Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach

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Abstract

Chronic pain is one of the most common health conditions, affecting nearly six million Canadian adults. Despite abundant research on chronic pain in general, there is limited knowledge on how racialized immigrant women experience living with chronic pain and how this relates to their broader social circumstances. The purpose of this qualitative, exploratory study is to understand living with chronic disabling pain as situated in and contextualized by the lived experiences of immigrant women residing in Ottawa, Ontario, and to explore the perspectives of the women's care partners as well as physicians providing care for chronic pain. Semi-structured interviews were conducted with 24 participants. The dissertation is guided by the social determinants of health framework and an intersectional lens. Four interconnected themes from the data analysis have been generated: (1) The trajectory and meaning of pain; (2) Reasons for pain and triggering factors; (3) Pain consequences; and (4) Coping and control. Findings indicate that chronic pain is a subjective, complex, biopsychosocial, and multidimensional phenomenon. Pain is a deeply personal experience linked with meaning. Results also highlight an association between the distribution of the social determinants of health during the life course and pain. Furthermore, the pain has profound, multidimensional impacts on the women and their families, and its treatment is a challenging task for health care professionals. In addition, the findings show that pain is often poorly recognized, underestimated, and inadequately managed. Finally, the results illustrate the perseverance and incredible resilience of the women and their carers. The findings provide several implications for policy, research, and practice.

Keywords: immigrants, chronic pain, intersectionality, social determinants of health, lived experience, population health, qualitative methodology

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Contents

Chapter One: Introduction

Statement of Problem

Chronic pain, defined as pain lasting at least three months (Merskey & Bogduk, 1994/2012), is increasingly becoming a significant health problem (Sá et al., 2019). Chronic pain is an invisible state and a subjective experience (Jackson, 1994; Kleinman, Brodwin, Good, & Good, 1994; Ramage-Morin, 2008). Inextricably, it is highly influenced by sociocultural factors (Bates, 1996; Morris, 1991).

Chronic pain is also one of Canada's most common chronic health conditions, affecting nearly six million Canadian adults (18 years and over) (Schopflocher, Taenzer & Jovey, 2011). It is associated with substantial disability and costs to individuals directly affected by this condition, their families, and society (Goldberg & McGee, 2011; Lynch, 2011; Reitsma, Tranmer, Buchanan, & Vandenkerkhof, 2011). These costs are disproportionately borne by women, who have generally reported higher rates of chronic pain (Moulin, Clark, Speechley, & Morley-Forster, 2002) and pain-related disabilities (Blyth, van der Windt, & Croft, 2010). Additionally, some evidence indicates that chronic pain is more common among immigrants (Kurita, Sjøgren, Juel, Højsted, & Ekholm, 2012) and specific racialized populations (Health Canada, 201; Palmer et al., 2007). Yet chronic pain and its related disability are not given the attention they warrant, particularly from the standpoints of immigrant women living with chronic pain, their caregivers, and physicians providing care for it.

Research Questions

This study investigated the following questions: 1) How do immigrant women residing in Ottawa live and cope with chronic disabling pain? And how does this relate to their broader social circumstances? 2) How do the intersections of gender, racialized status, socioeconomic status (SES), and disability shape their lives?

Furthermore, the study addressed the following sub-questions: 1) How do immigrant women perceive chronic disabling pain and its determinants? 2) How do their caregivers understand chronic disabling pain and immigrant women's needs (see Appendix A for caregiver definition)? 3) How do physicians providing care for immigrant women living with chronic pain understand their pain and needs?

Objectives and Purposes

This exploratory, descriptive qualitative research project aimed to understand living with chronic disabling pain as situated in and contextualized by the lived experiences of immigrant women residing in Ottawa and contribute to the growing literature on disability, chronic pain, and immigrant women's health. This study was designed to give immigrant women living with chronic pain a voice as they deserve a space in the literature to articulate their realities. I also sought to extend our appreciation of disability as an integral part of human life diversity. This research, guided by the Social Determinants of Health (SDoH) framework with an intersectional approach, also explored the complexity of intertwined factors that determine chronic disabling pain and how it was expressed, understood, and handled. Additionally, this dissertation aimed to address the difficulties and challenges immigrant women faced, the coping resources and strategies they employed to live a "normal" life, and the broader social factors that could support or undermine their coping strategies.

The study has also attended to the social context of chronic disabling pain by exploring the perspectives of formal/informal caregivers of immigrant women and physicians providing care for chronic pain. Finally, my research has illustrated the existing pain management and care strategies in light of the participants' views and explored the women's unmet needs and potential participant-identified solutions to inform the development of interventions to assist them. The study was also meant to provide policy- and practice-relevant information for health care providers, policymakers, public health officials, non-government organizations, advocacy groups, and researchers. Thus, this research has important health care implications.

To establish the context for my research question, I briefly examine the historical development of key institutional features of Canada's immigration policy. I then offer an overview of immigrants' broad sociodemographic characteristics, in general, and immigrant women's, in particular, in Canada.

Setting the Context: Canada's Immigration Policy

Historical injustices and legislation reforms. Before examining Canada's immigration policy history, it is essential to note that I drew from immigration literature and data sources (see for details, Statistics Canada, 2019b) that used administrative definitions (see Appendix A for immigrant categories and terms). I acknowledge that these distinctions are not an accurate representation of immigrants' circumstances. For example, refugees are most often labelled as involuntary migrants. These bureaucratic categories may have been legitimatized by a state to control and manage the immigration process (de Hass, 2021; Erdal & Oeppen,2018). Nonetheless, making a clear-cut distinction between voluntary and forced migration is inappropriate as it ignores people's agency. Rather than applying a dichotomous, reductionist classification, building on the work of other researchers, I consider migration as a continuum and spectrum of experiences in which both "voluntary" and "forced" or "involuntary" immigrants deal with considerable constraints in their home countries while they exercise their agency concurrently as far as possible (de Hass, 2021; Erdal & Oeppen, 2018).

Immigration has been central to Canada’s economic development, has short and long-term social benefits, and has dramatically enriched Canadian culture (Beach, Worswick, & Green, 2011; Immigration, Refugees and Citizenship Canada [IRCC], 2020). Indeed, immigration has been viewed as a key instrument of the nation-building that shapes Canada’s diverse nation (Beach et al., 2011; Boyd, 2013; IRCC, 2020; Green & Worswick, 2017; Thobani, 2000; Whitaker, 1991).

Historical injustices embedded in discriminatory immigration policy, however, challenge Canada’s identity as an inclusive, multicultural society. For example, in response to an increasing number of Chinese working on the Canadian Pacific Railway, after the completion of the construction, the government passed the Chinese Immigration Act in 1885, which imposed a head tax on Chinese immigrants, limiting their entrance to Canada and significantly discouraging women’s migration (Abu-Laban, 1998; Boyd & Vickers, 2000; Coté, Kerisit, & Coté, 2001; Matas, 1985). It was the first of a series of such measures directed at the Chinese that continued until 1947 (Matas, 1985).

Another example is the Canadian Immigration Act of 1910, which prohibited immigrants belonging to any “race” deemed undesirable (Green & Green, 2004; Matas, 1985; Thobani, 2000). Racialized immigration policy overtly sought to restrict the entry of non-preferred “races” from Africa, Asia, and the Caribbean for permeant settlement (Thobani, 2000). With the 1919 revisions to the 1910 Act, the word nationality was added to that of race, which expanded the government’s power over the ethnic composition of immigrants (Green & Green, 2004; Matas, 1985). Preferred countries mainly included the United States, Australia, New Zealand, and northwestern European countries (Green & Green, 2004; Thobani, 2000). Later, the admissible classes were further extended to cover prospective immigrants from southern Europe (Green & Green, 2004). Admission based on country of origin continued until the early 1960s (Green & Green, 1999, 2004).

As a result of changing the global economy, growing anti-racist movements, and national liberation movements, Canadian immigration policy underwent two major changes in the 1960s (Thobani, 2000), which significantly changed immigrants' characteristics (Green & Green, 1995). First, in 1962 Ottawa adopted a non-discriminatory policy (Beach et al., 2011; Green & Green, 1995, 1999; Green & Worswick, 2017; Whitaker, 1991), and in 1967 the point system was introduced (Beach, Worswick, & Green, 2011; Green & Green, 2004; Green & Worswick, 2017; Whitaker, 1991).

As such, prospective immigrants could no longer be denied entry to Canada because of their race or nationality (Green & Green, 1995). Yet, they were required to pass a points test based on several qualities such as age, education, language, and occupation (Coté et al., 2001; Green & Green, 2004). Therefore, applicants' human capital and potential labour market success played a fundamental role in their admission (Green & Green, 2004). Under this new Act, applicants were divided into two main categories with different admission standards, the independent—later was named an economic class—and the family class (Thobani, 2000). Family class immigrants—sponsored by family already in Canada (Green & Worswick, 2017)—who did not have to satisfy the points criteria, was not new and had co-existed parallel to economically driven immigration. Though at this time, as a distinct class, the family class is clearly described (Boyd & Vickers, 2000). Abandoning the previously discriminatory approach to immigration and adopting the point system had a significant impact on the level and composition of immigration to the country (Beach, Worswick, & Green, 2011; Coté et al., 2001), which will be discussed later.

The year 1976 was a significant turning point in Canadian immigration policy. The federal government introduced a new Immigration Act that came into effect in 1978; the Act still forms the framework for Canadian immigration policy (Abu-Laban, 2004; Boyd, 2013; Green & Green, 1999). This Act outlined the objectives of the Canadian immigration policy. It identifies three main goals: to facilitate the reunion with close family members, to fulfil Canada’s humanitarian traditions, and to foster economic development in all regions of Canada (Green & Green, 1999). The 1976 Act was the first Canadian immigration legislation that defined refugees as a distinct category of immigrants. However, refugees as a class of immigrants were formally recognized in 1969 when Canada signed the United Nations Convention Relating to the Status of Refugees (Boyd & Vickers, 2000; Canadian Council for Refugees, n.d.; Whitaker, 1991).

In the 1990s, the points system was adjusted stressing on a broader range of skills and general human capital characteristics such as experience: a shift away from a focus on occupation (Beach et al., 2011; Ferrer, Picot, & Riddell, 2014; Green & Green, 1999; Green & Worswick, 2017). There was also an increase in points awarded for education and language proficiency (Green & Green, 2004; Green & Worswick, 2017). Again, the Immigration Act underwent another reform and was replaced by the Immigration and Refugee Protection Act (IRPA), which came into force in 2002. IRPA is now the primary federal legislation regulating immigration to Canada. The new Act strengthened the human capital model of immigration with a clear emphasis on immigration’s economic component (Boyd, 2013; Ferrer et al., 2014; Green & Green, 2004; Green & Worswick, 2017). Since the mid-2000s, new programs, such as the

Canadian Experience Class and the Provincial Nominee program, have been added to enhance the human capital model and address regional and labour shortages (Ferrer et al., 2014; Green & Worswick, 2017).

Although over the years, reforms to immigration legislation have led to the removal of barriers to people who were once denied entry, some argue that the immigration policy is still discriminatory, albeit not overtly so (see for details, Abu-Laban, 2004; Thobani, 2000). Moreover, in general, by these measures, women, especially racialized women, have been mainly targeted for exclusion from entering the country (Abu-Laban, 1998; Coté et al., 2001). For instance, Black railway workers' wives were refused entry until 1943 (Coté et al., 2001). However, some European women came to reunite with their families, or some others were encouraged to immigrate to do domestic work and other female-gendered forms of paid employment (Coté et al., 2001). In other words, gendered exclusion intersects with racialized exclusion.

Additionally, the point system imposed higher limitations on women's immigration than men, given that women do not enjoy equal rights to training, labour market, or education in most countries (Coté et al., 2001). Valued skills are also highly gendered because most in-demand skills are traditionally male-dominated (Coté et al., 2001; Dobrowolsky, Arat-Koç, & Gabriel, n.d.). By contrast, much of women's expertise has never been recognized under the point system as "high skills" (Dobrowolsky, Arat-Koç, & Gabriel, n.d., p. 1). Moreover, women were historically admitted as dependents (Coté et al., 2001). Put simply, the underlying theme of labour market needs and family reunification is the male bias and male breadwinner household model (Harzig, 2003). The point system reinforces women's subordination in the labour market and the socially constructed dichotomy between valuable public work and less valuable housework (Abu-Laban, 1998). In summary, the point system criteria favoured those with money from countries with educational opportunities based on the Western scientific model (i.e., class-advantaged Western men) and reinforced exclusions relating to race/ethnicity, gender, and class (Abu-Laban, 2004).

Another example of the immigration policy's discriminatory applications was the exclusion of gay men and lesbian women from the family class category until 2002 (LaViolette, 2003). Canadian immigration policies also exclude people with disabilities. Discriminatory treatment of persons with disabilities traces back to Canada's first immigration Act, which came into effect in 1869, two years after Confederation (Hanes, 2009; Mosoff, 1998; see also Chadha, 2008; Whitaker, 1991). The exclusion of people with disabilities is still present in Section 38(1) of IRPA (Hanes, 2009, see also Council of Canadians with Disabilities, 2018; El-Lahib & Wehbi, 2012; Mosoff, 1998), although the Act does not explicitly list disability as a prohibited ground (MacIntosh, 2019; Niles, 2018). According to this section, the would-be immigrants may have their application denied on medical grounds and found medically inadmissible if their health conditions cause excessive demand on existing social or health services (Government of Canada, 2001a). Recently as a significant step forward in ensuring the immigration system is more inclusive of persons with disabilities, the cost threshold was increased to three times the previous level, and the definition of social services was amended (Government of Canada, 2018).

Despite all of these concerns, Canada is "perceived as a role model for successful migration management" (Organisation for Economic Co-operation and Development [OECD], 2019, p. 30) and recognized as having "the most elaborate and longest-standing skilled labour migration system in the OECD" (OECD, 2019, p. 13).

Demography of immigrants. The annual number of immigrants admitted to Canada is one of the most fundamental components of immigration policy (IRCC, 2018, 2020). Since Confederation, the annual intake of immigrants has fluctuated not only because of modifications in Canada's immigration policies, but also due to political upheaval, humanitarian crises, and Canada's and other countries' economic situation, among other reasons (Boyd, 2000; Statistics Canada, 2018a). Yet, since the 1990s, immigration has been a key driver of Canada's population growth and continues to be (Statistics Canada, 2018b).

Currently, international migration, both permanent and temporary, accounts for more than 80% of population growth (Statistics Canada, 2019a). It is projected that in a no-immigration world, considering the country's aging population and low birth rate, Canada's population growth could be close to zero around 2050 (Statistics Canada, 2015). To help offset the economic and fiscal challenges expected to arise from this issue, in 2017, the Government of Canada tabled its multiyear Immigration Levels Plan to grow annual immigration levels significantly (IRCC, 2020). While from the early 1990s, the number of immigrants has remained relatively constant, in 2018, Canada admitted more than 321,000 immigrants, the highest number since 1913 (IRCC, 2020). The projected immigration level plans have been even higher for the following years, with admission targets of over 360,000 in 2022, about 1% of Canada's population (IRCC, 2020). As a result, the number and proportion of the foreign-born population have continued to rise. In 2016, Canada had a foreign-born population of 7,540,830 (Statistics Canada, 2017d). They represented 21.9% of the total population (Statistics Canada, 2017d), the largest proportion in the G8 countries and one of the highest among the OECD (OECD, 2020). Of those admitted in that year, female immigrants outnumbered male immigrants (22.6% vs 21.1%) (Statistics Canada, 2017a).

Evolving immigration policies not only significantly altered the annual level of immigration and the foreign-born population, but they also changed the characteristics of immigrants to Canada across several dimensions, including source country, ethnic composition, gender, and immigration class. According to the first Canadian Census in 1871 (Statistics Canada, 2017b), more than 90% of the Canadian population reported the British Isles and French origins. While these origins remain among the most common ethnicities/ancestries, their proportions are much lower than in 1871 (Statistics Canada, 2017b). Since the 1970s, there has been a steady decline of immigrants from European countries and an increase of immigrants arriving from countries of other continents, resulting in increasing diversity. Currently, 61.8% of Canadian immigrants come from Asia, followed by 13.4% from Africa, 12.6% from the Americas, 11.6% from Europe, and 0.7% from Oceania (Statistics Canada, 2017d). In 2016, more than 250 ethnic origins or ancestries (Statistics Canada, 2017b) and 200 places of birth (Statistics Canada, 2017d) were reported by the Canadian population.

As mentioned, the percentage distribution of immigrants living in Canada by admission categories has also been changed. During the 1980s, nearly one-third of immigrants were sponsored by family (30%), while 40% arrived through the economic category (Statistics Canada, 2017e). In 2018, a higher proportion of immigrants were admitted under Economic Class programs (58%), comprised of six economic-focused immigration streams, including Federal Skilled Worker, Quebec Skilled Worker, Provincial Nominee Program, Start-Up Visa Program, Business Immigrant, and Canadian Experience Class (IRCC, 2020). In that same year, a smaller proportion (26.5%) of newcomers came under the family reunification pillar, and more than 28,000 were admitted as refugees, the highest number in the world (IRCC, 2020).

The proportion of immigrant females in the immigrant population has also changed substantially. Nearly a century ago, 38.7% of immigrants were female (Hudon, 2015). The gender ratio became less skewed then after, and in 2018, girls and women represented slightly over half of the Canadian immigrants (IRCC, 2020). There has also been a trend toward gender parity in admission groups, particularly in the economic category, with more women have been admitted as economic applicants. The gap between females and males, however, remains (Hudon, 2015; IRCC, 2018). For example, in 2017, women comprised 48.5% of the Economic Class compared to 51.5% of men (IRCC, 2018).

Gender-disaggregation of data also shows that the female principal applicant to male principal applicant ratio in economic class has changed significantly in recent decades, with an increasing proportion of principal applicants being women. While the gap has been narrowed, it still exists (Hudon, 2015, IRCC, 2018). For instance, in 2017, 44% of principal applicants were women and 56% were men (IRCC, 2018). Women are also over-represented in some sub-categories. Notably, 25% of female economic principal applicants were admitted as caregivers, aligning with this sector's historically gendered nature (IRCC, 2018).

Socioeconomic status of immigrants. As aforementioned, Canada's admission system places heavy emphasis on educational attainment through its points' allocation. Therefore, this is unsurprising that immigrants tend to be more educated than the Canadian-born population; the highest educated foreign-born population in the OECD (OECD, 2019). As of the 2016 Census, 50% of immigrants, who landed in the five years before the Census, aged 25-64, had a bachelor's degree or higher, compared to 25% of the Canadian-born population (Statistics Canada, 2017c). Recent immigrant women were even more likely to have a bachelor's degree or higher than their male counterparts; the reverse pattern was observed in the 2006 Census (Statistics Canada, 2017c).

While immigrants are more educated than the Canadian-born population, recognizing their foreign qualifications is still a key challenge (Agopsowicz & Billy-Ochieng, 2019; Boyd, 2013; Grant, 2016). Indeed, Canada has set in place certain education and skills provisions for immigrants' selection, but, in reality, barriers to credential recognition and professional experience impede immigrants' access to employment, which is commensurate with their education and experience (Boyd, 2013). Consequently, many immigrants have difficulty participating in the labour market, are often underemployed, have higher education–occupation mismatch, or are overly represented in low-paying jobs.

For example, Hou, Lu, and Schimmele (2019), using census data, examined the trends in over-education among university-educated workers from 2001 to 2016. They found that over these 15 years, recent immigrants (those who arrived in Canada one to 10 years before the census) experienced an occupational downgrading, which was accompanied by an increase in the education–occupation mismatch and over-education rate. It means that their educational qualification exceeded what was required to adequately perform the job (Hou et al., 2019). These results are consistent with the findings of another study (Agopsowicz & Billy-Ochieng, 2019), indicating that only 38% of university-educated immigrants aged 25-54 work in an occupation that fits their education level compared with 52% of their Canadian-born counterparts.

As mentioned, many immigrants also face unemployment. For example, a report from Statistics Canada (Yssaad & Fields, 2018), looking at the Canadian immigration labour market data between 2006 and 2017, found that the employment rate for working-age immigrants (25 to

54 years) was lower than the Canadian-born population (79% vs 84%) in 2017. This employment-rate gap between immigrants and the Canadian-born, however, was the lowest rate recorded during the 12 years. Immigrants who immigrated recently (were in the country for five years or less) had lower employment rates than long-term and established immigrant groups, indicating that time since landing is an important determinant of immigrants' labour market outcomes. While with time spent in Canada, immigrants' labour market outcomes converged with those of the Canadian-born, it did not disappear. Gaps in labour market performance between immigrant women and Canadian-born women were more pronounced than that of their male counterparts. In essence, the employment rate for immigrant women at 72% was notably lower than the rate for their Canadian-born counterparts at 82% (Yssaad & Fields, 2018).

Moreover, the literature indicates that, in general, the wage gap between immigrants and non-immigrants is profound. According to the Conference Board of Canada (2017), the median hourly wages of university-educated immigrants were 20.6% lower than those of their Canadian-born population at the national level. The difference was more pronounced among women (i.e., the difference between immigrant women and Canadian-born women) than men (i.e., the difference between immigrant men and Canadian-born men), 23.2% for women and 19.2% for men, respectively. Lower earnings, however, are not confined to educated immigrants, and immigrants rarely achieve wage parity with Canadians. The gap in median earnings between the Canadian-born and immigrant workers has indeed widened over the past three decades, climbing to 10.3% in 2016 from 3.8% in 1986 (Agopsowicz & Billy-Ochieng, 2019). The gap in earning stems from discrimination and disqualification of education and labour market experience of the home country (Statistics Canada, 2008).

Immigrants’ earnings also vary by their entry stream (Crossman, 2013; IRCC, 2018; Picot, Zhang, & Hou, 2019). Principal applicants under the economic class are more likely to achieve wage parity with the Canadian average within five years of landing, but this has not been the case for other categories (El-Assal & Fields, 2018; IRCC, 2020). Generally, compared to economic principal applicants, family class immigrants have significantly lower incomes (El-Assal & Fields, 2018; IRCC, 2018). Studies of refugees’ earnings outcomes have yielded inconsistent findings (see for details, Picot et al., 2019). A recent study (Picot et al., 2019) examining refugees’ economic outcomes found a considerable group variation. The results showed that immediately after arrival, refugees had annual earnings below those of family-class immigrants. While for some groups of refugees, earnings increased much more rapidly after landing than family class immigrants, this was not the case for all. In the initial years, the entry program to Canada seemed to be a matter, with privately sponsored refugees earning more than government-assisted refugees. Human capital characteristics such as knowledge of an official language and educational attainment could be accounted for either none or very little of the differences. However, discrimination, the acquisition of occupational training in Canada, disqualification of education and labour market experience of the home country, among others, may have contributed to the earning differences (Picot et al., 2019).

Generally speaking, Canada’s labour market is not equally welcoming to all immigrants. For example, an occupational breakdown of the workforce in Ontario, the province with the most immigrants, sheds light on the gendered and racialized discrimination in the labour market (Block & Galabuzi, 2019). Racialized immigrant women had higher unemployment rates than their non-racialized peers and made 78 cents for every dollar that non-racialized immigrant women earned (Block & Galabuzi, 2019).

To conclude, there are significant inter-group and intra-group differences among immigrants in Canada. The literature highlights how racialized status, gender, and immigrant status intersect in the labour market. It also demonstrates that immigrants in general, and racialized women in particular, disproportionately experience the gender wage gap and related employment inequities. Years of research have shown an association between health conditions, including chronic pain, SES, and discrimination, among other factors, in significant and complex ways, which will be discussed in detail in Chapter Three. While these data are compelling, they do not take into account immigrants’ histories and experiences. Differences in power, privilege, and poverty are much more complex and need to be investigated.

Organization of the Thesis

In the next chapter, I introduce the thesis’s conceptual and theoretical foundations that guided my exploration into the experiences of immigrant women living with chronic pain, their caregivers, and physicians. In Chapter Three, I critically analyze the relevant knowledge across the literature and identify the gaps. Chapter Four presents the methodological undertaking and research activities of this research. In the next three chapters, I provide the results of the study. The analytical discussion of the findings is presented in Chapter Eight. In the last chapter, the concluding chapter, suggestions for improving care and treating chronic pain among immigrant populations are offered, along with limitations, strengths, and scope for future research.

Chapter Two: Theoretical Framework

The dissertation is guided by the SDoH framework (Solar & Irwin, 2010), while I employed an intersectionality lens (Hankivsky & Christoffersen, 2008). As such, this chapter begins with a brief overview of the notion of the SDoH. Then I examine the conceptual framework underpinning this study and extend some of its fundamental theoretical tenets. After that, I explore the application of this framework in demonstrating a causal link with health conditions. Next, a brief overview of the feminist intersectionality perspective and its central principles is presented, emphasizing the benefits of intersectionality for the analysis of SDoH.

Social Determinants of Health

The SDoH are the social and economic factors that influence health (Canadian Public Health Association, n.d.; Government of Canada, 2001b). The recognition that social and environmental factors influence the population's health is traced back to the mid-19th century (Jayasinghe, 2015; Krieger et al., 2010; Raphael, 2006). Pioneers in this area include Rudolf Virchow (1821 – 1902), whose famous contribution was to the social causation of the typhus epidemic in Upper Silesia (Brown & Fee, 2006), and Friedrich Engels (1820 – 1895). The latter reported the association between poor living conditions of the working class in England and high mortality (Jayasinghe, 2015). Subsequently, Chilean president Salvador Allende (1908 – 1973) was concerned with the role of socioeconomic and political injustice in generating health inequities (Jayasinghe, 2015; Krieger et al., 2010). All reinforced the social origins of illnesses.

SDoH are conditions in which people are born, live, grow, work, play, learn, and age (Healthy People 2020; Wilkinson & Marmot, 2003; World Health Organization [WHO], n.d., 1986, 2008, 2017a). The distribution of power, money, and resources strongly determines the quality of these health-shaping living conditions (WHO, n.d.). The unequal distribution of the social determinants is indeed shaped by a broader set of forces, including socioeconomic policies, political circumstances, and social norms (Mantoura & Morrison, 2016; Marmot, Allen, Bell, Bloomer, & Goldblatt, 2012; Raphael, 2006; WHO, n.d., 2008). These broader factors have been identified in the literature as the "causes of the causes" (Marmot & Commission on Social Determinants of Health [CSDH], 2007, p. 1153) and structural determinants (Whitehead & Dahlgren, 2006b).

The "causes of the causes" produce inequities in health—the systematic, unfair, avoidable, and modifiable differences in health status—within and between societies (Government of Canada, 2001b; Kelly, Morgan, Bonnefoy, Butt, & Bergman, 2007; Whitehead & Dahlgren, 2006a; WHO, n.d., 2008). Social determinants, in other words, are potent predictors of morbidity (i.e., ill-health) and mortality (i.e., death) (Ansari, Carson, Ackland, Vaughan, & Serraglio, 2003; Kelly, Morgan, Bonnefoy, Butt, & Bergman, 2007; Mikkonen & Raphael, 2010; Wilkinson & Marmot, 2003). The Public Health Agency of Canada (2020), Wilkinson and Marmot (2003), Mikkonen and Raphael (2010), Raphael, Bryant, Mikkonen, and Raphael (2020), and WHO (2017) recognize records of seven to 17 distinct and yet overlapping determinants (for review the list of the SDoH, see Appendix B).

There is also growing acceptance that immigration is a core determinant of health, which I will discuss in the next section (Abubakar et al., 2018; Bierman, 2006; Castañeda et al., 2015; International Organization for Migration [IOM], 2009; Kapilashrami & Hankivsky, 2018; WHO, 2017b). Yet, the WHO's framework critically fails to include immigration in its list of health determinants—all official records of health determinants, except for Raphael et al. (2020), ignored immigration, as well.

Immigration as a social determinant of health. Immigration is inextricably linked with other determinants to influence health, adding another layer of complexity to the various pathways through which the SDoH interact (Abubakar et al., 2018; Bierman, 2006; Castañeda et al., 2015; IOM, 2009; Kapilashrami & Hankivsky, 2018; WHO, 2017b). The migration experience has an enormous impact on health and well-being, positively or negatively, throughout the migration cycle (Abubakar et al., 2018; Bierman, 2006; Castañeda et al., 2015; IOM, 2009; Kapilashrami & Hankivsky, 2018; Lu & Zhang, 2016; Zimmerman, Kiss, & Hossain, 2011). Immigrants have varying risk and vulnerability levels based on a combination of legal, socioeconomic, cultural, behavioural, and communication barriers surrounding their migration process (IOM, 2009; Kapilashrami & Hankivsky, 2018).

As immigration is a multistage cycle and complex dynamic process, the physical, mental, and social well-being of immigrants are indeed shaped by the experiences and situations in the home country, during migration, in the place of destination (Abubakar et al., 2018; IOM, 2009; Kapilashrami & Hankivsky, 2018; Zimmerman et al., 2011), and in some cases return phase as well as interception (Zimmerman et al., 2011). In other words, the socioeconomic and political context during the migration cycle can create an accumulation of disadvantages throughout the immigrants' lifespan (Abubakar et al., 2018). Admittedly, immigration is both a consequence of the SDoH and a determinant per se that can result in changes in SDoH (Castañeda et al., 2015).

Theoretical Framework

I built my theoretical foundations on a conceptual framework developed by the WHO CSDH (Solar & Irwin, 2010), which describes the root causes of health inequities and how these "cause of causes" can lead to unequal health outcomes. This framework offers a way to conceptualize the origins of inequities in health outcomes. The CSDH conceptual framework is established on many elements of previous models and theories of the social production of health or what Krieger has named "theories of disease distribution" (as cited in Solar & Irwin, 2010, p. 15). These theories are the social production of disease/political economy of health, eco-social frameworks, and psychosocial approaches (Solar & Irwin, 2010). These theories reject the individual-oriented premises of the biomedical and lifestyle philosophies (Krieger, 2019; Raphael, 2006).

The political economy of health theory is concerned with how power, politics, and economics shape population health profiles (Krieger, 2019; Raphael, 2006; Solar & Irwin, 2010). Psychosocial theories focus on the brain-mediated biology of stress and how its physiological consequences across the life-course increase peoples' vulnerability to disease (Krieger, 2019; Solar & Irwin, 2010). These theories also emphasize the experience of living in unequal societies, which is associated with the feeling of shame (Solar & Irwin, 2010) and stress-related health behaviours (Krieger, 2019). The central focus of the eco-social theory of disease is on how we embody or incorporate our lived experiences in a historical, societal, and ecological context (Krieger, 2019; Solar & Irwin, 2010). One of the strengths of this framework is bringing these complementary theories together.

The CSDH conceptual framework is displayed in Appendix C1, outlining the multifaceted approach to understanding health inequities. This framework provides a better understanding of the root cause of health problems. Each concept is now described along with its causal relationships and effect modifications. The CSDH conceptual framework defines two categories of social determinants: structural and intermediary determinants of health. The vocabulary of structural and intermediary highlights the causal priority of the former. In short, the model depicts how the structures in which populations live influence intermediary determinants that ultimately determine the well-being of societies (Solar & Irwin, 2010).

Structural determinants have two main components: socioeconomic-political context and socioeconomic position. Socioeconomic-political context refers to a spectrum of factors in a social system and consists of governance, macroeconomic policies, culture and societal values, social policies, and public policies (Solar & Irwin, 2010). Social socioeconomic and political context creates hierarchical social stratification in society, rooted in the systematically unequal distribution of power, access to resources, prestige, and discrimination (Solar & Irwin, 2010). Indeed, individuals are stratified (i.e., assigned to a social location) according to markers of power such as gender, race/ethnicity, income, education, and occupation, among others (Raphael, 2006).

Socioeconomic-political context, structural mechanisms, and the resultant social status are structural determinants of health—Solar and Irwin (2010) used the term SES for the people's position; I preferred to change the name to social status to be more comprehensive. People's position within social hierarchies, in turn, through a set of intermediary determinants, shapes differences in exposure and vulnerability to health-damaging conditions (Solar & Irwin, 2010). The main intermediary determinants are material circumstances (e.g., living and working conditions, financial means to buy healthy food, warm clothing), biological and behavioural factors (e.g., genetic factors, Lifestyle factors), psychosocial factors (e.g., stressful living circumstances, social support, and coping styles), and health system.

This framework considers the non-linear correlation and feedback loops. For example, socioeconomic-political context and social status have a reciprocal interaction, and illnesses caused by intermediary determinants can then circle back to the structural determinants. To rephrase it, the framework “reflected how the ‘macro,’ ‘meso,’ and ‘micro’ level determinants affect each other in a fluid way” (Canadian Council on Social Determinants of Health [CCSDH], 2015, p. 25). Simply put, the framework explicitly considers the relationship between determinants and feedback.

Power, as mentioned, is an essential concept in this framework. Solar and Irwin (2010) note that power has been conceptualized in two different ways: “(1) ‘power to’ - the ability to bring about change through willed action; and (2) ‘power over’ - the ability to determine other people’s behavior, associated with domination and coercion” (p. 23). The former tends to be framed as a positive perspective emphasizing greater participation of previously excluded groups and new forms of collective action, whereas the latter closely linked to notions of domination and oppression. Consequently, they argue that tackling the SDoH inequities is a “political process that engages both the agency of disadvantaged communities and the responsibility of the state” (Solar & Irwin, 2010, p. 23). In this dissertation by systems of power (e.g., racialization and racism), I meant the systems that shape people’s socials positions, experiences of privilege and oppression, and “the intersecting processes by which power and inequity are produced, reproduced and actively resisted” (Hankivsky et al., 2012, p. 35).

In summary, the SDoH framework provides “a window into the microlevel processes by which social structures lead to individual health or illness, and offers the opportunity to consider the macrolevel processes by which power relationships and political ideology shape the quality of these social structures” (Raphael, 2006, p. 668). This framework is based on a holistic approach and identifies interactions between determinants, critical components of a population health framework seeking health equity (CCSDH, 2015). To put immigration in the reference frame of WHO’s framework, the historical context and social, economic, and political environment of migration create the overarching forces determining who migrates, from where, and their place of destination. These broad structural policies, therefore, make differential access to rights, resources, and opportunities in navigating everyday life, which has a profound influence on the health and well-being of immigrant populations (Abubakar et al., 2018; Bierman, 2006; Castañeda et al., 2015; Wallace, 2019). Adding immigration to the structural determinants of health of WHO’s framework provides a more holistic approach to understanding the complex and interrelated effects of SDoH through the life course. Consequently, although my theoretical framework was built on the WHO’s model, mine is unique, as it put emphasis on immigration, itself, as a SDoH.

A critical approach to social determinants of health. As already stated, the lists of determinants somewhat vary, yet many researchers call attention to understanding that SDoH are interrelated. Nevertheless, the SDoH have often been treated as separate concepts and, accordingly, as distinct health determinants, ignoring their complexity and closed associations (Benoit & Shumka, 2009; Hankivsky & Christoffersen, 2008; Veenstra, 2013). Thus, calls are being made to think about innovative approaches for framing health determinants and to explore the dynamic interrelationships among the determinants (Hankivsky & Christoffersen, 2008; Potvin, Gendron, Bilodeau, & Chabot, 2005; Raphael, 2006). For example, Raphael (2006) has argued that “one shortcoming in the work on social determinants of health is the failure to consider ‘a master conceptual scheme’ to illuminate how the SDoH operate rather than merely acknowledging that they exist” (p. 654). It is well-known that health is a “resource for everyday life” (WHO, 1986, p. 1). Therefore, we need a conceptual analysis that explores an in-depth understanding of daily living (Potvin et al., 2005) or what Raphael suggested, a “critical social science perspective" (2006, p. 654). An intersectionality lens offers such a critical approach to SDoH and health inequities (Hankivsky & Christoffersen, 2008; Weber & Fore, 2007) that I discuss in the next section.

Intersectionality. In this part, I present a brief overview of the feminist intersectionality perspective and its central tenets. I then highlight how SDoH conceptual framework can benefit from the insights of intersectionality. The term intersectionality is coined by Kimberlé Crenshaw and rooted in the Black feminist theory (Crenshaw, 1989). Other scholars such as bell hooks (1990) and Patricia Hill Collins (1990) have also published extensively on intersectionality. Some activists and scholars, however, trace the earliest articulations of intersectionality back to the Sojourner Truth speech, "*Ain't I a Woman?"* delivered in 1851 (Bowleg, 2012; Brah & Phoenix, 2004; Morrison, 2014; Simpson, 2009). Intersectionality is defined as:

> a way of understanding and analyzing the complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing ways. When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves. (Collins & Blige, 2016, p. 2)

Intersectionality, as a critical feminist instrument, is an innovative analytical perspective. It departs from traditional paradigms in multiple critical ways (Bowleg, 2012; Hankivsky & Christoffersen, 2008; Hankivsky et al., 2017), which have been the rationales for this research.

First, it examines how macrolevel structural factors (e.g., ageism, ableism, sexism, racism, heterosexism, classism, to name a few) intersect with microlevel social identities (e.g., age, culture, (dis)ability, gender, immigrant status, racialized status, sexual orientation, and social class) to create and sustain social hierarchies (Bowleg, 2008, 2012; Davis, 2008; Weber & Parra-Medina, 2003). Importantly, intersectionality posits that social categories are interdependent and mutually constitutive (Bowleg, 2008, 2012; Brah & Phoenix, 2004; Collins, 1990, 2015; Davis, 2008; Hancock, 2007; Hankivsky et al., 2017; Hankivsky et al., 2010; Kapilashrami & Hankivsky, 2018; Kazanjian & Hankivsky, 2008; McCall, 2005; Morris & Bunjun, 2007; Morrison, 2014; Nash, 2008; Shields, 2008; Weber & Parra-Medina, 2003; Yuval-Davis, 2007). Intersectionality is far from representing a linear additive model of social identities (Bauer, 2014; Bowleg, 2012; Hancock, 2007; Hankivsky & Christoffersen, 2008; Hankivsky et al., 2010; Kazanjian & Hankivsky, 2008). In other words, social identifiers work together to produce what McGibbon and McPherson (2010) named "a complex synergy" (p. 61). Intersectionality is against essentializing any categories (Hankivsky et al., 2010). Strictly speaking, there is no definite hierarchical ordering of social identifiers (Hankivsky et al., 2010). They, in fact, should be considered in tandem rather than distinctly.

The attention to concurrent intersections of social categories and macrolevel structural factors embedded in intersectionality is well aligned with the non-linear correlation and feedback loops, both positive and negative, at multiple levels of SDoH framework. Yet, my research would benefit from adopting a more complex view of intersectionality when the macrostructures of inequality were not separated from the microstructures of the social construction of meaning (Choo & Ferree, 2010). An intersectional lens focuses on the processes that create and reinforce social stratification markers (Webber & Parra-Medina, 2003). Intersectionality indeed can expand the explanatory powers of WHO’s framework and have the potential to develop a richer conceptual framework.

Second, intersectionality explores the social constructions of inequity and social forces that shape people’s lives, and therefore their health. It also aims to achieve social justice (Hankivsky & Christoffersen, 2008; Hankivsky et al., 2017; Hankivsky et al., 2014; Hankivsky et al., 2010; Kazanjian & Hankivsky, 2008; Kelly, 2009; López & Gadsden, 2016; Rogers & Kelly, 2011; Weber, 2006; Weber & Parra-Medina, 2003). These are core tenants of SDoH as well (Bowleg, 2012; Hankivsky & Christoffersen, 2008).

Third, intersectionality is interdisciplinary (Dhamoon, 2011; Davis, 2008; Hankivsky et al., 2017; Kelly, 2009; López & Gadsden, 2016; Shields, 2008; Weber & Parra-Medina, 2003). The interdisciplinary approach of intersectionality recognizes the inherent complexity of health problems. Thus, it can offer sound solutions to the call for innovative strategies for framing health determinants and needs adjustments being made regarding the theoretical framework (Kivits, Ricci, & Minary, 2019). Embracing the complexities is critical to understanding health inequities resulting from social inequities (Hankivsky & Christoffersen, 2008; Kelly, 2009). Intersectionality can address the complex interaction of health determinants (Bauer, 2014; Hankivsky & Christoffersen, 2008; Iyer, Sen, & Östlin, 2008; Sen, Iyer, & Mukherjee, 2009). It can deepen our understanding of inequity by better reflecting on the world’s complex realities and enriching population health research (Bauer, 2014). Indeed, similar disparities along with one social determinant of health can create differential effects when interacting with other determinants (Iyer, Sen, & Östlin, 2008; Sen, Iyer, & Mukherjee, 2009). Intersectionality combines intersecting axes of discrimination. In this essence, none of the SDoH is necessarily more important than any other (Bauer, 2014; Hankivsky et al., 2010). The importance of the interrelation of SDoH is also echoed by the Public Health Agency of Canada (2013). Intersectionality also promotes the notion that health outcomes are not merely because of individuals' genetics or lifestyle (Bauer, 2014; López & Gadsden, 2016), which are rooted in traditional public health discourses and remain dominant across the field (Heard, Fitzgerald, Wigginton, & Mutch, 2019).

An intersectional approach aims "to reveal meaningful distinctions and similarities" (Association for Women's Rights in Development, 2004, p.2). Put simply, a focus on only one social category without attention to concurrent intersecting statuses obscures substantial heterogeneity (Bates, Hankivsky, & Springer, 2009). Intersectionality posits that each individual occupies a "unique social space" at the intersections of various social status positions (Ransford as cited in Bowleg, 2012, p. 313). In other words, intersectionality's promise lies in its potential to address within-group differences as it embraces multiple interlocking privileges and oppressions (Bowleg, 2012; Davis, 2008; Dhamoon, 2011; Hankivsky & Christoffersen, 2008; Hankivsky et al., 2017; Hankivsky et al., 2010; Kapilashrami & Hankivsky, 2018; Kelly, 2009; Morris & Bunjun, 2007; Nash, 2008; Rogers & Kelly, 2011; Shields, 2008). An intersectional approach provides a more nuanced understanding of intergroup and intragroup differences, which is necessary to analyze various immigrant groups' experiences resulting from their unique living conditions at different stages of their migration process (Kapilashrami & Hankivsky, 2018).

Fourth, intersectionality is committed to tackling the role of power and understanding power dynamics at multiple levels – interpersonal, institutional, and societal systems (Bauer, 2014; Choo & Ferree, 2010; Collins, 2015; Collins & Blige, 2016; Dhamoon, 2011; Hankivsky & Christoffersen, 2008; Hankivsky et al., 2017; Hankivsky et al., 2010; Kapilashrami & Hankivsky, 2018; McGibbon & McPherson, 2011; Morris & Bunjun, 2007; Shields, 2008; Weber, 2006; Weber & Parra-Medina, 2003). The CSDH also called for understanding the role of power in producing health (Solar & Irwin, 2010). As Hankivsky et al. succinctly state,

> An intersectional lens shows that while health is experienced at the level of the individual, individual health outcomes and inequities, manifested in the body, are inextricably linked to interacting processes and structures of power at multiple levels. (2017, p. 11)

Fifth, intersectionality also enhances understanding of the accumulation process of socioeconomic disadvantages and advantages and how interlocking systems of inequality shape adulthood life outcomes (Hinze, Lin, & Andersson, 2012). Indeed, the cumulative consequences of structured disadvantage over the life course mediated through laws, policies, and institutions, impact health and well-being. Attention to the life course aligns with life course perspectives—one of the main pathways and mechanisms of the WHO's framework (Solar & Irwin, 2010). Finally, the perspectives and experiences of oppressed groups are at the centre of the intersectionality perspective (Bowleg, 2008, 2012; Choo & Ferree, 2010; Dhamoon, 2011; Hankivsky & Christoffersen, 2008; Hankivsky et al., 2017; Morris & Bunjun, 2007; Rogers & Kelly, 2011; Simpson, 2009; Weber & Parra-Medina, 2003).

In summary, this perspective is a non-additive way of understanding social categories. It emphasizes on how these categories and social systems of power (i.e., drivers of inequity) intersect simultaneously in specific time and place (Choo & Ferree, 2010; Collins, 2015; Hancock, 2007; Hankivsky & Christoffersen, 2008; Hankivsky et al., 2017; Hankivsky et al., 2014; Heard et al., 2019; Morris & Bunjun, 2007; Morrison, 2014; Shields, 2008; Weber, 2006). It has indeed paid attention to the particular historical trajectories and contexts that produce and sustain health inequities (Bauer, 2014; Collins & Blige, 2016; Hankivsky & Christoffersen, 2008). Attention to historical context is consistent with the theories of disease's social production and the political economy of health. Intersectionality, in other words, is a promising analysis lens that looks into the dynamics and complexities of the interactions of social identifiers at the individual, institutional, and structural levels in the production of the social processes of oppression and domination, and their impacts on health.

