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Title: Self-management of chronic pain: the role of religious faith

Abstract

Self-management forms an essential part of the management of chronic pain. It affects approximately 7.8 million people in the UK with older people more likely to suffer chronic pain. In the UK, the National Health Service is committed to providing patient centred care, which embraces the religious and spiritual needs of patients. This aspect of care is governed by uncertainty and there is a lack of understanding about the influence of religious faith on illness and no clear guidance on how faith needs are best addressed. This study explored the inter-relationships between chronic pain and religious faith amongst older people.

Key words

Self-management, Religion, faith, pain, older people, long term conditions.

Introduction/Background

Self-management forms an essential part of the management of long-term conditions and is actively promoted both at an individual and policy level (Leontowitsch et al 2010). In the UK supporting and promoting the self-management of long-term conditions is a key policy initiative. It involves a shift away from clinicians taking the lion's share of responsibility, to a more collaborative approach where patients are actively encouraged to self-manage their condition (Coulter et al 2013). Chronic pain (pain lasting more than three months) is regarded as long-term condition in its own right and it affects approximately 7.8 million people in the UK (Price et al. 2013). The incidence of chronic pain increases with age and older people are more likely to be affected (Price et al. 2013). Self-management forms an essential part of the management of chronic pain. It may be defined as

strategies people undertake to promote health and well-being (Audulv et al. 2012) or the management of symptoms, treatment and psychosocial effects of living with chronic conditions (Blair et al. 2009).

In the UK there has been a shift towards a more holistic, person focused approach to the treatment of people with long-term conditions, involving the promotion of diversity. One aspect of this is the need for religious expression. The National Health Service is committed to providing patient centred and holistic care, which embraces diversity. As part of this holistic approach health professionals are expected to take into consideration the religious and spiritual needs of patients. Evidence suggests that assessing the spiritual and/or religious needs of patients is challenging for health professionals (Royal College of Nursing 2011). It is an area governed by uncertainty and hesitancy in terms of how the topic should be broached with patients and how patients who require support can be best supported. There appears to be a lack of understanding about the influence of religious faith on illness and no clear guidance on how faith needs are best addressed. Disentangling social, faith and cultural influences is not straightforward, but perhaps reflects the complexity of how people express their religious belief in their everyday lives. This makes it an important consideration, when developing holistic care (Atkin et al., 2008).

How older people express and manage their pain is not well understood. Older people are frequently reluctant to report pain, not wishing to be a nuisance, believing that nothing can be done or that complaining about pain is an unacceptable challenge to their doctor's expertise (Closs and Briggs 2002; Schofield and Reid 2006). Three quarters of the UK population identify with a religious belief (Office of National Statistics 2001), yet little is known about its influence on pain. In comparison with the volume of research examining ethnicity and pain, there is little research which has explored how faith may influence issues related to pain and its management. To date, ethnicity has been the main cultural lens through which disparities in healthcare have been viewed and little

attention has been given to how different faiths may induce differences in the self-management of pain.

In this study we applied a broad meaning to self-management, to include anything participants did themselves to manage their own pain. This included self-administration of prescribed analgesics and other treatments. The aim of the research was to explore the relationships between chronic pain and religious faith amongst older people from five different faith groups. We were interested to find out how older people self-managed their pain and whether their religious faith had any bearing on how they chose to manage it.

Methods

Study design

Semi-structured qualitative interviews were undertaken with a purposive sample of people aged 65+ who identified with one of the five most common faith groups in England, namely Christians, Hindus, Sikhs, Jews and Muslims.

Inclusion criteria

People were included in the study if they were 65 years and over and had chronic pain and identified with one of the five faith groups.

Recruitment of participants

Purposive sampling was used to recruit a diverse sample of participants across the five faiths. The aim was to get approximately equal numbers in each faith group and approximately equal numbers of men and women within each of these. Recruitment from this 'hard to reach' population was extremely challenging. Therefore snowball sampling was the main approach employed. This method involves asking participants to referral others, whom they know or associate with, to the study. This method can provide access to a hard to reach participants but has the potential to add

bias to a sample. While obtaining a 'representative' sample is not the aim in qualitative research, the potential for participants to be recruited with similar views is increased by this method (Atkinson and Flint 2001). To reduce this potential bias and obtain a diversity of opinions, participants were recruited through a range of different people and organisations. These included faith leaders such as Church of England ministers and Rabbis or individuals who had a connection with one of the five faith groups through their work in the community. Numerous meetings were attended (by invitation) including lunch clubs, friendship groups and activity groups), held in places of worship and run by people associated with one of the five faith groups, to recruit participants.

