America is still a patriarchal society: as one woman noted (A3), they represent the first generation of women largely stepping out of the home and striving to succeed in a professional field historically dominated by men. The pressures of society lead to pressures within their selves and they command their minds to have power over their bodies and the pains which they may be experiencing.

In the opinion of the researcher, the most striking of these responses from the study's participants were the following:

- For the Indian women, Ayurvedic care was not utilized and religion played a significantly minor role in the pain alleviation process.

- For the American women, familial support was largely not utilized and education has actually led to a conscious suppression of pain and sickness, thus posing the risk of actually increasing self harm.

These trends are seen as significant because they speak volumes about larger cultural trends, thus emphasizing how attitudes towards pain are a product of one's culture. India is an industrializing nation in which there exists a rising, predominant middle class. Associated with these trends, and as supported by this research, there is a shift from older traditions to newer ones. Comparatively, America is a highly individualized nation moving into a post-industrial age. The inwardness of the interviewees' responses seems to be in support of these nationalistic qualities.

CONCLUSION

This study is significant for a variety of reasons. First and foremost, the emic responses to bodily pain, and the ways in which they reflect their culture at large, contribute to a much needed body of information. This information can then be translated into culturally congruent care both *for* patients and *from* practitioners.

Furthermore, the comparative nature of this study holds implications for charting possible trends for both countries. First, the comparison has the potential to note tendencies for India's rapidly changing environment. India's middle class is growing and education standards are rising. Industrialization

is continuously gaining speed. America was characterized by these same factors only a century ago; thus how America is today, holds messages for India's possible trends of tomorrow. Secondly, as a result of globalization there is virtually no culture untouched by others. As seen in this study, these educated Indian women are utilizing a Western, allopathic approach to treatment: while these educated American women tend to be adopting a more Eastern approach in regards to religious views.

However, these trends cannot be assumed. As Morris notes, "Social responses to pain will not remain unchanging because society rarely stands still" (1991:55). These studies must continue precisely for this reason.

This study did have its limitations though, and suggestions for further research follow. This study's subject matter was extremely broad in nature. Time may be better spent focusing upon just one aspect, say religion for example, in order to get a much needed and more in-depth scope.

Also, the sample size was incredibly small; a much larger one would obviously carry more weight. Along these lines, the sample could be broadened to encompass a wider range of respondents: from various professions, socio-economic levels, regional disparities, races within America, etc.

Another fault is this study placed primary emphasis on qualitative data and the quantitative data is greatly lacking. This is reflective of goals present in the initial gathering of data in India: priority was given to the qualitative and

the quantitative was not considered to be as significant at the time. However, as the researcher has advanced in her studies, it is realized both forms of data must be incorporated into research.

As one can see, the responses from the American group were much more detailed and in depth when compared to the Indian interview responses. The prevalent point exemplified here attests to the power of being able to speak the language. Though the Indian women did speak English, there were still difficulties. And while a translator was standing by to assist in further explaining cultural-sensitive differences, problems were still omnipresent.

The American responses were probably more in depth for two reasons. First and most obviously the interviewer's primary language matched the primary language of those interviewed. Secondly, the focus group format allowed for more sharing. These women were not simply answering questions, as were the Indian interviewees; they were sharing their stories, telling their life experiences. It is safe to say, they fully enjoyed the process. At one point, one individual (A2) made the comment, "I never get this window into other people's lives. It's fascinating!" Furthermore, based on the experience, these women decided to form a "Women's Solidarity Group," an opportunity for women from various disciplines to get together and participate in one another's experiences, offering a supportive environment to further

share frustrations, fears etc. Within one week of the focus group these women had arranged such a meeting.

Along the lines of language compatibility and utilization of effective interview techniques, other tenants of effective anthropological data collection should be incorporated. Participant-observation, multiple interview sessions and developing report with interviewees are essential. Various issues (i.e. time, funding) prevented the researcher from fully incorporating such strategies; however, here their importance should be stressed.

Despite these limitations, the data collected does hold relevance. It serves as a glimpse into certain aspects for two groups of highly educated women regarding bodily pain. It also serves to stress the importance of "putting the person back into the experience of pain," thus making it an appropriate topic for the social sciences. Finally, it is the hopes of the researcher that this project may serve as a pilot study for a larger, more quantitative work studying personal experiences with bodily pain.

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