In this sense, intersectionality precisely has the ingredients required for the right approach to understand the lived experiences. SDoH theoretical perspectives and an intersectionality lens share many overlapping tenants, including attention to multilevel analysis, complexity, power, context, as well as a commitment to social justice and equity. As Iyer, Sen, and Östlin noted, "Insufficient attention to intersectionality, in much of the health literature, has had, we believe, significant human costs" associated with health inequities (2008, p. 21). By employing an intersectionality lens, I aimed to present the perspectives of participants, particularly those with the least amount of power, at the centre, to understand the pain meaning within a broader context, and to address similarities in experiences as well as within-group differences. The other goals were to facilitate addressing the complexity of chronic pain, guide the interpretation of results, and enrich mainstream health research. Finally, intersectionality fulfills my genuine commitment to social justice.

Chapter Three: Statement of Knowledge

This chapter is divided into three sections. The first section provides a general overview and definition of pain and the biopsychosocial model of pain. In the next part, I establish the rationale for considering pain as a public health condition, describing the prevalence of chronic pain, and the magnitude of pain's impact on individuals, family, friends, communities, and society. Then I move to determinants of pain and discuss the roles of several determinants in increasing or decreasing someone's risk of developing chronic pain.

The literature review is derived from a range of published and grey research literature sources. I applied no limits for publication date, country of origin, or study design to search for these. I searched numerous electronic databases such as Medline, Embase, PubMed, Cochrane Database of Systematic Reviews, Web of Science, PsycINFO, CINAHL, and Google Scholar, to ensure that the majority of relevant studies have been identified. My aim here was to review the most important and critical aspects of the current knowledge of chronic pain. I mostly searched for systematic reviews, meta-analyses, and meta-ethnographies. I also explored references of included articles and publications by leading academics working in the field of chronic pain research. The literature review offers a context for the study and demonstrates the gaps in understanding chronic pain amongst immigrant women.

Chronic Pain

Pain definition. Pain is defined as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage, or described in terms of such damage" (Merskey & Bogduk, 1994/2012, p. 210). Pain is one of the most frequent reasons people seek medical care (Finley et al., 2018; Gureje, Von Korff, Simon,

& Gater, 1998; Musey et al., 2014). To illustrate, findings of a retrospective cross-sectional study, analyzing the secondary data from the emergency department databases in a large urban teaching hospital in the United States, indicated that pain was a chief complaint of more than half of the visits (Cordell et al., 2002).

There are two broad categories of pain: acute pain and chronic pain. While acute pain is a warning sign and survival mechanism (Bates, 1996; Lumley et al., 2011; Sessle, 2011), chronic pain is the "pain that continues when it should not" (Institute of Medicine, 2011, p. 278). It persists beyond "normal" tissue healing (Merskey & Bogduk, 1994/2012). Nonetheless, it is argued that this definition is impractical and illogical because normal healing time is hard to determine. After all, some types of pain have pathology, which rarely heals. Others occur in the absence of known pathology, and therefore normal healing time cannot be ruled (Steingrímsdóttir, Landmark, Macfarlane, & Nielsen, 2017).

Recently, after reviewing decades of research, the International Association for the Study of Pain (IASP) proposed a new definition that describes pain as: "[A]n aversive sensory and emotional experience typically caused by, or resembling that caused by, actual or potential tissue injury" (2019, para. 8). Both pain definitions draw attention that pain is an experience and always subjective. The attribution of meaning through experience is, therefore, an intrinsic part of pain (Ahmed, 2015; Mailis-Gagnon & Israelson, 2005; Morris, 1991).

Chronic pain and the biopsychosocial model. Historically, in the Western biomedical tradition, there is a tendency to consider pain as a symptom of something, an indicator of a diagnosis, and a result of underlying pathology, which is identified solely on a biological level or as a pathophysiological component of pain (Bates, 1996; Croft, Blyth, & van der Windt, 2010; Lynch, 2011). Hence, chronic pain has been assumed to be studied and sorted under the diseases supposed to cause it (Croft et al., 2010). In a biomedical approach, which fails to consider sociocultural and psychological factors, the focus is on the material part of the body. Therefore, chronic pain is reduced to “etiological mechanisms; biological processes that are measured in ‘objective’ quantitative terms” (Good et al., as cited in Bates, 1996, p. 22). Neither all people who have a particular pathological condition will develop chronic pain, nor are all chronic pains due to underlying causes (Croft et al., 2010, Lynch, 2011)—the etiology of most chronic pains remains unknown (Meana, Cho, & DesMeules, 2004).

The biopsychosocial model, initially introduced by Engel (1977) in a landmark paper in *Science,* is the most heuristic approach to the understanding of chronic pain (Gatchel & Howard, 2008; Gatchel, Peng, Peters, Fuchs, & Turk, 2007; Mailis-Gagnon & Israelson, 2005, see Appendix D). This model highlights the fact that chronic pain experience is influenced by the interaction amongst psychological, socioeconomic, and cultural factors and, therefore, it is a multifactorial dynamic experience (Gatchel & Howard, 2008; Gatchel et al., 2007; Mailis-Gagnon & Israelson, 2005; Shipton, Ponnamperuma, Wells, & Trewin, 2013). In other words, this perspective shifts the focus away from the traditional biomedical model, focuses on the illness instead of the disease, encompasses the whole person perspective, embraces diversity and the individual differences in the pain experience, and takes into account the social context of people living with chronic pain (Health Canada, 2019; Gatchel & Howard, 2008). The biopsychosocial model is grounded in systems theory (Engel, 1977) and a “multilevel, multisystems approach to human functioning” which bands together the biological, psychological, and social systems (Suls & Rothman, 2004, p. 119).

To elaborate more, the latest version of the International Classification of Diseases (ICD) of the WHO, ICD-10, includes some diagnostic codes for chronic pain conditions, yet the codes do not reflect the accurate epidemiology of chronic pain (Treede et al., 2017). To respond to this shortcoming, among others, and to arrive at a consensus on a more robust classification of chronic pain, the Task Force of the IASP, based on the current scientific evidence and the biopsychosocial model, in collaboration with the WHO, developed a new classification for the upcoming 11th revision of the ICD (Nicholas et al., 2019; Treede et al., 2019). In the new classification, a single diagnostic code or "parent" code, "chronic pain," is created, defining chronic pain as persistent or recurrent pain lasting longer than three months. Beneath the "chronic pain" are several other codes, including several chronic secondary pain syndromes and a novel concept, "chronic primary pain," by which chronic pain for the first time is conceived as a health condition in itself, even when the underlying condition is missing (Nicholas et al., 2019; Scholz, 2019; Treede et al., 2019). The World Health Assembly officially adopted the final version of ICD-11 in May 2019, scheduled to go into effect in January 2022 (Scholz, 2019). Indeed, chronic pain is now considered a clinical entity in its own right after many researchers asked for it (Breivik, Collett, Ventafridda, Cohen, & Gallacher, 2006; Croft et al., 2010; Goldberg & McGee, 2011). Considering pain as a condition per se is an essential step in validating the experiences of people living with chronic pain around the world (Health Canada, 2019).

As Croft et al. (2010a) suggest, to consider a health condition as a public health problem and view it from a population health perspective, the condition has to be common, has to matter—limiting life or diminishing its enjoyment—and has a high direct or indirect cost. Chronic pain has these characteristics, which I will explain further in the next section.

Chronic Pain as a Health Condition in Itself

Chronic pain prevalence. Chronic pain is one of the most prevalent conditions worldwide (Sá et al., 2019). Current reports on chronic pain prevalence vary, ranging from 8.7% in an interview study of adults aged 18 to 85 to 64.4% in a questionnaire study of adults aged 30 and over, according to a systematic review and meta-analysis (Steingrímsdóttir et al., 2017). These variations might be real, but they are more likely due to differences between studies in definitions of chronic pain (i.e., the adopted threshold for pain chronicity based on 3-month, 6-month), populations (i.e., general population versus primary care), demographic characteristics of samples particularly age but also including income, sex, gender, and ethnicity, levels of comorbidity, geographical settings of the study population, methods of data collection (i.e., phone interview, face-to-face interview, mail-in survey, Internet survey), and cultural contexts (Häuser et al., 2014; Ramage-Morin, 2008; Reitsma et al., 2011; Schopflocher et al., 2011; Steingrímsdóttir et al., 2017; Zaki & Hairi, 2015).

For example, Steingrímsdóttir et al. (2017) found considerable inconsistency in the definition of chronic pain in the literature, a problem that has been discussed for several decades. This discrepancy makes identifying the prevalence estimates of chronic pain across existing studies difficult. Similarly, studies of chronic pain prevalence among the Canadian population have yielded varying findings. The prevalence rate has been shown to range between 18% and 35%, comparable to those found in other parts of the world (Meana et al., 2004; Moulin et al., 2002; Reitsma et al., 2011; Schopflocher et al., 2011; Tripp, VanDenKerkhof, & McAlister, 2006; Hopman, Towheed, Anastassiades, & Goldstein, 2003). According to recent estimates, about six million Canadian adults (18 years and over) live with chronic pain, and almost half of them have lived with this condition for more than one decade (Schopflocher et al., 2011).

The incidence of chronic pain is also expected to increase further in the near future in line with an aging population (Meana et al., 2004; Phillips, 2009; Ramage-Morin, 2008) and parallel to the burden of non-communicable diseases (Jackson, Thomas, Stabile, Shotwell, Han, & McQueen, 2016). For instance, an analysis of five cycles of the Canadian Community Health Survey (CCHS, 2000/2001, 2007/2008, 2009/2010, 2011/2012, and 2013/2014) indicates that the prevalence of self-reported chronic pain among the general Canadian population, aged 12 years and over, living in private occupied dwellings, increased by 5.7%, from 16.3% in 2000 to 21.0% in 2014. The same trend was observed across all provinces in Canada and all age categories, albeit at different rates (Shupler, Kramer, Cragg, Jutzeler, & Whitehurst, 2019).

Impact of chronic pain. As stated, chronic pain is a major global health concern, given the evidence that it has a profound impact on persons living with it, their caregivers, other family and friends, and society in general (Goldberg & McGee, 2011; Henschke, Kamper, & Maher, 2015; Phillips, 2009; Reid et al., 2011). Chronic pain interferes with sleep, work, leisure, sexual function, can affect mental and emotional health, and result in significant disability (Breivik et al., 2006; Choinière et al., 2010; Croft et al., 2010; De Souza & Frank, 2007, 2011; Fine, 2011; Green, & Hart-Johnson, 2010; Liebeskind, 1991; Lynch, 2011; Mäntyselkä, 2012; Meana et al., 2004; Prefontaine & Rochette, 2013; Ramage-Morin & Gilmour, 2010; Reid et al., 2011; Reitsma et al., 2011; Schopflocher et al., 2011; Tang & Crane, 2006). Studies have also shown that chronic pain is associated with low self-rated health status and quality of life (Breivik, Eisenberg, & O'Brien, 2013; Eriksen, Jensen, Sjøgren, Ekholm, & Rasmussen, 2003).

Canadian research supports these results. To illustrate, a study of Canadians living with chronic pain on the waitlists of eight tertiary pain treatment centres, Multidisciplinary Pain Treatment Facilities (MPTFs), located in seven provinces across Canada, highlights the poor psychological status and health-related quality of life (Choinière et al., 2010). Similarly, the quality of life for Ontarians living with severe chronic pain was worse than those with many chronic diseases such as heart disease and diabetes (Hogan, Taddio, KatzShah, & Krahn, 2017).

Chronic pain can also affect psychological functioning (Breivik et al., 2013), which is associated with higher rates of depression, anxiety, and suicide (Campbell, Darke, Bruno, & Degenhardt, 2015; Fine, 2011; IsHak et al., 2018; Mills, Nicolson, & Smith, 2019; Racine, 2018; Reid et al., 2011). This association, however, is likely bidirectional (Mills et al., 2019; Rashiq & Dick, 2009). Importantly, pain and depression may intensify physical and psychological symptoms and lead to poor social functioning (IsHak et al., 2018). Canadian studies (Meana et al., 2004; Munce & Stewart, 2007; Rashiq & Dick, 2009) have also shown an association between chronic pain and depression. The prevalence of depression among Canadians who had chronic pain was two times the prevalence among those who did not have it (Meana et al., 2004; Rashiq & Dick, 2009). Moreover, the pain was reported with more intensity—a higher level of pain—among those who had depression (Meana et al., 2004).

Furthermore, chronic pain, represented by conditions such as low back pain and headache disorders, is one of the leading causes of disability worldwide (Jackson et al., 2016). According to the Global Burden of Diseases, Injuries, and Risk Factors Study, in 2017, the single greatest cause of years lived with disability around the world, for 354 causes in 195 countries and territories, was chronic low-back pain followed by headache disorders (James et al., 2018). In agreement with international estimates, results of a Canadian population-based study (Reitsma et al., 2011), using data from seven cycles of the National Population Health Survey (1994/95, 1996/97 and 1998/99) and CCHS (2000/01, 2003, 2005 and 2007/08) indicated that 11.4% to

13.3% of Canadians with chronic pain were prevented from taking part in at least a few activities because of pain—with highest rates of pain interference in daily activities among women.

Likewise, other Canadian studies showed that chronic pain affected the ability to carry out daily activities (Meana et al., 2004; Moulin et al., 2002), with higher rates of restricted activities among women than men (Meana et al., 2004). It is also documented that activity restriction by increasing psychological distress can mediate the association between pain and depression (Gilmour, 2015). In a similar vein, based on the 2017 Canadian Survey on Disability, pain-related disability was the most common type of disability among Canadians aged 15 years and over; about 4 million Canadians reported a pain-related disability (Morris, Fawcett, Brisebois, & Hughes, 2018). Women were more likely to experience a pain-related disability than men (17% women vs 12% men), as are the older Canadians (4% aged 15 to 24 years, 14% aged 25 to 64 years, and 26% aged 65 years and over) (Morris et al., 2018).

Chronic pain also has social consequences. Pain can restrict social contact and prevent people from attending social or family events (Dueñas, Ojeda, Salazar, Mico, & Failde, 2016). For example, a Canadian study (Moulin et al., 2002) demonstrated that nearly 60% of Canadians experiencing chronic pain had great difficulty attending social and family events. Additionally, chronic pain interferes with employment status. Across Europe, about 20% of surveyed people with chronic pain reported having lost their job (Breivik et al., 2006). In Canada, more than half of Canadians living with chronic pain incur a loss of income, have to reduce their work responsibilities or lose their job. It has been estimated that employees with chronic pain have 28.5 lost workdays per year on average (Lynch, 2011). In brief, chronic pain affects the persons living with chronic pain. Still, it also has a severely detrimental effect on their family and social circle (Dueñas et al., 2016), which I will be elaborated more in the following section.

Impact of pain on caregivers. In 2018, one in four Canadians was a caregiver for someone, a family member or a friend, with a long-term health condition, disability or aging-related needs (Hango, 2020). Caregivers are being recognized for their important contributions to society and the economy. Although taking on such responsibilities may be a positive and rewarding experience, it can have significant consequences for caregivers, including the impacts on health and well-being, participation in the labour force, financial costs, and reduced time available for other activities (Hango, 2020). In particular, those who care for their partner or child are more likely to be experiencing difficulties, such as psychological distress and health consequences, than other caregivers (Turcotte, 2013). Similarly, chronic pain places a substantial physical, emotional, psychological, and financial burden on the caregivers of individuals living with pain. For instance, caregiving responsibilities can generate feelings of sadness, nervousness, grief, burden, frustration, and helplessness, limit social activities and isolation, and reduce the quality of the relationship with the care recipient (Ojeda et al., 2014). Research has also shown an association between caregiving for individuals living with chronic pain and sleep disturbance, physical morbidity, and increased interpersonal conflict (Riffin, Fried, & Pillemer, 2016).

Not addressing chronic pain is costly. Chronic pain is costly. A review (Breivik et al., 2013) of recent studies on the economic impact of chronic pain has shown that national healthcare and socioeconomic costs of chronic pain in Europe and the United States represent three percent to 10% of Gross Domestic Product. Absenteeism, productivity losses, early retirement, and disability retirement are major contributors to these costs (Breivik et al., 2013). Chronic pain is hurting the Canadian economy as well, both directly through costs related to treatment and provision of health care services and indirectly through low productivity, absenteeism, lost tax revenues, and strain on the welfare system (Lynch, 2011). The economic costs of pain are more than heart disease, cancer, and HIV combined (Lynch, 2011).

In addition, people with pain conditions utilize more health care resources than individuals without pain (Henschke et al., 2015; Meana et al., 2004). Researchers in Canada (Hogan, Taddio, Katz, Shah, & Krahn, 2016) performed a retrospective cohort study using three cycles of the CCHS linked to Ontario health administrative data from 2000 to 2011 to estimate the annual per-person incremental medical cost to manage chronic pain. The per-person cost was 51% greater than treating a similar patient without chronic pain. Indeed, people with chronic pain had greater health care utilization than their matched controls across all measured variables; more emergency department visits, more physician visits, more hospitalization, and more having a CT and an MRI. Extrapolating the Ontario population estimate and per-person cost to the 2014 Canadian population, the authors, revealed that the overall annual estimate to manage chronic pain for Canadians aged 12 years and over was around $7.2 billion annually, which was more significant than Canadian estimates for diabetes (Hogan et al., 2016).

Enrico (2016), however, argues these costs were underestimated for two reasons. First, the study only captured the publicly funded portion of the cost of managing chronic pain. For example, both physiotherapy and psychotherapy, which are often covered from the patients' pockets or third-party insurance, were not measured. Second, the CCHS questionnaire's capability in identifying chronic pain is limited (Enrico, 2016). Another Canadian study (Guerriere et al., 2010), measuring the human and economic burden of chronic pain for individuals on waitlists of MPTFs, highlighted that 95% of these costs were privately financed—out-of-pocket expenses, time costs, and third-party insurance. Physiotherapy and massage therapy were the two most common reported privately financed expenditures. Additionally, the burden of costs associated with time lost from the labour market was considerable for both people living with chronic pain and their caregivers (Guerriere et al., 2010).

Similarly, a recent study (Wong, Côté, Tricco, Watson, & Rosella, 2021) examined the effect of back problems on healthcare utilization and costs in a population-based sample of Ontarian adults. The findings showed that Ontarians with back problems had higher rates of all-cause healthcare utilization, all-cause physician visits, all-cause emergency department visits, and healthcare costs than those without back problems, representing a substantial economic burden provincially, corresponded to an annual burden of $532 million for women and $227 million for men (adjusted to 2018 Canadian dollars).

In summary, given chronic pain's prevalence, its impact on the quality of life, associated disability, and the costs, chronic pain should be considered an important, distinct, and independent public health problem. It is not surprising that it is named "the disease of the century" (Prefontaine, & Rochette, 2013, p. 280), and as such, it needs concerted attention.

Social Determinants of Health and Chronic Pain

Chronic pain affects all population groups regardless of gender, education, income, age, sex, ethnicity, and racialized status, yet it is not distributed equally (Goldberg & McGee, 2011). In other words, there are strong relations between frequency and/or severity of chronic pain and SDoH, which call attention to the importance of the macrosocial determinants that shape the patterns of chronic pain as well as its distribution. Understanding chronic pain determinants is essential in providing prevention and management strategies (Mills et al., 2019; Smith, Macfarlane, & Torrance, 2007). Resembling most diseases, many determinants of health are associated with chronic pain development, yet there is a complex interaction between these factors. Hence my aim here is not to isolate risk factors or determinants of chronic pain but to identify a few determinants that have emerged repeatedly throughout the literature. These determinants are age, genetics, sex, gender, SES, race/racialized status, ethnicity, culture, migration, social support networks, and health care (see Appendix A for Conceptual Definitions). Although the literature represents these determinants in various contexts, this review primarily focused on their application to immigrant women populations. Several cautionary notes are warranted before moving to the next section.

First, I have adopted the terms used by the researchers whose works are cited. I am, however, aware of the significant challenges in defining race/ethnicity and acknowledging social and historical contexts within which “race” as a concept is situated (Hankivsky & Cormier, 2009). My intention by no means was to reduce the dimensions of social inequities to the biological characteristics of individuals. I admit that race is a social construct and am aware that reporting health inequity data without adequate context and explanation can be counterproductive, leading to blame or misunderstanding (Hutler, 2022). Nevertheless, as an equity stratifier, race-based data can inform how racialization and not race impact health; yet the term that accurately captures this construct has been debated in Canada (Bauer, Mahendran, Braimoh, Alam, & Churchill, 2020).

Second, analyzing socio-demographic data using credible methods is vital for identifying and addressing inequities in health outcomes (Bauer et al., 2020; Wellesley Institute, 2017), including chronic pain. Yet, “demographics have historically been masked by broad, ill-fitting categories” and non-standardized, fragmented data (Wellesley Institute, 2017, p. 9). For example, the terms sex and gender are often used interchangeably in pain research. There is also inconsistent and unclear use of race, ethnicity, and culture (Edwards, Fillingim, & Keefe, 2001;

Ezenwa, Ameringer, Ward, & Serlin, 2006; Rahim-Williams, Riley, Williams, & Fillingim, 2012). Consequently, here, as mentioned, I have adopted the terms used by the scholars whose works are cited. Third, the general ethnic/racial categories disguise significant heterogeneity within these population groups (Mailis-Gagnon, 2010; Meghani, Byun, & Gallagher, 2012). Fourth, these categories are social constructions that are fluid and continually changing (Howard, 2000). Finally, as stated earlier, these factors do not exist in isolation. Thus, a limited set of variables cannot yield a nuanced understanding of how the SDoH are compounded in daily life. As a result, the following sections focus on different health determinants of chronic pain, yet none are mutually exclusive; each intersects and overlaps with others.

Age and chronic pain. Chronic pain can affect people of all ages (Bonathan, Hearn, & Williams, 2013; Mills et al., 2019), but it is most common in older adults (Mills et al., 2019). Canadian studies also demonstrated a trend toward increasing prevalence with increasing age, generally for both sexes (Meana et al., 2004; Moulin et al., 2002; Rashiq & Dick, 2009; Reitsma et al., 2011; Schopflocher et al., 2011).

Genetics and chronic pain. At least 150 genes associated with chronic pain in humans have been identified (Mills et al., 2019); however, an overview of the current state of knowledge on human chronic pain concluded that the genes have small effects (Zorina-Lichtenwalter, Meloto, Khoury, & Diatchenko, 2016). In other words, "there is no 'chronic pain gene'" that contributes substantially to the development of chronic pain at the population level (Mills et al., 2019, p. e278). Some evidence has suggested that chronic pain clusters in families, yet much of this may be better explained by psychosocial factors within families (Smith et al., 2007).

Sex, gender, and chronic pain. Population-based studies across countries have consistently indicated that chronic pain is more prevalent in women (Bailey, 2013; Bartley & Fillingim, 2013; Blyth et al., 2010; & Breivik et al., 2006; Croft et al., 2010b; Fillingim, King, Ribeiro-Dasilva, Rahim-Williams, & Riley, 2009; Mogil, 2012; Saastamoinen et al., 2012). There are two exceptions: Ireland (Raftery et al., 2011) and New Zealand (Shipton et al., 2013), where no significant differences between men and women were found. Literature shows that many pain syndromes only occur in women (female-specific), such as menstrual pain and endometriosis (Mogil, 2012). Women are also at greater risk for several chronic pain syndromes (female-dominated), such as fibromyalgia and temporomandibular disorder (Bailey, 2013; Mogil, 2012). Furthermore, the prevalence of several common chronic pain syndromes, such as low back pain and headache, are more predominant among females (female-prevalent) (Fillingim et al., 2009; Mogil, 2012).

A review of clinical pain studies has demonstrated that women tend to report more frequent pain, but they are also at greater risk for pain-related disability than men (Unruh, 1996). These findings are in line with a consensus report on sex and gender differences in pain, which concluded that patterns of disability might differ by sex, and chronic pain, from the same pain condition, is more likely to be disabling for women than for men (Greenspan et al., 2007). Other studies also confirmed that women are at greater risk of pain-related disability (Bailey, 2013; Blyth, 2010). Canadian studies (Meana et al., 2004; Moulin et al., 2002; Munce & Stewart, 2007; Reitsma et al., 2011) also found a higher prevalence of chronic pain among women, with one exception (Rashiq & Dick, 2009).

While the findings from clinical and epidemiological studies show the higher rates of chronic pain among women, conflicting evidence exists regarding pain severity. Previous studies reviewing the experimental literature on gender and pain responses indicate that women are more likely to have lower thresholds, greater pain sensitivity, and higher pain ratings (Berkley, 1997; Fillingim et al., 2009; Fillingim & Maixner, 1995, for definitions see Appendix A). Nonetheless, the observed differences are relatively small, affected by various confounding variables, and not always consistent (Berkley, 1997; Fillingim & Maixner, 1995).

In a similar vein, a recent systematic review critically appraising the results of experimental pain literature on sex differences in the perception of various kinds of laboratory-induced stimulation—thermal, pressure, ischemic, muscle, electrical, chemical, and visceral pain—in healthy humans concluded that a consistent pattern of sex differences in human pain sensitivity had not emerged (Racine et al., 2012a). For example, while women tolerated less pressure pain than men, ischemic pain was comparable in both sexes, and there was no sex difference in many other pain modalities. The authors argued that the presence/absence of sex differences could be explained by methodological variability, type of stimulus, and the outcome indicator—pain intensity, threshold, or tolerance (Racine et al., 2012a). They discussed that selection of pain measures showing sex differences, among others, might contribute to the bias that women were more sensitive to pain (Racine et al., 2012a).

In contrast, Mogil (2012) demonstrated a very consistent pattern, with women showing greater pain sensitivity than men. Based on a meta-analysis, some suggested that the lack of sex differences could be explained by insufficient statistical power (Riley, Robinson, Wise, Myers, & Fillingim, 1998). Likewise, Mogil (2012) points out that even though the size of this sex difference could be debated, the evidence is still overwhelmingly in support of sex differences in pain.

Mechanisms driving differences. Because of chronic pain's complex and multicausal nature (Hoffmann & Tarzian, 2001), the mechanisms underlying sex/gender differences in pain are not well understood and still under investigation (Bailey, 2013; Greenspan et al., 2007; Lee et al., 2015). The differences between genders could be due to multiple biopsychosocial factors, including sex hormones, endogenous pain control mechanisms, opioid function, anxiety and responses to stress, gender role expectations, and pain reporting (Fillingim et al., 2009; Musey et al., 2014). Indeed, neither sex nor gender alone can account for the observed sex pain differences. Although the distinction between these two concepts is important, it is not always easy to attribute differences in chronic pain uniquely to either sex or gender since they are not independent of one another.

From the biological point of view, research on hormones' effects on pain has received the most attention, but it is still constrained and suffers from methodological inconsistencies (Bartley & Fillingim, 2013; Mogil, 2012). It has been documented that sex hormones influence the neurotransmitters involved in pain perception (Bartley & Fillingim, 2013). It appears that testosterone, which is mainly produced in men, plays a protective role. Compared to males, sex hormones in females vary during the different phases of the menstrual cycle; an increase in estrogen would promote an analgesic effect. In contrast, a decrease in estrogen would increase pain sensitivity to most pain modalities (Bartley & Fillingim, 2013).

Additional support for hormonal modulation of pain comes from cross-sex hormone treatment as part of the gender reassignment experience in people who identify as transgender. A study demonstrated that more than half of those treated with testosterone experienced improvements in chronic pain had already presented before the start of treatment (Aloisi et al., 2007). The researchers, however, pointed out that pain changes reported might also be related to psychosociocultural factors (Aloisi et al., 2007).

In contrast, the findings of a recent systematic review summarizing the results of 10 years of the experimental evidence on pain and sex/gender revealed that the involvement of gonadal hormones in sex differences in pain sensitivity in healthy humans is either inconsistent or absent (Racine et al., 2012b). Even when the effects of estrogens in sex-related differences in pain sensitivity were observed, the findings were minimal (i.e., relatively small magnitude). Therefore, it was argued that the results should not be translated into significant sex differences (Racine et al., 2012b). Based on the findings, the authors have proposed that various psychosocial mechanisms, such as different coping styles, may play an essential role in sex-related differences in pain (Racine et al., 2012b).

For example, a systematic review (El-Shormilisy, Strong, & Meredith, 2015) concluded that there are associations between gender, coping patterns, and functioning, with women in pain tend to use coping strategies that predispose them to poorer functioning. Other researchers argue that women employ more active coping strategies because of the greater role women have in taking care of the family, which is an effort to maintain themselves or their families in good health (Mailis-Gagnon, 2010; Mailis-Gagnon et al., 2007). Nonetheless, coping styles could themselves be affected by other psychosocial factors (Racine et al. 2012a).

The evidence also failed to support that depression could mediate sex differences in pain. The findings were also inconsistent or contradictory concerning the role of anxiety (Racine et al. 2012a). Additionally, literature has demonstrated that responses to pharmacological and non-pharmacologic pain treatments vary between sexes, yet the results’ pattern is not uniform across studies. For example, a meta-analysis reported a significant sex effect in morphine-induced analgesia with greater morphine analgesic effects in women (Niesters et al., 2010). However, no sex differences in analgesic responses to ibuprofen after dental surgery or greater cutaneous anesthesia were produced in men than women using lidocaine, examining pain pressure (Fillingim et al., 2009). The discrepancies in response to pharmacological pain treatments can be mediated by differences in pharmacodynamics, drug pharmacokinetics, or starting pain levels (Mogil, 2012). Regarding non-pharmacologic interventions, for example, intensive dynamic back exercises were more effective for women, while conventional physical therapy showed better results in men (Fillingim et al., 2009).

From the gender perspective, gender-specific beliefs/expectations have been posited to explain variability in pain. Of note, social learning and gender-role stereotypes are suggested to be more likely to contribute to these discrepancies than biological differences (Robinson et al., 2001). For instance, the masculine role is stereotypically associated with stoicism, whereas the feminine role is more associated with greater willingness to report pain (Bailey & Bernstein, 2013; Bartley, 2013; Mogil, 2012; Racine et al., 2012b; Samulowitz, Gremyr, Eriksson, & Hensing, 2018). The observed differences were not unique to Western studies. For example, a study examining the social acceptability of pain demonstrated that for both Japanese men and women, pain behaviours in women were more acceptable than in men (Hobara, 2005). A meta-analysis evaluating the relationship between gender roles and experimental pain responses in healthy human participants also supports claims that learned masculinity encourages stoicism (Alabas, Tashani, Tabasam, & Johnson, 2012).

Gender differences in power, which are associated with differences in access to moderating resources, and higher levels of stress resulting from the multiple roles—parenting, working outside the home, and housekeeping—that women carry, can also contribute to increased pain conditions among women (Gilbar, Bazak, & Harel,1998; Mailis-Gagnon & Israelson, 2005). Prolonged activation of the stress system is becoming increasingly recognized as an important component of chronic pain (Gatchel et al., 2007). It has also been discussed that early exposure to environmental stress or a history of childhood sexual abuse may potentially explain pain sensitivity differences, yet the findings are, again, not consistent on all outcome measures (Bartley, 2013; Racine et al., 2012b). Moreover, gender differences in power determine access to the other SDoH. For instance, a Canadian study (Meana et al., 2004) found that women had higher chronic pain rates and higher rates of depression, lower incomes, and less formal education. Thus, the authors conclude that it is reasonable to link the differences in chronic pain to a combination of biological and psychosocial conditions (Meana et al., 2004).

The mechanisms underlying the association between pain and disability are also not well understood. A systematic review and meta-analysis (Lee et al., 2015) aiming to identify putative mediators (i.e., variable), which could explain the effect of pain in people with low back pain or neck pain on disability, showed significant mediating effects of self-efficacy (i.e., the individuals' belief in their ability to perform specific tasks (Vearrier, 2015)), psychological distress–including depression, stress, and anxiety—and fear. Yet, because of the low quality and the limited number of these studies, definitive conclusions about the causal mechanisms cannot be made (Lee et al., 2015).

There are two other points worth mentioning. First, experimental studies examining pain differences are confounded by the sex/gender of participant-investigator interactions (Greenspan et al., 2007; Mogil, 2012). Second, a growing body of literature suggests that provider and patient characteristics, such as gender, can influence patient-provider encounters and hence pain management and patient outcome (Fillingim et al., 2009; Hampton, Cavalier, & Langford, 2015; Samulowitz et al., 2018). For example, evidence asserts gender bias in the provision of pain treatment. Compared to men, women receive fewer pain medications and effective pain relief (Fillingim et al., 2009; Samulowitz et al., 2018), and their pains were psychologized by health care professionals (HCPs), and consequently, they received more mental health referrals (Samulowitz et al., 2018).

Taken together, the evidence confirmed a paradox. Women have a higher prevalence of chronic pain, they more frequently report pain, but their pain reports are more likely to be discounted as emotional or psychogenic. Therefore, women receive less effective pain relief. Differences between men and women arise because of biological differences, gender-based roles/expectations, asymmetry in power, and interactions among these factors. The impact of biological sex accounts for a fraction of these differences, and gender explains the rest.

Socioeconomic status and chronic pain. SES is a composite indicator. Studies used different operationalizations such as education, occupation, job position, income, and wealth or a combination of these variables to define SES (Fliesser, Huberts, & Wippert, 2017; Henschke et al., 2015). Regardless of the definition used, the studies repeatedly demonstrated that individuals with socioeconomic disadvantage are more likely to have chronic pain (McBeth & Jones, 2007; Poleshuck & Green, 2008; Riskowski, 2014) and its severe forms (Blyth, 2010; Poleshuck & Green, 2008). For example, a U.S. study (Grol-Prokopczyk, 2017) using 12-year longitudinal national data found enormous socioeconomic disparities in chronic pain, with clear socioeconomic gradients, among American adults aged 51 and over. The study revealed that people with lower levels of education and household wealth were more likely to have chronic pain than those with more education and greater wealth. Less educated and less wealthy people also had more severe pain and pain-related disability (Grol-Prokopczyk, 2017).

Similarly, another study showed that both chronic pain and high-impact chronic pain—“chronic pain that limited life or work activities on most days or every day during the past 6 months” (Dahlhamer et al., 2018, p. 1002)—were more common among the U.S. adults living in or near poverty and adults with less than a high school education compared with who had at least a bachelor’s degree (Dahlhamer et al., 2018). Likewise, a nationwide Austrian study demonstrated that even at the same level of pain, people with the lowest SES— based on education, income, and professions—were two to three times more likely to report an experience of pain-related disability compared to people with the highest SES (Dorner et al., 2011).

A trend of higher rates of chronic pain with a lower SES was also observed in European studies. Research in Wales (Jonsdottir, Ahmed, Tómasson, & Carter, 2019), Sweden (Jöud et al., 2014), Finland (Saastamoinen, Leino-Arjas, Laaksonen, & Lahelma, 2005), Austria (Dorner et al., 2011), Great Britain (Macfarlane, Norrie, Atherton, Power, & Jones, 2009), France (Leclerc et al., 2009), Denmark (Kurita et al., 2012) and England (Davies et al., 2009) have also confirmed that lower educational attainment (Dorner et al., 2011; Jonsdottir et al., 2019; Jöud et al., 2014; Kurita et al., 2012; Leclerc et al., 2009; Saastamoinen et al., 2005), lower income (Dorner et al., 2011; Jöud et al., 2014), lower occupational class/profession (Dorner et al., 2011; Macfarlane et al., 2009; Saastamoinen et al., 2005), lower neighbourhood SES (Davies et al., 2009), and increased deprivation (Jonsdottir et al., 2019) were associated with chronic pain. Moreover, economic hardship and daily financial worry also have significant detrimental effects on chronic pain; greater pain is observed among people with higher financial stress levels than individuals with little or no financial pressure (Rios & Zautra, 2011).

Canadian studies also confirm an association between occupation (Meana et al., 2004), household income (Meana et al., 2004; Rashiq & Dick, 2009), and chronic pain. Yet, it is impossible to determine the direction of an association—whether low income is a result or consequence of chronic pain (Rashiq & Dick, 2009). Regarding the education component of SES, Canadian findings are inconsistent. While one research found no association between education and chronic pain (Meana et al., 2004), a study of chronic pain in Canadian seniors living in long-term health care institutions (Ramage-Morin, 2008) supported the relationship between education and chronic pain. The author argued that education might reflect the past lifestyle and environmental factors influencing health. Therefore, they concluded that education is a more sensitive measure than current income in this specific population (Ramage-Morin, 2008). Similar results were also observed by others (Rashiq & Dick, 2009) using the Canadian National Population Health Survey data; the low educational level was an independent factor in increasing chronic pain risk.

Mechanisms Driving Differences. Poleshuck and Green (2008) summarized some of the possible explanatory mechanisms underlying SES differences in pain. First, higher education is associated with better navigating health care systems and more effective coping strategies. Second, people with lower SES generally have demanding jobs with low job satisfaction and limited autonomy. Third, childhood abuse is more common among socioeconomically disadvantaged people. In light of the above studies, it is reasonable to conclude that chronic pain prevalence generally follows the social gradient—the higher SES, the lower prevalence.

Race, ethnicity, culture, migration, and chronic pain. As mentioned earlier, ethnocultural research is not without problems because it fails to appreciate the various social, cultural, and economic differences within the groups (Mailis-Gagnon, 2010). Beyond overgeneralization, another risk associated with ethnocultural pain studies is reinforcing stereotypes and misconceptions (Roy, 2006). On the other hand, data on race can indicate the impact of racialized status on outcomes. It is neither a reflection of personal identity but can serve as an indicator for identifying systemic racism (Government of Ontario, 2018).

Examining ethnic differences in experimental pain stimuli revealed that African Americans demonstrated lower pain tolerance and, to a lesser degree, lower pain threshold (Rahim-Williams et al., 2012). Similarly, a review of studies found a greater sensitivity to experimental pain stimuli, higher levels of pain, and disability among African Americans than non-African Americans (Edward et al., 2001). Moreover, the literature generally documented racial and ethnic differences in experience, perception, reporting (Krupić et al., 2019), prevalence, progression, and outcomes of chronic pain (Campbell & Edwards, 2012), as well as racial and ethnic inequities in pain assessment and treatment (Green et al., 2003; Meesy, 2011), across all types of pain and in all settings (i.e., emergency room, postoperative) (Green et al., 2003).

For instance, a systematic review (Orhan et al., 2018) examining the racial, ethnic, and cultural differences in pain beliefs found preliminary to moderate evidence regarding the differences in illness perceptions, self-efficacy, pain attitudes, and coping strategies in different ethnic/racial populations. To elaborate, the results showed that African Americans used more praying and hoping coping strategies than non-African Americans (Orhan et al., 2018). Similarly, results of a meta-analytic review examining differences in pain coping between White and Black Americans indicated that Black individuals endorsed more frequent engagement in passive pain coping strategies, such as praying and hoping, which are associated with poorer pain outcomes (Meints, Miller, & Hirsh, 2016).

Regarding differences in pain treatment, results of a systematic review showed that minority patients, African Americans, and Hispanics are more likely to have their pain untreated than White patients (Cintron & Morrison, 2006). Likewise, a review of studies found that African Americans are less likely to receive opioid analgesics for chronic pain (Mossey, 2011). These results were confirmed by Meghani et al. (2012), who conducted a meta-analysis and systematic review to examine the magnitude of the association between race/ethnicity and analgesic treatment in the United States. They found a systematic bias in chronic pain treatment, which was most substantial for Blacks/African Americans. The undertreatment/treatment gap remained consistent across pain types, type of analgesia (opioids or non-opioid), and settings; the most pronounced inequity was in opioid analgesics' prescription. The authors concluded that the size of difference was sufficiently large to impact clinical outcomes, and race/ethnicity "are important determinants of how pain is assessed, treated, and managed" (Meghani et al., 2012, p. 158). A Canadian study (Kaseweter, Drwecki, & Prkachin, 2012) exploring racial differences in pain treatment recommendations of 50 undergraduate students replicated racial biases in pain treatment. The students exhibited a prowhite treatment bias, prescribing more pain treatment for White patients than Black patients (Kaseweter et al., 2012).

Regarding the prevalence of pain, a recent U.S. population-based research reported that chronic pain was more common among non-Hispanic white adults than in all other racial and ethnic subgroups (Dahlhamer et al., 2018). European studies have also shown ethnic differences in chronic pain. A U.K. study demonstrated that age and gender-adjusted widespread pain were more common among South Asians (i.e., Indian, Pakistani, and Bangladeshi) than Europeans, with a pronounced inter-group difference (Palmer et al., 2007).

A Danish study found a higher prevalence of chronic pain (1.68 times higher odds) and substantially higher pain intensities among individuals with a non-Western background than their Danish peers (Kurita et al., 2012). Likewise, studies from Sweden (Hjörleifsdottir Steiner, Johansson, Sundquist, & Wändell, 2007) and Norway (Kumar, Grøtvedt, Meyer, Søgaard, Strand, 2008) showed that the prevalence of self-reported pain was higher in immigrant women with backgrounds from certain non-Western countries than native-born women.

In contrast, Shipton et al. (2013) found no difference in the reported prevalence of pain between different ethnicities in New Zealand. In a similar vein, Stanaway et al. (2011), investigating the difference in back pain characteristics in Italian-born men and Australian-born men aged 70 years and over, found no difference in the prevalence of back pain between the two groups. Yet Italian-born men with back pain reported greater frequency and severity of pain compared to Australian-born men. Further analyses showed that differences were explained by socioeconomic factors, particularly the level of education and occupation (Stanaway et al., 2011). This finding is in line with another study showing that globally, more than a third of low back pain has been attributed to sufferers' occupations (Jackson et al., 2016). Among immigrant populations, systematic reviews, meta-analyses, and clinical reviews confirm that refugees, who have had severe exposure to violence, are at substantially higher risk than the general population for trauma-related disorders, including chronic pain (Kirmayer et al., 2011; Crosby, 2013).

In Canada, one study (Meana et al., 2014) found no significant ethnic differences in chronic pain prevalence with one exception—higher rates of chronic pain among South Asians aged 65 and older. In another study, Rahman conducted a secondary data analysis study using the CCHS survey (years 2007-2013) to examine the differences in chronic pain between Euro-Canadians and Canadians who self-reported as South Asian, Middle Eastern, East Asian, or

Black Canadians (2015). The results demonstrated that Euro-Canadians reported chronic pain (19.3%, 95%CI: 16.9%-21.6%) and severe pain intensity (17.3%, 95%CI: 16.3%-18.1%) significantly more often than the combined four groups (13.1%, 95%CI: 10.8%-15.4% and 13.0%, 95%CI: 10.6%-15.3%, respectively). No significant difference in chronic pain expression among the four groups was found. However, inter-group differences in pain intensity were observed; East Asian groups had statistically significant lower pain intensity than Black Canadians. The author explained the difference might stem from social learning and cultural factors, as stoicism is highly valued in East Asian cultures. More importantly, this study shows the heterogeneity in pain intensity reporting (Rahman, 2015).

Another research (Rashiq & Dick, 2009) found that the non-racialized status is associated with a decreased risk of chronic pain. Additionally, a study by Mailis-Gagnon et al., 2007 revealed European groups' over-representation at a pain clinic in downtown Toronto. Several factors, such as the preference for a referral to traditional medicine, referral bias, and potential differences in chronic pain prevalence, might explain the underrepresentation of visible minorities (Mailis-Gagnon et al., 2007).

Culture also plays an essential role in perceiving ourselves and how we respond to health messages. An individual's cultural background affects attitudes, expectations, and the development of meanings, behaviours, and emotions associated with pain (Bates, 1996). The meaning we assign to pain or how pain is appraised is strongly influenced by the culture, and pain is inextricably engaged in the deepest levels of the complex socio-cultural systems of explanation (Bates, 1996; Edwards et al., 2001; Kjellströ, 2010; Mailis-Gagnon & Israelson, 2005; Morris 1991).

Mechanisms driving differences. The mechanisms underpinning the differences mentioned above are complex and multifactorial. A biopsychosocial pain model best explains the differences (Edwards et al., 2001; Green et al., 2003). The relationship between pain and ethnicity is influenced by culture, learning, and experience rather than biological differences (Peacock & Patel, 2008). In other words, while one all-inclusive general explanation for these differences is not possible, psychosocial factors, such as beliefs and attitudes, language, social expectations, SES, perceived discrimination, and environmental factors, can contribute to these differences (Rahim-Williams et al., 2012).