Recruitment of participants was labour intensive and required contact with over 70 community groups and individuals to obtain diverse sample of 44 participants across the five faith groups (see table 1). Participants spoke a range of languages including English, Hindi, Bengali, Urdu, Punjabi, Sylheti and Gujarati and were aged from 65 to 91.

Table 1: Breakdown of participants by gender, faith group and ages.

Ethical issues

The study was approved by the National Research Ethics Service Committee, Yorkshire and the Humber, Ref: 09/H1313/64. A participant information sheet and consent form was given to participants in advance of being contacted by the researcher. Written, informed consent was obtained from all participants prior to the interview. Where appropriate, language interpreters were used to read through the consent forms and ensure the participants fully understood the purpose of the study. Participants were given assurance about how confidentiality and anonymity of data would be maintained throughout the study.

Data collection

Data collection was undertaken using semi-structured, face to face qualitative interviews. A thematic topic guide containing questions and probes that functioned as triggers to encourage participants to

talk was used. Whilst all topic areas were covered in each interview, there was some variation in the order and phrasing of questions and the level of probing required. The majority of the interviews were completed in the homes of participants or in a location of their choice, usually at a group they attended. All interviews were completed by the researcher (JE) and lasted between 20- 60 minutes.

The interviews explored participants' experiences of pain, their self-management and interaction with health professionals and whether their faith influenced the way they managed their pain. The qualitative data collection and analysis were undertaken concurrently, as this allowed for emerging themes to be explored in consecutive interviews. After a number of interviews had been completed (N=7) additional questions were added to the interview schedule. Whilst participants (n=3) did mention discussions with religious leaders, these discussions tended to focus on practical issues such as taking medication when fasting rather than descriptions of pain.

Participants whose first language was not English, were offered the support of an interpreter. While most participants in the study could speak and understand some English, the level of English and available vocabulary was not always sufficient to answer specific questions. Under these circumstances the presence of the interpreter had to be offered sensitively to participants prior to the interview to avoid offence or risk undermining the participant. Interviews with people who preferred (requested themselves) to have a language interpreter present during the interview were conducted in real time, where the interpreter simultaneously translated the interview questions and responses. Interviews were audio recorded and the English dialogue transcribed verbatim.

Data Analysis

The analysis of the interviews was undertaken using a modified Framework approach. The Framework approach provides a systematic, transparent and rigorous approach to analysis, which involves a structured process of sifting, charting and grouping data according to themes observed in the transcribed data (Ward 2013; Clarke 2012). We chose Framework analysis as we wanted a

method that would 'facilitate constant comparison techniques through the review of data' (Gale et al 2013: 119). The initial aim of analysis was to understand the broad experience of pain for this group of older people and avoid any assumption that faith dominated a person's life. The analysis began prior to the completion of the final interviews and the stages of the Framework approach (Richie and Lewis 2003) guided the analysis iteratively.

Interview analysis procedure

The approach to the analysis of the final sample of 44 participants is briefly described below.

Familiarisation, coding and thematic coding frame development

The research fellow (JE) read and re-read a sub-sample of the transcripts to familiarise herself with the data and identify recurrent and significant themes in the accounts. Notes from the transcripts were taken, and along with reference to the aims and objectives of the research, were used to inform the creation of a thematic coding frame. The thematic coding frame was then discussed with other members of the research team (SJC, MB) who independently read through a sub-sample of transcripts and applied the thematic coding frame to them prior to the discussion. The remainder of the transcripts were then coded (indexed) by the research fellow using the software programme NVivo 8. During this process JE, SJC and MB met regularly to discuss the on-going indexing and to refine the coding.