Some argue that the experimenter's ethnicity may influence chronic pain experimental results (Alabas et al., 2012; Zatzick & Dimsdale, 1990). Others have suggested that ethnic stereotyping, racial discrimination, the assumption about the homogeneity of racialized populations (Ezenwa et al., 2006), a lack of availability of opioids in minority neighbourhoods or access to other medications (Ezenwa et al., 2006; Green et al., 2003), and less involvement in medical decision making (Green et al., 2003) might explain disparities in pain management among racialized communities. Regarding coping strategies, evidence has suggested that exposure to high levels of chronic stress, often associated with racism and discrimination, can produce chronically high levels of sympathetic activation, reducing coping resources and abilities (Edwards et al., 2001). Additionally, several studies indicated that perceived discrimination is associated with multiple physical health outcomes and indicators, including pain (Bowen-Reid & Harrell, 2002; Gee, Spencer, Chen, & Takeuchi, 2007; Pascoe & Richman, 2009).

Others point out that acculturation strongly influences reporting pain among ethnic minorities (Palmer et al., 2007; Rahman, 2015), yet it cannot explain all the differences (Palmer et al., 2007). Results of a qualitative study, examining the everyday lives of immigrant women with chronic pain in Norway, showed that participants believed that stressful life events, both the distressing events in their past lives and worries about the future, and physically weary workdays were the causes of their pain (Nortvedt, Hansen, Kumar, & Lohne, 2015).

Briefly, the findings regarding the association between race/ethnicity and pain have been quite mixed, and general conclusions are difficult to draw. As Ernst (2000) remarked, existing differences between immigrants and non-immigrants "should not be assessed only in one dimension … but in many" and have to be explained by social causes and not ethnic background (p. 122).

Social support networks and chronic pain. Response to chronic pain is a dynamic interactive social process, and the individuals' social network influences the meaning given to pain as well as perceived care needs and expectations (Sturkenboom, Dekker, Scheppers, Van Dongen, & Dekker, 2007). Chronic pain may lead to physical and emotional dependency and have far-reaching social, physical, and psychological consequences on the functioning of the family and the lives of significant others, such as emotional turmoil, financial losses, and role reversal (De Souza & Frank, 2007, 2011; Dueñas et al., 2016; Prefontaine & Rochette, 2013; Roy, 2006; Turk, Wilson, & Cahana, 2011; West, Usher, Foster, & Stewart, 2012). For example, one-fifth of people living with chronic pain participating in an extensive scale survey conducted in 15 European countries and Israel felt incapable as a partner/spouse (Breivik et al., 2006). Emotions such as anger associated with chronic pain also hurt the interpersonal relationship (Dueñas et al., 2016).

Studies also showed that being single—divorced, separated, widowed—and experiencing lower social support are associated with chronic pain conditions and increased medication needs (Bergman, 2005; Kurita et al., 2012). In contrast, relatives' emotional support, either by providing a buffer against hopeless feelings or offering financial support—by reducing the need for getting back to work during episodes of pain—is associated with better outcomes for people living with chronic pain (Averill, Novy, Nelson, & Berry, 1996). In a similar vein, a Canadian study (Meana et al., 2004) found a strong association between chronic pain, higher dependence on others, and low perceived social support. The evidence discussed in this section highlights the robust association between social support networks and chronic pain.

Health care and chronic pain. Inadequate treatment of chronic pain in Canada because of not having access to a variety of appropriate or adequate pain management services is well documented (Health Canada, 2019). Lack of public funding and reimbursement, lack of coordination across providers, lack of a clear pathway to care, and lack of specialists, among other barriers, impact availability and access to pain management services. The subjective nature of pain also complicates the process of assessment and diagnosis (Health Canada, 2019). The subjectivity of pain and inadequate training (Rice, Ryu, Whitehead, Katz, & Webster, 2018) led medical educators to describe the management of chronic pain as unrewarding, challenging, and stressful (Rice et al., 2018; Webster et al., 2017). A scoping review of medical education training for chronic pain, although not limited to Canada, found "significant discrepancies between the prevalence of chronic pain in society and the low priority assigned to educating future physicians about the complexities of pain and the social context of those afflicted" (Webster et al., 2017, p. 1467). Moreover, research suggests that medical trainees become less patient-centred (Bombeke et al., 2010) and report reduced empathy (Nunes, Williams, Sa, & Stevenson, 2011) throughout their training. Barriers such as those imposed by time pressures and tiredness (Bombeke et al., 2010) and a change from idealism to realism can contribute to these issues (Nunes et al., 2011), respectively.

Conclusions and knowledge gaps. Reviewing the current state of chronic pain epidemiology and its SDoH confirms that chronic pain is a subjective, multidimensional, complex, and a distinct global health condition associated with disability. Chronic pain affects all aspects of individuals' lives. It has high costs to families, communities, and society. There are substantial inequities in the magnitude, severity, and treatment of chronic pain among populations, including women, those with lower SES, and specific ethnic/cultural communities. The literature reveals intersections between immigration status, gender, sex, racialized status, culture, and SES over the life course.

Table 1: Summary of the Available Evidence and Knowledge Gaps

What we know	What we don't know yet
Chronic pain is a by-product of bio-psychosocial factors.	What are the perceptions of Canadian immigrant women about the causes of their pain? What is the meaning of pain at the intersections of being a racialized disabled woman?
Women have a higher prevalence of chronic pain and pain-related disability.	Why? How do negotiations of new gender and familial roles impact women's conditions?
Some ethnic groups/immigrants have a higher prevalence of chronic pain and pain-related disability.	Why and how? What is the role of racism? What is the impact of immigration?
Low-income households are more likely to report chronic pain.	To what extent is low-income related to chronic pain in the context of immigrant women?

What we know	**What we don’t know yet**
Social support networks have a bidirectional relation with disabling pain.	What are the intersections of gender, immigration, disability, and social support networks? How do they impact immigrant families?
There is a relationship between chronic pain and working conditions.	How do working conditions interact with other factors?

Chapter Four: Research Activities and Methods

This chapter describes the study's methodological undertaking and research activities.

Methodology

Harding (1987) defines methodology as "a theory and analysis of how research should proceed" (p. 2). Similarly, Patel and Patel (2019) described methodology as "the systematic, theoretical analysis of the methods applied to a field of study" (p. 48). The aim of the methodology is then, as Kaplan (1964) noted, "to describe and analyze these methods, throwing light on their limitations and resources, clarifying their presuppositions and consequences, relating their potentialities to the twilight zone at the frontiers of knowledge" (p. 23). Here, I follow Fonow and Cook's (2005) formulation of feminist methodology, which, "involves the description, explanation, and justification of techniques used in feminist research and is an abstract classification that refers to a variety of methodological stances, conceptual approaches, and research strategies" (p. 2213).

There are well-established key features of feminist research, which are why I chose this methodology for undertaking this dissertation. First, it gives voice to people whose voices are ignored or silenced to uncover hidden knowledge (Brooks, 2007; Hesse-Biber, 2012); feminist research should be not just for those populations, but where possible, with them (Doucet & Mauthner, 2007). Second, feminist research, methodologically, challenges "conventional or mainstream ways of collecting, analyzing, and presenting data" (Doucet & Mauthner, 2007, p. 40). Third, this type of research is concerned explicitly with social justice (Doucet & Mauthner, 2007). Fourth, feminist methodology tries to understand the power structures and "*how* power influences knowledge production and construction processes (Doucet & Mauthner, 2007, p. 40).

Finally, feminist research has paid attention to reflexivity—acknowledging how the researchers' social location and their underlying scholarly or analytic assumptions have a role in constructing knowledge (Doucet & Mauthner, 2007).

Study Design

Research design is a "blueprint" for data collection to answer research questions (Bhattacherjee, 2012, p. 35). The choice of research design depends on the nature of the research phenomenon being studied (Bhattacherjee, 2012). To achieve the research's aim and gain insight into the viewpoints of immigrant women living with chronic pain, their caregivers, and physicians, I chose a qualitative research design. A qualitative approach examines why and how specific experiences occur (Korstjens & Moser, 2017). It is therefore suitable for exploring life experiences, eliciting perceptions, feelings, and thoughts, gaining in-depth information about people's opinions, and providing the rich, detailed accounts of social life (Astalin, 2013; Creswell, 2007; Denzin & Lincoln; 2003; Hesse-Biber, 2010; Mayoh, Bond, & Todres, 2012; Moser & Korstjens, 2017, 2018; Polkinghorne, 2005). Qualitative research is indeed explanatory and focuses on the meaning and the nature of social phenomena (Mykhalovskiy et al., 2018; Noble & Smith, 2014; Tong, Sainsbury, & Craig, 2007).

Within the qualitative paradigm, I chose face-to-face, semi-structured, in-depth interviews, which is the most frequently used data collection method in qualitative research (Kelly, 2010; Tong et al., 2007; Noble & Smith, 2014). A semi-structured interview is an excellent tool for participants' active involvement in constructing data about their lives (Reinharz, 1992). In particular, this method is a valuable tool in gathering data from people who feel disempowered by their illnesses and who, due to disability, may be unable to participate in other types of research (Low, 2013).

There were 24 participants in the study, 13 immigrant women living with chronic pain, six physicians, and five care providers. Their demographic information was summarized in Appendix E. The participants received no remuneration for their participation. All of them were interviewed face to face except one who was interviewed by email at their request. Data collection took place from March 2017 to May 2018. Most participants were interviewed on one occasion. Three participants were interviewed in two sessions due to their circumstances. All face-to-face interviews were audio-recorded and ranged from 35 to 130 minutes in length, an average of 56 minutes.

Setting

I undertook this study in Ottawa, a mid-sized Canadian city, for several reasons (for the definition of a mid-sized city, see Appendix A). First, Ottawa’s immigrant population has been growing twice as fast as the city’s general population (City of Ottawa, 2010a), where migrant women have been predominant in this populace (City of Ottawa, 2010b). Second, while there have been some signs that recent immigrants prefer settling in smaller urban centres (Chui, Tran, & Maheux, 2007), the need for understanding the experiences of smaller metropolitan areas has remained (Edge & Newbold, 2013). Third, to the best of my knowledge, no study has explored this topic in Ottawa. Before moving to the interview inquiry, it is crucial to have a sense of the city’s population characteristics, as these shape the social and economic context in which participants lived.

Ottawa demographics. The city of Ottawa is the second most populated city in Ontario and the fourth largest in Canada (Statistics Canada, 2017d). In 2016, Ottawa’s population was 934,243 and grew by 5.8% between 2011 and 2016, faster than the national average of 5% (Statistics Canada, 2017g). The city's population recently reached the one million mark in 2019 (CBC News, 2019; Statistics Canada, 2022a).

With an average age of 40.1, nearly 70% of Ottawa's population is in the working-age bracket of 15-64. The distribution of Ottawa's population by age group shows the same aging trend present at the national level (Statistics Canada, 2017g). Ottawa is a very diverse city, and ethnic diversity continues to grow. According to the Census 2016 (Statistics Canada, 2017g), almost one in five residents were born outside of Canada, and 26% of residents self-identified as a visible minority (i.e., racialized group). More than 50% of immigrants came from Asia, followed by Africa (21%), the Americas (14%), and Europe (9%)—reflecting similar trends at the national level. About 50% of Ottawa's immigrants are economic immigrants, 29% are sponsored by the family, and 24% are refugees (Statistics Canada. 2017g).

Three-quarters of Ottawa's population, aged 25 to 64, have post-secondary education (Statistics Canada, 2017c), making Ottawa the most educated city in the country (Statistics Canada, 2017c). With Ottawa's economy dominated by employment in the public sector and high technology (Statistics Canada, 2017c), the city also has one of the country's highest median household incomes. In 2015, it reached $86,451, an increase of 4.4% since 2005 (Statistics Canada, 2017f).

While Ottawa is considered a prosperous city, this is not the case for all Ottawa residents. Unaffordable housing, food insecurity, and poverty disproportionately affect new immigrants and racialized populations. For example, according to the last Census, about a third of households spent almost 30% or more of their household income on housing—an accepted threshold for affordable housing—which compromised their ability to pay for food and other basic needs (Statistics Canada. 2017g). In 2017, seven percent of households experienced moderate to severe food insecurity (Social Planning Council of Ottawa, 2018). The rate among recent immigrant households (i.e., those who landed between 2011 and 2016) was about two and a half times (18.8%) that of non-immigrant households (Social Planning Council of Ottawa, 2018).

Moreover, nearly 13% of Ottawa residents lived below the low-income threshold based on low-income measure after-tax in 2015 (Statistics Canada. 2017g). The rates were worse for recent immigrants and racialized people; the differences were more pronounced among women, putting them at higher risk of living in poverty than men (Social Planning Council of Ottawa, 2018). Higher rates of unemployment could partially explain this difference. At the time of the 2016 census, Ottawa's unemployment rate was 7.2% (Statistics Canada. 2017g).; the unemployment rate among new immigrants was more than twice as high at 15.1%, with the highest percentage among immigrant women than immigrant men (Social Planning Council of Ottawa, 2018). In sum, Ottawa's population is characterized by ethnic diversity and higher than average income and education, albeit not for all.

Interview Inquiry

In this section, I describe the seven interdependent stages of the interview inquiry outlined by Kvale (2007): thematizing, designing, interviewing, transcribing, analyzing, verifying, and reporting, which I went through. To produce high-quality interviews and ultimately significant new knowledge, I paid equal attention to all stages.

Thematizing. This stage refers to clarifying the study's purpose, exploring the current state of knowledge, and developing a conceptual understanding of the phenomena investigated and theories that may help answer the research questions (Kvale, 2007). As mentioned in Chapter Three, before embarking on my interview journey, I had reviewed the literature, which continued during my thesis writing.

Designing. This phase involves planning the research techniques (Kvale, 2007). I provided three interview guides (see Appendices F1, F2, & F3) containing a series of simple, brief, and open-ended questions about the list of topics to be covered, with accompanying queries to probe more detailed and contextual data (Kelly, 2010; Kvale, 2007; Moser & Korstjens, 2018). I arranged the interview guides logically, which means topics moved and narrowed from the general and central questions to the specific sub-questions (Creswell, 2007; Kelly, 2010). To generate information about the complexity of experiences and mutuality of identities, I have followed Bowleg's (2008) suggestions for women living with chronic pain. As such, the questions focused on meaningful constructs and tapped the mutuality of identities rather than relying on demographic questions alone.

The interview guide for women living with chronic pain consisted of the five major content areas: 1) the experience of pain (participants' beliefs and their perspectives as well as pain history—how their pain started and its journey until the time of interviewing); 2) origin and determinants of their pain (such as immigration, gender, racialized status, SES, working conditions); 3) effects of pain on everyday life (such as relationships, physical activities, quality of life, social activities); 4) daily management of chronic pain and help-seeking patterns (such as self-treatment, professional help, informal help). The interview guide for caregivers covered the three major content areas: a general description, consequences/effects of pain on everyday life, and pain management. The interview guide for physicians focused on three core questions: general description, describing good care for chronic pain, and factors influencing access to care.

Sociodemographic data for all three groups were also obtained at the end of the interviews through a brief questionnaire to construct the profile of the participants (see Appendices G1, G2, G3).

Ethical considerations. As this study involves human beings, the research needed to consider three complementary and interdependent core principles of respect for persons, concern for welfare, and justice at the forefront (Tri-Council Policy Statement, 2018). I paid close attention to ethical issues throughout the interview inquiry (Kvale, 2007). Ethical guidelines emphasize the need to obtain the participants' informed consent voluntarily, to secure the confidentiality, security, and privacy of the informants, to consider the possible consequences of participation, and to be attentive to the role of the researcher in the study (Kvale, 2007; Tri-Council Policy Statement, 2018). I, therefore, prepared consent forms (see Appendices H1, H2, & H3, H4) and applied for the ethics approval.

Sampling. I followed the general principles that govern all forms of sampling: the sampling plan should be ethical, feasible, efficient, practical, and stem logically from the conceptual framework as well as the research questions, among others (Kemper et al., as cited in Palinkas et al., 2015, p. 542). There is no consensus as to how many qualitative interviews are enough. The number of participants, as suggested by Kvale (2007), should neither be too small to find differences among groups rarely, nor too large to analyze the results hardly. Determining the number of participants is subject to peer review and judgment (Hesse-Biber, 2007), which tends to be around 20-30 (Low, 2013) or 15 ±10 participants (Kvale, 2007).

The most often cited guiding principle for assessing a sample size's adequacy, an essential component of rigour, is saturation (Guest, Bunce, & Johnson, 2006; Hennink, Kaiser, &

Marconi, 2017; Morse, 2000, 2015). Saturation, as Morse points out, “is the building of rich data within the process of inquiry, by attending to scope and replication” (2015, p. 587)—whereby no new themes emerge from the data or what Sandelowski names “informational redundancy” (2008, p. 875). Again, there is no generic sample size for obtaining data saturation, as saturation is about the in-depth and highly contextualized understanding of specific phenomena rather than the number per se (Fusch & Ness, 2015). Scholars argued that the study purpose and design, the nature of the topic, characteristics of the study population, analytic approach, quality of data, the underlying theoretical framework, and available resources are factors influencing the sample size to reach saturation (Hennink et al., 2017; Kelly, 2010; Kvale, 2007; Morse, 2000, 2015). Hennink et al. (2017) discussed that in order to develop a richly textured understanding of the meaning or reach meaning saturation, 16 to 24 interviews are needed.

On the other hand, Braun and Clark 2021 disagreed with “attempts to ‘capture’ data saturation” (p. 201). They argued that the concept of saturation is inconsistent with the assumptions of reflexive thematic analysis and noted, “judgements about ‘how many’ data items, and when to stop data collection, are inescapably situated and subjective, and cannot be determined (wholly) in advance of analysis” (p. 201). From their standpoint, “theoretical saturation is as much, or even more, about the *quality* of data collected – their richness, depth, diversity and complexity” and not about the “*quantity”* of data gathered (p. 202). In addition, researcher subjectivity has been recognized as “a resource, rather than a potential threat to knowledge production” (Braun & Clarke, 2019, p. 591).

Recruitment strategies. Upon approval from the Research Ethics Board at the University of Ottawa and the Ottawa Health Science Network Research Ethics Board (OHSN-REB) (see Appendices I1 & I2), I made strenuous attempts to maximize participation and employed diverse strategies to recruit immigrant women. Flyers (see Appendix J) were placed in community health centres, community associations, cultural centres, churches, mosques, grocery stores, medical offices, and the Ottawa Hospital Pain Clinic. Flyers were also circulated among the local immigrant communities, social service agencies, and my networks. In addition, notices were placed on the webpage of the Arthritis Society. Finally, advertisements were published in free local newspapers and shared via social media (e.g., Facebook).

I adopted mixed sampling strategies for the recruitment of the participants. The first approach was the purposive sampling of a variety of information-rich participants who were knowledgeable about the phenomenon of interest and willing to communicate at length and in-depth (Creswell, 2007; Hesse-Biber, 2007; Low, 2013; Moser & Korstjens, 2018; Palinkas et al., 2015; Patton, 2002; Polkinghorne, 2005; Teddlie & Yu, 2007). Purposive sampling is a widely used technique, leading to a greater depth of information and increasing the transferability, if participants carefully were selected (Teddlie & Yu, 2007).

Among several types of purposeful sampling designs, I utilized maximum variation samples. Maximum variation sampling means selecting informants based on a wide range of differences and backgrounds including diversity in demographic characteristics (e.g., age, the country of origin, immigration category) to make the most of the diversity and representativeness relevant to the research question (Moser & Korstjens, 2018; Polkinghorne, 2005), while finding important common patterns (Creswell, 2007). Using this strategy has also been in line with the tenets of intersectionality, aiming at deconstructing the essentializing conception of immigrants (Hankivsky et al., 2010). The second strategy was the snowball sampling technique, through referrals that were provided by other participants (Low, 2013; Moser & Korstjens, 2018; Noy, 2008; Polkinghorne, 2005), which is an effective way of reaching hard-to-reach groups (Sadler, Lee, Lim, & Fullerton, 2010).

The inclusion criteria for participation in the study were quite broad, as I sought to learn from diverse women’s lived experiences and perspectives, which has been reflected in the demographic findings. The inclusion criteria for immigrant women were as follows: being a first-generation immigrant woman; aged 18 or older; residing in Ottawa; able to communicate and to provide informed consent in English; and living with chronic pain for at least six months, whether recurrent or continuous, and having anxiety and/or depression and/or some activity limitations as a result of pain (such as walking, lifting, exercising, doing household chores, attending social activities, working outside the home, sleeping, maintaining relationships with friends/family, maintaining an independent life, having sexual relations, or driving). Notably, to avoid excluding women who do not read but speak in English, as a possibility of showing through snowball sampling, verbal consent was also provided (see Appendix H4).

Exclusion criteria for women were as follows: Individuals whose pain did not interfere with their lives—as mentioned above—or whose pain started less than six months at the interview time. The IASP indicates the most convenient point of division between acute and chronic pain is three months. Still, for research purposes, six months is often suggested (Merskey & Bogduk, 1994/2012).

To recruit caregivers, at the end of the interview with immigrant women, I asked the interviewees to give a recruitment flyer (see Appendix K), prepared for caregivers, to their formal/informal caregivers, if they wished, so their caregivers could contact me directly. To be eligible to participate in the study, inclusion criteria were as follows: any person involved in providing emotional and/or support of daily living—activities of daily living (ADL) or instrumental ADL, such as bathing or housework, respectively (Ramage-Morin & Gilmour, 2010)—to immigrant women with chronic pain; 18 years of age or older; and ability to communicate in English. Finally, physicians working on chronic pain were identified through the list of MPTFs the Ottawa Hospital and the Canadian Pain Coalition provided. They were recruited via email (see Appendix L). The inclusion criteria for physicians were practicing in Ottawa and providing care for chronic pain.

Interviewing. The interviews were conducted at a time and place convenient for the interviewees in a "natural setting" (Creswell, 2007, p. 37), including participants' homes, coffee shops, and workplaces. Locations were carefully selected to ensure limited background noise, safety, and confidentiality of what would be shared. After arriving at the interview site, I gained the interviewee's written informed consent to participate in the study. This process required, given complete and accessible information about the research; the amount of time that would be needed to complete the interview; my commitment to confidentiality, anonymity, and the conservation of data; potential risks or benefits; and having an opportunity to ask questions and to withdraw the research should they wish to do so.

With the interviewee's permission, the interview was audio-recorded to avoid interviewer-recall bias and permit usual conventions of social interaction (Kelly, 2010). I, therefore, was generally taking brief field notes during interviews. The opening question was, "Could you tell me a little about yourself?" to establish rapport and provide space for respondents to talk freely about their experiences (Kelly, 2010), which is essential to the success of an interview (Fontana & Frey, 2003). If necessary, I re-ordered the questions to investigate topics further as the conversation evolved and clarified queries, primarily by repeating the interviewee’s words. These strategies allowed me to avoid the interview inquiry’s potential problems surfacing in the analysis stage (Kvale, 2007). Clarification and interpretation of the meaning of what was said permitted me to have “an ongoing ‘on-the-line interpretation’ with the possibility of an ‘on-the-spot’ confirmation or disconfirmation of the interviewer’s interpretations. The result can then be a ‘self-correcting’ interview” (Kvale, 2007, p. 102).

During the interviews, I observed the visual cues, bodily gestures, and facial expressions, took brief notes to record feelings, and completed notes soon after interviewing. This strategy provided me with more precise access to the meanings of the later analysis of transcripts (Hesse-Biber, 2007; Kvale, 2007). I also paid attention to the silence periods, which sometimes indicated that the informants were in pain or became tired (Low, 2013). Besides, I prepared for “meaning-oriented reply” (Kvale, 2007, p. 11) questions or other “probes” (Hesse-Biber, 2007, p. 126) as part of active listening to encourage the interviewees to elaborate more if the issue was relevant to the research (Hesse-Biber, 2007; Kelly, 2010; Kvale, 2007).

The interviews ended by me saying, “Is there anything else you would like to share with me?” to give the informants an additional opportunity to present their experiences. Then I devoted time to a day-to-day conversation to show my interest in the interviewee as a person, not just as a research participant (Darlington & Scott, 2002). It was a shared experience that the interviewees expressed that they obtained new insights about their life-world, added to what they had said, or considered the research interview as an act of healing (Taylor, 2002) and a space of care (Averett, 2021). For example, one of the participants said:

> I really appreciate what you are doing because people don’t know what the other people are going through … because we are as the women, we’d like to keep things you

> know not to tell outside. But if somebody comes to you, like you, so you'd better take it out from your chest and say. You know, I'm really happy to take out what I have to hold for many years. (P2)

Transcribing and analyzing. I transcribed Interviews verbatim at the earliest possible opportunity, using Trint speech-to-text platform. I meticulously checked the transcripts to ensure accuracy and fill in missing details. Audio-recording was associated with loss of body language, gestures, and postures (Kvale, 2007). Also, transcription involves another abstraction, losing the voice ad intonations (Kvale, 2007). As a result, if relevant, pauses, emotions, repetitions and tone of voice were included in the transcripts. The participants were given the opportunity to see the full transcript. The interviewees were asked to review the transcript and return any comments, corrections, or feedback if necessary or desired. Few interviewees made minor clarifications to the transcripts to clarify or articulate a better point made in the interviews.

I started the analysis after the first interview using a thematic analysis procedure. Thematic analysis is a method for identifying patterns or themes within qualitative data (Braun & Clarke, 2006, 2019; Clarke & Braun, 2013). This method is appropriate for a wide range of theoretical frameworks, not tied to a particular epistemological or theoretical perspective (Clarke & Braun, 2013). Thematic analysis is a practical, flexible, robust, and systematic method that can provide nuanced, rich, complex, and detailed results (Braun & Clarke, 2006, 2014; Clarke & Braun, 2013).

I applied the six-stage non-linear analysis provided by Braun and Clarke (2006) to perform a thematic analysis. First, I familiarized and immersed myself with the data. In other words, I lived the data (Moser & Korstjens, 2018). Transcription was an excellent way to familiarize me with the data. I repeatedly read all transcripts to obtain a sense of the breadth and depth of the data. Then, I took notes, initial ideas were marked, and codes were assigned. In this phase, I coded extracts of data inclusively and coded for as many patterns as possible (Braun & Clarke, 2006). Indeed, I used the "splitting" coding approach as "it generates a more nuanced analysis from the start" (Saldaña, 2013, p. 23). During this stage, I reclassified the coded data, re-coded some of them, and even created new categories.

In the third stage, I organized my data into meaningful groups and gathered all data relevant to each potential theme. I combined different codes to form the overarching themes. At this phase, I also had a set of codes that seemed not to fit anywhere. I, therefore, as advised by Braun & Clarke (2006), created a temporary theme called various and later managed them. Some extracts were included in more than one category. For finding patterns, I followed the characteristics Hatch (2002) offers: similarity, difference, frequency sequence, correspondence, and causation. The themes were not necessarily dependent on quantifiable measures; instead, they captured a critical element of the research questions. The data were also scrutinized for "negative cases" (as cited in Hesse-Biber, 2007, p. 145) or "divergent cases" because they are essential for enhancing the conceptual richness (as cited in Low, 2013, p. 96). Equally important, I observed discordant elements within participants' discourse, as they might give insight into deeper meanings (Low, 2013).

In the subsequent phases, I reviewed, refined, and named the extracted themes (Braun & Clarke, 2006). The last step was the final analysis, including selecting descriptive compelling extract examples to complement the identified findings (Braun & Clarke, 2006). It is important to note that the analysis is an iterative approach whereby I moved back and forth between data collection and themes. To ensure an excellent thematic analysis was generated, I adopted a 15-point checklist of criteria suggested by Braun & Clarke (2006, see Appendix M).

Verifying. In qualitative research, the term trustworthiness or verification refers to an overarching concept utilized to judge the quality, rigour, and credibility of a study (Korstjens & Moser, 2018; Morgan & Ravitch, 2018; Morse, Barrett, Mayan, Olson, & Spiers, 2002). It includes the mechanisms used during the entire research process to ensure reliability and validity (Kvale, 2007; Morse et al., 2002). I employed numerous techniques proposed by Lincoln and Guba (1985) to address trustworthiness's various tenets, including credibility, transferability, dependability, confirmability, and reflexivity.

To ensure credibility, I adopted three procedures. The first one was two different forms of triangulation; data and theoretical triangulation (Creswell, 2007; Korstjens & Moser, 2018). To build more comprehensive interpretations and perspectives, I gathered the data from three diverse sources with different viewpoints, including women living with chronic pain, their caregivers, and physicians. Multiple and varied voices or “multivocality” (Tracy, 2010, p. 844) provided me with a more complex, in-depth understanding of chronic pain. I have also brought two different theoretical perspectives, SDoH and intersectionality, to examine and interpret the data.

The second strategy was the member check (Guba & Lincoln, 1982), member validation (Kvale, 2007), or member reflections (Tracy, 2010), which is the most crucial technique for establishing credibility (Lincoln & Guba, 1985). For this, the interviews' transcripts were sent to the participants for their feedback. A few participants also had the opportunity to reflect on my initial interpretations. A couple of them provided some suggestions that incorporated to the final results. Persistent observation was the third way to establish credibility (Lincoln & Guba, 1985). I constantly read and reread the data, developed the codes and themes, and revised them accordingly.

By providing a rich, thick description (Guba & Lincoln, 1982; Mills, Durepos, & Wiebe, 2010) of the experience of chronic pain in sufficient detail and putting them in context, I aimed to make sure that the findings were transferable. For this purpose, narrative excerpts were used throughout the thesis to enhance transferability (Kelly, 2010; Kvale, 2007). When I provided narrative passages, potential identifying details were changed or omitted. Attribution by country of origin, and age, among other personal characteristics, when combined with the speech pattern or view expressed in the quotation, might identify the speaker to readers even if the quotes were anonymized. To respond to some informants' requests, avoid deductive disclosure, breach respondent confidentially, and retain the data's integrity, I decided not to mention such identifiers.

To ensure dependability and confirmability criteria, I used the audit trail (Guba & Lincoln, 1982), whereby I transparently described the research steps taken throughout the study. Transparency of research activities, including descriptions of sampling strategies, interview procedures, data collection, and analysis, supported the other trustworthiness criteria. I also considered the other recommendations suggested by Morse et al. (2002). These recommendations include methodological coherence (i.e., ensuring congruence between my research question and the method), sampling appropriateness (i.e., recruiting participants who know about the research topic), collecting and analyzing data concurrently, and theoretical thinking.

Finally, being self-critical about biases or reflexivity by continuously exploring my explicit and implicit assumptions and how these shaped my research activities was my last strategy to document the trustworthiness (Creswell & Miller, 2000; Finlay, 2002; Fontana, 2004; Hesse-Biber, 2007). The inclusion of a reflexive account is a valuable means to promote the rigour of the research process (Berger, 2015; Dodgson, 2019; Jootun, McGhee & Marland, 2009). It is considered “a hallmark of high-quality qualitative research” (Barrett, Kajamaa, & Johnston, 2020, p. 9) and “the gold standard of determining trustworthiness” (Dodgson, 2019, p. 220). Retaining reflexivity throughout the different phases of research is also an essential act in preserving ethics (Ackerly & True, 2008; Berger, 2015; Dowling, 2006). Additionally, it is a requirement of the intersectionality approach (Hankivsky, 2014a, 2014b; Hankivsky et al., 2010, 2014, 2017).

Positioning myself. Self-reflexive practice started from the early stages of research design and continued through data collection, analysis, and conclusion (Barrett et al., 2020; Berger, 2015; Dowling, 2006; Jootun et al., 2009; Malterud, 2001; Tracy, 2010). I draw on two types of reflexivity outlined by Dowling (2006). The first one was epistemological reflexivity, where I, the researcher, at a very basic level, as Hertz attested, constantly questioned ‘what I know’ and ‘how I know it’” (as cited in Jootun et al., 2009, p. 42). Through the research process, the SDoH theoretical framework and intersectionality lens, informed by my various educational training in Western biomedicine, population health, and feminist studies, have guided me to formulate the study questions and choose the methods of inquiry and analysis. My theoretical framework and intersectionality lens have also supported me in moving beyond the individual stories to a broader understanding of the experience of chronic pain. Two points bear noting as related to why I chose this topic. First, I have a personal attachment to chronic pain because my mother lived for years with chronic pain. Second, I was inspired by the life of a refugee woman living with chronic pain who shared her story with me while pursuing a MA in Women's Studies.

The research produced is indeed the product of interactions between the participants and me. We were partners in my endeavour; this study is a collaborative knowledge construction. This commitment to the situatedness of knowledge (Davis, 2008) is well aligned with the tenets of intersectionality (Hankivsky et al., 2010; Larson, George, Morgan, & Poteat, 2016), which has been my approach to this research. No doubt that my presence, body language, emotional reactions, and form of involvement might affect the respondents' accounts (Carstensen-Egwuom, 2014; Polkinghorne, 2005). Yet, I tried to ignore any preconceived ideas about the topic and not lead the interviews to allow the interviewees to remain the author of their stories; I just supported them to produce fuller and deeper accounts.

The second type of reflexivity was from a critical feminist standpoint, which is referred to as "positioning" and emphasizes the "politics of location" (Dowling, 2006, p. 13), which again, has been in line with the intersectionality lens. As Davis noted: Intersectionality enhances "the theorist's reflexivity by allowing her to incorporate her own intersectional location in the production of self-critical and accountable feminist theory" (Davis, 2008, p.71). As such, I recognized that I had been part of the social world under study and a product of society's institutions and structures (Hesse-Biber, 2007; Jootun et al., 2009). To underscore the active role I played in interpreting the data, it is worth noting that the themes were analytic outputs "developed," "constructed," and "generated" by myself (Braun & Clarke, 2019, p. 594). I was cognizant that I had been the key instrument of the research process, and my history, context, social background, values, perceptions, and thoughts regarding the research could influence the interpretations I would make (Creswell, 2007). Bringing to consciousness my beliefs and putting aside them allowed me to provide a more accurate account of the informants' experiences (Jootun et al., 2009). In other words, I am "a knowing subject who discovers, but more as a material body through whom a narrative structure unfolds" (Bruner as cited in Finlay, 2002, p. 211). Therefore, I spent substantial time noting my immediate thoughts and interpretations after each interview before starting a structural analysis.

I was also mindful of the privilege and opportunity that I experienced as a well-educated woman in Canada, presenting my ideas from the intersection of being an academic, a physician, and an immigrant woman. My personal and professional identities were closely intersected. To be more transparent, I am an immigrant woman, a wife, a mother, who has survived the war, and a feminist from a middle-class background, with racialized status.

Before entering the field, I thought, "Am I an insider or outsider in this research?" Being an immigrant could position me in the insider's role when I would interview women living with pain, yet did not denote complete sameness within the group, considering the enormous diversity among immigrant women. Besides, my personal experiences as a physician and a caregiver could position me in an insider status when I interview physicians and caregivers, respectively. As a physician who worked for about five years in a multicultural society—not my home country—before moving to Canada, I understand the challenges of physicians in their encounters with patients who have a different language, cultural values, and expectations than me. Yet as a physician not practicing in Canada and without personal experience of chronic pain, I could not claim an insider position. Concerning caregiving experience, there are differences between the caregivers in my study and me; I had an opportunity to benefit from an extensive support network in my home country.

I believe that my insider knowledge and experiences were beneficial in some respects. Informing the participants that I am a physician and immigrant woman might lead to having better access to the field and facilitate recruiting participants. It might also help me in gaining trust and achieving rapport. Some participants told me that "it is great to help another immigrant woman." The other prevailing cultural value that came up was valuing education. A few participants defined themselves as "a well-educated person" or "raised in a well-educated family." As well, my medical training and experience allowed me to set a comfortable environment for participants and ultimately increase their willingness to share their experiences and provide more abundant data.

My insider status, however, was not without drawbacks, as my prior knowledge might have shaped how participants perceived me and what was said. For example, my interviewees warmly greeted me, yet sometimes I felt that few participants were trying to provide "textbook" or "right" answers during the interviews. To avoid social desirability bias—the tendency to respond in a manner that presents a favourable impression (Gee et al., 2007)—I reminded the interviewees that they were experts; I was interested in their opinions, and there were no wrong or rights answers. These responses also allowed me to reduce the possibility of authority and power imbalances between the participants and me. I tried to have a collaborative, non-hierarchical relationship, as I remained cognizant that power relations, both at a micro and macro level, can unintentionally influence the interview process (Finlay, 2002; Hesse-Biber, 2007). Attention to power is also central in intersectionality-informed research (Hankivsky, 2014a, 2014b) because knowledge production is twined with power (Hankivsky, 2014b; Hankivsky et al., 2010). My insider's position might also carry the risk of withholding information the participants assume to be visible to me (Berger, 2015), or they masked important nuances

(Probst, 2015). For example, a physician said, “you know this, you are a physician, right?” Conversely, being an outsider, the participants might consider themselves more experts. Yet, there was a risk; the interviewees could neither relate to me nor were confident in my ability to represent their experiences.

In conclusion, both insider and outsider statuses had advantages and disadvantages. The insider and outsider statuses, however, are fluid, multidimensional, and ever-shifting (Hesse-Biber, 2007) because who I am is neither static nor unitary (Doucet & Mauthner, 2008). Indeed, I have found the dichotomy of insider versus outsider overly simplistic and unsure how to position myself (Dwyer & Buckle, 2009; Paechter, 2013). I can not fully occupy one or the other, and ultimately I suited myself in a “space between” (Dwyer & Buckle, 2009, p. 60).

Chapter Five: Findings – Immigrant Women

Chapter Five provides the research results and presents the main themes and subthemes that were developed from the participants' narratives. I begin this chapter by offering the participants' demographic data, followed by the themes. Then, I present the findings based on my interviews with immigrant women living with chronic pain. Experiences of caregivers and perspective of physicians will be provided in the Chapters Six and Seven.

About the Interview Participants

As mentioned earlier, I interviewed three groups of informants: Immigrant women living with chronic pain, their caregivers, and physicians providing care for chronic pain.

Immigrant women. Participants represented a range of socioeconomic statuses and entered Canada under varying immigration paths. They ranged in age from 30s to 60s. One was in her thirties; three were in their forties, five were in their fifties, and four were in their sixties. Of the 13 participants, two had lived in Canada for less than 10 years, four between 11-19 years, and seven for 20 years or more. Seven participants lived in Asian, European, and African countries other than their home country before immigrating to Canada. There was also a variety in the way the women came to Canada. Six women came here as refugees, both government-sponsored and privately-sponsored, three as family class, four as economic immigrants—of those, one had come as an international student then later became a permanent resident. The countries of birth also varied. Of the 13 informants, 10 were born in Asia, two were born in Africa, and one was born in South America.

Regarding the family status, seven of the informants were living in a conjugal relationship, and four were divorced. Of these, nine had children ranging in number from one to five. Two women never married. The participants were generally highly educated; ten were university graduates, two had college degrees, and one had some high school education.

In terms of employment, all of the women had been employed after immigration and worked in professions providing service, personal care, office work, teaching, academic jobs, or professional jobs on various levels. Yet, at the time of the interviews, only eight out of 13 were employed due to pain-related disabilities.

Of the 10 participants who answered the income section of demographics, three reported an annual household income of less than $20,000, two had incomes between $40,000-$59,900, and four earned between $60,000-$79,999. One participant’s income exceeded $80,000. Three women lived in social housing.

The participants reported diverse types of chronic pain, such as fibromyalgia, rheumatoid arthritis, whiplash, back pain, and complex chronic pain. One informant was a cancer survivor. Some women described multiple sources of chronic pain. The length of time the participants had experienced chronic pain ranged from two years to most of their lives. A brief overview of the participants’ demographics is presented in Appendix E.

Caregivers and physicians. Regarding caregiver informants, all were employed. The majority of them (four out of five) ranged in age from 31 to 40 years. Four out of five had lived in Canada for more than 20 years. All were university graduates. Two were spouses, two were children of the participants, and one was an HCP. Group three participants, physicians, were predominantly females and aged less than 50. They had various types of training and provided chronic pain management for less than five to 20 years. They self-identified as being exposed to providing care for the immigrant population, including immigrant women.

The following section will describe the main themes and subthemes identified by analyzing the interview data. The data analysis revealed four interconnected themes: (1) The trajectory and meaning of pain; (2) Reasons for pain and Triggering Factors; (3) Pain consequences; and (4) Coping and control. The list of themes and subthemes can be found in Table 2.

Table 2: List of Themes and Subthemes

Theme One: The Trajectory and Meaning of Pain	**Theme Two: Reasons for Pain and Triggering Factors**	**Theme Three: Pain Consequences**	**Theme Four: Coping and Control**
Omnipresent Nature of Pain: “Every day, Every night, Always.”	Multifactorial Nature of Chronic Pain: “Accumulation of Many Things”	Interruption of Life Activities	Avoidance, Pacing, and Modification: Listen to my Body
Pain is the “Enemy,” the “Beast,” and “Torture”	Immigration Journey: “Migration, Stress, and Chronic Pain are in Combination”	Interpersonal Relationship: Isolation	Distraction and Maintaining Social Connections as “Painkiller”
The Whole Person Experiences Pain	Gendered roles and generational sacrifice: “Pain of Life”	“Pain Can Change People” and “Create a New Person”	Search for Information: Knowledge is Power
			Struggling and Acceptance: Do Not Fight

Theme One: The Trajectory and Meaning of Pain

The first theme, the pain trajectory, is further supported by three subthemes: (1) Omnipresent nature of pain: "every day, every night, always;" (2) Pain is the “enemy,” the “beast,” and “torture;”; and (3) The whole person experiences pain. This theme, the opening perspective for chronic pain, explores the definition of pain and its trajectory.

Omnipresent nature of pain: "Every day, every night, always." The women made a clear distinction between acute and chronic pain. Chronic pain was a never-ending experience:

> [Acute pain is] short-lived, and I know that it will eventually go away. So, if you know pain is acute, it's very easy to deal with it. But chronic pain is different. Much lower levels of chronic pain have a much greater impact because they just don't leave you, and they limit your activity level your function. So, …I think that it's important to make the distinction. (P13)

For the majority of the women, the pain started with low intensity and, over time, "escalated" (P6) and "worsened" (P8). An interviewee explained, "It was insidious. It was gradual. Once it set in, it became more and more extensive" (P13). For almost all women, the pain was omnipresent. One participant said, "You wake up with it. Go to bed with it" (P6). Another informant had a similar experience: "I have pain…every day, every night, always" (P9).

While few women had a specific location for pain, for the majority, the pain was diffuse and shifted from one location to another part of the body. Women experienced pain when they were active and/or resting. The pain was both constant and varying. Yet pain's intensity varied daily and was sometimes worse than others. For example, one participant described the variability of her pain as a "background pain" to "severe bedbound" crises:

> [Pain] changes in terms of intensity. There are times that it is more manageable; it's milder. There are periods that it is much more severe. There are periods that it's so severe that I am bedbound. There are periods that, um, it's more it's in the background." (P13)

Pain is the "enemy," the "beast," and "torture." While no one knows pain more than the person living with it for an extended period of time, some women found it difficult to articulate what pain was. Some could not put words to what they were experiencing and found pain resistant to expression. One of the participants mentioned, "It is difficult to say, like, how you spell 'G'" (P1). Another interviewee said, "I don't think you can find a very definition of pain. It's a pain. [It] doesn't matter what kind of pain. Pain is pain." Later she added, "Gradual death. Gradually, silently, you're dying. That feeling" (P11).

Several informants metaphorically described their pain as, "I am walking on the needles. … [Like] a truck passed over. … Like knives cutting from here [to] there" (P9). In one participant's words, pain "is like you have a knife stuck in there almost all the time and feeling like, you know, somebody is twisting and turning it" (P6). Other participants defined pain as the "beast" (P5) or the "enemy" (P4): "Pain is enemy because it's against whatever you want for the best of your life."

Two women, P8 and P10, called pain "torture." One of them explained: "I had to list it like torture. You have to have it. You know you don't have [a] choice when you get torture" (P8). Another informant defined pain as a means of purification: "It's something like purification. … Make the soul. Make it good. Make it smooth. Make it tender. All together" (P9). One participant defined her pain as "excruciating" (P3), which represented the worst pain someone can experience according to the McGill Pain Questionnaire (Melzack, 1975), a widely used instrument for assessing pain: "It's excruciating, tiring, limiting. Sometimes I hate it. When I am in pain, I hate it" (P3). Another woman thought using a numbering system was ineffective in measuring her pain. To convey the severity of her pain, she stressed, "Oh my God, my pain. I don’t know. If I want to say from zero to 10, I will say it’s above. *It’s crazy* [her emphasis]” (P2).

Some described the pain as a “partner” who accompanied them everywhere. Finally, three women, P1, P3, and P11, focused on the unfairness of life and chronic pain: “Why me?” they asked. The role of culture was also highlighted. The participants believed, “Culture affects how you understand [pain], how you manage it, [and] how you seek help and support” (P6).

The whole person experiences pain.