Charting of data, mapping and interpretation

Using the final coding index, JE charted the data into 20 separate charts which represented each of the initial four themes by each of the five faith groups. The four themes were: the nature of pain, patients' response to pain, interaction with health professionals, and faith and pain. At various stages these four themes were discussed with the research Steering group, Advisory group, and SJC and MB changes made in accordance with these discussions. As a result the four themes were reconfigured into five new themes representing an analytical framework through which the

interaction of pain and faith could be understood. Interpretation of the data was informed by the wider literature (pain, faith, culture, ethnicity and older people) to expand on the descriptive accounts, particularly where the data lacked 'richness'.

Findings

In the context of self-management we found that participants drew on their religious faith and association with religious groups as additional tools to self-manage their pain. Self-management strategies were frequently sought out of concerns about the side effects of medicines and simply to obtain relief from their pain. Self-management came under the theme 'patient's response to pain' and incorporated the following subthemes described below.

Adjusting the mind: positive framing of pain

This involved thinking more positively about their pain with participants embracing their pain in an attempt to prevent it defining who they were and enabling them to control their pain when it became intense. Through their faith or belief in a God, participants found strength to manage and cope with their pain. Sometimes this came through the indirect effects participants reported their beliefs had in terms of making them a 'positive person'. This adoption of a positive attitude towards pain appeared to enable participants to live with their pain more readily and was grounded in a combination of psychological and practical strategies. A Christian participant considered that the strength gained through faith was 'psychologically uplifting' and indirectly impacted upon mental well-being. Participants could not predict how they might manage pain without their faith, but felt it would be potentially harmful. One Christian participant predicted that depression would be the likely outcome of no faith.

I think it would be probably a good deal worse because I think one would be more liable to, if not clinical depression, 'dis-spiritment' which is the next worse thing. You know if you get in that cycle of being low, dispirited and depressed, pain tends to get worse and I think that if I

didn't have the support of my faith and the Christian community, but I know myself very well and I could easily be a depressive, you know. None the less and this could become uppermost and you would get a cycle that goes down and exacerbates the pain (01 Christian Male).

In a Christian context, the existence of chronic pain and coping with it was frequently rationalised, justified and measured against the suffering of Jesus Christ. Although experiencing pain was seen as an inevitable consequence of progression through the life course, suffering in itself was regarded a necessary part of being a Christian, and almost an expectation in this faith group.

In our study religious belief provided a framework in which the meaning and purpose of pain could be appraised. Hamel and Lysaught (1994:62) pointed out how religious traditions 'can be especially integral to the process of interpreting identity, existence, and experience because they are by nature sources of meaning'. A belief in a transcendent reality and the existence of a divine being provided participants with a purpose and meaning for the existence of pain which was insufficiently addressed by other factors, including reasoning. Belief in a transcendent being appeared to help many participants through positive appraisal and framing of their pain experience. Having a reason for pain helped some participants through a reduction in the likelihood of feeling depressed or isolated. Koenig (2012: 7) noted how religious beliefs can provide answers to difficult existential questions and influence the cognitive appraisal of circumstances making them feel less distressing, reducing anxiety and increasing a person's sense of control over them.

Distraction: individual and collective

Distraction was a common method used by participants across all faiths to focus their mind away from their pain. A dual purpose sometimes underpinned this activity: on the one hand reading in itself was used as a means of distraction and on the other hand reciting passages from the Quran or Bible drew on individuals' beliefs that in reciting these passages relief from pain would be forthcoming through the connection with their experience of God.

If I read the Quran my mind diverts somewhere else and that's like you forget about your pain for that time being (17 Muslim female, speaking through interpreter).

Other methods of distraction were used including meditation combined with yoga. For Hindus the use of meditation and yoga created a sense of calmness. The strength of association between these methods and religious faith varied across participants but in general the creation of inner calmness impacted on the management of their pain. This method tended to be used by Hindus and it reflected in Hinduism where the practice of 'yogin' is discussed in the sixth chapter of the 'Bhagavad-gita', a religious book (Knott 1998:39). Through the practise of this form of meditative yoga, which differs from the more physical forms (hatha and siddha yoga) the pathway to the liberation of and transformation of the self from personal actions is achievable. It is said to allow an individual to disappear and achieve the ability to withstand pain (Knott 1998).