> I am a person who likes to finish things. I don’t like procrastinating things. [Not being able to do what I want to do] really bothers me so much. It changes my mood…then I can get frustrated. I can get nervous. ... When you have pain, it really affects your mood. (P4)

> When I have too much pain, it affects me emotionally, and I am not in a good mood; I cannot be happy. … Sometimes I am really sad and angry. (P1)

> I’m pretty sure I was a lot angrier when I was in a lot of pain…even little things will irritate you, like things you would normally just cope with. … If you’re in so much pain, you can’t sleep properly, you can’t function properly. It does affect you, probably stresses you more because you can’t do what you need to do. So, you’re getting frustrated. (P6)

As illustrated above, both chronic pain and physical limitations imposed by pain affected the whole person and created emotions and feelings of anger, guilt, frustration, embarrassment, irritability, hopelessness, despair, shame, anxiety, depression, and low self-esteem. These feelings went hand in hand in the journey of living with pain. The interviewees underscored the overlap between physical and emotional pain. Put differently, pain caused anxiety, depression, and change in moods, which, in turn, made the pain worse. Persistent stress and depression also created and worsened pain—Keeping up with life's demands caused excessive strain and emotional stress, as mentioned earlier. Pain and the feeling of despair indeed created a vicious cycle, "Pain changes your mood, and your mood changes your pain" (P5).

Few women had thoughts of self-harm and death. The physical limitations imposed by pain contributed to such feelings. An informant said, "I told my doctor, 'I don't want to live because there's no point in living in bed. Can you help me for a mercy killing?'" Death also meant relief from pain: "You wish you were dead because of pain [laugh]. You know, you feel like you would be pain-free" (P11).

Theme Two: Reasons for Pain and Triggering Factors

This theme describes the determinants and root causes of chronic pain and presents the pain's triggering factors from immigrant women's perspectives. This theme includes three subthemes: (1) Multifactorial nature of chronic pain: "Accumulation of many things;" (2) Immigration journey: "Migration, stress, and chronic pain are in combination;" and (3) Gendered roles and generational sacrifice: "Pain of life." The subthemes partly overlap, but they are presented separately for clarity. The first subcategory explains the complexity of chronic pain and how the interactions between biological and psychosocial circumstances– the determinants of health—create pain during the life course. The second subtheme, immigration journey, provides a glimpse of women's migration stories and a detailed picture of multiple immigration stressors contributing to their pain. The third subtheme explains how gender intersects with other social markers, such as racialized status and disability, and frequently amplifies their effects in shaping chronic pain experiences. Then I will briefly describe the pain's triggering factors.

Multifactorial nature of chronic pain: “Accumulation of many things.”

Every woman’s reasons for developing chronic pain were unique, complex, and often caused by numerous factors. Informants reflected on the accumulation of events during their life course that led to chronic pain development, highlighting chronic pain’s multifactorial nature. As one participant nicely put, “Everything helped. They worked [as a] very good team” (P9). Likewise, when asked about the reasons for her pain, another interviewee told me, “It is the accumulation of many things” (P10).

Among the reasons, some reported early life factors such as adverse or traumatic life events, hospitalization at a young age, or complicated and challenging childhood. One woman said, “When I was born, my mother was [noticeably] young. Then after one month, she got another pregnancy. And she got pregnant next year [with] another one. We [my siblings and I] were, you know, fighting for nutrition” (P8).

Few women connected the onset of pain with previous injuries such as a car accident or sports injuries. While some informants had experienced physical traumas, others had experienced psychological traumas. In other words, women talked about what was happening in the present and what had happened in the past. Many believed that their history contributed to their current pain conditions and past experiences put their marks on their bodies. Pain, according to the participants, was a multidimensional phenomenon lying at the intersections of sex, gender, culture, racism, sexism, ageism, socioeconomic status, and anti-immigrant sentiment, among others.

Few reported that pain clustered in their families, suggesting a heritable component. Yet, they felt that while genes increased their chance of developing pain, the environment's importance was undeniable.

> [The reason for my pain is] genetics. Bad genes. We don't have good genes [laugh]. I think I collect all of those genes. … I think with genetic background, [the] environment can affect. I don't believe that environment alone could affect. For me, both genetics and environment but more portion of genetics. (P1)

Contrary, another participant, like several other women, believed that the reason for her pain was not genetics: "Nobody has pain in my family. It [only] attacks me" (P2). A couple of women reported pain in their families but believed it was not genetics. For example, a participant indicated, "I always saw my parents in pain, but [it was] not genetics" (P8).

The significance of age also requires underlining. The image of chronic pain as a disease of the elderly was common. Take, for example, this extract: "When your age is going up, pain can come, and you cannot avoid this" (p2).

For most women, the reason for the pain was stress-related, and they linked pain to a build-up of stress: "Stress goes to your body and causes the pain" (P3). Informants spoke at length about their stresses related to their status as immigrants (e.g., moving to a new country, financial difficulties, and unemployment), the stress of being a woman, and stress because of significant losses. Central in all narratives was women's stress at losing family support, particularly the lack of traditional women supporters and limited friendship networks. Loneliness was a constant challenge for many women. Yet, one participant thought that:

> We overestimate [stress]. I honestly believe wherever there are medical conditions for which we don’t have a simplistic, reductionist positive medical approach understanding, we immediately search for other answers, and stress is a low-hanging fruit that everyone tries to get hold of and say, ‘It’s stress.’ … I find it to be extremely superficial. It’s just the way we are looking at everything. … I think life challenges, including illnesses and chronic pain, do create stress in people’s lives. Then it becomes a very difficult cycle. I’m not saying that stress doesn’t aggravate the perception of pain [or] it doesn’t precipitate pain; it does. But even the term stress is that I have problems with. Are we talking about physical stress? Winter is stress[ful] physically. It is stress[ful] psychologically because it makes people more isolated. For that reason, I’m going to…really challenge this whole notion of stress and pain. Because for too long, we have brushed off the experience of pain or blame the stress for it. … So, to me, our understanding of the role of stress in illness is very rudimentary. It’s very primitive; it’s very basic. It’s not a straightforward relationship, and it’s very easy to blame stress for everything that happens that’s much more complex than that. (P13)

Immigration journey: “Migration, stress, and chronic pain are in combination.” As mentioned earlier, more than half of the informants, irrespective of their immigration categories, had lived in other countries—other than their home country—before settling in Canada. For them, the immigration journey involved a series of movements: departure, passage, and arrival. For example, three women experienced extreme poverty or financial difficulties during their passage to Canada. Few reported that they “crossed the border on foot” (P4) alone or with their kids.

A couple of women experienced trauma in the pre-migration and journeying phases of immigration. Some had fled persecution or experienced war and underwent a dangerous journey:

> I have to run away [because of the war]. War invents pain; imports pain distributes pain. … I had to pass rivers. Deep waters at night and walking in the mountains in cold weather with a group afraid of the border guard. …in the group, [there were just a few] women, the other all were men. … We were running. Because of the pain, I was vomiting all the way. Many times, the leader of the group [said], "Let her die. We are not going to sacrifice for one person." (P9)

All women expressed how resettlement in a new country had been difficult and was associated with social isolation, exclusions, racism, financial difficulties, and adjustment to a new culture, to mention a few. Most women believed that "migration, stress, and chronic pain are in combination," and as immigrant women, "we have to prove what we can do. We also have to cross many barriers, language [is] one of them, racism, sexism, all that, and the anti-immigrant sentiment" (P4). Women also spoke of stressors as they adapt to the new culture: "Different culture, different language, different values. You worry; that causes a lot of stress. … Stress is there all the time" (P11). Some found that starting a new life in Canada was like being born again: "You are just like a baby. You start learning things" (P8).

Many had difficulty finding meaningful and permanent full-time employment in the early years of arrival, particularly professional immigrants. Language was not indicated by most of the participants as the main barrier to social and economic inclusion, as many informants identified as being fluent in one of the official languages when they arrived in Canada. A woman described the frustration of having to take English language classes to upgrade her qualifications:

“I think it was wasting time going to school [for studying English]. It’s not a school for well-educated people. It’s for people [who] don’t read and write English. I didn’t get the point; just wasting our time” (P12).

Lack of foreign credential recognition and the privileging of Canadian work experience were among the barriers preventing many women from securing employment in their fields of expertise, resulting in their under- and unemployment. Consequently, some had to work in “survival jobs” with poor working conditions, which were more physically strenuous and demanding to support themselves and/or their families. An immigrant woman explained how ageism, coupled with racism and sexism, had been a barrier to employment. She recounted the challenges she faced:

> When I came here, I couldn’t work in my profession. So, I tried for several years but [was] not successful; I think it was due to gender and age. The interviews that I did were so disappointed. I can’t forget the first interview when I was asked, “Why you want to be a professional [in such a male-dominated field]?” In the other one, I was asked, “How can we consider you as a senior professional because of your experience while you don’t have Canadian experience?” … So, I started to work in other jobs. … Pain started because of my job. (P10)

The informants also spoke of the stress of being in casual or temporary contracts without job security. To build Canadian experience, some did volunteer work. Several women chose to pursue a college diploma or university certificates as a solution to unemployment or underemployment, while they had to work to uphold their families: “I started working as a volunteer. I did volunteer to [get] experience. On the days I was not doing the volunteer, I worked as a causal. And I studied [concurrently]" (P12).

Another informant who chose to go back to school described, "The best opportunity for me was to study because I couldn't find a job easily without a Canadian degree. [But it was] too much pressure physically and emotionally" (P1). Some spoke about how the devaluation of their valuable assets—education and work experience—impacted their labour market performance and their broader integration within Canadian society. The experience made them feel out of place and unwelcome in a country they had chosen to be their new home:

> [I had] difficulty finding a place in society. [By] a place, I mean recognition for your work [and] for the capacities you [have]. Because it was very difficult to find work, stable and regular work. It's not the thing that I had prepared. … I knew that I had skills that this society could profit from. (P3)

Consequently, most women faced financial challenges, notably in their early years of immigration to Canada. Single women and single mothers generally had lower incomes and greater financial hardship. Some struggled to pay bills and found it difficult to meet their needs regarding transportation, housing, food, clothing, prescriptions, buying school supplies for children, and other necessary expenses. A woman described her experience:

> Every time I went shopping, I had to carry so many bags. I didn't have a car. … I had to save the bus [ticket]. So, these carrying groceries, I think, never let me get well. One time I bought so many things [because they were cheaper than usual] and then when I came back, I was crying…you know no help, with children and no help. (P8)

One participant described food poverty. She explained how she had reduced her food intake or skipped meals to ensure that her children had food and would not go hungry: "Sometimes when I come home, if I don't have enough money, I just buy a little bread. Drink tea. That's it! And sleep. Because I want to save for my kids to eat" (P2). For this informant who dealt with financial issues, there was no one to turn to:

> You know, in this country, I cannot knock on anybody's door and ask to give me [money], no. We can't don't do this, and we can't borrow money. The only person you can borrow money from is the Western Union. (P2)

One woman had relied on her family to send money. Still, she found it deeply distressing: "My family like supported me. … They paid for food, gave me money for survival just survival …just the basic things…but it was hard for me. I had to ask for the money, and it was hard" (P12). Meanwhile, the support provided by the Canadian government helped her to decrease her financial difficulties:

> We get a [child] tax benefit some months after arrival. It wasn't a lot, but it was good. We survived—we bought boots for the kids. I didn't buy anything for myself. No jacket, neither boot. I said, you know, "It is OK for me now. I can just [dress in] layers." … I remember one day. There was a snowstorm. There were no buses in this snowstorm. So, I came back walking [pause] I did not have snow boots [crying]." (P12)

Experiences of racism and exclusion: "You don't belong here." Issues related to racism and discrimination permeated several interviews. Some women felt they were not at home, which was associated with a deep sense of loneliness. The suffering women experienced continued even years after arriving in their new home. They experienced racism in workplaces, universities, and the health care system "every single day." According to one of the participants,

> Sometimes, you feel that you don't belong here. You see a lot of things, and you see a lot of people with negative thoughts. You can see racism [and] prejudice in their face. They don't open their mouth, but [they show it] with their face, action, and body language. In the end, you feel that you're being judged or somebody [is] looking at you differently. …You feel that isolation. You feel lonely. You feel that you don't belong here. …that causes a lot of stress. … Sometimes they say, "Oh, from that part you came, can you drive?" … You know those questions sometimes are killing [as] somebody stabs you. … *These assumptions happen every single day* [her emphasis]. (P11)

Similarly, another woman described the experiences of hidden, covert, and subtle racism. She highlighted that some employers made assumptions about immigrants' work habits: "They are not going to tell you, 'You are foreign, and you are lazy.' But they have this way of thinking in their spirit. … They don't show. … It's happening in different places for me" (P3).

A couple of women described how their classmates were going quiet and not acknowledging them when they greeted them. For one woman, again, the role of ageism was undeniable.

> They started laughing, and you see they are whispering between them. When we [immigrant students] got them like in the cafeteria to have lunch or like to go to the library to do something, they didn't sit with us. … They made fun of us, our language, our accent. ...most of them were young. … I thought when I went back to school, oh, I was the oldest one. (P12)

Women felt alienated not only by their White peers but also by their professors. For example, one interviewee stated, “Even you can feel the racism from some of the profs” (P4). A woman spoke about the discrimination she experienced based on multiple overlapping social identities. This participant felt that she was denied a service because she was nor White neither in a wheelchair—her disability was not visible:

> After I graduated from university, I applied for so many jobs. I didn’t have any [Canadian] experience. Most of the jobs go to White people because…they have the experience. They have, you know, connections and those things. I didn’t [have]. … I couldn’t find [job by myself. So, I sought assistance through an agency helping persons with disabilities to find a job]. They said, “You are good. You can find a job by yourself.” I was so mad. …I was not White. (P8)

Another participant described how racism had affected her employment opportunity. She explained that she had worked as a volunteer with an organization. She wished to turn her volunteer position into salaried employment: “I did very well for the interview. [But] they hired somebody else. She was White. I was very shocked” (P12). She continued that she thought the reason was that the clients she had served, although very well educated, preferred to contact someone who would be White.

Several participants indicated that the feeling of being excluded resulted in questioning themselves about belonging, which for one woman (P4) was associated with losing her sense of self: “[You are] working very hard, but a lot of times you really feel the pressure. You really feel being excluded. [Then] you question yourself about belonging.” Consequently, some participants had decided to return to their home country, but:

> After a few years, you cannot go back. It’s hard to go back. It’s very hard. … I couldn’t live life over there because of changes. We changed over here, and there were a lot of changes over there. I cannot go. I will be lost over there. … [You] feel like you don’t belong anywhere, you don’t belong here, and you don’t belong there. You are in the middle. That’s another factor, which is very strong factor. (P11)

Another informant expressed a similar feeling:

> I realize that I am a stranger within my own culture because I don’t think the same way, I don’t behave the same way, I have a different lifestyle. … I consider myself really a citizen of this globe. Someone that belongs everywhere and doesn’t belong to any particular place. (P13)

Worries and loneliness: The Pain of leaving loved ones. Some of the women moved to Canada on their own or with children. Others accompanied their husbands to Canada. However, two women’s husbands subsequently returned to their home country. Four women got divorced after moving to Canada. Women’s anguish at the loss of family support and limited friendship networks at that most crucial time in their lives was central in most narratives. Worries about those left behind—some in dangerous situations—were also part of many women’s everyday lives. A woman spoke of the pain she held in her heart:

> So, you know pain is not physical; it’s also mental …the pain of leaving your house, leaving your loved ones, and losing people and experiencing war, experiencing a lot of these things, they give you pain in the heart that creates later on pain in your body. (P4)

Another participant explained,

> Immigration also means a smaller social network. With regards to instrumental support, with regards to emotional support, a smaller network is not good for any illness, definitely not for chronic illnesses. So those are some of the aspects of this intermingling interaction with immigration. (P13)

Some women described how not having access to extended family members and other supportive relationships resulted in loneliness. A woman talked about the agony of staying away from those she loved:

> When you are [an] immigrant, there is no family beside you, and it's a big problem. When you see nobody, family close to you and beside you, you get mad and sad, and you get depression. You miss your family, and you think if my family were here, they could help me, they could give hope to me. (P5)

Gendered roles and generational sacrifice: "Pain of life."

> You are by yourself [here in Canada]. You don't have your community, but you're not alone—the kids [are] with you. And then you have to carry all of those [responsibilities]. And so, these are all pressure on my body. So, my stomach was screaming, my back, my neck. You know everywhere was screaming at me. (P8)

All women strived to fulfill paid and unpaid responsibilities, a significant stress source, particularly for married women with preschool or school-age children. One participant described her situation as "a woman of many" (P4). Gendered roles and generational sacrifice were recurring themes. The majority of women felt responsible for and prioritized family and household tasks. One of the participants said, "women have a more demanding life;

multitasking" (P13). Some women highlighted that men only had one major role, that of paid work:

> We [as women] are working just like men, but we are working double because we are taking care of kids and home, and we also work [outside]. But when [men] come back from work [in] my culture, they will not do anything. They will not help the woman. So, I mean, we have different stresses. But I believe we [also] as women [are] exposing ourselves for more. We always take care of everybody but do not take care of ourselves. (P10)

Indeed, working full time and being on duty at home made it easy for women to forget about taking care of themselves. Another participant, who had lived in Canada for a while without her husband, said:

> Pain also comes from fatigue. Right? You are fatigued. You are tired. You didn't sleep well. You have too many tasks to do. You're stressed out. All these things and then you have small children. You have a job, two jobs, the third job is the housework. You have to clean, [and] you have to cook. I mean, you cannot tell your kids, 'I'm sick. I'm taking the day off.' It's not a job you can take time off. (P4)

Similar experience shared by another woman:

> [One day] I felt the pain. The real pain that I didn't experience before. I don't know how to explain it to you. … I couldn't sleep. I couldn't get up from my bed…just like if there was a big rock on my shoulder and my body. And since then, the pain is not going. I [think the reason is] *all the responsibilities* [her emphasis], and the pain that I went

> through in all my life; pushing myself to do things [one] after another. … [That day] I felt how much I was tired. (P10)

Being a single parent resulted in added stress, particularly when the women could not afford childcare or take a sick day. Take, for example, this passage:

> I went through a tough life. Without [a] husband, it is not easy. I was here with my husband, but my husband left. … He wanted to go back home to do something for the family … to save some money and settle the kids. I said, "Okay, no problem." So, he went back home and never came back again. He went there, married again, and settled a new family there. [I stayed here] with kids in my hands. All were young. I was running by myself. ...taking kids to school, when they were sick, I had to [take care of them], and I was working at the same time. I was running back and forth. … My daughter used to run out of the house. I have the one going all after [her]. … It was so stressful. … It was very hard, hard. That's the thing—it is really affecting all my body. The pain begins there. … [One time] she left the house, and she came back, I think after two months. When she came back, she came back pregnant. So, I called my husband [and told him] what [was] happening to my daughter; he didn't really care. … That's my pain. My son [is] like kinda depressed. I keep talking to him, and I keep approaching him to go to school all the time he dropped the school. … I worked two jobs; finish one and running to the second.… I changed my shift from my other job to make sure he made it to go to school, drove him to school. … I was almost getting fired from my job because of the phone. I had to follow where my kids were. … I was thinking about my kids, I was thinking about finance. The reason for the pain was the stress I was in it. Because I used to go [to] work in the early morning. …I came home I felt very very tired I had to cook,

> clean the house for the kids. Then I saw the time—it's late. I had to stop, and early morning took a shower. Go to work. Where I worked was just around the freezer, you know, everywhere was freezing [pause] after I took a shower. So, all my body is getting in pain. That's why I get this [pain]. … [My other son] goes out with the bad people sometimes comes [back] drunk. Sometimes he takes a knife. I cannot sleep because [I have] to see what he's doing every minute. … I have so many bills to pay here. If I don't pay those bills, how my kids can live? And sometimes my kids want these [things]—when they see with the friends, they want. You feel it. "Why my mom doesn't buy this? Why doesn't my mom do this?" But they don't know what the situation I am in it. So, it makes me feel very painful. … Sometimes I just put them down. I talked to them to understand what the situation was because one hand could not clap. I have to provide all these, so I'm standing for them. … That's the life I am going through, plus [a] job. The pain of life is the worst pain. It is not an easy pain. … Sometimes I think, what life is. You know, running by yourself, raising kids. … The pain I'm in is a lot of pain, emotional pain, life pain. (P2)

Another participant believed that her pain resulted from being a "hard worker," among other reasons. She explained that she had not been able to finish her studies in her home country. Instead, she had to start paid work because her family needed her financial support:

> I worked in a company, and then I came home and took care of my family. You are a girl. They are men, but [they are] not for working just for ordering, only ordering. … Our garden was big, and I was [the only one who was] working. [My brothers] didn't care. And when we were building other things in the house. I had to carry [the blocks of] cement. They were very heavy. I had to carry them to put them in their place. My

> brothers didn’t care. So, I think that carrying heavy things has affected me. Even inside the home, like I need to clean, I have to do all that. [And grocery shopping], flour, rice, sugar. They were heavy, and I had to carry them…that ruined my health. This is my life, and now I am handicapped. (P9)

While some women shared their responsibilities with their spouses, others oversaw most of the housework and care of children and had made sacrifices to benefit their husband’s careers.

> It was hard with small kids and a [professional] husband who liked finding a good job. …he went to school; he took some courses. But still, he couldn’t get a job. So, I was the breadwinner, but at the same time, I was the housewife and the mom, the cooker, the driver, *everything* [her emphasis]. (P12)

However, women were proud of their sacrifices to settle their families in Canada, as they offered their children secure futures. It was simultaneously a pleasure and a burden: “I am so proud. … I think even my kids are proud. They are proud of me and told me, ‘Mom, you did a lot.’ They appreciated me” (P12). Another participant echoed this, “I like my life here, and I’m happy with my life here and my family. But maybe it caused me the pain” (P3).

Few were taking care of their older adult family members or other relatives with health conditions:

> I have an extra responsibility. … I am a caregiver [taking care of my father]. How can I take care of him with my long working hours? How can I take care of myself and take care of him? … I take him from one doctor to another. … My work is not easy. I am stressed all the time. And you cannot predict when you are safe or not safe [at work]. So, my job is not easy. And when I come back home totally stressed. … And so, after

> everything, at night, I feel I am down. So, all the pain comes to me and then [in the morning] I'll try my best to drag myself from bed to go back to work. (P10)

Another woman, who had also been a caregiver for a couple of decades, defined caregiving as a demanding, stressful task requiring time commitment. She explained how caregiving had affected many aspects of her life, including her social network: "Those years that I could have possibly invested in creating better networks, I was in the position to support others and had very little time for my own network." (P13)

The women also talked about gender differences and structural ways that created environmental constraints and opportunities that usually benefited men more than women and had resulted in reduced access to resources: "There are differences [between men and women]; a lot. Also, society. For example, [I had applied for a scholarship], but it was given to a man; no kids, you know, no responsibility. He grew better than me, for sure" (P8).

Three women also experienced abusive relationships. One of them explained how her pain had developed after being abused, among other reasons, and another woman described how she had fled a violent situation and was compelled to live in a shelter.

Pain triggering factors. All women identified factors changing pain intensity, such as the weather, particularly cold and wet weather. The psychosocial aspect of the weather was also crucial for women. For example, one informant explained, "very long winter periods that impose even less activity, just in itself restrictive—clouding cold temperatures that put the muscles into spasm like it's just for sure. Everything even psychosocial aspects; the isolation that one experiences in wintertime" (P13). Certain activities, emotions, and stress were also described as triggering factors.

> “If I bend a little or [if] I wash dishes, five, six, and ten, after that I have pain, a lot in my hand. … Peeling apples [pause], I want to scream from the pain.” (P9)

> “If you have small pain when you have stress, this small pain is big.” (P5)

> “Weather bothers me. Cold weather bothers me. Humid weather bothers me more than cold weather.” (P5)

> “I recognize exactly two reasons. OK? One is stress, and the second one is the weather.” (P3)

Regarding emotion as a triggering factor, one woman recounted how painful it was to lose her six-year-old nephew and how being in mourning had induced a pain flare-up. Aging was also mentioned as having an aggravating effect on pain. An interview said, “When you are younger, you can tolerate more” (P5). Another participant pointed out,

> Age is a huge risk factor. I am actually feeling it a lot. Every year relative to the previous year, I found my challenges in terms of severity increase. So, I can see that it won’t get any easier as I age. (P13)

To summarize this theme, the cumulative effects and intersections of childhood adversities, premigration journey difficulties, sexism, ageism, racism, discrimination, gendered responsibilities, lack of social support, and downward mobility contributed to the experience of chronic pain.

Theme Three: Pain Consequences

Another salient feature of immigrant women’s accounts in this study was how the pain had interrupted/disrupted every aspect of their lives including informants’ identities. For all the women, pain meant a significant restructuring of life and relationships and revisions in expectations. The following section will describe the impacts of chronic pain on participants' daily living activities, social relationships, and changing identity.

Interruption of life activities. The pain was the focal point of women's everyday experiences and permeated all aspects of their lives. The women indicated that chronic pain had adversely affected their daily lives in several ways and made it challenging to get through daily tasks and activities that others took for granted. Depending on the severity of pain, walking, dressing, cooking, baking, cleaning, grocery shopping, household chores, taking a shower, and driving became compromised. Take, for example, the following excerpts:

> I cannot do simple things that normal people can do [because of pain]. (P5)
>
> I couldn't [get myself] dressed. I couldn't take my bag. It was very very very hard. (P3)
>
> I couldn't wash my hair ... I couldn't comb my hair. (P11)

Even performing the smallest task required labourious efforts: "Take a shower; it is very hard for me. It takes too much energy. Sometimes I lie on the bed and think, 'Should I shower?' Making a salad is [also] a big deal for me. (P1)

Getting out of bed was one of the most painful activities: "I think the most difficult is to get up…in the morning; very hard and pain-pain-pain" (P11). Sitting was also unbearable: "I am not able to sit, especially when [the surface] is hard" (P7). While sufficient sleep is required for the body to repair, almost all women had trouble getting to sleep and/or staying asleep. For example, one of the participants stated, "I never sleep deeply with this pain" (p9). Another informant echoed lack of restorative sleep: “I don’t have any deep sleep. … I dream of like two, three hours of sleep” (p11).

Pain also caused a lack of energy. The women felt tired, which was made worse because of sleep disturbances. Fatigue kept them from doing things they would like to do: “I felt so tired and exhausted by [pain] that I didn’t have much energy to do the other things I wanted to do” (P6). Another woman shared a similar experience: “… not having a good sleep at night, I’m so tired and exhausted in the morning” (P11).

The informants reported a repetitive pattern of good and bad days that directed their daily activities: “Sleep is very important for my making day good or bad. If I didn’t sleep well during the day, I don’t have [the] energy” (P7). Both pain and lack of sleep deteriorated women’s memory. A woman said, “I suffered a lot. I can say suffer a lot because my memory had bad days. ... Sometimes I read something, and half an hour later I forgot” (P1). Another interviewee noted, “Lack of sleep affected my memory” (P11). Likewise, one participant said, “When the pain comes, you forget things because you are tired” (P3).

The informants could not concentrate, which affected their productivity: “you can’t concentrate as much as you want. … My focus like my capacity and ability to focus was very impaired” (P6). Chronic pain also made it difficult to enjoy even the simplest pleasures; one of the participants said, “Of course, not to mention the hobbies and personal interests. Those are the first ones that you have to eliminate”. (P13)

Impact on employment. As with other aspects of life, women’s professional lives also suffered. Participants explained they had to stop working, switch paid jobs, work only on a part-time basis, or be forced into early retirement due to pain. At the time of the interviews, five of the 13 participants were no longer at work, and one worked reduced hours. The exclusion from the labour market further reduced their social connection and impacted their finances. One of the participants explained how pain reached the point of making it impossible to work after working on a very part-time basis for a while.

> I'm retired now. I retired much sooner than I had anticipated due to illness. So, a big slice of [my social support] is taken out because [of that]. … [And] financial implications are huge. Retiring much earlier than you are supposed, working mostly part-time most of my adult life, [financially affected me]. (P13)

As a result, some described insufficient financial resources or losing job health benefits hindered their treatment-seeking options. An interviewee explained, "None of them, [physiotherapy, massage] are available. [If I want] I have to pay. They are not covered [by OHIP]" (P8).

Despite the pain, some continued to work and bear the pain because of financial issues or to keep supplementary health benefits. Some pushed themselves, as going to work was essential to their sense of well-being and self-identity. It also kept them in touch with people, which will be discussed later under the last theme.

Interpersonal relationship: Isolation.

> You have to deal with basic survival issues. Then you have fewer chances of intermingling thinking about social interactions. … Pain could affect the level, the intensity, [and] the frequency of socialization that [one] may be able to engage in. (P13)

Participants discussed the impact of pain on limiting social activities. Women's relationships were suffering, and they became isolated, while many described themselves as "sociable people" before living with chronic pain. Some avoided social and family events because they found it physically challenging to keep going and thought they would likely exacerbate their symptoms:

> Sometimes, a friend of mine said, "Let's do this." For example, drink. But I know that I can't drink too much because it makes me tired, and the day after, all day, I should stay in bed, and they said, "Oh no, come on." I should then explain my [condition], and I don't want to do that. Or going to a party and dance; I know that if I increase my activities, it could affect pain. I could have fun, but the day after, I would suffer. (P1)

Another participant (P3) said, "I feel guilty because I [can't] accompany my husband and my [kids]. She continued, "Sometimes you feel a sense of shame, not shame, but embarrassment" (P3).

A couple of women found it difficult to participate because of difficulty in driving or using public transportation: "I have a social circle [but] sometimes I can't go. Driving is too much for me" (P4). Likewise, another participant told me, "I can't go. I can't drive. I can't even use the buses" (P9).

Finally, some, but not all, talked about having difficulty with sexual relations. One of the participants, for example, explained that a sexual relationship is part of intimacy and, therefore, difficulty with sexual relations could strain the relationship.

Role reversal and dependency: "I am not a good mom." All women received help with daily activities such as running errands, preparing meals, or taking a shower when they were in severe pain. They stressed that their friends, neighbours, and family members (i.e., husbands, children, and mothers) offered support. The interviewees underscored the importance of practical, instrumental, and emotional help provided by their loved ones. For women living in a romantic relationship, their husbands had the most significant assisting role. For a small number of women, their children substantially helped emotionally, socially, and sometimes financially. For two participants, mothers were a valuable source of support as they would take care of their daughters while they were in pain. A woman living alone received support from her friends and neighbours. In addition, one woman relied on a paid formal carer for daily activities.

The pain had a dramatic impact on the experience of motherhood for some women. Prescribed gender role expectations highly influence the motherhood experience in most cultures, which consider motherhood a highly valued role for women. Being a “good” mother or wife was central to women’s identity. Some women reported difficulties managing the competing demands of chronic pain and motherhood. Consequently, they felt guilty because they could not fulfill their roles. One of the informants mentioned that she liked to cook for her kids, but she could not. As a result, she felt guilty (P11).

Sadness was evident as participants spoke about their dependency on their children. They felt they were not good moms as their kids undertook their responsibilities, and the position of the carer and care for was changed: “I am not a good mom for my kids. … I have to ask my kids, ‘Could you bring my heat pad from the room? Could you bring water for me?’” (P4). Another mother described how pain affected the enjoyment of playing with her children: “I never had a chance to have fun with my children to do sports” (P8).

But reliance on family members in terms of “becoming dependent” was not experienced universally by all participants. Despite the experience of pain and associated limits, a woman (P8) asserted: “I am an independent person, but a lot of [people] are not like me. They are healthy, but they cannot manage their normal life." She then added that she had not gotten the government's help that she needed. Consequently, she was financially dependent on her children: "I can't clean my house. Poor my [kids]. [They are] paying so much for me, [for] all of these things that the government doesn't cover. They are helping this way" (P8).

Women's spouses also took over household responsibilities. Participants were grateful for the help but felt guilty. They consistently reported feeling conflicted by receiving support and expressing a desire for independence. These feelings sometimes were made worse by friends' or family members' critical reactions. Yet, the women moved beyond self-blame and judging themselves, as they were able to identify dominant discourses that resulted in those feelings and how others judged them.

> I felt guilty. My husband is young, and I am in bed and can't move … but he understands and tries to help me. This is our life … I ask for many things that my poor husband does. … Sometimes, people make me feel guilty, for example, saying, "Oh, your poor husband works there and comes back home and then makes a meal." … My grandma loves me, but she is an old traditional woman back home, so in my country, 80 years ago, people thought women should do kitchen work. She called and asked, "What are you doing? Lie down, and what is he doing? He is cooking; oh, wow, you should go and do." She never understands, and I don't want to try to explain. I should lie about those things, or I should get those things. Sometimes I avoid it, but sometimes it affects me. (P1)

Another participant expressed:

> My husband is very supportive. … He started working with me, like cleaning. What I need is to tell him [what] to do. I think it's the culture like I lead [housework]. [In] our culture men don't participate in housework.'" (P12)

Along with physical and financial aids, families provided emotional support:

> When somebody tells me that let us go out, or you are invited to this and that, I will say, "I'll see." I don't want to go—because of the pain, [I have] no energy. But at the same time, I know if I go, I will have fun. So, most of the time, I push myself and most of the time, my kids [are] my motivation. (P10)

No one believes you: My sickness is not imaginary. As mentioned earlier, most participants felt that their social life had been limited and reduced by their pain. One reason for that was their inability to undertake the activities they had performed in the past. The other reason was that they felt that they were not understood or believed because they looked "normal." They had been told that they were "exaggerated" the pain (P1). The variability of pain and its invisibility made it even more difficult for people to believe them. People did not understand why the women looked well and were ill.

> [Pain] is invisible, and it is not constant. That's the other thing because someday the people see you. Oh, very good. … And then the next day, you cannot move. Then the people don't believe you. It's invisible. It is hard to convince or try to communicate or tell them that you have pain because they don't understand how you are good one day and bad the [other] day. (P3)

The perceived need to continually reiterate, explain and legitimize pain was frustrating and made a living with pain even more difficult.

> It's too much for me to talk about [pain]. It's boring, and I don't have the energy to talk about it. …a lot of explanation. [Each time I go to a party] at the beginning, I have to explain. [Otherwise, if I get tired,] I should sit and smile. … It is a lot of pressure physically and emotionally because I [want] to look happy; sometimes, I fake my smile. (P1)

Another informant (P4) similarly expressed her frustration: "I get frustrated. I say, 'You don't know the pain that I have.'" Consequently, she kept her pain to herself: "You don't want to say every time, 'Oh, I am sick, I feel sick, I can't do this.' I would say, 'I am fine; just a long day at work'" (P4).

The disbelief experience led to the loss of relationships and a sense of isolation. Some withdrew from family and friends. Some restricted their social activities and declined invitations rather than risk potential discrediting. A few did not tell others when they were in pain or were selectively disclosing their conditions. It resulted in feeling a sense of not being themselves. From her experiences, a woman concluded:

> Even at the very basic level of the conversation, just to be able to empathize or understand what during that period of time you're going to, even a simple question of how you are doing, some days it's so difficult to answer. And I am still trying to find a way of answering it in a way that I'm not answering it. Because I know people don't want to hear the answer. So, even responding to a question that I'm not sure what that person wants me to say, in itself, already creates a distance. The inability to express yourself at that level means that you can't go very deeply [with] that relationship. [This]

> has been a process I'm just learning now—I have to save that for very few when I can actually honestly, in a very authentic way, be myself. (P13)

To maintain credibility, a couple of participants hid the pain and pretended to be "normal." They did not want to be judged as a complainer or to make their loved ones worry:

> I would be able to hide the pain. You know, not complaining, not telling anybody; pick whatever pill I have … I don't want people to be tired of me…and I don't like to complain to my kids. I don't want [to make] them worry. (p11).

Participants were conscious of how their pain altered family dynamics. Therefore, they were "putting a mask on" (P4), but some sensitive observers recognized their agony and unrealistic cheeriness masks: "They looked at my face and said, 'Do you have [pain]?' [They] said, 'it shows [in] your face.' You know, how much you are hiding, it shows" (P11).

Some decided not to disclose their condition to their supervisors or managers. Being an immigrant intersected with other identity markers:

> Because you being an immigrant is a condition too. OK? When you find work, you want to excel. You want to do the best of yourself. And if you say, "I have a condition, I have pain from time to time, I have to be late. Oh, some days of absence". The person is not going to [give] you the job. (P3)

Accordingly, almost all women chose not to share their pain experiences and kept it a personal issue: "I don't want anybody knows what I am dealing with. That's why I want to [keep] my things private; [the pain] I am going through" (P1). Some had been told that they were "difficult persons" or "patients." Meanwhile, women thought that chronic pain was not easy for others to understand and grasp if they had not had it. The following quote reflects this:

> Unless if you experience chronic illness and not just [chronic pain]—because some people might have a heart condition, have hypertension, I mean illnesses that are so global that really affect different spheres of your life—it's hard, to be fair, it's really hard for people to understand it. (P13)

Therefore, they accepted that,

> the vast majority of people out there won't be able to understand you. I often jokingly say to my husband that I am a Martian [who] has to live with people on the planet Earth. ... I'm starting to learn that it's even unrealistic to expect people to understand it. So, I think I gave up on that. The level of conversation I have with people is increasingly, unfortunately—I have to say with most people—at a superficial level." (P13)

Not only friends and family but also the HCPs and the social system did not believe them. They struggled to convince their doctors that their pain was not imaginary. Although invisible, their pain was real.

> I went to the hospital, to the emergency, and the doctor who was there told me, "No, you imagine the pain." I told him, "I do not imagine the pain. I am not; I am not here for four hours to [waste] my time. … My [sickness is] not [an] imaginary sickness, [it is a] real sickness." (P3)

While chronic pain is not confined to adults, it is more difficult for people to believe a young person is in pain. Some of the informants were teenagers when they encountered HCPs for the first time. One woman was not believed because she was too young to have pain. The participant described how her young age had been a disadvantage in her encounter with HCPs, "Pain started when I was [young]. It was really early for that age. … No one found out what's that. They're just saying, 'you are super sensitive to pain'" (P1). For some physicians, pain without identified pathology and objective evidence was non-existent pain and remained unreal unless they would find something through laboratory tests or imaging.

Sometimes the women were being questioned by work colleagues and dealing with an unpleasant work atmosphere. While they preferred not to disclose their condition at the workplace, as mentioned earlier, at times, they had to do to regain their credibility:

> One thing that made [one of] my colleagues a little harsh with me, not nice with me, [was that] she didn't understand that I can be very well one day and the next day I cannot. … I decided to find literature and sent it by email to every person who worked with the team. But it wasn't easy. (P3)

"Pain can change people" and "create a new person." As mentioned, pain changed informants' identities and how they became utterly different people, which I discuss in this section. Women accepted pain as part of their current realities. Their experiences with chronic pain were a part of who they were: "Pain is part of my life. … It's part of me; the pain. So, I get used [to it]" (P9). The erosion of self-identity was evident as participants spoke of how the pain had gradually taken over their lives. They talked about how pain was a life-changing reality: "Pain can change people" (P1).

In learning to live with pain, the informants talked in different ways about how their experiences impacted their sense of themselves. Some participants reported a sense of personal loss. They believed that they were no longer the person they had been and described how the experience of pain had altered their perception of themselves. They were no longer the person they used to be, no longer “happy,” “fit,” a “good host,” “mom,” and “wife,” which were central components of their sense of self. The pain took everything that once defined them, stealing their identities. They were unable to perform the roles that were ascribed to them by society.

> Before the [pain], every afternoon, I put on music and dance. I was a very happy person. … I always invited my friends. I cook for everybody. … I cannot invite them [now] because I am not [a] good host as before. I’m [also] not patient. … When [my kids] ask a question, I am not patient. (P5)

It was hard for a few women to accept the loss of their former active selves as they could no longer live the life they had previously. They mourned those losses and felt grief. They continuously compared current ill selves and their former old selves and continued to refer to past and now, indicating an overwhelming sense of loss of a previous, valued self and life. One informant described her transition from being an active sportswoman to an observer:

> I was active. … But now I cannot do simple things that [other] people can do. … I cannot walk like ‘normal’ people. I sit here at the window and see people [who] are running. They are jumping. They are walking, you know. … [The pain has] completely changed my life, and I don’t like this life. (P5)

Defining other people without pain as “normal” suggests that this participant experienced her pain as reflecting “otherness” as a person who was not “normal.” It also appears that the pain changed her sense of identity, which had been previously defined by activity. Another informant echoed this:

> I have to be mature. I have to be an adult and limit myself, and I think that's because my inner child still wants to jump up and down, do things, and we are, as human beings we are very activity-oriented. (P13)

Chronic pain also created a new layer to the identity of some but not all women I interviewed, as they spoke about how they were irreparably altered. Some experienced the loss of their former independent lives. They were no longer the abled-bodied person that they were. The experiences of pain for this group of women were inseparable from their everyday experiences of disability:

> I am disabled; of course, I am disabled. When I am not able to work, when I am not able to cook, when I am not able to clean my house, when sometimes, not always, driving by myself; that means I can't serve by myself; that means disability. (P7)

Moreover, limitation caused by disability was considered "the worst part" of chronic pain to deal with (P8). Yet, there was not a polar distinction between disabled and abled bodies. For most of the women, the severity of their disability determined whether they considered themselves to be a person with a disability:

> It's a spectrum. Not being able to do what I normally was doing, yeah, that was an impairment. Yes, I had to stop working for a period of time. Yes. That was an impairment. But I was able to continue to live in the other aspects of my life. Yes. So maybe for a short period of time. Yes. But totally incapacitated; no. (P6)

Another woman explained:

> I’ve never seen myself as somebody with a disability … because, in a sense, disability is a big word. You know where you are in the spectrum. I am for now; I think I am low. In a sense, I could go to work. I could do chores at home. There are things that I can’t do, but I don’t, I don’t consider myself disabled. I shouldn’t say that I am disabled. (P4)

Yet, the experience of disability usually did not originate in women’s impairments or illnesses. They often arose from how society failed to meet their needs and placed barriers in their way, bringing the social dimension of disability. Some spoke about how buildings were built in a way that was not meant for people with disabilities: “If there is no scooter I don’t go for [shopping]…I can walk with walker better [than cane], but I cannot take walker everywhere” (P5). Another participant recounted the challenges she faced: “Most places I have to go for therapy; there is no parking, even disability parking. Now I have a disability parking, but that doesn’t help at all” (P13).

Sometimes, as a label, the challenge with a disability was so intertwined with stigma. Therefore, women neither wanted that label. For some, being dependent on a disability pension was defined as a disability:

> So, the disability; no-no-no. It’s a big, big, big thing. … I don’t want to be. … I don’t want to be on disability; no, no, I am still young. No-no-no, I can’t. I’m good at work. I can earn my money. I don’t want somebody to give me every month a check or something. I don’t deserve that. I don’t want to abuse the system. … I want to feed myself. (P12)

While some viewed themselves as a person with a disability, their disability claims were denied and not legitimized by social services or insurance companies. One woman, whose application for disability benefits had been refused, explained: “No disability [benefits], no unemployment pays. I applied for both. They said, ‘You are not qualified.’ ... I don’t have [the] energy for fighting them right now” (P7).

Another participant also asserted attempting to qualify for disability benefits was time-consuming: “I have a disability. Yes. But I didn’t have the disability pension because you have to do a lot of work [to get it. … But I have the] pass for handicapped people” (P3).

A couple of informants expressed other aspects of their identity, highlighting their sense of self was not merely defined by pain. For example, one woman (P4) defined herself as an “educated person.” Another woman described herself as: “I am an immigrant educated woman with a disability. … I am a feminist too. I am a mother and wife” (P3).

Sense of personal loss was also characterized by profound diminishing personal control and agency. Women describe how pain controlled and had agency over them, which resulted in the sense of helplessness:

> Pain is an awful experience that you have no control over when it comes. It can take over your life. … It’s basically like part of you for a long period of time, and it’s not a fun part of you. It makes you feel helpless. Sometimes like just it’s nothing I could do to get [rid of] it. It’s, you know, [you] have no control. That’s my basic explanation. (P6)

As the above excerpts indicated, both the loss of personal control and independence contributed to either change or a loss of identity. Moreover, identity negotiation was ongoing, and identities dynamically have been evolving throughout the pain experience. The following account demonstrates how personal identities may shift throughout chronic pain: “The problem with pain [is that you have] to let go of the person you were every year and create a new person, and that can be challenging" (P13).

However, experiences gained from living with chronic pain were not always negatively redefined women, as one participant mentioned: "Pain makes you" (P8). Some other informants indicated that having to live with pain made them much more emphatic and compassionate or a stronger person, as evident in the following excerpts:

> It depends on how you look at pain. It can make you stronger [or] you can be a loser. It depends on how you will deal with it. … I think it makes me stronger. (P1)
>
> I think pain makes people more sensitive and more human. (P9)

Another participant, like several of the other interviewees, explained how living with chronic pain had made her more sensitive and empathic:

> [Pain] gives me appreciation. I go to the shopping mall, and I see people coming with their scooters and their walkers and elderly and frailty and who knows, maybe a hundred different diagnoses. And I just see them very differently. It really gives me a sense of appreciation for what they had to go through and the coping skills they have developed, and how invisible they are; at least, they are invisible to the eyes of many. …These are our role models, and we just pass by them and don't even look at them and give them attention, seek their companionship, and seek their advice. They are a wealth of knowledge, and they are libraries on their own, and we just miss that. (P13)

She then elaborated on how pain prompted an existential search for meaning in life:

> [Pain] has allowed me to think about life at a much deeper level. Look for the meaning of life in little things. In a way that I'm not sure I can ever go back to where I was before with a busier, more demanding, more engaging, more quote and quote successful life that left so little time for that search for meaning, more existential life. So, like everything else, there are two sides to every coin. I think the key to productive coping, to this meaning searching component of pain, is to be aware of the fact that all life experiences just bring something new, a new challenge, and new developmental demand. There is no good or bad about anything. It's about making the best of that situation. (P13)

She continued about the wisdom and growth she gained: "[Pain] is an experience that wakes you up; helps you grow as a person" (P13). Similarly, another informant said, "Pain taught me… [to make] time for observation" (P3). Indeed, some women gained important things such as wisdom and self-awareness resulting from their pain.

Theme four: Coping and Control

The last theme explains the coping mechanisms utilized by the women in response to pain and their endeavours to control the pain and move forward in life. This theme consists of four subthemes. Three categories pertaining to how participants dealt with pain through self-management skills, and one, although interrelated with the other subthemes, mostly illustrate immigrant women's experiences with the health care system.

The informants employed various strategies to control and ease pain, manage pain's consequences, maintain everyday life, fulfil their social roles, and regain a sense of mastery or control over the pain. Because of the pain course's unpredictability and episodic nature, women had to manage pain continually. Therefore, they found that coping with chronic pain was an ongoing process and a highly demanding, stressful task, which needed time management skills, as the following quotations illuminate:

> Getting into the life—just doing your regular daily living activities, your job, your social activities, your mind, having, like, a clear mind—where you don't have to think about how to get out of [pain]—I think that is tiring in itself. (P6)

> These days, I learned how to manage [pain]. For example, if I know I am gonna go out a day, I wake up later, try to have a good sleep, try not to do anything that makes me tired, such [as] time management. (P1)

> How to manage [pain], you know, puts a lot of stress. (P11)

Women utilized a combination of physical, religious, behavioural, social, and psychological approaches to cope with pain, which is highlighted in the next section. Notably, again, the various coping strategies are presented under four distinct subthemes for clarity, yet they indeed overlap, as the following account illustrated:

> Lots of avoidance of many, many activities, adaptation, changing the way you do things, much slower pace, accepting the fact that you can get very few things done in a day, prioritizing. Truly time management skills are required to get through the day. Tremendous maturity to know that many things that give pleasure and meaning to your life, you may have to skip for a long period of time. Tremendous patience. (P13)

Avoidance, pacing, and modification: Listen to my body. Despite the pain, all participants tried to remain active. They frequently adapted their physical positions to mitigate their pain to carry out their daily activities. An informant explained, “Even when I sit on a couch, on a chair, I have to change my position all the time" (P5). To manage pain, they also paced themselves, took short breaks, and moderated their activities. Everyday tasks took more time than before. In one of the participant's words: "The chore that I used to do within two hours, now maybe it will take me four hours because I have to take a break and I cannot do the cleaning and the [other chores] at the same time" (P10). A woman (P3) who loved gardening explained how she had practiced movements needed for gardening (e.g., bending) that did not persist beyond the point of tolerable pain.

Another strategy to cope with pain was avoiding triggers (e.g., food, weather, and stress) resulting in pain. The women needed to be ever vigilant. They listened to their bodies, did what their bodies told them to do, and adjusted activities to their needs to minimize pain. A woman told me, **"**I became very limited in everything. I tried not to aggravate any pain. … I'm just trying to find out what is bothering me, so I avoid" (P8).

The informants described monitoring their pain variations and used it to make daily activities decisions. For instance, one participant highlighted how keeping a diary gave her clues about her pain and facilitated her pain management: "I'm listening to my body. I have a notebook and every day I write it down. For example, if today I eat something that eases the pain, I continue that one. If get worse, I will stop it" (P7).

In contrast, few participants dealt with their pain using an entirely different approach. Sometimes, they attempted to function at the same pace, motivated by a desire to fulfil their obligations as a wife, mother, or grandmother, despite knowing that this was likely to flare up their pain. An informant explained, "I'm taking care of my grandson. But I think that affected me a lot because of the physical [movements]" (P8). Some also pushed themselves on, despite the pain, to avoid being dependent or a burden on others: “I manage my pain as much as I can. I don’t want to be disabled. I don’t want to be at the mercy of other people to do things for me” (P4).

Some women reported that they had drawn upon inner strength to keep going and named it stubbornness: “Some people say, ‘you are lucky you are so mobile.’ But I am stubborn, I make myself mobile” (P11). A couple of women tailored their habits: “I used to go to the shopping [mall], you know, but now I am going to online shopping. All my habits changed” (P1).

Near half of the women used technical aids and assistive devices such as wheelchairs, walkers, canes, and orthotic devices to help them with mobility, be physically active, and perform tasks and daily routines such as cooking. Getting help from others was another coping strategy employed by the participants. Few women paid for housekeeping activities that they could no longer perform.

Several women boosted chronic pain relief by attending exercise classes such as going to a gym, practicing yoga, swimming, and stretching activities (P4, 5, 6, 10, 11, 12, and 13). Sometimes, however, it was difficult to exercise because they were tired, had other priorities, or were very busy. A participant said, “Recently, I feel like I don’t want even to go to the gym; feeling to get there from work is too much for me. … No energy, you know” (P11). Some attempted to balance their roles and responsibilities, rethought their obligations, and redefined their priorities. For example, they gave up activities at home to free up time to devote to other activities: “I started going to gym. I didn’t care about the house. Stay [at the gym] three hours, four hours, take some classes. Enjoy it. … It’s very good for me” (P12). The participant added that it was essential for her to learn to say "no" to demands from others: "I started to think I need to say no when it affects my health" (P12).

Distraction and maintaining social connections as "painkiller." All women strived to keep themselves occupied. This strategy operated at both the body and mind levels. They engaged in pleasurable activities and/or new hobbies they loved to do, such as watching TV (P2 and P5), listening to music and singing (P7), and photography (P8). They explained that these activities help them to forget pain, avoid thinking about pain and make their mind busy:

> Photography is really a meditation for me. It's like I'm not living in this world. (P8)

> Watching TV helps me to forget about the pain. (P2)

For one of the women, however, the distraction strategy did not work:

> Distraction …; I failed miserably. I tried, but it didn't work. …I was not able to do that. [Pain] controlled me [instead] than I was able to control it. (P6)

Some used the language of agency and control. A woman expressed her strength and resilience in challenging chronic pain in these affirming statements:

> I try to avoid thinking about pain. Maybe that's why I'm strong. Even at midnight [when] pain comes, I say, "Go away. I don't want you to stay with me. I [have more] power than you. … Go-go-go-go-go-go-go away [with a laugh], I don't want you." (p7)

As mentioned earlier, when in pain, many avoided engagements in social activities as a coping strategy. It was a way to avoid provoking pain or legitimizing the pain experiences. Yet whenever possible, some engaged in social activities, instead of self-isolating, as a distraction strategy: “Sometimes I go to a party. I like parties. Yes, I am [a] party girl [laugh]. When I come home, I don’t feel this pain” (P2). Like several other interviewees, another informant believed, “The friends, gathering … it’s like a painkiller for you” (P9).

As the above excerpts indicated, women assessed the costs and benefits of engaging in activities. A couple of women found that although engaging in certain pleasurable activities, such as gatherings, could aggravate their pain, the psychological gains derived from this engagement could outweigh the benefits.

Furthermore, some stated that their spirituality and praying were key coping resources. For example, a participant (P4) stated, “After my pray …and my blessings … I really feel good and [it] relaxes me. Yeah, I think even listening to the [holy book] can soothe my mood.”

“Job is a therapy” and “relief.” Four participants (P2, P10, P11, and P12) made themselves busy with work. They explained how their work was a place for healing, recovering, and improving their well-being. The job also prevented feelings of loneliness and boosted their mental health:

> Sometimes work [made] me better. Why? Because I am laughing, smiling, all those things, joking. Leave the stress at home and then go to work. … So, it relieves me from the stress. So, when I go to work, it is really relieving me from stress. … [It helps] forget the pain. (P2)

> [Doctor] recommended that I would stay at home for about one month [to rest], but I couldn’t because of mental health. I was just crying. … I [could] not stay at home. It [was] not good for my mental health. (P10)

Giving meaning to the lives of other people, particularly immigrants, brought self-realization and self-respect:

> I like [my job]. I'll keep with it because [it] keeps me energetic … I'd like to help, to support. I want to support [people who] don't have anybody. They have no friends. I don't want them to be myself. … Job is a therapy for me because when I [help people], they become happy with. … I think the job is wonderful for me. …work is a relief for me; it's my life. … I have no family and [am a] very sociable person. … I don't like being stuck at home. (P12)

A combination of coping strategies was also used in the workplace, including modifying activities, limiting time spent, pacing, adjusting working hours, and flexible working arrangements, which enabled women to perform work tasks. Few had to manage mobility issues for getting to, from, and around work. Consequently, a degree of autonomy to work from home or schedule was great support provided by their employers. An informant said,

> I am tired in the morning, and I have to go [to work] later. I had to tell my supervisor that I had these, and I made my own schedule to come later and stay later. It was not a problem for me to stay later [and my supervisor accepted]. (P3)

Another interviewee explained,

> I talked to my supervisor, and she advised me, "Work half days, and then we'll see what will happen." I tried that for two weeks, but it was exhausting. … After two weeks, I told her, "I cannot do it," and tried alternate working; one day work and one day off. I have had [this] routine since then. (P10)

Another strategy was ergonomic adjustments, which reduced the amount of discomfort and pain they felt and the body's strain. An informant reported, "At work, I had to have an ergo assessment done. They had changed my chair, my desk. They had given me a different kind of mouse" (P6). Yet, coping strategies were reported less frequently at work because they resulted in others becoming aware of women's condition—most of the time, the participants were reluctant to share their experiences with their colleagues, as stated earlier.

Search for information: Knowledge is power. All women took other proactive measures and sought information from the Internet, books, or other resources. They spent countless hours searching for different resources to help overcome pain. They elicited information from people they trusted, such as friends, families, support groups, and HCPs, to better understand their conditions. They looked for information about their conditions, how their pain could be treated and when they would get better, and if there would be any cure. They conducted their own research and commonly reported that they needed to become knowledgeable regarding their pain to enhance their ability to cope and make decisions, as illustrated in the following excerpts:

> I did a lot of research on my own … reading books and going online. (P11)
>
> Last year I had very bad pain [in a new area]. I went to YouTube. I found an exercise. … [The video] explained how to do it. It released that muscle, which was stuck, and I got rid of the pain. … I am a good researcher [laugh]. (P8)
>
> I discovered a new treatment [suggested by a friend of mine]. So, I went to get an assessment and did one session, two sessions; by session five, the pain has significantly relieved. ... It's not gone one hundred percent, but it's like I can live, I can manage. (P6)

Less than a third of the women participated in support groups and reported that it offered connection, compassion, and understanding during their journeys. Take, for instance, the following extracts:

> I went to [that] Association and took the course. … They have specialists. They have people who will help you like physiotherapists, psychologists… different kinds of support. They are very well in support. … The information is very important. It's very, very important. (P3)

> I am going to the [Association's] meeting every month, so they have some tips. I still don't feel one hundred percent but [it] effects. (P1)

Seeking treatment for chronic pain: Experiences of being a patient in pain. To reduce their pain, all participants also used medical and alternative therapies such as physiotherapy, massage therapy, acupuncture, chiropractic, and meditation, including mindfulness. A few sought psychological support. The informants used various therapies to ease persistent pain, from medications, such as anti-inflammatories, and opioid and non-opioid painkillers, to injections and surgical procedures. Some of the therapies women used helped them relieve their pain, some did not, and some even made things worse: "With the chiropractic, acupuncture, the physio, and the massage my [pain got better but] I still cannot sit for a long time on the chair" (P10).

All participants mentioned taking painkillers: "I never go to walk without Aleve or ibuprofen. I have to wake up early in the morning and put it in my mouth before going to work; otherwise, I couldn't even stand" (P2). Nonetheless, most women were reluctant to take prescription medication and not be willing to use "chemical" means to treat chronic pain. A couple of women reported negative experiences with chemicals and unfavourable side effects.

Some interviewees found other ways to accommodate their pain. For example, a couple of interviewees used “hot packs” (P1, P6, and P10), “herbal remedies” (P2, P3, P4, P9, and P11), or “visited a naturopath” (P1, P8, P11), which offered temporary relief.

As I covered initially, seeking health care was another coping strategy utilized by all women. The first step on the pain journey was often the medical diagnosis to get a meaning, although a medical one. Informants reported a search for a cause of the pain and a strong desire for a medical diagnosis. A biomedical explanation was necessary to affirm what they experienced was not imaginary. Besides, determining an underlying reason for the pain was critical in understanding how pain could be fixed or helped them make decisions. A participant explained,

> [The pain] continued for years and years. Either MRI, they said, “Nothing; doesn’t show anything.” … I tried to find a specialist on my own to see. … So, I asked my doctor to refer me there, and I went there and [the doctor] did some tests and everything. And [the doctor] said, “…it’s a lot of pressure on that nerve and causing [pain].” So, I said, “What’s the solution for that?” (P11)

Another informant stated: “I was looking for a reason for pain…I am always curious...curious about my body…it [finding the reason] helps for my decisions. … It’s not inheritance or not in my sequence that kind of things” (P1). In that journey, as previously stated, some women reported being mistrusted, unheard, and/or psychologized by their HCPs. They described that their doctors did not take their pain seriously, which caused distress. When women were told nothing was wrong with them, all in their heads, or they were stressed out; they interpreted these as their pains were psychogenic.

The women had various views on and experiences with pain treatment and management. A couple of women were highly disappointed with the quality of pain management services. Their encounters were associated with disagreement and disappointments and therefore were critical of some services they had received. Take, for example, this passage:

> When it comes to pain, definitely the level of knowledge and understanding of the complexity of pain often lack, [including an] accurate diagnosis. It takes many, many years for people even to have a diagnosis; very often, that's even not an accurate diagnosis and the fact [is] that we just don't have ways of dealing with pain. We don't have the tools…or maybe because it's so expensive, the system doesn't want to spend. … [The] priorities are different in our health care system, and pain is at the very bottom of the ladder. …from knowledge to expertise, skills, understanding, treatment availability, funding availability, everything is lacking. …even the gold standard, the so-called pain clinics we have in Ottawa, [are] not even an interdisciplinary clinic. If they have social workers and nurses, who knows? If they [have a] physiotherapist, I haven't seen that. But if they do, then it's a tokenism because they are not using them. These people are just there to support the medical staff with their medication prescriptions and injections, and procedures. Where are the supports for psychosocial aspects of the experience of pain? That's really not there. A couple of years ago, they referred me to this program that was supposed to be exactly what I'm talking about. It was [an] extremely basic one. I went for the information session, and I decided not to go for the actual program. …it was such a diluted intervention […that] I said to the representative of the program that I don't see [where] your intervention is. … In fact, there were maybe about 15-20 of us that participated in the information session, and more than half decided not to go along with

> it. … Another major shortcoming of our system [is] that everything comes out of pocket. There is no rehabilitation covered by OHIP for people with chronic pain. … OHIP doesn't cover physio. I have insurance, but it covers 80 percent of what the insurance company considers legitimate billing, which is only a hundred dollars per session. So, about half of it is out of pocket. That's just one. They are so many times my medications have not covered or supplemental not covered or whether it is occupational therapies or other practitioners that have not even been recognized by insurance or others. So that's certainly that's a major drain. … I have a wonderful family physician, a major resource really for me. [But] I've had terrible specialists in the past, very unhelpful, very narrow-minded. (P13)

The women also talked about HCPs' lack of empathy, knowledge in pain management, and effective interprofessional communication. The participants repeatedly mentioned long waiting times to see a specialist or get into pain clinics, short consultation times, delay in diagnosis, cultural incompatibility of services, affordability issues, and lack of an integrated multidisciplinary approach. Women asserted that not acknowledging the many inter-and intra-group differences between and among immigrant and refugee populations might obscure how chronic pain was experienced, understood, and coped. After diagnosis and treatment, ongoing support from HCPs was also fundamental in the pain journey. The health care system's failure to recognize their pain, find a cause, or provide effective treatments, contributed to feelings of hopelessness, frustration, and helplessness.

The women also spoke about having better access to a range of traditional and alternative treatment services beyond medication, such as acupuncture, chiropractic, psychological support, physiotherapy, and occupational therapy. Some of the women were ill-informed about treatment choices; elements of power and autonomy were always at play. A few were denied being referred to alternative care providers to treat their pain because the physician thought that treatment would be ineffective. Consequently, some women considered their family physicians gatekeepers who controlled women's access to consultations with specialists or other HCPs. Yet, most women were powerful advocates for themselves. They had learned that self-advocacy was a critical key in the Canadian health care system:

> [Physicians] take for granted that they are in a position of power. … Even my doctor; I like him very much. He's been my doctor for a long time, but we came a long way because of the way he used to talk to me; [he] patronized me. Talking not down, but in a way that [seemed] I didn't understand. I told him, "Wait a minute! You know this is not what I am telling you. … You don't listen to me, and I have to listen to you. … I have to take care of my body. I know what is good for me, what is bad. If I know that I couldn't walk or function without that medication, I might have taken it, but I [should have] a choice to say no." … I [also] remember that [a] doctor gave me a medication. … And I read the medication [brochure information] before I took it and found I have an allergy. I was upset, but I'm glad I knew how to read and understand that I am allergic to it. … The doctor didn't explain. The pharmacist didn't explain. [They were] really not paying the extra attention. They should take time. (P4)

As illustrated above, the women believed that listening to the patient, giving information, and sorting out options were critical to creating trust between patient and provider. Providing detailed information about the treatments and possible side effects was highlighted as a key to making informed choices. Participants also spoke that it was essential for providers to view them as human and not as objects and understand this wholeness. While most of the women endorsed their HCPs who were caring, not all medical encounters turned out as the women had desired:

> You are not an object. You are a person with all the content a person has and the struggles [a] person has. … One of the things that I realized is that the doctor has ten minutes for you. Ten minutes! That's why I love my doctor because he stays with you. He listens and asks you, "[Do] you have another thing you want to share with me?" The patience, caring, and, you know, that he's trying to help you. … But other doctors take a position very far from the patient. When you're crying in the consultation because you have pain and don't know [what] to do, and you have a family, they say, "Do not be emotional!" [And then they offer you] a Kleenex. That's not the way. The person is crying because something happened…be more human. (P3)

Informants also discussed that sometimes the physician's apparent solutions might not be best suited to the patient: "Believe me, my family doctor, the only thing they gave me [was a] painkiller. And they said [go to] physiotherapy. But physiotherapy is not covered, its expense [is not covered]" (P9)

A woman reported racism, stereotyping, and discrimination in the health care system:

> I can see firsthand stereotypes, neglect, [and] racism that is embedded in the health [system]. Many, many doctors, or health practitioners don't have the sensitivity to how to really take care of a person as a whole. … [Or] talking me down like I don't understand English. Talking to me loud[ly]. You know I'm telling them, "I understand what you talked to me." (P4)

In encounters with HCPs, some women realized that hoping for a cure was an unrealistic expectation, as the following pieces illustrate:

> I don't believe in hope. … I accepted [pain] as it is; it is not getting better; it might get worse. (P1)

> All these years, I have solved [different types of pain] just by listening to myself to my body and trying to find a solution, but for this one, I think there is no solution. (P8)

> I have tried anything anybody told me because I really want something to relieve my pain. … For many years, I have been suffering every day having this type of pain, and so far, there has been no solution for it, nothing. (P11)

Finally, not all encounters with the Canadian health care system were negative. Some informants encountered HCPs who listened and responded with empathy. A few described how they had gained knowledge from the HCPs' explanations and information. These women had a high level of satisfaction because sufficient consultation time made them feel validated and heard. One interviewee who was pleased with her family doctor and services available within her community stated: "I'm fortunate that I do have a family doctor who is part of like community health centre. … My community health centre is pretty good. It's very multicultural and dealing with immigrant and refugee people for a long time" (P6).

Struggling and acceptance: Do not fight. Women learned to live with pain instead of battling and fighting against it. One participant explained how a friend's advice had helped her to accept the reality of pain:

> He said, “if you want to fight it every day and say, ‘Why it affected me? Why me? … Why not someone else?’ It is gonna bother you all your life. But if you accept it and never think about those ifs, you can deal with it.” And I found it true. … I think when you accept something … it gives you strength. (P1)

Acceptance meant that the informant focused on learning to live with pain, as she expressed the idea of achieving a balance between fighting against pain and living with pain. As the above excerpt indicates, pain management was a learning journey and took a little while. Another interviewee echoes this: “[At] the beginning I was crying all-time—all-time crying how I will live. What will I do with this pain? … [Now] I *laugh all-time* [her emphasis] with this pain” (P9). Another participant, like several of the other interviewees, noted,

> The problem with progressive pain—not just chronic long term—but chronic and progressive illness, including pain, is that you are constantly challenged with new demands. … In the beginning, it’s a shock. So, you’re kind of, you’re used to your past coping, your past strategies, your past lifestyle. It really shakes you up. That transition, hopefully, if it does take place, you come up with a more advantageous position. If you get stuck, then it’s too much and too overwhelming. It can be very damaging. (P13)

Given the identity crisis mentioned earlier, acceptance was a fundamental component in shaping the informant’s adjustment to living with chronic pain. Acceptance was a crucial stage in their journeys to move forward with their lives: “If you don’t accept [the reality of pain], you can’t deal with it. I am not saying fighting but dealing with it. That’s different. That’s the key I’ve found during [my journey]” (P7).

Adopting a positive attitude towards their experiences with pain was another strategy used by some participants. For example, a few focused on what they could still do rather than what they could no longer do because of the pain. Some reminded themselves that other people were living with other health conditions, and therefore they were not alone:

> It’s sad to have pain. Even [I was] crying. I tried to finish that [thoughts]. I tried to see it as a condition. I tried to risk analysis. I said, “OK other people have other conditions, and I have this condition.” (P3)

Chapter Six: Findings - Caregivers’ Viewpoints

This chapter presents findings based on my interviews with caregivers (N = 5). As stated earlier, caregivers—who the women had nominated—were interviewed to understand the experience of chronic pain within a broader social context. To learn about the variation in their care provision experiences, I purposively strived to recruit informants with different relationships with the women. The caregivers included four family caregivers, two spouses and two adult children, and one HCP providing alternative care who was involved in one of the women’s care. All family caregivers were economically active. As a result, they bore a double burden of working and being caregivers.

The caregivers’ accounts have highlighted various lived experiences; each offered different insights depending on the severity of pain, their relation to the woman experiencing pain, and the number of persons who provided care. For example, a spouse perceived a constant pressure to meet the wife’s care needs he supported, but not all caregivers followed this trajectory. In the following sections, I provide the definition of pain, root causes of chronic pain, consequences of the pain, and coping strategies from the caregivers’ perspectives.

Theme One: The Trajectory and Meaning of Pain

Like the women living with pain, most caregivers believed that pain was difficult to describe. One participant said, “You can’t define [pain]” (C2). A spousal carer explained the reason: “I’m not the person living with chronic pain. I think the sufferers would be in the best position to define it” (C5). Another interviewee voiced a similar opinion: “I think it’s very difficult to find a word to define [pain], and everybody’s pain is different. [It is] discomfort. [It] can be physical pain. It can be emotional pain and, you know, the level, again, is very subjective" (C3).

Theme Two: Reasons for Pain and Triggering Factors

In many respects, the caregivers' perspectives regarding the reasons for their care recipients' pain were similar to the women's opinions. The carer recognized pain as a complex, biopsychosocial phenomenon in which biological (e.g., genetic, biochemical), psychological (e.g., mood, stress), and social factors (e.g., cultural, familial, socioeconomic)—unique to each individual—dynamically interact with each other. Like the women, they viewed pain holistically, integrating the body, mind, and society. The impacts of gendered roles and responsibilities as well as the impact of immigration and downward mobility were also raised by caregivers echoing the experiences described by the women.

In agreement with the women's perspective, the caregivers described how cumulative damage of stressful life events, such as discrimination, poverty, living in a war zone, accidents, and divorce, during the life course led to the pain. Take, for example, the following excerpt, which highlights the intersections of gender, immigration, employment, and income:

> My mom was the firstborn child. … She had brothers and sisters to take care of. And from that, she really did, unfortunately, carry a lot of emotional and physical burdens. She had to do a lot of things, you know, around the house, cooking, cleaning, taking care of children, lifting a child, things like that, which probably really impacted her physically, and building up when we moved to Canada. … I think when she moved here, her body wasn't exposed to the chemicals and things like that. I think from a cellular level, her pain began to multiply, and she was getting inflammation in her body. I also

> think, oh, some of her pain is probably, you know, …emotional problems, getting divorced, with children, no job, no money, barely any clothing—I think that that was also stressed on her. And obviously, we know now that stress triggers your body parts as well. … I think a lot of her pain also comes from her always being scared for us all the time. … I think that fear causes pain as well. …my mom was always in pain over worrying about [her kids]—scared to put your child in a situation where they're stuck at ESL, they might not catch up, and they might be bullied because of their accent or whatever. …anything that doesn't make you feel good is obviously going to excrete bad chemicals in your body, bad hormones in your body. Your levels of cortisol or whatever will go up, and you know it impacts everything inside of you. … She [also] speaks to her family back home every single day. If they're having a problem, she's in their problem 100 percent, and she's trying to fix it, and she goes to bed thinking about it, and she wakes up in the morning thinking about it, and she's always trying to come up with solutions. She's not physically there to be able to support them with a lot of things. So, all she can do is support them in her brain, which in turn is probably destroying her body physically. … A lot of physical deterioration happens with stress. … And unfortunately, I think that the commitments that she has,…I think, every single day, it makes it worse. … She never has time to heal. She always has so many responsibilities. (C1)

The alternative HCP articulated several reasons, underscored the intersection of gender with other determinants of health, such as occupation and income:

> Being [an] immigrant here, being a single mom, working hard to survive a family, forgetting about the lifestyle that she could provide for herself, such as exercise, eating healthy, not having stress, all of those accumulations… some trauma that she had. [Also]

you’re worried about yourself and your family …sometimes you have to start labour work, and all of those physical demands, [and] emotional demands—emotional demand on immigrants is so much that the chronic pain starts first emotionally. And after that, of course, emotional [factors] affect the [body]—there is a big relationship. [Additionally] …more workload on women—you have to work outside; you have to work inside. So, for sure, gender matters. [Also, after a severe pain crisis], she pushed herself to go back to work … because of [her] financial situation [to] bring food to the table. I think those clearly affect her. (C3)

A spousal carer said:

All the items together…the immune response…all of them attacking. …the moods, the age. ...the nature of [her work] was demanding and stressful. [Besides] you have to leave everything; everything you built. Come here [and] start from zero; that’s stress. That’s, that’s a pain. (C2)

Another interviewee pinpointed the following reasons:

I think it comes from trauma that she has survived as well as autoimmune [conditions]. I guess, you know, people are genetically predisposed [and] the environment and trauma bring it out. … She’s lived through two wars, and I think trauma and psychological part can also impact your body. …losing people, losing your homeland … working full time…worrying about people back home. [Also, people] passed away in a faraway, and we’re not there for the rituals. So, I think that takes a toll on people like my mom. (C4)

The informant continued:

> A lot of people in our culture, [when] something happens to them, [for example, if] they hit their knee or fall, they'll just keep going. They try to be tough. I think, in our communities, we have to really push people to feel comfortable asking for help. Even my mom, some days, talked like, you know, "I don't want to bother you." Come on! You're not bothering me. *It's, it's, it's cultural*. It's like, it's pride. (C4)

Another participant, C3, had a similar opinion. In their experience, when non-immigrants are in pain, they look immediately for help. Conversely, immigrants don't look at the very earliest stage of their pain for help; they ignore it. While financial issues, lack of insurance for alternative care, and being busy were among the reasons for the delay, the informant believed that immigrants seek help primarily when the pain level is so strong to stop them form functioning.

The caregivers identified various triggering factors that increased the pain, such as cold weather and emotional stress, which were in agreement with the women's perspectives. However, given the complex causality of pain, as discussed, it was difficult for some participants to determine unfavourable factors.

Theme Three: Pain Consequences

Caregivers explained how the pain affected the women's lives in their entirety. For instance, an informant said, "the person with her ability is now not able to do very simple things. …deciding between watering plants or taking a shower [seems] a joke, but now it's a reality." (C2)

In agreement with the women, the caregivers reported pain had prevented the care recipients from performing many tasks. Consequently, the caregivers provided a comprehensive range of support, primarily instrumental activities of daily living, including physical care, housework, shopping, providing transportation, emotional support, and accompanying the women to medical and other appointments. Just as family caregivers played a crucial role in the women's adjustment to and living with pain, they, themselves, were also affected by the women's pain, which will be discussed in the next section. Identity-change also noted by caregivers. For example, a caregiver mentioned, "I describe the pain as something that completely takes over your personality…and changes you. …pain becomes part of your personality" (C1). Likewise, a spouse, C2, said that his wife was not the person he had known, highlighting the identity changes over time, echoed by some women. Some participants, akin to the women, also believed that pain was part of the women's life. One explained the reason: "she's lived with her [pain] for so long [that] I don't think she remembers what it feels like to not be in pain… she's just used to it" (C1).

Being a child in the context of chronic pain. As mentioned earlier, mothering roles, particularly in caring for young children, were noticeably impacted. While mothers reported having trouble playing physical games with their children, children described facing difficulties in nurturing relationships with their mothers that were taken for granted by most children. Lifting children, giving them a nurturing touch, and a big warm cuddle were adversely affected by the pain. As mothers learned to live with their pain, the children grew up with it. An informant whose mother had been living with chronic pain for a long time remarked:

> I remember certain things…from my childhood that I always wanted, but I didn't get [them] because she was always in pain. So little things, you know, you're three or four years old, and you want your mom to pick you up and hold you. And because my parents were divorced, my dad couldn't do that. He wasn't there. So, I would see all the kids

> around me and, you know, their parents would pick them up and hold them—my mom could never do that. I know why now, and now it's not a problem, but that really bothered me as a child. I remember always wanting to sleep next to my mom in her bed, but because she was in pain all the time, she needed rest. … She never let me sleep next to her. (C1)

Chronic pain in the context of everyday life. Family caregivers also faced some challenges in managing their loved one's chronic pain in the context of everyday life. Caring for the women living with chronic pain created considerable strain for carers and affected their family and personal life, work schedules, and social relationships. The pain has had a significant impact on the organization of social and family life, including the division of household tasks between spouses. Adult children caregivers did not live with their mothers. Thus, they had less intensive direct exposure to their mothers' pain than the spousal caregivers.

Findings also indicated that seeing a loved one suffering without being able to ease the pain resulted in stress, loneliness, and even burnout—the more demanding the caregiver's responsibilities, the greater the amount of emotional stress. Consequently, not surprisingly, a spousal carer reported diminished psychological well-being, elevated stress, and mental health issues. For this informant, who was the primary caregiver, chronic pain was a life-changing reality that permeated all aspects of his life and created day-to-day challenges. He adjusted his social roles to accommodate his wife's physical limitations, as the pain impacted her ability to complete household activities—the unpredictable nature of pain magnified the constant demands to meet his wife's care needs.

The severe pain of his wife also contributed to increased interpersonal conflict and discord. Moreover, chronic pain had prevented his wife from participating in regular social activities she and her husband used to do. Therefore, they stopped participating in those activities, which limited their social engagement. The informant also reported losing social interaction opportunities with mutual friends, which worsened feelings of loneliness. When he left the house to attend to necessary outside matters, he reported feeling guilty for leaving his wife. He explained:

> I saw her suffering, [so] I suffer, but I shouldn't express that. I'm suffering [but] someone should control the life. Pain, well, yeah, raises a lot of fight…her pain causes her being less tolerant, [makes her] angry. She just wants to put anger at someone. I understand. Sometimes it makes me more nervous. Sometimes it causes me to get more tired—tired of discussions over and over and over. Some of the activities have not happened anymore. … Some of the activities are not going to happen together—not [ride] bike together…not going to a lot of parties…not to gym…definitely we have lower energy at home. … [In the mornings], I don't have time. I have to rush to work. … Mainly, I'm not happy she's in pain, consistent pain. I should sometimes ignore it, not talk about it, just to control the situation. … It has affected me. (C2)

This participant found himself disoriented with a loss of the familiar world but tried to control his emotions, redefine priorities, cope with new responsibilities, and govern the situation, which will be elaborated more on in the coping and control section. He also reported a loss of their former intimate relationship and mourned that, highlighting his yearning for the past. In addition, this partner commented on his own unique identity challenges—as he shifted from a partner to a caregiver.

Another participant, C5, also stressed how observing the experience of pain was distressing and exhausting: “Perhaps the main challenge is to witness the difficulties the person [living with pain] faces and not always know how to help.” He continued, “The lack of family network and social support place greater demands on both the person and the helping family member” (C5).

As the above excerpt indicated, caregiving’s burden was augmented by the lack of social support and family network because of immigration. Nevertheless, sometimes, network ties with family, friends, and colleagues were a source of stress and strain: “Family thinks [she is] lazy. Family thinks [she is] nagging. Family thinks [she is], you know, faking” (C2). This participant explained how the family’s high expectations destroyed his wife’s self-image and resulted in her feeling unworthy and being like “a garbage” who depends on his husband’s “charity work”—the family viewed her as an object of his pity.

Another issue raised by carers was their role in legitimizing pain, highlighting that not being understood and having genuine compassion made the women’s hardships more difficult to bear, echoing the women’s perspectives. For instance, an informant noted, “it’s sad that [my mom] has to live [with pain]. It’s even sadder that people around don’t understand” (C1).

Finally, an adult child carer who was also dealing with her own health issues described how she learned to set caregiving boundaries, but not being able to do enough for her mother and give back to her further contributed to the feeling of guilt and helplessness:

> She has a different style than me, like she wants to get everything done. I sometimes choose to put things on hold to take care of myself. Sometimes I feel guilty. … I feel helpless… hopeless, and sad for her. I can’t make things better. But I try to be there for

> her emotionally. … I mean, I have a lot of empathy for her. … Sometimes, I feel like I am doing enough? (C4)

Consequently, she decided to relocate to a nearby residence, indicating the impact of geography. She explained the reason:

> Right now, I can help her. But if things get worse from now, it'll be very tough. … In our culture, we keep our family together. I can't picture my parents go to homecare or something like [that]. I probably want them to live near me or with me. (C4)

This passage also stressed how cultural values played an enormous role in the caregiving journey, implying the intersection of geography, gender, and culture. The excerpt also showed the informant's concerns about the future and living in uncertainty. A similar issue was raised by a spousal caregiver, C2, who extensively talked about his worries, fears, and anxieties because of an uncertain prognosis and an unpredictable course of the pain. He believed the future he and his wife had imagined for themselves as a family unit might no longer be attainable, and they could not achieve their life goals as planned.

In a nutshell, these examples underscore the broad range of emotional reactions such as loneliness, helplessness, alienation, and guilt when witnessing a loved one undergo a painful experience. The burden of caregiving was augmented by the lack of social support and family network. These feelings were made worse and frequently triggered by insensitive remarks and high family expectations, which will be elaborated on later. The impacts of pain were far-reaching into the family structure, particularly for spouses, including financial and social activity losses, as well as role reversals.

Even though caregivers faced many mental, emotional, physical, and financial challenges, they could find meaning in their caregiver role. Indeed, caretaking was an opportunity to learn valuable lessons and made the caregiver-care recipient's time together more precious. Taking care of loved ones living with chronic pain was associated with a sense of greater personal strength and a deeper appreciation of life. Chronic pain trajectory was considered a long joint journey for all family caregivers, where activities were shared and enjoyed together for some. A caregiver offered insights about how she learnt life lessons from her mom's pain:

> I never felt like a burden with [the help I provide]. My mom makes the help that I give her not seem like help. It's no help for me. It was like that time that I was hanging out with my mom. …she's the type of person who doesn't let her pain ever interfere with anybody's life. She doesn't even talk about her pain, and she doesn't even show it. …you'll see it on her face, and you'll feel really bad …she's very independent. … I think her pain has affected my life—I hate to say this; it sounds rude—positively … I see how hard my mom works, and it makes me want to work just as hard. I see how much pain she's in every single day. … She motivates me; if she could do [something], I'm an able-bodied person with zero pain in my life, could do it [too]. So, I think that positively it has impacted me. I'm sure negatively it has impacted me as well. … I think it makes me a better person. (C1)

A spouse echoed a similar view indicating that such experience "can help you become more empathic, resilient, and open-minded; and hopefully less-judgmental of others' life experiences that are different from our own" (C5). He also emphasized that he did not see himself as a caregiver. Indeed, in his words, he lived “with a loved one with chronic pain,” underscoring the reciprocal supportive partnership.

Theme Four: Coping and Control

The caregivers described various strategies that women employed to control and ease the pain, including physical, religious, behavioural, social, and psychological approaches echoing what the women explained. Medication was one of the main methods of managing the pain for all participants, in line with a biomedical approach. Nonetheless, the medication was often caused severe side effects and viewed as bothersome as the pain itself. A carer went on to describe:

> When [my mom] came here, she thought, like everybody else, “Western medicine’s going to be great. It’s free, so beneficial; I’m so happy.” But then, once, it started to destroy different parts of her. I think that she came to her senses, started doing her own research, and eliminated certain things. …she was smart enough to stop it and not let it go too far. … She figured it out herself because, excuse me, her doctors never did. Once she figured out what was exacerbating her pain, she was able to [reduce the pain by] eliminating [the factor]. … The health care system…failed her. I think that my mom came to this country trusting the health care system, and the health care system put her on medication for over 20 years, which destroyed the rest of her body; gave her surgeries that, at this point, we don’t know if she needed to do that. It was all free, but did it make her worse. If the medicine is hurting them, then at least give them an alternative. I think that support means giving several options. You’re not supporting someone by choosing an option for them. … And you know she struggles to find a good doctor in which she

> finds one [finally]. …She has had to find these things [by her own]…it hasn't been easy, but she was able to overcome it. (C1)

This excerpt also highlighted the importance of establishing a good rapport for satisfying patient-provider interactions. However, developing such rapport took time and was mainly created because of the women's effective advocacy. Another carer shared a similar experience: "I think over the years my mom has had a really much better relationship with her doctor, but I think it was a lot of because she's able to advocate for herself and speak English very well" (C4). Moreover, some carers became advocates for the care recipient, as they found it "tiring to have to advocate for yourself. Somebody should be advocating for you. … I'll continue to support my mom from her standpoint. If there are appointments that she would like me to go with her, I'll go." (C4) The caregiver's advocacy extended beyond medical care and included supporting the women's values, beliefs, and ideas.

Emerging from the interviews with professional and family caregivers was also a picture of a fragmented health system, resulting in suboptimal care. The caregivers' experiences with HCPs were marked by the gaps in compassionate, inclusive care and the absence of choice. The informants questioned the myopic, individualistic, and biological focus in health care, with a hierarchical prejudice that stigmatized the women and constrained their choices. The caregivers defined good care as a whole person care approach—acknowledging the different elements that makeup who patients are as people and employing a range of treatment modalities. They emphasized the need for a holistic treatment, which meant receiving multidisciplinary support and continuity of care in a more comprehensive, easily accessible, and timely manner. Another caregiver, C5, noted, "Medical science's underdeveloped interventions targeting pain, a narrow focus on medications, long waiting times, cost of rehab services not covered by OHIP, insensitivity of health professionals, the lack of a holistic approach to patient care" were barriers to care. A lack of timely access to care, particularly pain clinics, was also raised by a carer, C2, whose wife was waiting nearly two years to access the treatment she needed.

Interviewees felt that women were forced to use their own initiative and make suggestions to HCPs for potential choices. An informant, trained and practiced in alternative health care, expressed the following concerns:

> … One of the things I've found in Canada's health system [is that] we don't put enough time for our diagnosis, especially the family doctors. … One of the problems we have in Canada is that the family doctors are overloaded with many cases. Also, emergency departments…I think they are overloaded with not that much knowledge to diagnose—based on a short history, you have to explain in five minutes of the doctors' time they diagnose you. … Some doctors never told [patients that they] had an alternative…The patients themselves are looking for alternatives… [but] sometimes it's late; already damage happened. … Unfortunately, this is so so hard for family doctors, at least 90 percent of them, to send their patients to alternative care professionals. You know, there is no relationship in Canada between alternative care and medicine. I had to work hard to prove myself, and I wish they would be a bit more open-minded. I've heard from a lot of my patients that doctors [told them], "Oh, you want to see a physiotherapist, chiropractor, naturopath; what can they do for you?" … If OHIP can cover alternative medicine…I think people can become out of that chronic pain much faster. (C3)

A carer had a comparable opinion: "Chiropractic and massage seem something fancy… but it's not fancy for the person with [pain]" (C2).

Lastly, similar to the women, an interviewee addressed how some HCPs treat pain based on racial profiling and class discrimination and how the concerns of racialized women were brushed off:

> I think health care providers don’t always take racialized women seriously. … It could be perceived class issues. Sometimes when they find out [my mom] is educated, they suddenly give her more respect, which is ridiculous. I mean, I have seen people say to my mom like, “Oh, you have a university degree. Oh, you have degrees.” Suddenly it’s like you’re not like those women over there. It’s a lot of assumptions. I think, and it’s not just healthcare providers. (C4)

The participant also recalled another encounter with an HCP. The care recipient was in a hospital because of a skin rash following an allergic reaction to a medication. The HCP told her, “I don’t know what to tell you. You’re so dark.” The informant continued:

> … And I know things like that hurt her. … I don’t know if that doctor was racist, but he wasn’t culturally competent. Things like that, and I know, sometimes healthcare professionals, I don’t know, maybe see the hijab or something [else, then] they make assumptions and speak to her very loudly… it’s stressful. (C4)

It is important to note that the caregivers, themselves, utilized self-protective measures to balance caregiving tasks with their other activities and cope with caregiving responsibilities. As mentioned earlier, some attempted to know their limits, made time for themselves, or sought HCPs consultation and shared their concerns about the effects of caregiving on their mental and emotional health. They also interacted with the health care system to obtain information and services or negotiated with other family members to mobilize their support and divide their care responsibilities. Yet, even in families where siblings made collective caretaking, women still provide most informal care, particularly emotional care, highlighting the gendered nature of caregiving.

Chapter Seven: Findings – Physicians' Perspectives

This section is organized around physicians' experiences providing care to chronic pain patients, including six participants with various specialties. All worked in the chronic pain management field; most described their clinical settings as tertiary pain clinics. The majority of respondents were women, and one-third had nearly two decades of clinical experience. To avoid breaching respondents' anonymity considering their small sample size, I decided not to disclose their sociodemographic data in detail. Nonetheless, I acknowledge that the physicians were not a homogeneous group. Their age, gender, and class, among other social identities, shaped their experiences.

The Trajectory and Meaning of Pain

To describe pain, several interviewees (Dr2, Dr3, and Dr4) followed the ISAP definition of pain and the science underpinning it; it was not the terms in which women and their family caregivers expressed pain. For example, a physician defined pain as "an unpleasant sensation that's usually associated with not real or potential, tissue damage or injury" (Dr2). Another informant explained that chronic pain is "very likely a reorganization of the nervous system to continue sending pain messages even if that warning system is no longer needed" (Dr5).

While pain is understood scientifically, similar to the women and caregivers, physicians believed that pain was a "subjective experience" (Dr5), highlighting that "everybody's experience of pain is different" (Dr1) and "everyone has their own story" (Dr6). Like the women, the physicians believed that pain "prevents you from doing things you want to do or have to do" (Dr1), underscoring the impact of pain.