More widely, places of worship provided social activities, which acted as forums for the exchange of information and strategies how managing chronic pain. Places of worship became influential in encouraging participation in collective activities and acting an access point to exercise and yoga session and other social activities such as luncheon clubs.

Praying when in pain

Praying is an inherent part of most, if not all religions (Hinnells 2010). Therefore it is not surprising that many participants prayed when in pain. Participants felt that praying or talking to God helped their general well-being and acted to facilitate an ongoing relationship with their experience of God. Generally, praying when in pain appeared to help participants deal with their pain and was underpinned by beliefs that God would provide them with the tools to cope and accept their pain. Differences were observed in terms of participants' expectations of praying. Christian and Muslim participants were more inclined than Hindus, Sikhs and Jewish participants to focus their prayers on asking God to help them cope with their pain rather than asking him to take it away.

Yes, she's saying that, you know, um because I do pray to God probably he's kept me like this, it could have been a worse condition. I mean there are a lot more people who are (in a) worse condition than I am so I'm just grateful (31 Muslim female, speaking through interpreter).

Beliefs were held that if God was going to take away their pain he would have done so already. Therefore there were no strong expectations that praying would remove their pain. The focus of prayer was on asking God for strength to endure pain.

While not disagreeing with praying, participants who followed the Sikh and Hindu faiths were less inclined to pray when in pain to ask for relief from their own pain. It was considered selfish to pray about one's own pain, though it was acceptable to pray for other people. Praying for others was not exclusive to Hindus or Sikhs and was expressed in Christian accounts.

The notion that praying for oneself is a selfish act may be influenced by religious doctrines which encourage thinking beyond the 'self' and encourage supporting and showing companionship for others (Koenig 2012). Indeed considering others above 'self' is a dominant principle reflected in all the five faiths included in this study (Hinnells 2010). Although participants were asked whether they prayed, attended their place of worship, observed festivals associated with their faith group and how often they engaged in such activities, their impact was not made explicit. An individual's identity is shaped by a whole host of factors, for example, the geographical area where a person is brought up, parental occupations, types of schools attended, health and friends and family who the person associates with throughout their lives. In turn, these influence and shape how individual responses in different situations and circumstances and it not possible to disentangle these influential and complex social and cultural influences associated with daily life beyond religion doctrines. (Jenkins, 2003; Aktins et al 2008).

When asked if they felt praying worked, many participants felt they gained some relief from it but some participants questioned whether the response they gained from praying was directly from God or a psychological response created by praying.

To be honest I never think about that at all. I am sure that there are people in other religions including Judaism who think that by being good and praying you would help to relieve it I don't know. Is that not a psychological situation? (02 Jewish male).

The data implied that the perceived level of devotion to their faith may have influenced how participants framed the outcome of prayer and its impact on pain. Participants who expressed a strong commitment to their faith were less likely to frame the outcome of prayer as 'psychological' and saw any benefits as God's response to their request for support. This might be expected as people with a stronger commitment to their faith may want to believe that relief comes directly from God. Drawing on Bury's (1982: 169) conceptualisation of chronic illness as 'biographical disruption' where daily life routines and the 'normal rules of reciprocity and mutual support' become disrupted by illness, the existence of chronic pain may be challenging to the relationship participants had developed with a God prior to the onset of their pain. The ongoing and fluctuating nature of pain may create uncertainty over their relationship with God which has to be managed in the same way as other disruptions to their lives. No participant openly blamed their understanding of God for the pain they were personally experiencing, but some believed that pain and suffering were consequences of human deviance providing a rationalisation in participants' search for a meaning and purpose for pain.

Herbal preparations

The complexity associated with disentangling social, faith and cultural influences become apparent in the use of herbal preparations and complementary medicines and therapies. Many participants, particularly Hindus, Sikh and Muslims employed a range of herbal preparations to treat their pain.

Underpinning the use of these resources to manage pain was a strong link to the cultural heritage of the participants. However, cultural heritage often went hand in hand with religious heritage. Examples of these herbal remedies included homemade teas, preparations brought in India for massage, olive oil and almond oil and salt baths. These were often used to relieve pain when it was particularly uncomfortable,

But when I'm sometimes feeling too much pain and feeling uncomfortable have Indian herbals. In a tea I will make a special tea with ginger and saffron and all those things mixed together in boiling water and make a special tea and then drink it before I go to sleep (04 Hindu female).