Importance of culture. The influence of culture on pain definition and experiences of pain was a dominant topic. As pointed out by all participants, the experiences of pain were linked to cultural beliefs and norms. The physicians highlighted that culture could influence the meanings, definitions, and expression of pain as well as pain intensity and tolerance; how pain was expressed depends upon cultural factors that interacted with the nature of the internal pain experience. For example, an informant said:

> Pain has very different cultural implications from one culture to the next. …it seems that people who are foreign-born ascribe more sort of existential meaning to the pain. … I'm sure that not all people who are foreign-born think this way, but I do know that some do. (Dr5)

Another interviewee had a similar opinion:

> What [pain] means has a lot to do with where you come from, what your culture is, and what the expectations of society are on you. … We get some people who are very very stoic and may present with a history that leads us to believe that they are suffering from like incapacitating totally debilitating pain. They may never say a word. (Dr1)

Similarly, another physician noted that cultures differed in their styles of communication; therefore, some people might not verbally express their pain, or they might rate pain as lower:

> Culturally, the way patients express pain is variable; that doesn't necessarily affect the amount of pain someone's experiencing. It's just the amount of emotion they're putting out when describing their pain. … I think the way pain is communicated varies. …some cultures [give] a more emotional description of pain, like they're more vocal and louder, and some will be more stoic … there's also a spectrum in every culture. (Dr3)

As the above excerpts indicated, although physicians admitted that how individuals respond to and express their pain varied between cultures, they believed that these dimensions were by no means consistent across a group of individuals or comprehensive—diversity exists within any culture. A similar concern was raised by another informant, whose words echoed those of the participants above: “These are all stereotypes, obviously stereotypes. It doesn’t obviously work for each person in that population. … I feel like that all important things to know are about how somebody is going to see the world” (Dr6). The cultural differences in pain experience, as one participant noted, were not limited to immigrants; There was a lot of diversity within Canada: “I think even in Canada, people are very different [in different parts of the country] (Dr1).

The caregivers also raised differences in the expressiveness of the pain because of the culture. Both physicians and caregivers asserted that the degree to which pain is expressed was influenced by social norms—culture permits or constrains how much one can complain.

The physicians also remarked that socialization within their familial background might influence how individuals reacted to and coped with pain. In other words, the role of social learning in pain behaviour by observing parents experiencing pain is emphasized: “I think if we went to a pediatric pain clinic, you would see a lot of the parents having chronic pain. So it’s like a learned behaviour. So, I think this plays a big role” (Dr4).

Another informant also explained:

> Is there anyone else…in their family that has pain? And it may not always be that similar etiology… [I mean] what they observed in terms of how [family] cope with pain, I think,

> will change how that person will cope with pain too. I think learned behaviours are relevant for children as they're growing up. (Dr6)

Culture, according to the physicians, further played a considerable role in how individuals interacted with the health care system. It affected people living with pain' attitudes about and expectations from the health care system, how they sought help, and the types of treatment they preferred, which I will describe in detail later.

Notably, in agreement with the women's and their caregivers' perspectives to keep the pain experience private to not their loved ones worry, a physician said:

> A lot of people, especially the older population, don't want to bother you with their pain. They don't want to burden you with what they're experiencing, so they really minimize their symptoms because…they don't want you to worry about them. (Dr1)

Theme Two: Reasons for Pain and Triggering Factors

Generally speaking, like the women and caregivers, the physicians used a biopsychosocial approach incorporating biological and psychosocial factors to describe the chronic pain etiologies. They repeatedly emphasized the multifactorial nature of chronic pain and how the intersections of gendered roles, power differential, stressors, and SES could lead to chronic pain development during the life course. For instance, several participants (Dr2, Dr3, and Dr4) noted that traumatic events immigrant women experienced in their lives and childhood, such as physical, emotional, and sexual abuse, could contribute to chronic pain. The process of immigration, including its several stages, particularly pre-migration and postmigration, where the chronic pain could be initiated or exacerbated, was also emphasized. Yet pre-migratory trauma, including torture, being a political prisoner, experiencing severe forms of persecution, including incarceration and physical punishment, collective or organized violence, rape and experiencing war, were repeatedly and more explicitly indicated. For one participant, there were no substantive differences in the reasons for pain between immigrants and non-immigrants: “I don’t see any major differences in how the chronic pain evolves and what the causes except for the fact that depending on where the patients are coming from, sometimes they’re more exposed to social, emotional stress” (Dr3).

The interviewees also acknowledged that pain could stem from working with low wages, hazardous and harsh working conditions, separation from family, and social exclusion during the integration phase. An informant explained: “the whole cost of uprooting yourself or your family or both…and getting settled” (Dr3). Another interviewee (Dr4) had a similar opinion and indicated that working in blue-collar jobs and working longer hours like two jobs to “make the American dream happens” could be among the reason for pain. Car accidents, falls, work injuries (Dr3), work-related pain (e.g., manual labour), post-surgery (Dr1), as well as malnutrition and malnourishment (Dr6) were also reported by the participants. While the interviewees stressed that often chronic pain was a manifestation of an underlying injury or disease, in their experience, sometimes the reason for the pain was not apparent and “it’s hard to say why the pain develops” (Dr6).

Participants also highlighted that immigration trajectories varied in significant ways. Again, the heterogeneity of immigrants was emphasized. The informants generally considered refugees who were coming from long-term war or conflict zone countries more at risk:

> It depends on how they immigrated. Were [immigrants] coming as refugees or coming from a relatively stable environment—straightforward immigration? … I suppose, in terms of later life experiences. … They may have a lot of things on their mind at the time

> that they're trying to leave—if there is a constant threat to their life—constantly worried. Are you going to survive another day? … Maybe they don't have time to process the trauma at that point…and then when they immigrate, and things start settling down, they start getting flashbacks, and that's when [pain] starts manifesting itself. That may be a reason why things start to develop after they immigrate. [And then] when you immigrate, it depends on again what kind of support system that they have here. Did they feel isolated now? … So now, this is their way of a cry for help. (Dr6)

Two informants (Dr4 and Dr6) also expressed that chronic pain could arise from acute pain; if it did not manage well when it did occur. One explained: "we know that if you don't treat acute pain, it has a higher likelihood of developing chronic pain" (Dr6). Other reasons rooted in biomedical pathologies, such as personality disorders or genetic predisposition, were also captured. Finally, the interviewees remarked on the overlap between emotion and pain. A physician explained: "It's hard to tell what proportion of the pain is more tied in with the emotions versus the actual injury" (Dr3).

The participants explained the complex interplay of biopsychosocial circumstances that triggered pain symptoms. In their experiences, changes in weather conditions, injuries, exertion resulting from physical activities, financial issues, looking after family, social stresses, lack of sleep, fatigue, anxiety, depression, emotional distress, lack of a diagnosis, and lack of treatment plan were the contributing factors. Take, for example, the following passages:

> Some people just have to keep doing what caused the pain because it's their job or it's their responsibility around the home, or they have kids that they have to pick up even though their back hurts. (Dr1)

> Separation from family, disconnecting and moving to a place where you have few social supports and feeling very isolated and alone leads to a kind of more worry, more anxiety, and they're, you know, feeding into the pain as well. … Pain catastrophizing; I see that lacking support may make the pain seem worse because there is no help in sight—no one that I can rely on, no one that I can go to and then there's no hope. So, therefore, the pain becomes louder, more meaningful. (Dr2)

Theme Three: Pain Consequences

In agreement with the responses of women and caregivers, the physicians underscored the enormous effects of pain on people's daily activities, quality of life, family, and social environment.

Believing patients' claims. The subjective nature of pain added to difficulties in believing and validating patients' accounts. There was a sense that few of the participants, particularly those engaged in examining patients' truth claims around pain-related disabilities, viewed the inquiry with skepticism. For instance, one clinician described the decision-making challenges associated with the legitimacy of clients' requests for disability claims. At times, it was not easy for them to believe the claimants' accounts; some clients were deemed as malingers or someone who exaggerated pain. Nonetheless, it was thought the potential reason was to legitimize pain.

> In some sense, they are looking for that support system through the insurance and through that process. You know, "I want to be treated. I want to get the money you know I deserve."…that's a thought I have. I don't know if that's true because I have no data…and I've never looked into it, but I think that may be a fact. … But I don't think

> that's an immigrant thing. I think that's an individual thing …I think it's more crying out for support. … You know, sometimes getting financial support legitimizes their problems. (Dr5)

Given the inherently subjective nature of pain and the lack of objective evidence of a claimant's disability made chronic pain disability very challenging to assess, it might be a reason to delegitimize pain. These observations aligned with the frustration of the women. As mentioned earlier, several women, who had sought compensation, indicated that an insurer questioned the legitimacy of their experiences.

Theme Four: Coping and Control

In the following sections, I will present the detailed reflections physicians shared on barriers and facilitators of service delivery to immigrants.

Being a physician in the context of chronic pain: Layers of complexity.

The physicians mentioned that they saw immigrant men and women as part of their practices, but as indicated by one of the informants, "I wouldn't say it's a huge part of my practice" (Dr2). Another participant also recounted, "[Immigrants] definitely have chronic pain as everyone does. ... So, I'm wondering what we're not doing to have them [in the pain clinic] (Dr3). One informant suggested a potential reason: "We're a referral centre. …we see who gets referred to us" (Dr5), highlighting that immigrants, particularly newcomers, might face challenges in accessing primary health care and having a family physician. While the referral system might be a hurdle and a potential explanation, the other interviewee proposed another explanation: "Immigrants' [clinic] is not a specific clinic in the pain clinic at the moment at least" (Dr6). Another informant had a similar impression, "I do not see foreign-born patients specifically because they are foreign-born. They're just part of what I see" (Dr5).

While the physicians whom I interviewed trained in pain management, no one specifically talked about training in immigrant care. For example, a participant noted, "in medical school, we did get some kind of formal training…and then throughout residency, there was nothing formal—no formal training" (Dr1). Even though none felt that their current education and training might fully equip them to address the needs of immigrant patients, they found accommodating immigrant pain care and effectively providing care for them challenging. For example, one interviewee asserted that working with the immigrant population is "always an added layer of complexity" (Dr1). The informants indeed noted that immigrants undoubtedly faced far more barriers to health than did Canadian-born populations. They identified several barriers to chronic pain management services for the immigrant population: language and cultural barriers, different expectations between care providers and patients, the lack of time, and economic barriers.

Communication: Pain is not in your head; it is in your brain. Effective communication between physicians and immigrant women and their caregivers was a central concern of all interviewees; they found it difficult when physicians and patients came from different cultural-linguistic backgrounds. While language and cultural barriers were common challenges in immigrants' health care and not unique to pain management, a physician noticed that considering the complex and multifaceted nature of chronic pain, "there can be a lot more nuance to it than straightforward [conditions]" (Dr1).

There was also a clear consensus on the need for interpretive services to address language barriers among physicians. The interviewees talked about different interpretation/translation service models they utilized, including professional interpreter services and untrained interpreters (e.g., family, friends). While the physicians recognized the merit of using an interpreting service, the practice of using interpreters was not without challenges, and neither guaranteed the quality of care. For example, access to interpreting services to help immigrants and their families was not universally available nor always supportive of socio-cultural values and beliefs.

Relying on family or friends in a clinical setting as an interpreter raised other concerns about knowledge of medical concepts and terminology, professionalism, and confidentiality. For instance, the physicians expected that clinical encounters be interpreted word-for-word, and interpreters did not answer questions that were being asked, but this was not always the case. The informants also reported that occasionally they found untrained interpreters to be selective in what they interpreted or summarizing the communication:

> It’s somewhat difficult to know whether the person, the family member, is actually translating what is being said in both directions and whether it’s being screened or modified in some way. And they can also, you know, dominate the conversation with what their observations are. (Dr2)

Some physicians matched their patients with other health care staff who shared the same language to create a supportive environment. The informants endorsed other HCPs in their team who can speak a language rather than Canada’s two official languages.

> I have a patient who comes to the clinic with an interpreter, and I think it helps a lot because we know that things are getting misunderstood. And with that particular patient, we actually had a colleague who spoke the same language. So, it was really great to have

> [that colleague who] was just able to do the whole interaction in [the patient's language]. It was perfect, and then nothing was lost in translation. (Dr1)

However, there were substantive differences between the physicians' perspectives and women's opinions about the language barrier. For women, language was not a barrier to care, although they recognized that it could be for many newcomers.

Cross-cultural communication was another challenge for the physicians. For example, two physicians described how difficult it was to tell their patients that pain had been produced by and processed in the brain, as patients misinterpreted it as a psychological case.

> We don't think the pain is in their head—[we] explain that there are some pathways from their brain to where they're experiencing pain. (Dr3)

> Sometimes it can be very challenging to discuss the subtle ways that the mind and psychology can interact with pain in the body; um, it can be a very difficult conversation to have. And I think partly it's cultural differences and partly communication. …telling the patients that it's all in your head…sometimes it's misinterpreted. …and that can also hurt feelings. (Dr2)

Indeed, the physicians thought that immigrant people living with chronic pain might disagree with the clinician's view that pain is, in part, emotional. From the women's standpoint, when the pain was defined as emotional, some felt that their pain was not valued as authentic nor seen as a credible explanation.

Consequently, the physicians stressed that the inability to address cultural differences appropriately could contribute to noncompliance. To overcome cultural barriers and bridge the differences, the physicians relied on the help of other staff whenever available. They believed that such colleagues could foster good communication and mutual understanding of and meanings of certain words.

> Finding someone who understands their culture makes a big difference. We do have some nurses from different backgrounds that are able to help… even if we're both speaking English because of the cultural difference, the nurses have picked up on some of the nuances of some of the things that are said. [They] can give us a bit of context with the why patients could be feeling in a certain way. I think it's worth a lot. And I think having someone who understands their culture…has a lot more buy-in. … It [also] helps with our treatment—that makes a big difference, I find. … I [also] find that patients will feel more accepted even though I think I try to make all patients feel accepted. (Dr3)

One interviewee also noted that the stigma attached to chronic pain and regarding pain as a kind of personal weakness might be a barrier to adequate chronic pain treatment:

> For some people, there is a little bit of embarrassment associated with having especially chronic pain. Because maybe you feel like there's not supposed to be anything wrong with you, or maybe feeling you shouldn't hurt, or you should be able just to push through, and you shouldn't need to see a doctor about this persistent pain that you have. So that's just something that I can think of as a possible barrier. (Dr1)

The above passage aligns with the HCP caregiver's opinion, who captured that immigrants did not often immediately seek help.

Other concerns raised by half of the physicians were gender preferences and religious beliefs among immigrants. They noticed that having a same-sex provider may be particularly important for immigrant women.

> In the context of discussing an immigrant population, cultural sensitivity, I think, is a big deal. [If a patient] presents and requests that the care team [should] be all-female, we need to be really open-minded and accommodate those sorts of requests and requirements. [Otherwise] that could have really negatively impacted [them]. (Dr1)

On the other hand, this participant, in particular, found that patients might not express their beliefs and practices that need to be respected. Consequently, applying cultural sensitivity to real practice was not straightforward. Therefore, the informant found it challenging at times to initiate the conversation about cultural practices that need to be honoured because of the risk of creating a sense of discrimination or racism if they inadvertently made cultural mistakes in their clinical practice.

While most physicians struggled to provide culturally appropriate care for their patients effectively, the feasibility made it a contentious issue. As a result, an interviewee suggested that it was up to patients to fit:

> [In an exercise program] everyone wears comfortable clothes…you know tees are very uniform, which to us is like really normal. But some immigrant groups may not find that comfortable. And then they get down on mats on the ground and do their exercises. And again, some people may not find that very comfortable. But that's part of the program. So, if you want to be a participant in the program, you have to do that." (Dr6)

It appears that the language used in this narrative created an "Us vs. Them" notion. Expressing "us" as "normal" could also lead to a kind of irrational group favouritism. This process of othering might stem from unconscious bias, which I will explain in the next chapter.

Several physicians also noted that immigrant families, particularly children, participated more enthusiastically in their mothers' care and were more likely to provide support than the Canadian-born population. They found that family was a considerable facilitator to care for immigrants. A physician recounted:

> A lot of the patients I see who have come to Canada from elsewhere come to appointments with family members, usually kids. It seems like often the dynamic is that the parent is unwell, and the kids are with them as social support… To me, family is [a] huge facilitator to care. (Dr1)

Another informant also commented, "You don't see Canadian-born children, you know, dropping their whole lives to take care of their parents" (Dr4). In the interim, the interviewees remarked that not having social support could be a barrier to care:

> Sometimes people don't have anyone else they can rely on—is there anyone else who can shovel your snow, cut your grass, or help with meals? And all of those things are probably less available to somebody who has just moved here, doesn't have family here, doesn't know anybody else here, probably hasn't had a chance to make friends, doesn't know what's available in the community. (Dr1)

Different expectations. In their reflections on providing care for immigrant patients with chronic pain, many physicians described a disjuncture between immigrants' expectations for pain management/treatment and the reality of what they could offer. Differences in expectation were identified as another barrier to care. A lack of familiarity with the Canadian health care system was regarded as a potential reason. From the physicians' perspectives, immigrant patients had their own preconceived notions of health care, reflecting their experiences with the health care system in their home country. In the meantime, the physicians had their specific expectations of care based upon a Western medical model. These different perspectives led to conflicting expectations of care. The physicians stressed that different understandings and expressions of pain—as mentioned earlier—could make a diagnosis difficult or result in treatment nonadherence.

Two main differences in expectations were mentioned. First, physicians believed that patients expected that their pain would be eliminated, would eventually end, and be quickly fixed, which was unrealistic. One interviewee described, “[some groups have] really high expectations [and] their expectations don’t coincide with what we can offer. … The expectation would be to get rid of the pain completely” (Dr3). Another informant told me:

> [The immigrant patients] are looking to the doctor for the answers to solve all the problems. … There must be something medical, [something] wrong, and that has to be fixed by a medical doctor. …They will hang all their hopes on me, you know, just to solve their problems. (Dr2)

The informant continued, “it’s might not [be] unique, you know, to this population of patients.” Meanwhile, the interviewee empathized with the patients, “it can be very demoralizing to patients to know that it’s an illness that probably won’t get better” (Dr2).

Second, the physicians noted that some immigrants, not all, had markedly different opinions regarding the type of care. For example, they preferred to see a particular type of health professional and/or had a strong preference for passive treatments of pain relief—which, in the physicians’ experiences, these types of treatments were less effective.

> I do have some patients who are less interested in a medical option. They don't want to take medication. They are not interested in taking pills every day…which I think is in contrast to some others like Canada and the U.S. [where] everyone just wants a pill…so, that's a barrier as well … I think, in some cases, it's cultural. (Dr1)

Several women and caregivers also commented on this topic, as previously mentioned.

Too limited time, long waitlists, underserved subspecialty. Even though building rapport was instrumental for understanding the complex pain trajectories, a few informants pointed out that short consultation time was another barrier that impeded their ability to provide care, agreeing with the women's and caregivers' perspectives. The physicians found that consultations with the presence of an interpreter took a lot longer, "I usually anticipate a longer appointment—needing [more] time to explain things" (Dr2). Still, the time allocated was perceived to be too limited. Another interviewee underscored that understanding the root causes of pain required deeper investigation and detailed history, yet it was challenging because of the short consultation time.

> [To provide good care,] I think you really have to take the time to get to know your patient because sometimes there are triggers or exacerbating factors that we may not have clued into that [and they] are really important parts of why this person has pain. So definitely [it is essential to] take the time to get to know your patient, which unfortunately we don't always have—waitlists are long, we're trying to see our patients that we've been following for years. We're trying to fit it into new consultations. Everyone's got to be out of [the clinic on time], so that can be tricky. (Dr1)

The physicians also commented on how access to specialist pain services was onerous. They further explained that there had been cutbacks in some services and a shortage of funds, echoing the women's and their caregivers' voices.

> Chronic pain is an underserved subspecialty across the country. (Dr1)

> We're under-serviced for pain management. … We have a long waiting list—about four years. (Dr3)

Contrary to the women's and caregivers' perspectives who expressed that long wait time in various stages of treatment in Canada, including finding appointments with specialists, delayed diagnostic services (e.g., MRI and CT scan), and family doctors' hesitancy for referral was among the reasons of delaying in diagnosis and treatment, few physicians, I had interviewed, blamed the health care systems and lack of knowledge of HCPs of the country of origin as barriers to optimal treatment; few assumed there was no health care in the countries that women came.

Two physicians (Dr1, Dr3) noted that access to primary care was another barrier—given the long waitlists for specialists, pain treatments, they believed, should start in primary care settings. Like the women and their caregivers, the physicians also found pain treatment across settings was often uncoordinated and at times challenging to follow up with patients, notably if they lacked a primary care doctor. For example, one informant (Dr1) said, "I think primary care is a big issue for everybody. It's a problem for people born here," highlighting the importance of solid cooperation between pain clinics and physicians in primary care settings. It echoed what the HCP caregiver proposed for closer collaboration between HCPs in primary care settings.

Economic barriers. Another roadblock to pain treatment was the cost. Despite free universal health care services in Canada, the out-of-pocket treatment-related cost was a matter of financial burden. Few participants talked about transportation barriers such as parking fees, the cost of prescribed medicine and some services, echoing both the women's and caregivers' voices. A participant expressed distress at the inadequacy of the health care system they worked. They found that the system had not always equitable despite all efforts to make it so:

> I do find that many of the patients I deal with are of low-income status, so that's often a huge challenge for patients [who] do not have any insurance for their medications. They usually don't have any coverage for physiotherapy, occupational therapy, [and] psychology, despite having a pretty significant need for all those services to manage their pain. (Dr2)

Another interviewee had a similar concern, "There's a lot of things that we can't prescribe because it would be just prohibitively expensive without insurance coverage—private insurance" (Dr1); therefore, these physicians remarked that it was not always realistic to expect patients to adhere to treatment plans and make lifestyle-related changes to reduce pain. Consequently, they tried to connect their patients with other available resources such as social workers to address social needs through appropriate referrals. Yet, these efforts were unsuccessful due to a resource-demand imbalance, a lack of infrastructure to facilitate inter-sectoral coordination of services, and a lack of integration of social supports and services into healthcare provision.

Notably, while most of the informants recognized the importance of SDoH in the etiology and exacerbating chronic pain and pain outcomes, it seemed that only a small number of interviewees assessed the social determinants and addressed them in their clinical practice. As a result, patient care mostly took place at the individual level and followed the traditional biomedical approach—focused on medical treatment rather than the social inequities that caused or exacerbated the pain. Indeed, the social aspects of the biopsychosocial model, although highlighted as determinants of chronic pain, were not well represented in pain management and were absent in everyday practice.

Essentials of good pain care. I begin this section by sharing extended accounts in which the physicians discussed what is meant by good chronic pain care:

> It has to be multifaceted. In terms of alleviating, we look at things like the 3P approach. So, we talk about physical activity, and I think it’s really important for people to stay active, which can be a tough sell. Because if people have pain whenever they move, they’re not going to want to move. And then the less active you are, the more likely you are to have other kinds of pain syndromes start. So, we tried really hard to encourage a reasonable amount of physical activity. We have a physiotherapist here who is wonderful and has put together a lot of classes that are appropriate for different types of people. And then I think it’s important for patients to understand pain psychology. So especially the transition from acute to chronic pain. And the easiest way I’ve found to explain that to patients is just to say that they’re rewired; things aren’t the way they would be—the pain signals are interpreted differently by your brain…which I think most people understand. But unfortunately, that doesn’t take the pain away. That doesn’t fix it. Right? Telling someone that they’re just going to have to live with it [is challenging]. But the other thing that we do offer—some lifestyle modification kind of classes. So, I think a big thing for people is pacing. … And then lastly, like the pharmacology and the interventions. So, when we offer patients different medications or interventions for their pain, we’re still

> really only looking at about a 30 percent reduction. So that’s a piece of the pie, but it’s definitely not the whole story. … We’re [also] moving toward a very patient-centred care model, which I think is appropriate. People should be in control of what is done for them medically to a point within like what’s medically reasonable. (Dr1)

> I’m a huge proponent of mindfulness and meditation; improving sleep is a big one. … I think psychology and psychiatry are often lacking in many clinics, especially for the immigrant population. … I focus on improving mood and then education around how pain works. Explaining is going to be a long road—not everything works for every person. (Dr4)

> I think good chronic pain care is a well-rounded approach to the patient. You can’t just focus on the pain and number and feel that you know that the target is that foot, and if you fix that foot, all would be better. I think, you know, looking at the patients…as a whole…looking at the overall quality of life of the patient and health of the patient [are important]. So, some of the pain treatments may be effective from a pain perspective but have terrible side effects. … You know, even though the pain may be treated, the patient may suffer from the pain treatment itself. I usually tell patients that *good pain care actually needs a large portion of the patient involvement.* (Dr2)

As the above excerpt indicated, the physicians believed that the multipronged, multidisciplinary pain management approaches, which combined various therapeutic modalities, were the best in helping patients with chronic pain. This approach aimed to help patients develop skills to cope with pain actively. The physicians also emphasized the importance of self-management strategies to reduce pain, regain functioning, and improve quality of life. Moreover, they described how successfully setting goals and expectations was essential to diminish pain. Goals should be patient-driven and focus on essential things for the person living with chronic pain. Despite the fact they wanted to provide the best evidence-informed care and best outcomes for their patients, they noticed that there was no cure for many pain conditions, nor the treatments were without side effects. Additionally, while the informants emphasized the need to adopt a comprehensive and multidisciplinary approach to improve pain, they acknowledged the lack of an integrated multidisciplinary approach outside the pain clinics.

Chapter Eight: Discussion

This doctoral dissertation explored Canadian immigrant women's experiences living with chronic pain as located in their socio-cultural context. The study also examined the women's caregivers' accounts and perspectives of physicians working in the pain treatment. The findings provide rich insight into the daily realities of living with chronic pain. Participants identified four themes that described their personal experiences: (1) The trajectory and meaning of pain; (2) Reasons for pain and triggering factors; (3) Pain consequences; and (4) Coping and control. This chapter provides an in-depth discussion of these findings, anchoring the analysis in the broader scholarship. This chapter is broken into four sections, each addressing a theme from the study findings—discussions of all three groups are combined under the themes. The first theme relates to the pain trajectory.

Meaning of Pain: Metaphors

I start this section by discussing what pain meant to the participants. Despite differences in the women's pain etiological underpinnings, I have found some similarities in their personal experiences. As the first step to understanding the women's experiences and following an intersectional approach, I acknowledge that the participants were not homogeneous. The intersections of age, racialized status, SES, and gender, among other markers of social differentiation, shape their daily experiences. However, in line with a meta-synthesis, I found more similarities than differences in pain experiences (Crowe et al., 2017). What the women had shared were the stories of despair, hopelessness, not being understood, isolation and withdrawal from the people, and loss of self-worth, identity, financial security, future, and their ways of being in the world, as well as the stories of hope, resilience, and making meaning of the pain.

For all three groups of informants and in line with the literature, the pain was a complex, deeply personal experience linked with meaning (Belton, 2019; Rysewyk, 2016). It was an experience underpinned by biology, and inextricably bound up and highly influenced by psychosocial factors, cultural processes, social identities, such as gender and socioeconomic position, complex power relations, language and dialect, religion, and the weight and meaning were given to scientific and other sources of knowledge (Belton, 2019; Bourke, 2014; Kirmayer, 1992; Morris 1991; Peacock & Patel, 2008). The culture shaped perceptions of pain, but it was also a crucial factor in influencing health care practices, help-seeking activities, coping behaviours and pain communication. Additionally, culture formed larger meaning systems such as social roles and expectations (Lasch, 2000).

Pain, for the women, was not just a symptom nor just felt; it was not simply a matter of nerves and neurotransmitters. It was a lived and experienced perception (Belton, 2019; Morris, 1991). The meaning of pain for the women was not the pain documented in their medical records. The meanings were created around the impacts of pain and concern about the long-term pain consequences and their future. However, in the biomedical field, their subjective feelings and perceptions were ignored; the pain was treated as an object which should be measured and monitored.

There is no doubt that valid pain assessment methods such as verbal or numerical rating scales or sensory qualities of pain—such as burning, stabbing, aching, dull, which are widely used in the biomedical field as part of the well-known McGill Pain Questionnaire— are necessary and provide an essential perspective on the area of pain language (Munday, Newton-John, & Kneebone, 2020). Yet, too much emphasis on these assessment methods is insufficient to create the meaning nor do they fully provide an accurate detail of pain experience, related feelings, and meanings. For instance, although in the context of the Indigenous population, Latimer et al. (2014) argue that Western standardized pain scales may not accurately capture the whole picture of pain experiences.

For the women, pain at times was not simple to explain. It was inexpressible and resistant to linguistic expression. Elaine Scarry (1985) has argued in her ground-breaking work, *The Body in Pain*, that extreme pain resists expression and destroys language. In other words, pain implied "a disruption of structures of explanation and meaning" (Bury 1982, p. 175). Consequently, to give voice and meaning to what had often been inexpressible, pain description frequently took the form of metaphor. Consistent with the literature, metaphors are an excellent way to convey experiences such as chronic pain, which are hard to articulate, are an essential part of language, devices that facilitate our understanding of the world and how we think, as well as a conceptual tool for shaping reality (Bourke, 2014; Erjavec & Volčič, 2010; Kirmayer, 1992; Munday et al., 2020; Pascalev, 2018). Put simply, metaphors "embody the situational knowledge" (Kirmayer, 1992, p. 339). They are context-dependent (Pascalev, 2018) and are constructed in interaction with the social world. They are means to "make latent features of the topic more salient" and transform a concept (Kirmayer, 1992, p. 332). Notably, a recent study, using systematic metaphor analysis, has shown that women created significantly more metaphors than men (Munday et al., 2020). Pain genuinely urged women to find novel ways to describe their pain. They became creators in representing their realities (Biro, 2011).

The women utilized a wide variety of metaphors to define their pain. They frequently compared their pain to having been hit by a truck. Some described their pain in terms of damage via a blunt or sharp object, like a knife, and defined it as a physical attack. The literature has shown that the unpleasantness of pain is sometimes accompanied by definitions such as attack upon the body, which means the intrusion of self, a fracture of bodily integrity, due to the immediate physical and social consequences of having pain (Bourke, 2014; Rysewyk, 2016; Sim & Madden, 2008).

Some defined pain as an enemy, which meant a foreign invader; the pain had hijacked them (Belton, 2019). Instead of being a protector, pain threatened their integrity as persons and destroyed everything around them, including themselves (Belton, 2019; Svenaeus, 2019). In a similar vein, Johnston-Devin, Oprescu, and Gray (2019), in their research aiming to understand the phenomenon of chronic pain in the lifeworld of people living with complex regional pain syndrome, described that living with chronic pain was a daily battle, where the participants were dealing with an unknown enemy. They are indeed warriors fighting for a diagnosis, cure, and maintaining function (Johnston-Devin et al., 2019).

Metaphorically some of the immigrant women describe their pain as torture. According to Scarry (1985), the tortured person—the person living with pain—loses control and agency over every little thing and is being violated by the pain. There is no security, and the future is uncertain. Pascalev (2018) also articulates the meaning of the tortured metaphor as something incurable, a pain without reason.

Defining pain as an enemy, a beast, and torture can therefore mean a lack of control over pain. In other words, the women were “taken over” by the pain (Burry, 1982, p. 172) and found themselves disoriented with a loss of certainty, control, and security. Metaphors are also consistent with the wording of the IASP definition, emphasizing the sensation of pain resulting from tissue or body damage or the adjective sharp, which is used to describe the severe pain sensation (Semino, 2010).

In agreement with the literature, some women talked about the “real pain” when it became persistent, chronic, and did not resolve like all the other pains they had (Belton, 2019). In searching for the meaning of pain, some had existential queries, such as, “Why me?”—why they, among many, had gone through such experience. The literature supports that illness raises some fundamental questions for those living with that, including the why me question (Kleinman, 1983). The question might root in religious, spiritual, or philosophical orientation—it might be difficult for women to grasp why a loving God allowed this to happen to them (Kneier & Silberman, n.d.). It could then potentially explain why one of the women perceived pain as a means of purification. It has also been discussed that such a question is not truly a question needing an answer; it is a cry of emotional poignancy and anguish (Kneier & Silberman, n.d.).

Reasons for Pain and Triggering Factors

The second theme described the reasons for pain. Most of the women and their caregivers identified the onset of pain with a period of intensified worries about family’s well-being. Some recounted the death of a family member in the home country as a trigger or aggravator of pain. Emotional upset, stressful life events, childhood difficulties, overdoing, immigration and its consequences, among many other hardships, were expressed as the root causes of chronic pain. Gender and discrimination were cross-cutting themes, as well.

Women’s explanations for pain varied greatly depending on pre-migration exposures and living conditions, such as trauma from war, persecution, migration phase, and post-migration living conditions. Accordingly, it was challenging to identify only one etiological explanation for the women’s pain. Yet, the shared experiences highlighted the importance of the unequal distribution of resources, both material and immaterial such as education, income, and power. The commonalities across narratives highlight the fundamentally social nature of their pain; thus, pain was a reflection of social hardship, highlighting the impact of structural political-economic contexts on women's experience (Yarris, 2011).

It has been well documented that the social context of an individual's life governs the risk of susceptibility and outcome of disease (Cockerham, Hamby, & Oates, 2017; Matteucci, 2015). Consistent with the intersectionality approach, I argue that a web of intersecting factors, including structures of power (e.g., racism), shaped both risks and impacts of pain. Intersectional analyses of pain revealed inequities at intersecting sites of oppression. The findings also support the biopsychosocial model of pain that posits a dynamic interaction between psychological, biological, and social factors resulting in pain. Of significance, while I sought to explore women's explanatory models of pain, given the intersectionality of SDoH, there was a multiplicity of relationships between all the mechanisms presented. The association was often bidirectional, and well-matched with the SDoH framework and intersectionality.

Immigration: A journey of interdependent structural stressors. Most of the women reflected on their lives before their immigration journey. For some women, their pain narrative began in early childhood or adolescence, even when the experience of pain started later in life. Consequently, to render a more holistic understanding of immigrant women's experiences, the study moved beyond exploring post-migration experiences and considered women's lives before arrival in Canada. This approach is also suggested by other researchers (Acevedo-Garcia, Sanchez-Vaznaugh, Viruell-Fuentes, & Almeida, 2012), who argue that immigrant health research needs to integrate the SDoH along the life course, as their health is embedded in both sending and receiving societies, in spaces of transit, and shaped by the interplay between home and host countries factors.

Research has shown that the cumulative exposure to political violence and permanent terror, as well as being the witness to the destruction of social, economic, and cultural worlds, homes, history, and identity, can gradually transform the invisible, internal painful wounds, “social suffering,” into ill health (Giacaman, 2017). Moreover, ample evidence suggests that early life factors such as emotional or physical trauma are associated with pain in adulthood (Macfarlane, 2016; Mills et al., 2019). Other premigration factors such as son preference and poor-nutrient diet will be discussed later when I will explore the association between gender and pain.

Women also experienced post-migration settlement stressors, including stressors related to their family members who were left behind while establishing themselves in a new work environment, caring for their families, adjusting to a new culture, lack of social support—an absence of extended family and friends—intimate partner violence, isolation, loneliness, poor living conditions, economic uncertainties, and racial discrimination; all have been linked to pain as will be discussed later.

Previous Canadian studies have also shown that immigration entails profound challenges and is associated with stress-inducing factors and impact on psychosocial resources, such as loss of social support, economic uncertainties, family upheaval, social isolation, downward social mobility (Ahmad et al., 2005; MacDonnell, Dastjerdi, Bokore, & Khanlou, 201; Yang, 2021).

Emerging evidence has also revealed that immigrants have an increased risk of chronic pain. For example, a Danish study found that immigrants had a higher prevalence of chronic pain and higher pain intensities than native-born individuals (Kurita et al., 2012). Similarly, a Swedish study concluded being an immigrant was associated with chronic widespread pain and fibromyalgia (Bergman, 2005). Another Swedish study, based on a large cohort of the general population, also found that chronic pain and its severe form were more common among immigrants (Dragioti, Tsamakis, Larsson, & Gerdle, 2020).

Systemic barriers to employment. Living in a new country was more challenging than the women had expected. Upon arrival to Canada, none of the women obtained employment in their area of specialization. Some had successful career trajectories and extensive experiences but were subjected to the scrutiny of their professional competence and skills as racialized “aged” women. Ageism and racism unfairly restricted some women’s opportunities and denied their human rights and the ability to reach their full potential. The systemic barriers related to non-recognition of foreign credentials, which are well known (Ontario Women’s Health Network, [OWHN] 2017; Premji et al., 2014), held back both women and their husbands from advancing their careers, which had financial consequences, among others.

The gendered, racialized, and ageist impacts of deskilling then led to under- and unemployment, which in turn, through multiple pathways such as lack of income, high levels of stress, and strenuous working conditions, resulted in chronic pain. However, women mobilized their skills; a few decided to return to school, obtain a Canadian degree, and change their careers. These findings are consistent with the literature (OWHN, 2017). Few undertook survival jobs to benefit their husbands’ careers or because their husbands refused to look for work outside their profession. Gendered roles and generational sacrifice to settle their families in Canada surfaced as an acceptable experience of immigration. This finding is supported by OWHN (2017), who aimed to understand the intersecting determinants that shape immigrant women’s experiences in Ontario’s labour market.

Some women worked in professions that exposed them to an increased risk of occupational injuries associated with chronic pain. A study confirmed that immigrant labour jobs and precariousness had a significant association with chronic pain (Tribble, Summers, Chen, Quandt, Arcury, 2016). For a few, their jobs were not only the source of their injuries and pain but also exposed them to structural barriers, such as lack of insurance plan or sufficient income, that prevented them from accessing adequate care—which will be discussed later. Additionally, downward occupational mobility put them at the bottom of the economic ladder, leading to lower access to resources during their lifetimes. Even after finding a job, there was a strong sense among the women that they had a distinct disadvantage in career advancement because of existing structural inequities, noting they had to work harder than their Canadian counterparts to progress in their careers. The participants' recall indicated an emotional burden of racial injustice and how being a racialized woman in Canada had socioeconomic costs.

Poverty and financial insecurity. Because of under- or unemployment, some lived in poverty for prolonged and extended periods. Consequently, meeting basic family needs such as acquiring groceries, paying rent, and buying supplies were challenging for some women. Studies have shown that those with low-income are most likely to report chronic pain (Lucas, Connor, & Bose, 2021). The findings are also in agreement with previous studies showing strong associations between financial insecurity, worry, or strain and increased frequency, intensity, or consequences of pain (i.e., disability) (Chou, Parmar, & Galinsky, 2016; Dragioti et al., 2020; Jablonska, Soares, & Sundin, 2006).

Interestingly, a recent study (Zajacova, Lee, and Grol-Prokopczyk, 2021), using an international survey that compared population pain levels in the United States and Canada, found that pain was higher in the U.S. than in Canada, mainly due to the worse economic conditions of U.S. adults, including a greater likelihood of low-income and financial hardship (Zajacova et al., 2021). One possible explanation for this is a combination of psychosocial and material elements

(Jay, Bendayan, Cooper, & Muthuri, 2019). Importantly, the family type was also a critical factor in shaping women's financial status and economic well-being. In line with previous research, women, generally speaking, experienced marked declines in family income after union dissolution and tended to be economically vulnerable outside of common-law unions and marriage (Fox & Moyser, 2018).

Food insecurity. Few participants explicitly talked about their experiences of food insecurity. Food insecurity is a well-established determinant of health linked to financial hardship (Polsky & Garriguet, 2022). The association between food insecurity and pain is documented. For example, based on an analysis of recent population health surveys, a Canadian study showed a greater likelihood of reporting chronic pain among food insecure individuals (Men, Fischer, Urquia, & Tarasuk, 2021). Specifically, food insecurity, a marker of multiple structural disadvantages, is a powerful predictor of pain (Men et al., 2021). Equally important, studies have consistently shown that immigrants, particularly recent immigrants, are more likely to experience food insecurity (Maynard et al., 2018; PHAC, 2018; Tarraf, Sanou, & Giroux, 2017).

Housing. Prolonged unemployment, relational conflict, and poor economic conditions resulted in homelessness for a woman and living in social housing for three. Evidence suggests that low income, lack of employment, and discrimination is associated with experiencing difficulties in finding an affordable home and housing precarity among immigrants, particularly recent immigrants (Canadian Council for Refugees, 2011; Hadi & Labonté, 2012). The high cost of housing and the shortage of social housing has also contributed to an affordability crisis for many low-income immigrants (Hadi & Labonté, 2012; Teixeira & Holiday, 2010). For example, the average wait time for social housing in Ottawa is about five years (City of Ottawa, 2022).

While affordability can be considered the main barrier, as Teixeira and Holiday (2010) eloquently put, “we may wonder whether efforts at improving foreign credential recognition will translate into higher incomes and therefore better housing outcomes” (p. 6).

Notably, my findings showed that all women who lived in social housing were one-person households or lone mothers. This result is in accordance with a previous study indicating that lone or unattached women are more likely to live in households in social and affordable housing (Claveau, 2020). While social housing had been a solution to meet the women’s housing needs, issues such as lack of after-school programs and access to transportation remained. Literature indicates that social housing is dysfunctional because of the lack of access to a wide range of community resources (Social Planning Council of Ottawa, 2010), highlighting that housing has an impact on health at both individual-household as well as area-neighbourhood levels (Hadi & Labonté, 2012). A lack of access to adequate housing can also slow integration into a new society and limit access to other SDoH (Canadian Council for Refugees, 2011; Hadi & Labonté, 2012; Social Planning Council of Ottawa, 2010). Housing establishes a sense of belonging, particularly for refugees, who are more likely to experience multiple displacements; therefore, housing stability is more than simply having a shelter (Fadlalla, 2011).

However, research on chronic pain and housing is quite scarce. As such, I have provided two supporting articles around homelessness as an indicator of housing inequity (Hadi & Labonté, 2012) have been provided. The first study (Vogel et al., 2017) examined the prevalence of chronic pain among homeless persons with mental illness in three Canadian cities. The authors reported that chronic pain among this population is more common. In light of the relationship between chronic pain and mental illness, they argue that it was very likely that mental illness also impacted the higher prevalence of chronic pain (Vogel et al., 2017). Similarly, a Canadian survey of people experiencing homelessness in shelters in Toronto revealed that more than half of randomly selected homeless individuals fulfilled the criteria for chronic pain (Hwang et al., 2011). Yet the cross-sectional nature of this study does not provide evidence of a causation pathway between housing and chronic pain; bidirectional relationships should be acknowledged (Hwang et al., 2011).

The pain of racism and discrimination. My findings showed several examples of intersecting discrimination based on racialized status, culture, and age, among others, at different levels. For instance, stereotypical assumptions and practices were manifested in women's workplace, educational setting, and encounters with HCPs. However, some women were reluctant to use words like discrimination and racism. This pattern was mainly observed among those living in Canada for a shorter period of time. The reluctance might be partially explained by the fact that identifying discriminatory experiences is a learned process (Viruell-Fuentes, Miranda, & Abdulrahim, 2012).

Experiences of racism among the racialized population in Canada are very well documented. For example, data from the 2019 General Social Survey demonstrated that visible minority populations, particularly Black, Southeast Asian, Arab, Latin American, and Chinese people in Canada, more commonly experienced discrimination than the non-visible minority population (Cotter, 2022). Similarly, racial discrimination during the provision of health services has been repeatedly demonstrated in Canadian research (Dryden & Nnorom, 2021; Mahabir et al., 2021). Despite the Multiculturalism Act's (1985) affirmation of the pluralistic nature of Canadian society and freedom from racial discrimination, pervasive forms of racism are still a serious problem in Canada.

Growing evidence also documents the critical role of racism and discrimination as determinants of health (Ahmed, Mohammed, & Williams, 2007; Krieger, 2014; Paradies et al., 2015). Specifically, numerous studies have recorded that experiences of discrimination and racism are associated with pain. For instance, a study of 393 African American male veterans (Burgess et al., 2009) found that experiences of racial discrimination were associated with higher levels of bodily pain. This association remained significant even after controlling for socioeconomic and health-related variables (Burgess et al., 2009).

An epidemiological study (Edwards, 2008) exploring the relationships between perceived discriminatory events and the report of back pain among African-American and Euro-American men and women also demonstrated significant positive associations between perceived discrimination and the frequency of back pain among African-American respondents. Experiences with discrimination—any experience— were measured in two domains, episodes of major lifetime discriminatory events (e.g., discouraged from continuing education, not hired or promoted) and perceived day-to-day discrimination (e.g., having people act as if they were not as good as they were). Notably, the type of reported discrimination associated with the back pain differed in African-American women and men, with perceived day-to-day discrimination being the strongest predictor of back pain in African-American women (Edwards, 2008).

Furthermore, the associations between racism, discrimination and pain were observed among other racialized populations. For instance, reports of everyday discrimination, after controlling for social desirability bias, age, gender, language proficiency, nativity, region, per capita income, education, employment, and marital status, were associated with several chronic pain conditions among Asian Americans (Gee et al. 2007). Interestingly, neuroimaging studies have noted that brain areas activated during the distress caused by social exclusion are those involved in physical pain, suggesting social pain is analogous in its neurocognitive function to physical pain (Eisenberger, Lieberman & Williams, 2003). Additionally, recent evidence suggests that the pain of social rejection and physical pain are interconnected as both rely on shared neurobiological substrates (Dewall, 2010). As Eisenberger (2012) pointed out, the unpleasant experience that is associated with actual or potential damage to one's sense of social connection or social value (owing to social rejection, exclusion, negative social evaluation or loss) shares common underlying neurophysiological circuitry with physical pain indicating a potential overlap in the experience of physical and social pain. Allen, Gilbody, Atkin, and van der Feltz-Cornelis (2020) also found that social exclusion is associated with chronic pain.

To explain how racism and discrimination contribute to chronic pain, scholars suggested several pathways, including biological, psychosocial, and material pathways (Ahmed, Mohammed, & Williams, 2007; Krieger, 2014; Paradies et al., 2015). One of the most common models of causality and a potential contributor to racial inequities in pain is the stress associated with racial discrimination (Berger & Sarnyai, 2014; Carter, 2007; DeWall, 2010; Edwards, 2008). Repeated experiences of discrimination and racism are, indeed, conceptualized as chronic social stressors (DeWall, 2010; Thoits, 2010). For example, Carter (2007) draws on minority stress theory and, at length, describes how race-based traumatic stress injury (i.e., a nonpathological emotional trauma caused by the stress of racism) is associated with pain. Extreme stress reactions then, over time, increase sympathetic nervous system activation and decrease endorphin production, resulting in increased muscle tension contributing to pain (Edwards, 2008).

Perceived discrimination and racism can also contribute to poorer mental health (Burgess et al., 2009; Noh, Beiser, Kaspar, Hou, & Rummens, 1999; Paradies et al., 2015) and sleep disturbance (Slopen, Lewis, & Williams, 2016); both have been related to chronic pain development (Burgess et al., 2009; Finan, Goodin, & Smith, 2013; Lerman, Rudich, Brill, Shalev, & Shahar, 2015; Linton & Bergbom, 2011). Discrimination can also affect access to care and the quality of treatment (Edwards, 2008, Paradies et al., 2015). As the HCP caregiver interviewee noted, racialized patients were more likely to delay visiting an HCP than non-racialized patients. A history of discrimination might potentially explain unwillingness to access care. It is well documented that a history of perceived discrimination can be associated with delays in seeking care among racialized populations, unwillingness to access care, and lower adherence to medical treatment (Burgess et al., 2009; Edwards, 2008). Numerous Canadian studies have identified lower access to healthcare among South Asian immigrant women (Ahmad and Stewart, 2004) and West Indian immigrants (Whitley et al., 2006).

Finally, racism has an essential role in shaping the distribution of other SDoH, such as SES, which has a well-established association with pain. Moreover, multiethnic studies found that experiences of racial discrimination contributed to racial inequities in pain outcomes, including disability and depression (Trost et al., 2019; Ziadni, You, Johnson, Lumley, & Darnall, 2020). Pain-related appraisals of injustices accounted for a significant degree of this relationship (Ziadni et al., 2020). Collectively, these findings suggest pain may serve as the embodiment of combined forms of discrimination (Johnson-Jennings, Belcourt, Town, Walls, & Walters, 2014); heart-breaking can become represented in or localized to the body (Eisenberger, 2012)—we, “literally incorporate, biologically, the world in which we live, including our societal and ecological circumstances” (Krieger, 2005, p. 351). As such, pain is a defensive action, a protective strategy, operating in the context of a threat to defend one’s self (Tabor, Keogh, &

Eccleston, 2017). Such understanding may provide a unique way of thinking about the interventions that could treat experiences of social pain (Eisenberger, 2012).

Loneliness. Most women living with pain, who participated in this study, described how the absence of their extended family support affected them in various ways resulting in loneliness. As mentioned earlier, a few women were able to mitigate some of these feelings through their nuclear families. Still, for others, their husbands, due to financial strains, particularly during their initial years, remained distanced, or their marriage ended in divorce after immigration. While the women were highly resilient and capable of building new social support networks, almost all had fragmented social ties upon arrival, resulting in feelings of social isolation and loneliness. This finding is consistent with existing literature indicating that immigrants are more likely to report higher levels of loneliness than native-born Canadians (Stick, Hou, & Kaida, 2021; Wu & Penning, 2015).

Moreover, studies have shown that race/ethnicity and length of residence also influence loneliness (Stick et al., 2021; Wu & Penning, 2015), with greater loneliness among non-British and non-French European immigrants (Wu & Penning, 2015), which was not alleviated by the length of stay in Canada (Stick et al., 2021). Disruption to social networks during migration, missing daily routines in the homeland, and encountering barriers to establishing new relationships, such as limited language skills and awareness of services, difficulty finding employment, as well as racism and discrimination, make immigrants vulnerable to loneliness (Johnson, Bacsu, McIntosh, Jeffery, & Novik, 2019; Stick et al., 2021; Wu & Penning, 2015). As participants noted, Canada's long, cold winters made social connections harder to maintain.

Pain, as previously noted, is modulated by social factors, including social connection and interaction, under the biopsychosocial model. A burgeoning body of evidence confirms that loneliness has been linked with risk for pain (Jacobs, Hammerman-Rozenberg, Cohen, & Stessman, 2006; Jaremka et al., 2013; Leigh-Hunt et al., 2017; Wolf & Davis, 2014). For example, a 7-year longitudinal study of an age homogenous, community-dwelling of Jerusalem residents shows that loneliness predicted near a five-fold increase in the prevalence of chronic pain over time (Jacobs, Hammerman-Rozenberg, Cohen, & Stessman, 2006). Another longitudinal study (Loeffler & Steptoe, 2021) examining the associations of pain and loneliness in a large population sample of men and women aged 50 years and older living in England found a bidirectional relationship over a 4-year period. Female sex, lower SES, defined by wealth, and depressive symptoms were associated with a greater vulnerability to chronic pain and loneliness (Loeffler & Steptoe, 2021). Of note, both chronic loneliness and episodes of loneliness are linked to pain. For example, a study of individuals dealing with fibromyalgia indicated that chronic loneliness and episodes of loneliness were associated with daily pain and higher levels thereof (Wolf & Davis, 2014). The association of loneliness and pain was, however, bidirectional. The stress of loneliness exacerbated pain, whereas pain limited social engagement, therefore, contributing to loneliness, which will be discussed in more detail later. The bidirectional link between pain and loneliness is in agreement with several lines of evidence (Gold & Roberto, 2000; Loeffler & Steptoe, 2021).

The stress and chronic pain cycle. Stressful experiences within the context of social structures, such as war zones combat, unemployment, discrimination, and poverty, can create pain. Studies indicate that stress triggers the hypothalamic-pituitary-adrenal axis activation and triggers the autonomic nervous system, resulting in pain (Abdallah & Geha, 2017; Ahmad & Zakaria, 2015). Of note, the relation between pain and stress is bidirectional, stress causes pain, and pain causes stress (Ahmad & Zakaria, 2015). Here, I emphasize that by considering stress as a trigger for the pain, I mean the upstream structural conditions that induce exposure to stressors instead of blaming informants for their inability to cope with stress. Therefore, the focus on stress here is on the sources and underlying causes of stress; some of them, such as racism and discrimination, were previously discussed in more detail. Ample evidence has found a link between stress and pain among immigrants (Wuytack & Miller, 2011) and how the complexity of stressful factors in immigrant women's lives influence their pain experience (Michaëlis, Kristiansen, & Norredam, 2015; Nyen & Tveit, 2018).

Gender. Several findings, such as son preference, intimate partner violence, and demands and stresses placed on women at home who provide the majority of unpaid care, lend support to the importance of gender roles in pain conditions. Regarding son preference, a recent study concluded that the different treatment of boys and girls in early childhood and discrimination against daughters because of the patriarchal nature of a family organization, which is prevalent worldwide, has considerable implications for health outcomes, for example, through nutrition input (Le & Nguyen, 2022). The robust link between a nutrient-poor diet and chronic pain is well-documented (Brain et al., 2021).

Experiencing intimate partner violence, which is a global public health issue, also highlights underlying inequitable gender norms (Leight, 2022). Two systematic reviews confirmed a relationship between pain and intimate partner violence (Stubbs & Szoeke, 2021; Walker et al., 2020). The literature also indicates that women who have experienced intimate partner violence have poorer pain outcomes, such as higher pain severity and higher pain-related disability (Walker et al., 2020). The association between pain and intimate partner violence draws attention to the importance of timely and effective assessment and management of intimate partner violence to prevent chronic pain (Wuest et al., 2010).

Respecting the demands and stresses placed on women, the major trends in family structures, influenced by macro structures of the political and economic spheres, in Canada and beyond over the past decades, are widely recognized, including an expanding the number of women in paid labour (Moyser & Burlock, 2018; Oláh, Kotowska, & Richter, 2018). In most countries, however, this transformation has not been accompanied by the sharing of unpaid housework and care between women and men, resulting in a double burden for women (Oláh, Kotowska, & Richter, 2018) and high rates of stress (Balaji, 2014; Delina & Raya, 2013; Werner et al., 2018). For example, a recent Canadian study, using data from the 1986, 2010, 2012, and 2015 General Social Survey, found that the bulk of unpaid work still fell to women and that Canadian women tended to spend more time on unpaid work in dual-earner families—1.2 hours greater per day (Moyser & Burlock, 2018).

Of significance, unpaid work is not only shaped by gender relations, but it is also influenced by the intersections of racialized status, disability, and age (Werner et al., 2018). As the narratives indicate, some women cared for their family members with disabilities. Moreover, as women aged, their care work rarely diminished. In addition, to gain Canadian work experience, a few worked as volunteers—another unpaid, unseen form of labour. Indeed, because of their exclusion from the Canadian labour market, some women were compelled to undertake volunteer work (Werner et al., 2018).

Notably, while immigration put forward new demands, most mothers felt that immigration resulted in a more collaborative and equal partnership with their husbands—mainly because there was no extended family support—ultimately increasing women’s authority. A meta-synthesis of post-migration changes in marital relationships in Canada also found that limited social networks and support can positively increase the mutual dependence of couples and more equitable sharing of household work (Guruge et al., 2010).

Immigration and identity change, acute pain, and familial cluster. Results revealed several other reasons for pain. First was the impact of immigration on changing identity and self. As Williams (2000) argues, biographical disruption—which will be discussed later—itself, needs to be considered an aetiological factor in the onset of chronic illness. Second, less central, but equally important and in line with the literature, another reason for chronic pain was pain itself, which underscores the importance of preventing acute pain from occurring and managing it well when it does occur to reduce the chronic pain incidence (Smith et al., 2007; Mills et al., 2019). Finally, chronic pain might cluster in families suggesting a social, psychological, and behavioural cause rather than a genetic component (Smith et al., 2007).

To conclude, the findings related to reasons for the pain are in concordance with several pathways proposed by scholars, such as the stress of the immigration experience (Bui, Doescher, Takeuchi, & Taylor, 2011), working in physically demanding jobs with poor working conditions (Kurita, 2012; Orrenius & Zavodny, 2009), barriers to care (Kurita, 2012), emotional distress, discrimination, lack of social support (Bergman, 2005), and financial hardship (Dragioti et al., 2020). The findings are also consistent with the literature demonstrating a linkage between chronic pain and SDoH during the life course, underscoring the complexity of pain (see Chapter Three).

Screening for social determinants of health in the medical encounter. Notably, while understanding the root causes and various health determinants shaping pain is essential as they contribute to the maintenance, worsening, or potential resilience of chronic pain, the presence of social determinants often went unrecognized during a medical encounter. This finding has been observed by other scholars (University of Washington, 2020). Moreover, the complexity of the social determinants was frequently oversimplified, and different racialized immigrant populations were repeatedly lumped together.

Although most physicians whom I interviewed believed that the social aspect of pain was influential, a few still emphasized that a lack of a sound health care system, particularly in home countries, could have a very prominent position in pain etiology. There is considerable evidence indicating that health outcomes, including pain, are explained less by health care than by the conditions of people’s lives (Karran, Grant, & Moseley, 2020). Consistent with the literature (Jaworsky, 2018), physicians, generally speaking, amidst their busy clinical duties, did not reflect on upstream political and historical factors driving health conditions, which might be rooted in the biomedical epistemology. Traditional, positivist health sciences tend to view the sources of health and illness as actions of individuals rather than resulting from the influence of societal structures (Raphael, Curry-Stevens, & Bryant, 2008).

As Muldoon (2002) noted:

> if health inequities are discussed at all within health professions curriculum, they are often presented without context or opportunity for discussion and reflection on their history or social meaning, leading students to develop harmful stereotypes based on the inferred conclusion that some populations are…perceive pain differently. (p. 3)

HCPs must be conscious of systems of oppression and how they shape lived realities and then move beyond awareness to address those systems explicitly. Wilson, White, Jefferson, and Danis (2019) have discussed that incorporating intersectionality into clinical practice could lead to a more successful patient-clinician encounter. It does so by providing a starting point to address some of the challenges that arise in clinical contexts due to attention to the complex identities of both patients and clinicians and the structural practices that shape those identities. In particular, an intersectional conceptual framework, which requires "an exploration of how institutional practices within the clinical environment, even those that seem neutral, unfairly advantage some and disadvantage others," can lead to more successful patient–clinician interactions (Wilson et al., 2019, p. 9).

Impact of Pain

The third theme, which was developed from the interviews, described the impact of pain. Pain affected every part of the women's lives. First, it interrupted their daily activities and resulted in functional limitations and disability. Second, pain impacted their social life. Third, it had life-changing emotional and psychological consequences. Finally, pain created changes to the sense of self.

Interruptions of daily activities. The first impact of pain was the interruptions of daily activities. For most participants, the impact of pain on daily life was profound. The pain took away a sense of "normalcy" and significantly curtailed activities of daily living. The women had trouble staying on task at work, taking care of their kids, concentrating, and/or keeping up with house chores. They had trouble falling asleep or woke up often during the night. Some never had a deep sleep. They felt tired and without energy. Hobbies were daunting. These findings reinforce previous evidence that pain impacts all aspects of daily living (see Chapter Three).

Even showering was challenging. Just the thought of getting up was exhausting. These findings are supported by the literature that indicates even the smallest and mundane activities of daily living are disrupted by the pain and have to be done effortfully and planned (Osborn & Smith, 2006). The pain made everyday tasks feel near impossible and resulted in the loss of function and disability. Mounting evidence shows chronic pain is associated with loss of function and disability (Snelgrove, & Liossi, 2013, see Chapter Three).

Disability further exacerbated pain's impact, for example, on employment and income. Before starting this discussion, a word on terminology is noteworthy. I acknowledge that the term disability neither simply expresses a medical condition nor a problem in women's bodies. Literally, disability is an umbrella term referring to the complex system of social restrictions and interaction between women and their contextual factors (sociopolitical and environmental barriers) that hinder their full and effective participation in society (WHO, 2011).

Disability. Findings demonstrated that because of disability, women faced barriers to employment, experienced job loss, reduced earnings, and/or economic hardship. There is strong evidence for a relationship between disability and poverty (Banks, Kuper, & Polack, 2017; Pinilla-Roncancio, 2015). Although this association is bidirectional, disability is both a cause and consequence of poverty, with each reinforcing the other (Banks, Kuper, & Polack, 2017; Pinilla-Roncancio, 2015). Evidence suggests that because of the systemic institutional, environmental, and attitudinal barriers, such as lack of employment, education opportunities, and lower wages, persons with disabilities are more likely to experience living in poverty (Pinilla-Roncancio, 2015). In Canada, 59% of people with disabilities were employed compared to 80% of their peers without disabilities in 2016 (Morris et al., 2018), indicating a high exclusion rate of people with disabilities from the labour market and barriers to employment. Additionally, people with disabilities earn less on average than people without disabilities. For example, one in four Canadians living with disabilities lives in low-income compared to about one in ten Canadians without disabilities (Wall, 2017). Consistent with this research, another study, based on data from the 2017 Canadian Survey on Disability, found that low income among persons with disabilities is higher even when employed full-time (Morris et al., 2018).

There are also gender differences in income for persons with disabilities. Women with disabilities are more likely to have lower wages than men (Schimmele, C., Jeon, S., & Arim, 2021), highlighting the intersections of disability, gender, and poverty. Income then shapes the quality of other determinants of health, such as housing and living conditions. For example, people with disabilities are more likely to experience food insecurity because of socio-environmental food access barriers (Schwartz, Buliung, & Wilson, 2019). To sum up, disability amplified existing structural inequalities, reinforcing living in precarious situations for some of the women.

Of significance, due to heterogeneity among women, not all women with chronic pain who explicitly mentioned that they were living with disability lived in low-income conditions. The severity of the disability, social characteristics, and family composition, such as being a lone parent or living alone, were associated with a higher risk of low income, which corroborates previous Canadian studies (Morris et al., 2018; Wall, 2017). Another study also highlighted that in examining outcomes of persons with disabilities, the severity of the disability is a crucial lens (Morris et al., 2018).

Impact of pain on social life. The second impact of pain was on social life. Many women grieved that they could not participate in social activities because of the pain limitations.

It was also hard to explain daily pain complexities and articulate them in depth. The pain created a wall between women living with pain and the outside world (Biro, 2010). At the same time, it prevents them from “breaching that wall by communicating the experience to others” (Biro, 2010, p. 15).

Women were also subject to scrutiny, mainly because of the invisibility of chronic pain, and they, as well as their caregivers, had to manage social judgement. These findings are observed by other scholars (Snelgrove & Liossi, 2013). Consequently, they tended to slowly lose contact with friends and relatives who were not understanding or did not believe them. Unsympathetic social contexts promoted complicated interactions with family and friends and sometimes resulted in adopting avoidance strategies (Snelgrove & Liossi, 2013). This strategy, however, led to intense feelings of loneliness and isolation, which was discussed previously. The experience of being disbelieved, stigma, and isolation is frequently reported in chronic pain literature (Newton, Southall, Raphael, Ashford, & LeMarchand, 2013).

The findings also indicated that pain led to job loss or early retirement. Considering some of the social interaction revolves around the workplace (Stick et al., 2021), the impacts of pain on unemployment magnified some women’s susceptibility to loneliness. Maintaining a family life was also challenging and resulted in marital tensions observed by others (Snelgrove & Liossi, 2013).

Emotional and psychological impacts. Another significant consequence of pain was its emotional and psychological impacts. In line with the literature, the collapse of the social world precipitated a range of emotions such as anger, sadness, and depression (Harris, 2014). Previous studies have shown that chronic pain is associated with suicidal ideation (Campbell et al., 2015), lower self-esteem (Breivik et al., 2006; Snelgrove & Liossi, 2013), poor mental health and depression (Breivik et al., 2006; Tappe-Theodor & Kuner, 2019; Williams et al., 2003; Zhou et al., 2019). Additionally, the findings are in agreement with a qualitative study examining the experiences of Turkish immigrants living with chronic low back pain in Denmark, demonstrating that pain affects life emotionally and influences mental well-being (Honoré Grauslund. Solmunde Michelsen, & Esbensen, 2021).

The unpredictability of the pain was also frustrating. Uncertainty about the future led to increased anxiety about finances and family life. In agreement with the literature, pain interrupted women’s expected life trajectory (Bury, 1982; Crowe et al., 2017; Toye et al., 2013; Toye, Seers, & Barke, 2014) and their caregivers’ expectations and plans they hold for the future.

Biographical disruption, repair, or flow. Experiences of loss and threatened identity were also found in the accounts. The participants, both women and caregivers, described profound changes to the sense of self because the women could no longer fulfill their social roles. As the pain was called into doubt the women’s self-worth, they felt guilty. The debilitating impact of chronic pain on the sense of self that emerged in this study mirrors previous studies (Osborn & Smith, 2007; Smith & Osborn, 2007; Smith et al., 2014; Snelgrove & Liossi, 2013). Similarly, one of the five themes that a qualitative meta-synthesis identified was a disrupted sense of self (Crowe et al., 2017). Two systematic qualitative reviews have also found that people living with chronic pain struggle to erode their authentic old selves (Toye et al., 2013; Toye et al., 2014). Immigrants living with chronic pain in Denmark also report changes in self-identity and perception of themselves (Honoré Grauslund et al., 2021).

Pain for the women was creating a disparity between what they expected of themselves and what they had done or had been, threatening their integrity (Chapman & Gavrin, 1999), or what Kwok, Chan, Chen, and Chuen Yee Lo named “self-discrepancy” (2016, p. 908). Self-discrepancy is when a person believes that “the present self is close to the person one fears to be (i.e., fear self) or the person one does not want to be (i.e., undesired self)” (Kwok et al., 2016, p. 908).

Chronic pain interfered with their identity expression by limiting the capacity of what they could do, changing who the women once were and what they wished still to be. The women had experienced ruptures in the “taken for granted assumptions and behaviours” (Bury, 1982, p. 169). The pain disrupted the “socially-set standards and cultural prescriptions of ‘normality’” (Williams, 2000, p. 50). These findings accord with what British sociologist Michael Bury (1982) has referred to as a “biographical disruption” (1982, p. 168).

The term biographical disruption describes a process that includes significant changes and disruptions in people’s lives, including their biographies, because of chronic illnesses (Bury, 1982). The participants’ accounts indeed supported the notion that chronic conditions, including pain, are associated with a threat to identity and the self (Charmaz, 1983, 1995; Gustafsson, Ekholm, & Ohman, 2004; Paulson, Danielson, & Söderberg, 2002; Smith & Osborn, 2007). For example, the fragmentation of the self and identity changes echoed the findings of Smith and Osborn (2007), who have demonstrated the debilitating impact of chronic pain in creating an “unwelcome self” that is incompatible with “the real me” (p.527).

In accordance with Smith & Osborn, 2007, I believe that loss of functioning and/or social role and feeling controlled by pain contributed to this process. For instance, the women struggled to fulfil socially valued roles, such as womanhood and motherhood, in their everyday life.

Researchers have underscored the centrality of motherhood to women's identity and the role of culture and gendered assumptions in the development of this identity (Ambrosini & Stanghellini, 2012; Johnson & Swanson, 2003; Laney, Hall, Anderson, & Willingham, 2015; Malacrida, 2009; Ross, 2016).

The concept of motherhood, albeit questioned by the ideological movements, is still a social duty and a fundamental step in the construction of female identity, reinforced by the presentation of the ideal mother in mainstream media and advertising (Ambrosini & Stanghellini, 2012; Malacrida, 2009). The women internalized the mothering ideologies. When they could not perform motherhood in conformity to the dictates of tradition and the cultural prescriptions defining the good mother, they felt inadequate, guilty, and unworthy (Ambrosini & Stanghellini, 2012; Malacrida, 2009).

It should be noted that some of the challenges that mothers described in achieving ideal motherhood might reflect gaps in social structures such as access to public space, including playgrounds, and the intersections between motherhood and disability (Malacrida, 2009). Moreover, the women's struggle to fulfill valued social roles in their everyday lives highlights the importance of chronic pain's social and cultural context (Smith & Osborn, 2007). The experiences of mothering with chronic pain also shed light on the continuous struggle mothers had in balancing their own health concerns with their family's needs and the expectation that they have to be the primary caregiver, despite being chronically ill. These findings are in agreement with the results of another study (Gustafsson et al., 2004), indicating women living with pain upheld their household and child-care duties rather than putting their own needs first.

Noteworthy, the changes that took place during the process of biographical disruption not only affected the women but also applied to their closest social relationships—family caregivers—as they were delegated new roles. No doubt, as narratives indicate, biographical disruption does not fully represent everyone's experience of chronic pain, nor was it always negatively life-changing. With adjusted expectations, creativity, and adaptation, the women found new and effective ways to retain their identities and/or create new identities meaningful to them.

Some women sought for a new self to overcome the disruption. Others attempted various strategies, such as pacing and keeping up, to work around the pain challenges and maintain a "normal life." This finding was mainly evident in those who lived with pain for a more extended time. Previous studies have also shown that people living with chronic illnesses or pain created a new "normality" (Bury, 2001; Sanderson, Calnan, Morris, Richards, & Hewlett, 2011; Sharpe & Curran, 2006) or "biographical repair" (Locock, Ziebland, & Dumelow, 2009, p. 1043).

Sanderson et al. (2011) suggested that the normalization processes depend on the severity of symptoms, ability to adjust to illness, or the influence of contextual factors, among others. Resources such as time, finances, and various forms of social support—emotional, instrumental, informative, and evaluative—can also facilitate returning to one's previous self or creating a new self (Chramz 1995; Pranka, 2018). To give an example, having financially secure partners allowed some women to reduce work hours or retire early. In contrast, as the narratives have shown, single mothers generally sacrificed their health to sustain their identities as mothers and/or workers.

Studies have also highlighted the need to take greater account of gender roles, caring responsibilities (Wilson, 2007), class (Ciambrone, 2001), and age (Faircloth, Boylstein, Rittman, Young, & Gubrium, 2004) on the extent to which chronic pain is experienced as biographical disruption. For instance, Wilson (2007), in a study of HIV-positive mothers, found that participants stressed the importance of maintaining their responsibilities to protect their children—a type of biographical disruption that co-occurred with instances of biographical reinforcement. Similarly, Ciambrone (2001) studied how women reconstruct the meaning of HIV infection in light of other disruptive life situations. They found for people whose lives are characterized by a series of disruptive events, such as precarious work, or economic uncertainty, chronic illness can be viewed as another link in a long chain of disruptive events rather than as a distinct rupture (Ciambrone, 2001).

Few women believed that chronic pain caused by age. The inevitability of chronic pain as an ageing process was reported by other scholars (Smith et al., 2014). Consequently, pain can represent a “biographical flow” (Faircloth et al., 2004, p. 242). It might explain why some women in this study did not experience biographical disruption.

As noted, not all pain experiences were negatively felt. Some women reported positive aspects of the pain experiences, such as spiritual growth, an enhanced appreciation of life, and creating new roles. This finding is consistent with Frank’s (1993) argument that the disruptive effect of illness can also be positively life-affirming. This result is also in concordance with a mixed-method study that supported the idea that pain is sometimes associated with significant personal development and greater wisdom (Owens, Menard, Plews-Ogan, Calhoun, & Ardelt, 2016). This finding resonates with a qualitative meta-synthesis (Snelgrove & Liossi, 2013) as well.

Analysis of the transcripts also revealed when other sources of identity, such as motherhood and ability, were undermined, the importance of maintaining other identities, such as employment, were accentuated. This finding resembled previous observations by Wilson (2007), who examined the inter-relationship between illness and key sources of identity. Simply put, employment provided a sense of identity for the women (Gini, 1998; Selenko, Mäkikangas, & Stride, 2017), mediating the sense of belonging, being a valued person (Fryers, 2006), and a sense of control (Jetten et al., 2017), necessary for self-esteem and well-being (Fryers, 2006; Jetten et al., 2017).

Impact on caregivers. The findings demonstrated that pain, although an individual experience, had a far-reaching impact on the family structure. There was a reciprocal interaction between the career and care recipient. Just as caregivers played an essential role in the women's adjustment, the carers were also affected by the pain. This result is also echoed by other researchers who summarize the literature describing the effects of geriatric patients' pain on family members' relationships (Riffin et al., 2016).

Before discussing caregivers' experiences, it is crucial to explore how the organizing principles and values shaped families' responses. All three groups of participants identified two distinct family caregiving systems, individualist and collectivist, highlighting the cultural embeddedness of caregiving. The physicians believed that immigrant populations were less self-centred and had social values that revolved around what was best for the family and the person living with pain. Caregivers' experiences also showed that they often considered the care recipient's needs over their own needs and desires. They, for example, relocated their place of residence for the benefit of their loved ones; it was not something common in individualist societies such as Canada—although diversity across the spectrum and within any culture was acknowledged.

An important aspect of the morality of collectivistic families is the obligation towards caring by family members, for whom caregiving is a labour of love (Pyke & Bengtson, 1996). In a similar vein, stemming from familial expectations rooted in cultural values, one caregiver, in particular, did not perceive the support provided to the care recipient as caregiving activities but as an act of living with a loved one with chronic pain. Other researchers who explored family care across the different cultural groups in the U.S. (Pharr, Dodge Francis, Terry, & Clark, 2014) and Canada (Andruske & O'Connor, 2020) have reported this finding.

The consequences of caring were various, including both negative and positive aspects. Caregiving was, in fact, stressful and an emotional burden; meanwhile was a rewarding task. This result ties well with previous studies (National Academies of Sciences, Engineering, and Medicine [NASEM], 2016; Smith, Fletcher, & Lister, 2021; Statistics Canada, 2022b). On the negative side, caregiving was associated with deterioration in health, increased stress, lower financial well-being, impact on work, role reversal, loss of social interactions, emotional impact, less self-care time, and living in uncertainty. The literature supports these findings (Hango, 2020, Marani, 2021; Schulz & Sherwood, 2008; Smith et al., 2021; Statistics Canada, 2022b; Wang, Ji, Kitchen, & Williams, 2021; West et al., 2012). For instance, the first meta-ethnography of the lived experiences of informal caregivers of people with chronic musculoskeletal pain found a constant burden in caregiving and role reversal as major themes (Smith et al., 2021). Pressure to meet the care needs of their loved ones, magnified by the unpredictable and fluctuating nature of pain (Smith et al., 2021), can result in a chronic stress experience compromising the caregiver's psychological health (NASEM, 2016). The loss of "normal" childhood, which an adult child caregiver reported, reflects the findings of Higgins et al. (2016).

Regarding the positive impacts of caregiving, some informants commented that caregiving was an experience with a feeling of being more human and was the practice of empathic imagination and self-cultivation. These findings are observed by Kleinman, who was caring for his wife (2009). Moreover, and in agreement with the literature, some families' relationships grew stronger and flourished, resulting in more family closeness (Golics, Basra, Finlay, & Salek, 2013; Walsh, 2016; West et al., 2012). For example, in some instances, role reversal positively impacted care experiences. This finding is directly in line with a previous study highlighting that when the caregiving dyad shares care tasks, instead of a complete loss of historical roles or identity, the identity maintains, although through a limited role, which is a positive step for both carer and care recipient (Smith et al., 2021). The results are also supported by a systematic review, meta-analysis, and qualitative synthesis (Higgins et al. 2016), indicating positive outcomes associated with growing up with a parent with chronic pain. These include developing independence at an early age, developing compassion or empathy for others, and learning life lessons (Higgins et al., 2016).

The findings, generally speaking, showed two approaches to caregiving: engulfment and balancing/boundary setting (Atkin & Ahmad, 2000). For one of the carers, caring became the centre of his life and the defining feature of self-identity—in line with the first approach. It was noted that engulfment occurs when it is hard for "carers to distance themselves from the situation" and "to separate themselves" from the care recipient's suffering (Atkin & Ahmad, 2000, p. 59). Adult children caring for parents, however, maintained their balance by setting boundaries and autonomy around what they would or would not do. Notably, carers did not necessarily fall exclusively into a single way of care experience, and some exhibited a mixed response (Atkin & Ahmad, 2000).

Taken together, the findings suggest that pain had a significant impact on the whole family as a functional unit, yet each family's experience of pain had unique features. The differences in caregiving experience can be due to the timing of entry into the caregiving role, the duration and intensity of the caregiving role, and the resources available for the family (NASEM, 2016; Statistics Canada, 2022b; Walsh 2016). For example, generally speaking, care-related stress was more significant among caregivers who provided more hours of caregiving. This finding is in agreement with a recent study by Statistics Canada (2022b). Moreover, the research confirmed that informal caregivers who spend more time on caregiving are more likely to have limited attention for self-care (NASEM, 2016). On the contrary, not living with the care recipients, as observed for adult children carers, helped them take care of themselves, although such caring was associated with feelings of guilt and self-blame. These feelings might stem from the collectivist approach to caregiving.

Beyond providing more hours of care, the differences in caregiving experience might stem from living with the care recipient (Barbosa, Matos, Voss, & Costa, 2021; Hango, 2020) and living in households with fewer people (Hango, 2020). As results indicate, one spouse, who was the sole caregiver had unmet caregiving needs. It is documented that the unfulfilled needs of carers are associated with lower well-being, lower life satisfaction, more daily stress, and worse self-reported mental health (Barbosa et al., 2021; Hango, 2020; Smith et al., 2021), which is in agreement with what my findings.

To sum, caregiving is a multidimensional and complex process in which the severity of care recipients’ pain and associated disability, composition of the family, the effects of culture and other caregivers’ social markers, such as age, marital status, and SES, shape the caregiving experience and impact its outcomes. These findings reinforce earlier research on caregiving among family caregivers (Sharma, Chakrabarti, & Grover, 2016).

Coping Strategies: Moving Forward

The last theme related to the coping strategies women and informal caregivers had utilized, including their experiences with the health care system and reflections of all three groups on barriers and facilitators of service delivery to immigrants.

Medical treatment. One strategy for all women was seeking pain treatment. Previous studies have shown the experience of chronic pain prompts a search for diagnosis and treatment (Lachapelle, Lavoie, & Boudreau, 2008). For some, diagnosis—a biomedical explanation—provides validation of their invisible illness and an acceptable explanation for the pain, which corroborates the finding of others (Toye, Belton, Hannink, Seers, & Barker, 2021; Toye et al., 2014). A vigorous effort to find a cure led women to try a variety of Western and a spectrum of other modalities such as acupuncture. Most went through trial and error in determining what might manage the pain.

The women and their caregivers were in contact with the health care system in various contexts, including but not limited to medical assistance in primary, secondary, and tertiary care, in clinic and emergency settings, pharmacies, labs, chiropractic, and physiotherapy. They were, generally speaking, satisfied with the Canadian health care system, yet they believed that there was room for improvement. While pain management has been considered a fundamental human right (Wallace et al., 2021), findings highlight diverse and intersecting barriers that collectively perpetuate disproportional access to and utilization of effective pain management services by immigrant women.

The barriers include structural and institutional barriers (e.g., discrimination and judgmentalism by HCPs, long wait times for pain clinics, inability to find a specialist, lack of continuity of care, lack of understanding and support from HCPs, feeling unheard or unbelieved, short consultation times), financial barriers (e.g., inability to afford prescription medications, inability to afford alternative therapies), and cultural barriers. A recent environmental scan also confirmed that factors pertained to funding, support, and having a centralized referral system influenced the care provided to people living with chronic pain (Brett & MacDougall, 2021). Similarly, the Canadian Pain Task Force (CPTF) identified numerous gaps in the management of chronic pain in Canada, including lack of public funding, long wait times, lack of specialists, language and cultural barriers, and lack of coordination across providers, among others (Health Canada, 2020).

Disbelieved patients: Uncompassionate health care professionals. The participants valued HCPs who gave them their full attention, listened to them, and understood how pain affected all aspects of their lives. Yet, not all informants felt that their HCPs had been supportive. In their medical encounters, some women felt that HCPs perceived that they were malingering or purposely exaggerating their symptoms. The women, therefore, were struggling to be taken seriously. As they were waiting for a diagnosis, some were classified as difficult patients.

Almost five decades ago, McCaffery defined pain as “whatever the experiencing person says it is, existing whenever the experiencing person says it does” (as cited in Clark & Iphofen, 2008, p. 30). However, this quote was not always put into practice (Clark & Iphofen, 2008); the disbelief was prevalent among HCPs that women had encountered. McCaffery’s definition underscores the subjectivity of pain, the point at which pain assessment frequently fails. There are no lab tests, biomarker, or X-rays that can confirm pain; thus, the women were not able to turn around to their HCPs and say, for example, “It is the proof of my pain; I am not hysterical nor psychogenic." Feeling not believed by HCPs is like the experiences of patients living with chronic back pain described by Allvin, Fjordkvist, and Blomberg (2019).

Underestimation of pain is well documented. For example, findings of a systematic review indicate that HCPs consistently underestimate pain compared with their patientès report (Seers, Derry, Seers, & Moore, 2018). Gendered bias in pain treatment is also reported by literature; women are more likely to have their pain reports discounted as psychogenic and inadequately treated by healthcare providers (Hoffmann & Tarzian, 2001). The lack of belief and/or pain underestimating also affected women financially. As chronic pain was difficult to prove, some women's claims for disability benefits were rejected. They are indeed "entrapped in medical and legal systems which are supposed to help" (Snelgrove, & Liossi, 2013, p. 296), and their efforts to compensate for the effects of disability and ease of economic hardship often failed.

My findings also revealed gaps in having empathy and compassion from HCPs for the patient, which is in line with the literature (Snelgrove & Liossi, 2013). As Dickman and Chicas (2021) discussed, dialogue with empathy can facilitate a more holistic understanding of lived experiences of patients and more effective care. Such dialogues can foster high-quality health care and better patient outcomes (Knoebel, Starck, & Miller, 2021; Roberts, Puri, Trzeciak, Mazzarelli, & Trzeciak, 2021). While the physical body is being cared for, the patient also needs attention to their "lived body," which is an integral part of holistic health care; they should be seen as a "whole, complete person and not as an assembly of parts" (Missel, Bernild, Westh Christensen, Dagyaran, & Kikkenborg Berg, 2021, p. 188).

Meanwhile, HCPs behaved in a way expected of them by institutionalized norms of behaviour in medical training, a system of knowledge based upon the positivist scientific method with little space devoted to treating patients as people rather than cases (Lupton, 2012). Therefore, findings might not be interpreted as HCPs were uncaring; rather, it should be perceived that HCPs need to gain skills that demonstrate their clients they are listening (Clark & Iphofen, 2008). Nonetheless, learning to empathize with patients and putting oneself in the patient's shoes is the first step to improving the pain treatment (Knoebel et al., 2021). No doubt that balancing empathy with "not getting too involved" can be a difficult task (Toye, Seers, & Barker, 2018).

Notably, compassionate pain management needs pain education for HCPs (ISAP, 2021). Despite developed and freely available resources, health professionals' training in pain management across the world is below recommended standards (Fong & Morley-Forster, 2018; ISAP, 2021). In Canada, a survey of health sciences programs across seven provinces found that 68% of programs were unable to identify designated hours in their prelicensure health science curricula (Watt-Watson et al., 2009). Moreover, the average total time designated for formal pain for faculties of medicine, nursing, and dentistry, for example, ranged from 15 hours to 42 hours. Contrary, veterinary students spend 2 to 5 times as many education hours focused on pain management as students in health science (Watt-Watson et al., 2009). A well-designed pain curriculum can enhance pain management practices, reduce the development of negative stereotypes and prejudices, and ultimately associate with positive attitudes toward chronic pain patients (Fong & Morley-Forster, 2018; Watt-Watson et al., 2009). Of note, another highlight of this study is that immigrants' families were more likely than Canadian-born families to accompany patients to physicians' visits. It is suggested that acknowledging and welcoming family members who accompany the patient can be an essential step to building trust (Kirmayer et al., 2011).

Fragmented health care system. Another barrier to effective pain management was the lack of coordination of care. Most of the women were visited by several HCPs in different settings, yet as they mentioned, continuity and coordination across providers and settings were often lacking. For example, medical records held in one health care setting were often not shareable, further contributing to the women's frustration and the fragmentation of care. Some found ineffective communication among HCPs, which led to harm. These results are supported by the Canadian Institute for Health Information's Experiences Survey on Inpatient Care, indicating that conflicting information from HCPs is the biggest challenge for coordination of care in Canada (n.d.).

Similarly, at the provincial level, Drummond (2012) pointed out that in Ontario, "The health care system is not really a system: What we have is a series of disjointed services in many silos" (p. 17). These independent silos "allow too many people to fall between the cracks" (p. 20). A significant contributor to this fragmentation is the limited usage of electronic medical records across the system, which does not allow the integration of services (Drummond, 2012). Digital health can facilitate the distribution and dissemination of health information (van Kessel et al., 2022). While Drummond's report was published about a decade ago, it still has a lot of relevance to what the health system needs today.

The Pan-Canadian Health Data Strategy Expert Advisory Group (2021a), for example, noted that significant gaps remain in Canada's health data ecosystem. This highly fragmented health data ecosystem results in poor patient and provider experience (Pan-Canadian Health Data Strategy Expert Advisory Group, 2021a). Importantly, digital health is not inclusive, meaning that the legislation around health data structure has primarily designated care providers as custodians (Pan-Canadian Health Data Strategy Expert Advisory Group, 2021b). Therefore, patients are not equal partners in care planning and monitoring nor have control of personal health information, which is not in accord with person-centred care (Pan-Canadian Health Data Strategy Expert Advisory Group, 2021b) —"integrated whole-population approaches to empowering people to have greater choice and control over their health and care" (Mulligan, Bhatti, Rayner, & Hsiung, 2020, p. 426). Moreover, fragmentation and discontinuity of chronic conditions care and treatment often result in suboptimal care (Tarrant, Windridge, Baker, Freeman, & Boulton, 2015), which is in line with this dissertation's results.

Another aspect of fragmentation is the lack of relationships between health and social care systems. Despite awareness of the importance of social context in an individual's health, there were barriers to addressing the SDoH in clinical settings (Nowak & Mulligan, 2021). Health systems are now increasingly looking to integrated care as a possible solution to accommodate the needs of patients (Mulligan et al., 2020; WHO, 2016). The integrated care is defined as "new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups" (United Kingdom's National Health Service, n.d., para. 2).

An essential component of integrated care is to address the diverse determinants of health by bringing together the clinical and social care systems (Mulligan et al., 2020). Social prescribing is a new, effective systems solution to address social needs and SDoH and to bridge the social and health care services (Mulligan et al., 2020; Nowak & Mulligan, 2021). It is a structured, formal pathway for HCPs to refer and connect people to a range of non-clinical support services in their communities (Bloch & Rozmovits, 2021; Mulligan et al., 2020). Early evidence from social prescribing interventions shows that this low-cost, feasible intervention has the potential to transform the medicalization of social needs, empower patients and health care providers, ease the burden on health care budget, improve health and well-being, and achieve health equity, particularly among individuals with complex chronic health conditions and needs (Bhatti, Rayner, Pinto, Mulligan, & Cole, 2021; Bloch & Rozmovits, 2021; Mulligan et al., 2020; Nowak & Mulligan, 2021).

Interestingly, a recent study (Fancourt & Steptoe, 2018) explored the impact of physical and psychosocial activities, such as cultural engagement undertaken by social prescription (e.g., going to museums, exhibitions), in reducing the risk of developing chronic pain in older adults. The findings showed that engagement in cultural activities was comparable with vigorous physical activity, reducing chronic pain incidence. The authors concluded that social prescribing is a valuable intervention to help prevent the development of chronic pain (Fancourt & Steptoe, 2018). While the literature points to a positive general impact on the health of social interventions, these interventions are not a routine part of physicians' practice in Canada, particularly outside of community health centres, and are not yet considered to meet the "standard of care" (Bloch & Rozmovits, 2021, E1700).

Multidisciplinary team approach: Not a reality. As the physicians noted, effective pain management should begin with a comprehensive assessment, including previous medical records, a detailed history of the pain, a discussion of expectations and realistic outcomes, and the development of a management plan, among others. The goals were to improve pain control, improve function, and enhance coping skills to deal with ongoing pain. For the physicians I interviewed, the multidisciplinary pain management approaches, which combined various therapeutic modalities, were the best in helping patients with chronic pain. ISAP (n.d.-b) also considers a multidisciplinary team approach to the optimal treatment paradigm. A multidisciplinary approach to the treatment of chronic pain is a best practice and cost-effective care (Health Canada, 2019; Hogg, Kavanagh, Farrell, & Burke, 2021). Furthermore, the Colleges of Physicians and Surgeons of Ontario, Alberta, Manitoba, and New Brunswick endorse such an approach to treating chronic pain (Peng et al., 2007).

This approach is based on the biopsychosocial model of pain and includes treatment components in four areas: medical, behavioural, physical reconditioning, and education (Agency for Healthcare Research and Quality, 2011), which the participants also underscored. Importantly, in the context of the immigrant population, a systematic review (Altun, Brown, Sturgiss, & Russell, 2021) has highlighted that chronic pain intervention strategies grounded in a multidisciplinary approach effectively manage pain intensity, physical function, and quality of life outcomes in this population.

Despite recognizing multidisciplinary and interprofessional pain clinics as the gold standard, the present results clearly indicated that the women did not have timely access to such clinics; the wait times were substantially longer than recommended. ISAP (n.d.-a), for instance, recommends a wait time of four months for persistent long-term pain without significant progression. The Canadian Anesthesiologists' Society (n.d.) also suggests the time of referral by the primary care physician to the first assessment by a subspecialist in chronic pain management should not be longer than six months—With some exceptions when shorter wait times should be targeted.