With the exception of one participant who spoke about drinking a 'holy water', these preparations were linked to participant's cultural heritage rather than religious beliefs by participants. In the context of this study 'cultural heritage' often drew on cultural influences originated from the customs and practises they experience whilst growing up. One example of this cultural heritage can be seen in the account of a Sikh participant who spoke about how using salt baths was common practice in India (where he had grown up) and a practice he had been brought up with. For him the use of salt baths to treat pain had no religious association but was a remedy used by many people through the generations in India. In other words the practise of having salt baths was a cultural norm.

It's an old remedy. It's from India, you know, we use in India, people say, how can you get soaked in... there's no bath in India, but people don't understand there is ways of having a proper bath, and they have their own ways of having a bath (36 Sikh male).

Similarly a Hindu participant explained that the herbal medication he took was cultural and comprised of ingredients used in cooking, particular Indian cuisine,

No it's just cultural, because like the herbal medication what he's taking, turmeric they use it all in the cooking. This is nothing coming out of any shops or pharmacy, and all this stuff is used in cooking every day (35 Hindu Male).

Although participants took these herbal preparations alongside their prescribed medications, there was a sense that these herbal remedies were considered more 'natural' than prescribed medication and less likely to have intolerable side effects. While the concerns expressed about pain medicine may provide one reason why participants took these remedies, a further explanation may be rooted in a belief system that equates natural products with God. Indeed, alternative and complementary medicine is sometimes associated with 'natural healing' (Lipton 2003; Ning 2013). This belief system might be accentuated in faiths whose largest presence is in less developed economies whose populations are less exposed to mass advertising of pharmacological medications, have different expectations about medication and no, or limited access to welfare provision. However, in some countries such as India and China biomedicine and complementary, alternative medicine have co-existed for many years (Ning 2013). For example, in India the 'Ayurveda' medicine system is 'widely respected and recognised by the Ministry of Health' (Laird 2008: 67). Using these complementary and alternative medicines in combination with biomedicine is seen as a cultural norm in these countries, forming part of an individual's cultural beliefs, norms and practices (Ning 2013). It is only when they are evaluated in countries where there is a clearer dichotomy between them that their use becomes less accepted and understood (Ning 2013). According to Hill (2006; 59) herbal preparations and medicine are commonly used in South Asian communities. In our study the use of herbal preparations to ease pain was particularly prevalent amongst Hindus, Muslims and Sikhs and when analysed in the context of their use being a cultural norm the use of them is likely to be viewed differently in these communities (Laird 2008).

Most of our participants using herbal and complementary medicines did not explicitly link the use of these remedies with their religion and instead talked about them in the context of cultural heritage.

However, the subtle influence of religion cannot be ruled out as, for example, the Indian Ayurvedic medicine system is argued to reflect 'Hindu world views' and other alternative systems are linked to 'indigenous religious beliefs' (Ning 2013: 144). Although individual belief systems did play a role in how these medicines were perceived, this was not universal. One participant originating from India did not put much faith in these preparations and preferred what she called 'western' medicine.

This preference for western medicine (e.g. biomedical preparations such as analgesics) was sometimes embedded in a belief that medicine from India would not work outside that country and on other occasions it was simply driven by the experience of finding these preparations less effective than pharmaceutically produced painkillers (analgesics).

Actually I wanted to consult with Indian doctor in India and wanted to buy some medicine from there. But my husband said as long as I am in the UK, Indian medicine will not work properly here, he believes. So he suggested (to) me to forget about Indian medicine. It might happen that the medicine of that region will not work here because there are environmental differences between two countries. As I'm in the UK, I've to try with products which are manufactured here. So I didn't try with Indian medicine (19 Sikh female, speaking through interpreter).

There was no evidence that the use of herbal medicine was linked to the level of acculturation into western society as several participants used herbal preparations alongside prescribed medication. This appeared to be merely an attempt to self-manage pain by drawing on those cultural resources available to these particular participants. Access to NHS services or cost did not seem to play any role in the use of these preparations. Although there is evidence that Muslim participants in particular experienced more difficulties accessing NHS services, they did not resort to herbal or complementary therapies/medicines as a consequence. In these circumstances the participants tended to seek conventional private treatment such as physiotherapy.

Discussion

Our study revealed that religious beliefs, practices and activities played varying roles in the management of pain in older people across these five faith groups. They provided an additional tool set for participants to manage their pain both directly and indirectly. It is important to bear in mind that a person's faith belief is articulated within the context of other aspects of their identity and in response to their experience of pain. As a result, irrespective of faith, common themes occurred but not in an essentialised, reductionist way. That is to say, faith was used as a personal and individual expression of identity by participants, rather than in a collective way, which reflected the doctrines and/or attributes associated with their religious faith.

The coping and self-management strategies participants employed were embedded directly in their religious beliefs and indirectly through support they received through their religious community. Participants used a range of self-management strategies. The use of multiple strategies to manage pain has been demonstrated in other studies. Crowe et al (2010) found the most common self-management strategies used by participants with back pain were medication, exercise and the application of heat. Similarly, Traska et al. (2011) found that distraction techniques, taking baths, and avoiding activities which might aggravate pain were commonly used by women with fibromyalgia. Shariff et al (2009) reported the use of mind and body management of pain which included distraction and pacing strategies. Participants in our study adopted similar strategies and these were not exclusively embedded in their religious beliefs (i.e. they were not dominated by their religious beliefs) but sometimes drew on them. This is exemplified by the use of distraction such as reading which on occasions included the Bible or Q'ran alongside other reading materials such as novels.

The direct use of religious activities was apparent in the use of prayer, which formed an important part of their self-management of pain. It appears to serve several functions. It was a means of maintaining a relationship with God at a time of uncertainty and induced a calming effect which

assisted participants in coping with their pain. Research into the effects of prayer has shown a similar effect to the placebo response, by stimulating the release of endorphins which calm patients and promote wellbeing (Benedetti and Amanzio 2011). DeZutter et al (2011) showed how prayer was used as a tool to manage pain and how its use was related more to pain tolerance than pain severity. Our findings suggest that severity of pain was sometimes the trigger for participants to ask for help via prayer, to cope with their pain and tolerance of it appeared to result through the effects of engaging in prayer. Not all participants reported relief from prayer and this might be explained in a similar way to the influence an individual's expectations and characteristics can have on responses to placebos (Andrade and Radhakrishnan 2009; Crow et al 1999). Indeed, studies have shown that an individual's expectations of prayer and desire for pain relief have bearing on the outcome (Krause, 2004; Jegindo et al 2013). Jegindo et al (2013: 422) compared the expectations and desire for pain relief between religious and non-religious participants. Personal expectations of the pain reducing effects of prayer were shown to reduce subjective ratings of pain intensity and unpleasantness for the religious participants in comparison with the non-religious participants who were asked to pray to a 'Mr Hanson'. The relief these participants gained from praying for peace of mind rather than asking for direct relief of their pain might be explained by physiological changes similar to those demonstrated by the placebo induced analgesia described above. It may be concluded that even in the case of placebos, if something works, it works whatever the underlying mechanism.

In the context of the adoption of complementary and herbal preparations, we found that the use of these strategies appeared to be underpinned by cultural beliefs and practices originating from participants countries of origin. This is in contrast to evidence that religious and spiritual identity predict the use of complementary and alternative medicine (Ellison et al 2012). Given the complex interplay between cultural and religious heritages, it is impossible to rule out any potential religious influence, as many of these medicines have their roots in religions (Ning 2013). As noted, the use of these self-management strategies alongside biomedicine is a cultural norm in countries such as India

and is used widely in south Asian communities outside India. Other studies have shown that health belief, cultural background and attitudes towards complementary and alternative medicine are stronger predictors of their use than demographic characteristics (Chang et al 2011). Similarly we found that participants' belief in complementary medicines was a determining factor in their use, though the impact of socioeconomic status on long term use cannot be ruled out as cost did feature in the accounts of some participants. Although complementary therapies had been used by participants without a South Asian background, they were widely used by Hindu, Sikh and Muslim participants.

The psychosocial dimensions of pain management are recognised as essential to the effective management of pain (Jenson 2011). These were very apparent in our findings, frequently due to social contact with their faith group. In keeping with the findings of other studies, we found that perceived social support, actual social support and opportunities to engage with others had a positive impact on well-being and perceived ability to manage pain. Other studies have demonstrated the benefits of collective religious activities on wellbeing. Howsepian and Merluzzi (2009) found that cancer patients experienced an enhanced sense of perceived social support which indirectly impacted on their adjustment to cancer. Similarly to the findings of Howsepain and Merluzzi (2009) our participants gained a sense of enhanced well-being through contact with people who shared their religious beliefs and provided practical assistance when required. In the general population of older people and in those with chronic conditions, social engagement has been found to have a buffering effect on the symptoms of disease. Levin (1994) reported that religious association may buffer the effects of stress, lift self-esteem and provide a sense of purpose and Golden et al (2009) found that higher levels of social engagement of any form had some impact on depression. Other studies have demonstrated a positive effect on blood pressure and quality of life in general (Schulz et al 2008). It is likely that engaging in activities provided by their places of worship mitigated participants' experiences of isolation and depression, indirectly increasing their ability to cope with their pain.

In our study these activities and association with a religious faith also provided a forum where experiences of pain management, particularly self-management strategies could be shared. This appeared to indirectly help participants' pain through encouragement of healthy lifestyles and a positive outlook, in keeping with other studies. It has been shown that association with a religious faith can promote well-being and general life satisfaction through encouragement of healthy lifestyles such as healthy diets, physical activity and promotion of positive outlooks (Levin 1994; Hinnells 2010; Koenig 2012; Park 2012). Participants in our study, particularly, Hindus, Muslims and Sikhs, were influenced by their faith group to engage in physical exercise and had invited speakers to discuss healthy lifestyles. Whilst healthy diets and engagement in physical activity may not directly impact on pain, they may reduce the potential of co-morbidity. There is evidence that group attendance is associated with greater adherence to exercise (Fraser and Spink 2002) and it is well established that the presence of multiple conditions can complicate the management of long term conditions, such as chronic pain (Taylor et al 2014).

Conclusion

Overall, we found that association with a faith group for most participants in our study facilitated well-being and provided an additional tool to self-manage pain. There was a sense of the 'collective' in terms of how the social aspects of belonging to all faith groups helped in day-to-day living with pain, and the wide use of complementary and alternative therapies. In addition, collective traits associated with each faith group were emphasised by participants (for example, Christians talked about the suffering of Jesus and Hindus and Sikhs mentioned Karma). However, there were also individual interpretations of religious scripture/doctrine and its underlying principles which played a significant role in its application. These interpretations were further enmeshed in personal judgements (religious and otherwise) of how pain should be understood within the framework of each specific religious faith. Since we only included older people in our study it is not possible to

report whether age had any impact on the way the participants chose to manage their pain in this context and whether our findings are unique to older people with chronic pain.

This study has demonstrated the complexity inherent in exploring the influence of religious faith and religious identity on pain expression. Indeed, religious identity is both shaped and informed by a complex interplay of a host of factors, for example, family, culture, ethnicity, race, age, socio-economic position, community, gender and age (Hamel and Lysaught 1994; Jenkins 2003).

Nevertheless, we have shown that there are aspects of the self-management of pain which are common across faiths (e.g. distraction, social support and alternative therapies) as well as unique to particular faiths (e.g. prayer, the meanings of suffering and Karma). The factors common to each faith tended to be practical, while the specific ones were based on beliefs. While health professionals tend to consider faith groups as having their own very separate requirements, it is important to remember that they have many common needs as well. This has the potential to inform how pain clinicians advise patients in the self-management of pain, considering factors both unique and common to diverse religious faiths. Further research is needed to explore how these findings could be used by clinicians to support patients of differing age manage their pain in their day to day lives. In particular, how clinicians could best approach patients in consultations to find out whether and how their religious faith may play a role in their pain management given the sensitive nature of religious faith.

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