The finding related to long wait times is concordant with several previous studies. For example, a systematic review examining the published literature describing MPTFs in several countries, including Canada, concluded that: "Availability of pain treatment facilities was scarce and the reported caseloads and wait times were generally high" (Fashler et al., 2016, p. 14). A comprehensive national survey conducted in 2005-2006 examined the distribution and services offered in MPTFs across Canada and found only one pain treatment facility for 258,000 Canadians and one for 305,000 Ontarians (Peng et al., 2007).

About 12 years later, access to MPTFs was still limited and even got worse; each pain treatment facility served an average of 354,000 Canadians (Choinière et al., 2020). In Ontario, because of a sharp decrease in the number of MPTFs, each facility served about 568,000 Ontarians (Choinière et al., 2020). An inadequate number of MPTFs resulted in long wait times. A study also revealed that wait times for the Ottawa Hospital pain clinic, even for those triaged as urgent cases, exceeded timelines deemed ideal by the patients (Liddy, Poulin, Hunter, Smyth, & Keely, 2015). These access challenges can reduce the patients' capacity to participate in daily activities, impact work or school attendance and significantly affect physical, psychological, and social functioning (Choinière et al., 2010; Liddy et al., 2017; Lynch et al., 2008).

Financial barriers. The results also indicate that some women living with pain struggled to afford the treatments. Access to all health care services in Canada, such as mental health, physiotherapy, and prescription medication, are not covered by Canada Health Act. As a result, many Canadians still rely on employer-provided benefit plans to access such services (Cheff, Hill, & Iveniuk, 2019). The universality of Canada's publicly funded health coverage indeed shows a problematic gap—the deservingness is based on a person's employment insurance status and ability to pay for some services. This result is in agreement with a previous study, which showed that about one in 10 Canadians did not fill their prescriptions or skipped doses of medications because of cost (Government of Canada, 2019).

Similarly, Cheff et al. (2019) also showed a patchwork approach to drug coverage: one in five working Ontarians did not have medication coverage. The inequities in coverage were much more significant for racialized workers than white workers (29.8 percent vs 19.5 percent). Another striking difference in coverage was observed by immigration status. Immigrants, particularly newcomers—who had been in Canada for less than five years—were less likely to have medication coverage (Cheff et al., 2019). These findings are worrisome as pharmacotherapy plays an essential role in pain treatment.

As the physicians noted, the affordability issue has been compounded by massive cuts to system budgets. These results echo existing research that broader health care reforms and cutbacks can create another barrier to service users. For example, in Ontario, since the financial crisis in 2008, a deepening of neoliberal policies in health care has resulted in austerity health care spending and privatization of health care delivery (Mahabir et al., 2021). Notably, the median wait time for adult pain treatment was reported to be 0.5 months (0.3–1) for non-public facilities and six months (2–14) for public facilities, which is about 12 times longer, meaning at least half of the patients were waiting six months, and some were waiting up to five years to gain access to treatment (Peng et al., 2007). A recent update to this work indicates a slight reduction in wait times (5.5 vs six months), with some people waiting up to four years, indicating a modest improvement in access to public MPTFs after a decade (Choinière et al., 2019). The difference in wait time in these two types of facilities is also striking and suggesting those who can afford to pay out of pocket for multidisciplinary pain treatment can receive it faster (Fashler et al., 2016).

A new study (Moir & Barua, 2021) comparing the performance of Canada’s health care system relative to its international peers—28 high-income OECD countries with universal health care systems—indicates that while Canada ranks eighth highest for expenditure on health care expenditure per capita, its performance is modest to poor, particularly its performance for availability and access to resources. Similarly, according to another study, from 10 OECD countries, Canada ranked seventh when measuring the percentage of patients who found the cost was a barrier to access (Moir & Barua, 2021). In addition, another study examining the performance of health care systems of 11 high-income countries found that Canada ranked second to last on an equity performance indicator, meaning Canada had one of the most considerable income-related inequities in performance based on the included measures (Schneider et al., 2021). Similarly, a recent study indicates that low-income Canadians are more likely to have lengthier wait times for publicly-funded health care than their high-income peers, which can be interpreted as evidence of inequity within the Canadian health care system (Hajizadeh, 2018).

Access to specialists. Along with other barriers described previously, lack of access to specialists was identified as a shared experience. This finding corroborates previous research indicating, although not specific to chronic pain, out of 10 OECD countries that track medical wait times, Canada ranked worst in the time it takes to get an appointment with a specialist (Moir & Barua, 2021). In Ontario, of the 26.5% of the population who required specialty care, 22.0% reported difficulty accessing that care. More explicitly, both recent and established immigrants were more likely to experience these difficulties than the native-born (Harrington, Wilson, Rosenberg, & Bell, 2013).

Cultural barriers: What about racism? In their reflections on providing care for patients with chronic pain, physicians found pain treatment and management a challenging task, mainly because patients wanted to be cured, which was not often a possibility. This challenge was compounded when the patient belonged to a different culture or could not speak one of Canada’s official languages. Previous research shows that pain is a complex phenomenon that is not easily measured and therefore makes its assessment and treatment a daunting task for HCPs (Goodwin & Kirkland, 2021; Snelgrove & Liossi, 2013). In a similar vein, a qualitative study examining the experiences of primary care clinicians and nurses indicates that care providers noted the treatment of patients with chronic pain is challenging, frustrating, and overwhelming (Webster et al., 2019).

To overcome the cultural and linguistic barriers, the physicians found cultural, linguistic and gender concordance of HCPs were made an enormous difference. Respecting differences and finding common ground for treatment plans aligns with best practices (Saha, Beach, & Cooper, 2008) and is an important moderator for treatment response (Altun et al., 2021). The physicians also used professional or informal interpreters to increase communication accuracy. This strategy was beneficial, although it added more complexity to their encounters, which aligns with the results of other studies (Cosio & Demyan, 2021).

In addition, the physicians tried to incorporate cultural competence into their practice. Yet, the general understanding of the culture within the field of medicine was often recognized as characteristic of patients. Usually missing, as narratives indicate, is that physicians are, themselves, not culture-free (Crowley-Matoka, Saha, Dobscha, & Burgess, 2009). The physicians ignored the culture of biomedicine where they were immersed and how “medical training and the adoption of a theory embedded in technical language and practices actually create the ordered reality, in which” they “discover and situate the patient’s ‘real’ problems” (Kirmayer, 1992, p. 326). Nor do they pay attention that the words and methods used to convey medical facts are powerful attitude shapers (Muldoon, 2022) and “how medical textbooks reinforce norms based on Whiteness” (Samra & Hankivsky, 2020, p. 857).

Consequently, the cultural sensitivity was sometimes limited to what Ahluwalia, Baranowski, Braithwaite, and Resnicow (1999) named "the surface structure" (p. 11) dimension of cultural sensitivity, which involves matching materials and messages to observable characteristics of patients. Surface structures, though important, cultural sensitivity needs a deeper understanding. It requires recognizing how cultural, environmental, social, historical, and psychological forces—the "deep structure" dimension of culture sensitivity (Ahluwalia et al., 1999, p. 11)—influence experiences of pain and how immigrant women perceive the cause, course, and treatment of chronic pain.

In other words, the over-reliance on cultural explanations obscured the impact of broader structural and institutional forces that created patterns of oppression and health inequities (Viruell-Fuentes et al., 2012). Simply put, another barrier to care was a lack of knowledge of the intersectionality of social identities such as age, sex, gender, education level, and income along with culture, and social, economic, political, and historical factors that were influencing the experiences of pain. Moreover, intersectionality calls for clinicians to acknowledge the power dynamic in their encounters. For instance, power differential plays important role in patient–clinician interactions. Shared decision making can reduce these power differences (Wilson et al., 2019). Notably, the equal sharing of power is one of the central tenants of patient-centered care (Nimmon, & Stenfors-Hayes, 2016).

Despite the importance of racism and its impact on health, none of the HCPs spoke about it and its potential impact on pain. Instead of culture, healthcare providers should begin by acknowledging racism and how racism, White privilege, and structured unequal power relation in society exclude and impact racialized immigrants (Dryden & Nnorom, 2021; Mahabir et al., 2021; Waldron, 2010). In this way, culture could be interpreted as "shared experiences of lack of power" (Hankivsky et al., 2017) despite biographical diversity. In line with the recommendations of the CPTF, "Addressing systemic inequities must be a central, integrated pillar of Canada's efforts to understand, prevent, and treat pain" (Health Canada, 2021, p. 6.).

Three points bear noting. First, beyond the cultural competency training, physicians did not receive any special training in immigrant and refugee health, which is concerning. This finding is supported by Pottie et al. (2011), who noted, "Immigrant and refugee health is a new subdiscipline. The skills, knowledge and experience that define expertise have not yet been determined, and there are no examinations, certification or developed courses that can be used as a proxy for expertise" (P. E831). Similarly, Gruner et al. (2021) have found that about 80% of Canadian medical schools spend less than 10 hours (nearly 40% between 5-10 and another 40% less than five hours) throughout the undergraduate medical program delivering refugee/migrant health curriculum.

Second, studies have shown that the myopic biological foci of many health care interventions using traditional design principles without addressing broader social determinants can exacerbate health conditions and inadvertently impede equity (Dickman & Chicas, 2021). The Canadian Medical Association (2013) also encouraged physicians to take a comprehensive social history as the first step in understanding and ultimately addressing SDoH. Developing the capacity to address SDoH, however, requires allocation of time and resources and ensuring a fit between the intervention and the organization's strategic plan, which might physicians did not consider as part of their core business or a priority (Bloch & Rozmovits, 2021; Pinto & Bloch, 2017). Nevertheless, addressing SDoH can improve patient experience and healthier populations (Pinto & Bloch, 2017). Undoubtedly, the lack of service integration, which was discussed previously, amplified this situation.

Third, attention to intersectionality, which requires a more complex assessment of a patient rather than labelling them, to find how all aspects of one's identity, not just culture, intersect and manifest themselves in experiences of pain can improve patient-clinician encounters (Wilson et al., 2019). A single-axis analysis based solely on culture would obscure how other axes of identity affect the pain experience. One of the intersectionality's contributions to the clinical environment is that attention to structural issues and SDoH can support clinicians in providing patients with needed resources (Wilson et al., 2019). Moreover, understanding the structural dynamics of identity markers may assist physicians in knowing the reasons for immigrant women's reluctance to accept some offered programs (Wilson et al., 2019).

Lack of holistic care: Autonomy or paternalism. While physicians emphasized the importance of a multimodal treatment plan, setting realistic, individualized goals that prioritize function and quality of life, most women and caregivers believed HCPs relied on medication alone, ignoring other treatment options. They talked in detail about the lack of access to multidisciplinary services, such as physiotherapy and chiropractic, and commented on the lack of holistic care. Previous Canadian studies have shown that physicians' propensity to prescribe drugs and provide services within a Western medical framework, which might not be in accordance with patients' traditions and practices, can impact levels of access to healthcare among racialized communities (for more details, see Waldron, 2010). In biomedicine, which is disease-centred, patient care is oriented toward "body parts instead of treating the whole patient in their life context" (Fuller, 2017, E641).

Women also described encounters within the health care system where their autonomy was not recognized. For example, many women found alternative modalities helpful for reducing pain, but oftentimes, their HCPs acted as gatekeepers, ignoring women's choices. Patients' autonomy and their right to make treatment decisions are fundamental principles of medical practice (Murgic, Hébert, Sovic, & Pavlekovic, 2015). Yet, the participants' views revealed concerning power relations in the medical encounter. Despite extensive critiques of paternalism, it remains a common practice in the health care system (Childress, 2020).

Importantly, "the reluctance of, or refusal by, healthcare professionals to use complementary and/or alternative health approaches is one of the main reasons why culturally and racially diverse groups are hesitant to access health services in Canada" (Waldron, 2010, p. 266). There is

> a dispute between alternative and orthodox practitioners over whose body of medical knowledge is best suited to treat illness. … While mainstream health practitioners have increasingly incorporated CAM [Complementary and Alternative Medicine] into their own practices, they continue to maintain a strong distinction between what they regard as 'scientific' medicine and CAM. (Lupton, 2012, p. 122)

To challenge the power imbalance and promote the development of more collaborative therapeutic relationships, the women tried to learn about their pain as much as possible. They actively sought health-related information obtained from supportive social networks, HCPs, and the media, such as the Internet, to gain clarity or affirm knowledge about pain. A study, which systematically reviews and synthesizes the existing research on Internet health information-seeking behaviour and its impact on the patient-physician relationship, showed that Internet health information seeking has resulted in a shift in the traditional information balance, empowering patients to be actively involved in the decision-making related to their condition and disease management, and has the potential to improve the patient-physician relationship (Tan & Goonawardene 2017). In other words, well-informed patients maintain a sense of control over their condition (Lupton, 2012; Tan & Goonawardene, 2017) and correspondingly enter into a comprehensive negotiation with their physicians (Tan & Goonawardene, 2017). Social location, however, can influence how people react to their position of powerlessness and how they are able to resist medical dominance (Lupton, 2012). For example, patients might become non-compliant or uncooperative (Lupton, 2012). Other strategies such as mindfulness-based practices, massage therapy, acupuncture, occupational therapy, and physiotherapy also helped to lessen the women's pain. Such therapies have been shown to improve psychological and physical functioning (Snelgrove & Liossi, 2013).

To wrap up this section, pain management is a persistent and pervasive problem in Canadian medical practice. Countless reports, guidelines, and initiatives call for the effective treatment of chronic pain, yet, as noted by the participants, inadequate pain treatment continues to be an issue. The health system is ill-equipped to deal with chronic pain; there is a gap between what is being learned and actions to improve pain care and patient experiences.

Other coping mechanisms: Self-management. As women found no cure for their pain existed, nor biomedicine could "fix" the pain, their attempts focused on managing pain. Rather than being at war with pain, they learned to live with it and make their lives and loved ones' lives the best. However, managing the mental, emotional, and social challenges of pain required an extraordinary effort; it was strenuous and tiring (King, 2012) and needed "conscious and deliberate action" (Bury, 1982, p. 176). The uncertainty of the pain course and its episodic nature further compound continuous adjustments.

Women described medical interventions as necessary but limited. Some lost their faith in health professionals' knowledge as they were passed from one HCP to another looking for a diagnosis, which is in concordance with the findings of another study (Snelgrove & Liossi, 2013). Their beliefs in medicine were then being replaced by confidence in their own expertise.

Realizing there is no cure and that their pain might get worse, they explored alternatives and utilized several self-management strategies. In line with a previous study, self-management techniques helped them take control and ownership of their health, reduce their dependency on the health systems, and increase their functional capacity (Snelgrove & Liossi, 2013). One point bears noting: During the interviews with physicians, it was common to hear that some types of coping were better than others; however, I agree with Litt and Tennen (2015) that “there is no ‘best’ way to cope with chronic pain. The effectiveness of a given coping strategy is context-dependent (p. 406).

Pacing and breaking down tasks into small, doable chunks was an important strategy in women’s pain management. They tried to avoid or limit pain flares by implementing pacing into their life. They also learned to use their energy wisely to be part of the activities they enjoyed. They prioritized their to-do lists. Listening to soothing music, reading, seeking distraction, creative expression through art, setting limits on activities, exercise, yoga, and prayer were other strategies utilized by the participants. These types of coping strategies have been reported by other researchers (Gustafsson et al., 2004; Miles, Curran, Pearce, & Allan, 2005; Toye et al., 2013).

Like a previous study, support groups provided a positive environment with good-quality and reliable information (Snelgrove & Liossi, 2013). They found that peer exchange of lived experience helped them better manage their pain through coping tips and strategies. A Handicapped Parking Permit was one of the helpful aids by decreasing pain by parking closer to the door, although it does not always work. Meanwhile, some of the women internalized stigma and felt that such aids publicized to the world that they were disabled. Similar finding reported by Smith et al., 2014. Some women who required workplace accommodation received the necessary support, highlighting the importance of workplace policies and practices in creating more effective, equitable, and inclusive workplaces (Jetha, Gignac, Ibrahim, & Martin Gini, 2021; Seggewiss, Boeggemann, Straatmann, Mueller, & Hattrup, 2019).

As independent persons, learning to ask people for help was challenging but beneficial. The women, in fact, struggled and avoided becoming dependent on others while needing support from their families. This finding is in keeping with a systematic review and meta-ethnography indicating that reliance on the family and friends is accepted, although with reluctance (Smith et al., 2014). The reluctance might stem from the fact that they avoided being seen as complainers (Smith et al., 2014).

Some pushed themselves to do chores, attend social events, or at work, but it caused them to rest for days after and reduce any activity or a flare and days of increased pain. Other researchers (Miles et al., 2005), who examined the experience of 29 people living with chronic pain in England, reported similar findings. There are many reasons for such an approach, including a desire for privacy or trying to keep the socially defined achievement standards to avoid devaluation or being labelled (King, 2012). As King (2012) noted, “in our competitive, achievement-oriented, advertising-driven, capitalist culture, an unspoken yet internalized mandate that says we…must always prove our worth. Ever-accelerating, unreasonable cultural standards push us to ignore or hide our pain and need for rest” (p. 62).

In contrast, some learned to say no and accept their limitations, although it was hard. They eased up on their “internalized demands for relentless production and performance” (King, 2012, p. 65) and resisted “unreasonable interpersonal and institutional demands” (King, 2012, p.

64). They “let go of internalized compulsions about time and work,” redefined, and rebuilt their lives and selves at a slower, quieter pace. At that moment, the pain brought unanticipated rewards (King, 2012, p. 66). However, this self-transformation was a lengthy discovery process, which was also observed by King (2012).

For few women, religion and spirituality offered a unique source of strength. As a coping strategy, religious and spiritual beliefs and practices were found to be helpful in chronic pain (Koenig, 2012). Religious and spiritual beliefs provide a subjective sense of control and gain power over life and other positive emotions, such as high self-esteem and being kind or compassionate, and answer existential questions (Koenig, 2012). This coping mechanism is particularly beneficial because it is not lost or impaired with a physical disability (Koenig, 2012). Religious and spiritual beliefs and practices can support “meaning-making by treating hardship as a normal part of life, and perhaps even a welcome occurrence that serves to fuel personal development” (Sen, Colucci, & Browne, 2022, Para. 6). The meaning-making might be “a core contributor to resilience” (Sen et al., 2022, Para. 6).

Although not a common experience, a few women compared their conditions to others’ illnesses and situations. An attempt to “rank” their situation provided them with a means of coping (Smith et al., 2014, p. 448). Social withdrawal was another way of coping with pain, as mentioned earlier. Because of fear of social judgment, few chose to wear a “mask,” a well-known coping mechanism with constraint (Strauss as cited in Mills, Curran, Pearce, & Allan, 2005, p. 435). While some decided to remain as isolated as possible, others found social interactions as a coping strategy; having a supportive and understanding social network was essential in dealing with pain. Interaction with friends and/or family has been shown to have the ability to buffer the negative impact of pain (Paolillo et al., 2018).

As such, for some women, employment by providing social interactions was a coping method. Moreover, it has been proposed that the social identities that are important for the individuals in defining themselves—like employment—act as psychological resources and provide them with the strength to fight back the illness (Jetten et al., 2017). Findings also indicated that employment was portrayed as a distraction from pain and as being productive to the community and society. These results echoed the findings of a U.S study exploring the pain narratives of Mexican immigrant women living with chronic pain (Flores, Zelman, & Flores, 2012).

For many, family relations were a precious source of resilience that helped them manage the impact of pain by outsourcing tasks. Informal caregivers provided a vast range of physical and emotional support. It has been well recognized that informal caregiving can boost the well-being of care recipients, is a vital national health care resource (Schulz & Sherwood, 2008; Statistics Canada, 2022b), and reduces costs to governments (Hango, 2020; Statistics Canada, 2022b; Wang et al., 2021).

Notably, social networks and social relationships were a double-edged sword as they played both protective and detrimental roles in the women's trajectories. Notably, the positive role of social networks and relationships in improving mental health and reducing stress has received substantial recognition, yet the harmful health consequences have received less scrutiny (Song, Pettis, Chen, & Goodson-Miller, 2021). For some, the interpersonal process between married couples generated social costs, such as relationship strain, relationship violence, and demanding social obligations. These social costs are gendered. Consistent with the traditional gender norms, women are more likely to encounter social costs than men (Song et al., 2021).

Another step in the women’s pain trajectories was learning to accept that they had a chronic condition, although this often took a while. Consistent with the findings of Risdon, Eccleston, Crombez, and McCracken (2003), who were studying what it might mean to accept chronic pain, the most dominant features of accepting chronic pain were: to focus on other aspects of life, despite pain; to acknowledge that a cure for chronic pain is unlikely; to take control of pain; to adapt goals to be more achievable ones; to accept the loss of self; and spiritual strength.

Caregivers’ resilience. Alongside the women, the informal caregivers also utilized various strategies to mitigate the negative impacts of pain on themselves. First, as mentioned earlier, an adult child caregiver said no to some requests. Second, some asked for help from their extended family members. Mobilizing a family caregiving team to reduce the burdens of caregiving was also observed by Walsh (2016). Third, the caregivers also sought HCPs’ consultations and interacted with the health care system to obtain information and services. Fourth, financial security allowed a caregiver to pay for some services such as cleaning to ease the caregiving burden. This finding is in keeping with a study that shows the resources available for the family can work as protective factors for caregivers, reducing their stress (Mercurio-Riley, Lee, Chronister & Swiga, 2013), highlighting the intersection of economic status and caregiving. Finally, engaging with their community networks, relocation, learning and making meaning of caring role, acceptance, positive growth, which is in line with a previous study (Walsh, 2016), were other coping methods that helped caregivers.

I would like to complete this chapter by emphasizing that the stories shared with me not only demonstrated that the women and their caregivers had faced a lot of adversity but also showed their perseverance and incredible resilience. The findings illustrated the participants' ability to withstand adversity, adapt to the changes, and keep moving forward.

Chapter Nine: Conclusion, Limitations, and Recommendations

The thesis sought to answer these questions: How do immigrant women residing in Ottawa perceive and cope with chronic disabling pain and its determinants? How do the women's caregivers view chronic pain and immigrant women's needs? And how do physicians providing care for immigrant women living with chronic pain understand their pain and their patients' needs?

This chapter, the concluding chapter, provides answers to the questions mentioned above and offers recommendations based on two streams of scholarship and theoretical perspectives, intersectionality and SDoH. This chapter also reflects on the strengths and limitations of this study. It considers opportunities for knowledge translation, including how best to enable the study outcomes to inform future pain prevention and treatment efforts.

This research had several objectives. First, this study aimed to gain an in-depth understanding of the complex journeys of immigrant women residing in Ottawa living with chronic pain, the meaning of living with the pain, and the challenges they faced in managing their conditions. Second, the study investigated the social context of chronic disabling pain by exploring the perspectives of caregivers of immigrant women and physicians providing care for chronic pain. This paper uses the SDoH approach to examine the root causes of pain and its outcomes. An intersectional lens is also utilized to examine how participants' different social identities were interconnected and how different axes of privilege and oppression create pain and its consequences. The study's overarching purpose was to contribute to health equity efforts, improve understanding of the SDoH in chronic pain, and promote concerted and united actions to reduce the burden of pain among immigrant communities.

Four interconnected themes from the data analysis have emerged: (1) The trajectory and meaning of pain; (2) Reasons for pain and triggering factors; (3) Pain consequences; and (4) Coping and control.

Regarding the pain trajectory, findings indicate that chronic pain is a subjective, complex, biopsychosocial, and multidimensional phenomenon. It is an invisible but real experience, which is often challenging to be validated and associated with a sense of not being believed. Pain is a never-ending experience and a threat to self. Pain meaning is influenced by a complex set of biological, psychosocial, and cultural interactions unique to each participant, which intertextually complicate and nuance the pain experience and its consequences. The data also show that pain is an experience affected by the overlapping social identities within the different socioeconomic, cultural, and historical contexts in which women live. These multifaceted differences also shape the coping strategies and women-HCPs' relationships.

Concerning reasons for pain, collectively and grounded in the SDoH framework, the findings indicate an association between the distribution of the SDoH during the life course and pain. The respondents describe the "root causes" of chronic pain and explain how the accumulation of childhood adversities, forced displacement, intimate partner violence, lack of social and financial support, loss of family, the stress of migration journey, racism, discrimination, gendered roles and responsibilities, power imbalance, poverty, housing issues, and working conditions contributed to the pain and/or its severity. The findings indeed underscore the intersection of systemic inequities and chronic pain and how social pain is experienced physically by the material body.

With reference to pain consequences, chronic pain has profound, multidimensional impacts on the women and their families, and its treatment is a challenging task for HCPs. A dynamic interplay of factors operating at multiple levels shapes the impact of chronic pain. The pain is associated with significant consequences for both the women's and their care partners' mental well-being as well as their personal and social lives. Living with the pain is a transformation that suspends everyday routines. It is associated with job loss, economic hardships, loss of roles and identities, and disability, which undermine the women's capacity to remain independent. Pain is often viewed as a permanent, not curable condition, for which successful treatment outcomes are difficult to achieve and therefore require lifetime management.

In relation to the last theme, women and their caregivers strive to mitigate the effects of pain in myriad ways, including medical treatment. Despite declarations that pain management is a fundamental human right, the results indicate that pain is often poorly recognized, underestimated, inadequately managed, and the pain treatment is not accessible nor realistic. There are limited care options available to the women, and their autonomy is often not preserved. Consequently, women utilize other coping strategies to accommodate the pain, accept and live with the pain, manage to shoulder the pain's consequences, and move forward.

Limitation, Strengths, and Directions for Future Research

I understand the findings of this dissertation may not represent the experiences and views of all immigrant women and their caregivers nor denote the perspectives of all physicians working in the pain management field for the following reasons. First, although the sample managed to capture a variety of perspectives, its small size limits the generalizability of the findings. Second, while the participants were mainly recruited through flyers that had been widely distributed, I recognize that harder-to-reach immigrant women, such as socially isolated ones, might not have been included in my research.

In addition, by limiting my study to women who could communicate in English, I might also have missed opportunities to speak with women who could not speak in English. Chronic pain impacts might also constrain some interested individuals from participating in this study. Last, none of the physicians who participated in this study were primary care physicians; future studies, therefore, should focus on this population. It would be helpful to extend the current findings by examining the experiences of other HCPs such as nurses, physiotherapists, and chiropractors.

Finally, while this study offered rich descriptions of immigrant women’s chronic pain experiences, I was unable to examine the differences and similarities in the pain experiences of immigrant and Canadian-born women. To the best of my knowledge, there were also little to no comparisons of pain among these two groups in the studies I reviewed. In particular, virtually, none of the studies examining experiences of people living with pain provided details about the demography of participants related to their country of birth, which made such observation difficult. Future work would benefit from the recruitment of both groups to permit this comparison. Nevertheless, I found similarities between immigrant women’s and other women’s experiences in the reviewed studies. Meanwhile, immigrant women faced unique challenges because of immigration, which influenced their pain experiences.

Despite these limitations, I believe that the study provides a rich, in-depth understanding of the complex journeys of immigrant women living with chronic pain and the challenges of managing their condition in Ottawa. This qualitative interdisciplinary research also offers valuable insight into family caregivers’ lived experiences and first-person accounts of physicians providing treatment for chronic pain. This study yields insight into a more profound knowledge of the factors influencing the relationship between immigration and chronic pain, which, in turn, could help enable targeted interventions tailored for racialized immigrant women living with chronic pain.

Bringing the patients' and their care partners' perspectives can also help to improve HCPs' understanding of ways to support their clients. Patient experience and their perceptions of care provided are critical components of healthcare delivery and integral to improving the quality of care and patient-centred care (Jha, Orav, Zheng, & Epstein, 2008). Investigating the perspectives of three different groups of participants allows for a better understanding of pain research's multiple facets and provides insights for HCPs, researchers, and policymakers. Of note, several women and caregivers who participated in this study were employed in health care or social services. A couple of them specifically worked with immigrant communities. Therefore, they shared their personal and professional perspectives, bringing their clients' viewpoints into the discussion, strengthening this study. Finally, this dissertation responded to the identified gap in the literature and recommendations of the CPTF (Health Canada, 2021) and therefore makes a significant contribution to the existing knowledge of pain and advances the literature on intersectionality and SDoH. In addition, my findings provide several implications for policy, research, and practice, which will be discussed in the next section.

In terms of future research, it would be helpful to extend the current findings by examining the experiences of immigrant women who self-identify as non-binary, those who identify with LGBTQIA communities, and the perspectives of immigrant men. Additionally, it would have been beneficial to conduct longitudinal studies to understand the interplay of the SDoH. As mentioned earlier, examining the experiences of other HCPs is also suggested.

Recommendations: A Roadmap for Health Policy, Education, Research, and Effective Pain Care

Participants proposed several ways to change current policies, programs, and practices to prevent pain and achieve better outcomes for immigrant women. These recommendations are well-aligned by suggestions recently put forward by Health Canada (2021) and the Canadian Agency for Drugs and Technologies in Health (Brett & MacDougall, 2021).

Health Canada (2021) has recently released the final report from the CPTF, *An Action Plan for Pain in Canada*, laying out more than 100 specific and targeted national actions. Applying an equity lens, these recommendations have aimed to ensure that Canadians living with chronic pain are recognized and supported, their pain is effectively treated, ultimately resulting in improved pain outcomes and reducing pain's impact on care partners and society. In parallel, but independently, the Canadian Agency for Drugs and Technologies in Health also identified optimal strategies and practical approaches to manage and provide care for people with chronic pain (Brett & MacDougall, 2021). My recommendations are organized into six domains, taking a multipronged approach.

Systems-oriented approach. Pain, as mentioned, is a complex health condition. Thus, its management needs complex interventions through an intersectoral collaboration of all levels of government, non-government organizations, the health care system, and people living with chronic pain and their care partners. A quick fix that addresses the pain as a symptom does not suffice. To achieve this, strategic prioritization and coordinated actions must address the unacceptable and unnecessary burden of uncontrolled chronic pain. We need a systems-oriented approach to address the root causes of pain and their interconnected relations. Improving existing national data and surveillance to explore the social context of chronic pain is recommended.

Prevention is better than cure. More effort should be aimed at primary prevention programs to avoid injuries, such as repetitive strain, leading to the development of chronic pain and the progression of acute pain to a chronic condition. For instance, strategies and interventions for reducing, eliminating, or controlling workplace harm are suggested to avoid work-related injury. Providing flexible work options and fully paid sick leave are other recommendations. In addition, a better understanding of the mechanisms involved in the progression of acute pain to chronic form is important to develop strategies for prevention. Given that many of the key determinants of pain are the SDoH, the emphasis on funding research should be directed at the root causes of pain, the macrosocial determinants, instead of biological determinants, micro-level focus.

Patient-centred approach. Multidisciplinary, fully integrated, and patient-centred approach is key to the successful prevention and management of chronic pain. Good communication and good collaboration, including sharing information and medical records, are necessary for continuity of care. To accomplish this, increased interprofessional communication is vital. Moreover, meaningful partnership and relationship should be established by which the patient, care partner, and HCP have a shared decision making (Chi et al., 2020; Nimmon, & Stenfors-Hayes, 2016; Wilson et al., 2019). Considering the impacts of pain on caregivers, their silent suffering, and their involvement in pain management, they should remain an integral part of the treatment team. Additionally, providing emotional and psychological support to them is necessary.

Pain assessment should be multifaceted and focus on seeking a careful history of the pain experienced, the impact of pain on social life, and the patient’s values. For example, Danise and Turk (2013) suggested a brief psychosocial screening that could be used as a guide to assess people living with pain. They proposed a set of questions with the acronym ACT-UP (Activities, Coping, Thinking, Upset, People responses), which is an efficient method to evaluate important psychosocial and behavioural factors that influence the subjective experience of pain. The questions are:

> 1. Activities: how is your pain affecting your life (i.e. sleep, appetite, physical activities, and relationships)? 2. Coping: how do you deal/cope with your pain (what makes it better/worse)? 3. Think: do you think your pain will ever get better? 4. Upset: have you been feeling worried (anxious)/depressed (down, blue)? 5. People: how do people respond when you have pain? (Danise & Turk, 2013, p. 21)

The examination of pain meanings and experiences can complement the knowledge of numeric self-reported pain. In other words, a more human-focused health care system is required, in which the patient has a voice and a story besides the illness’s chart. Cure and care are not the same; compassionate, empathetic care is crucial. Moreover, a comprehensive understanding of pain experience is a recommended best practice recognized by the CPTF (Health Canada, 2021).

Comprehensive, strategic approaches are also needed to address and overcome the limited time for conducting a thorough assessment. To limit adverse outcomes, and empower the patients, a risk-benefit assessment of each option should be discussed. In other words, pain management should focus on outcomes that patients consider essential, not medications alone, and include a holistic approach that addresses the root causes of the pain.

Tailored, targeted approach. A one-size-fits-all approach to pain care does not work. Pain management should be individualized. Therefore, while culturally grounded approaches to pain are essential, inter-group and intra-group differences should be acknowledged and considered in pain treatment. Access to a timely and broad spectrum of options tailored to the unique needs of each individual is needed. People with chronic pain should be provided services respectful of their interesting identities, such as gender, sexual orientation, socioeconomic status, age, and disability. For example, considering that women are more likely to experience chronic pain than men and the impact of gender on the meaning and living with pain, gender-tailoring treatment of pain is required. Similarly, understanding values, preferences, and approaches to pain management are necessary to improve equitable access to services for racialized communities. Notably, Eurocentric notions of what constitutes good pain care should not impose on people who may hold different perspectives.

Education and research. The pervasive presence of racism and discrimination in the health care system and its harmful impacts should be acknowledged. Consequently, supporting the creation and delivery of anti-racism and unconscious bias training as suggested by CPTF is a must (Health Canada, 2021). Indeed, effective health care systems should move beyond simplistic cultural differences to address the other intersecting factors and integrate the intersectionality lens and SDoH. Attention to the SDoH and intersectionality can render more responsive interventions geared to each client’s unique needs. As discussed previously, including intersectionality theory in medical curricula can challenge medical cultural norms, instigate conversations and reflections about power issues in medicine, and inform physicians about other social identities. Integration of population health perspectives, in fact, throughout medical education is essential to ensure the delivery of equitable care. Hassen et al. (2021) also identified several interventions to tackle anti-racism in health care settings. These interventions should

> incorporate leadership buy-in and commitment with dedicated resources, support and funding; a multi-level approach beginning with policy and organizational interventions; transparent accountability mechanisms for sustainable change; long-term meaningful partnerships with…racialized communities; and ongoing, mandatory, tailored staff education and training. (p. 1)

Ongoing efforts to enhance public awareness about chronic pain and its impact, such as National Pain Awareness Week Initiative, should be continued. It would help combat stigmatization and address the invisibility of pain. Notably, the material should be translated into multiple languages and be culturally safe.

Supporting scientific research is also critical to understanding the experiences of immigrant women and their families as well as to finding new, effective diagnostic, preventive, and therapeutic approaches. Undoubtedly, the engagement of people with lived experience to co-design pain research should be considered. Consistent with the F's goal (Health Canada, 2021), community-based and health services pain research is needed. Funding that extends pain research to understand the underlying mechanisms across the lifespan is also crucial. Such research provides opportunities to direct pain practice and policy.

Significant and multiple barriers to adequate, timely pain care exist. Therefore, enhanced continuing education and training to improve competencies related to pain management for HCPs are required. Despite several developments, including the recognition of pain medicine as a subspecialty in 2010, design a curriculum for future physicians in the diagnosis, prevention, and treatment of pain in Canadian medical schools, as well as for other health professionals such as nurses and pharmacists, there is still a gap in standard and widely available pain-related curricula (Health Canada, 2019). HCPs, in other words, receive little education around the complexities of treating/managing pain. Therefore, training of HCPs both during their schooling and later once they are in practice is recommended.

I recommend that a curriculum to advance HCPs' skills in immigrant health will be developed. For instance, developing and implementing a training program to introduce the immigration journey as a social determinant of health might enhance HCPs' knowledge of immigrant health.

Eliminating structural barriers. As the participants highlighted, underfunding contributes to understaffing programs and thus struggling to meet the needs of the patients. Increasing health funding then to improve access to multidisciplinary evidence-informed pain prevention and care services is required. Providing immigrants with assistance navigating the health care system can enable immigrants to get the care they need when they need it. Outreach efforts might be necessary to engage immigrants living with chronic pain who are not seeking care. Uniform reimbursement models are also needed for interpretation services outside the hospitals. Some services such as physiotherapy, which are valuable components of multidisciplinary, multimodal chronic pain care, are often not covered unless they are provided in a hospital. Public policies should address inequities in access to such services as well as medications; improving pain insurance coverage to have a more extensive, easily accessible, and timely pain management would be necessary.

Additionally, social prescribing—interventions focus on the psychosocial component of care—which has shown promising results by bridging the gap between clinical and social care, is recommended. Finally, pain prevention and treatment must continue outside the hospitals or clinic walls. Some suggestions are to provide an affordable childcare program to alleviate the caregiving responsibilities of immigrant women, invest in an affordable housing program, improve the labour market, expand community intervention programs, and improve the family reunification policy. Simply put, good pain prevention and treatment call for treating the social factors that create pain rather than treating its pathophysiology. In sum, "Addressing chronic pain requires multiple and diverse approaches to change, from policy and regulation to changes in programs, practices, and attitudes. It will require broad engagement and depend on perseverance, collaboration, commitment, leadership, and resources" (Health Canada, 2021, p. 1).

Concluding Thoughts

Chronic pain is a silent, common, complex health condition that profoundly impacts individuals, their families, and society. It is one of the leading causes of disability and costs billions of dollars every year in health care expenditures. In Canada, chronic pain has grown more prevalent in recent decades. Given chronic pain's high prevalence, cost and associated disability, its prevention should be considered a key public health priority. Inequities in chronic pain among racialized communities and women continue to be a significant and often neglected health policy concern. Despite the growing representation of racialized immigrant women within the Canadian population, relatively little is known about the pain experienced by this population. The present study responds to this gap. The results could guide policies, practices, and research to enhance pain prevention, treatment, and management. This research is intended to equip HCPs with an increased understanding of living with and caring for chronic pain to help them better serve their clients. Policymakers should ensure that SDoH across life are addressed in public health interventions.

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Appendices

Appendix A: Glossary of terms - Conceptual Definitions

Caregivers: They are defined as any person who takes on a caring role to provide emotional help and/or support for daily living—activities of daily living (ADL), such as bathing, or instrumental ADL, such as housework and grocery shopping (Canadian Caregiver Coalition, 2015; Ramage-Morin & Gilmour, 2010)—to an immigrant woman with chronic pain.

Culture: It is defined as “the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs” (United Nations Education, Scientific and Cultural Organization, 2001, p. 1).

Disability: Disability is a complex phenomenon covering a broad range and degree of conditions (WHO, 2013). Disability has three dimensions: impairments, activity limitations and participation restrictions. It results from the interaction between an individual and that individual’s contextual factors (personal and environmental factors) that hinder the person with disability from full and effective participation in society on an equal basis with others (WHO, 2013).

Economic immigrant: Economic immigrant includes immigrants who have been selected based on their ability to contribute to Canada’s economy in various ways: “their ability to meet labour market needs, to own and manage or to build a business, to make a substantial investment, to create their own employment or to meet specific provincial or territorial labour market needs” (Statistics Canada, 2019b, para. 1).

Ethnicity: It is referred to the diversity of beliefs, traditions, and behaviours held by members of a social group originating from common linguistic, religious, historical, and/or geographical sources (Bierman, Ahmad, & Mawani, 2009; Simpson, 2009). As an identity, ethnicity is self-concept and measured by how individuals feel connected to a specific ethnic group (Hankivsky & Cormier, 2009). Ethnicity is a socially constructed characteristic that implies a shared history and collective sense of identity.

Gender: Gender refers to the societal roles, behaviours, attributes, and activities that are assigned to women and men at a given time considered appropriate for them (Simpson, 2009; Spitzer, 2011; United Nations Children's Fund, 2017). These attributes, roles, and opportunities are context-specific and flexible, learned through socialization processes, and expressed through gender ideologies. Gender is part of the broader context of sociocultural power dynamics. It interacts with SES, ethnicity, racialized status, religion, sexual orientation, geography, dis/ability, and age, among other social indicators, to shape hierarchies and structure access to and control over power and resources (Simpson, 2009; Spitzer, 2011; United Nations Children's Fund, 2017).

Immigrant sponsored by family: This category, also known as Family class or family reunification, includes immigrants who were sponsored by a permanent resident or Canadian citizen and were granted permanent resident status based on their relationships such as the spouse, partner, parent, grand-parent, child or other relatives (Statistics Canada, 2019b)

Immigrant: Immigrant is defined as “a person who is, or who has ever been, a landed immigrant or permanent resident. Such a person has been granted the right to live in Canada permanently by immigration authorities.” (Statistics Canada, 2018c, P. 143)

Mid-sized city: Mid-sized city is a city with a population of over 300,000 and under two million (Tassonyi, 2017).

Pain sensitivity: It is the “proneness to react to standardized experimental or pathological stimuli” (Ravn, Frederiksen, Skovsen, Christrup, & Werner, 2012, p. 313).

Pain threshold: It is the minimum point at which a person begins to perceive a stimulus as being painful (Merskey & Bogduk, 1994/2012).

Pain tolerance: Pain tolerance refers to the maximum level or amount of pain that a person can handle or tolerate (Merskey & Bogduk, 1994/2012).

Race: Race is an idea and social construct that categorizes people based on a constellation of biologically shared traits such as skin colour, hair texture, facial features, and body shape. It is used to maintain social hierarchy (Benoit et al., 2009; National Collaborating Centre for Determinants of Health, 2018).

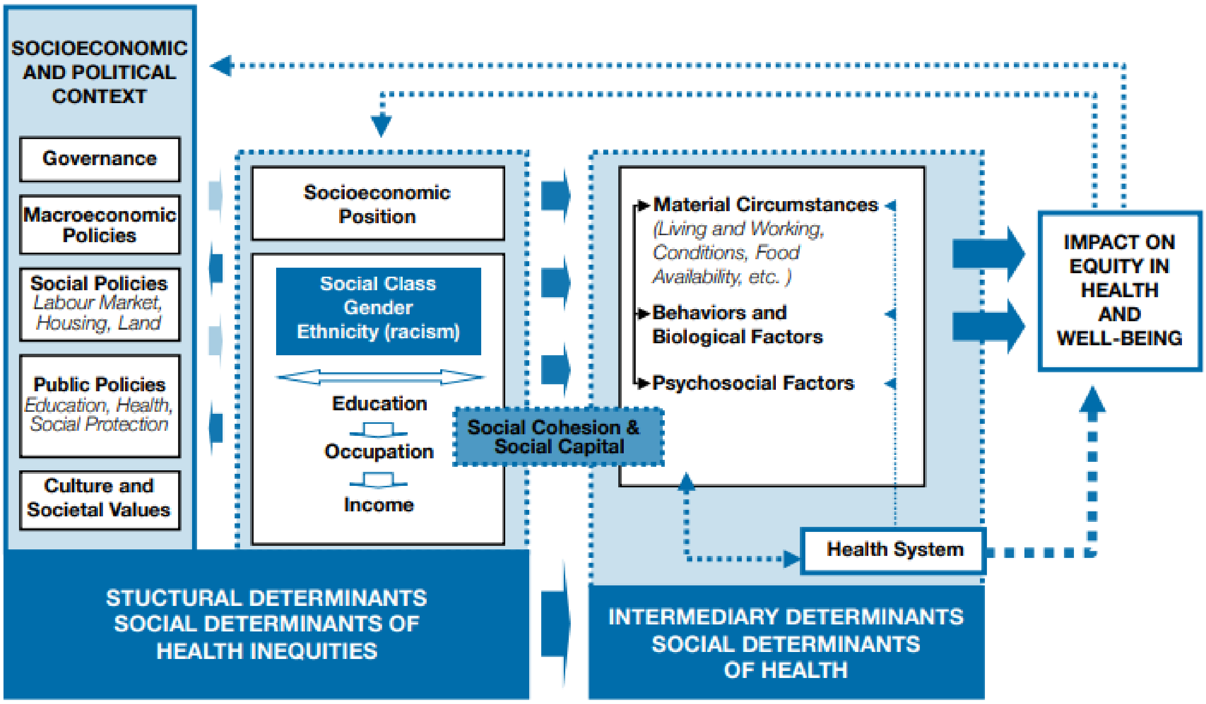
Refugee: A refugee is an immigrant who was granted permanent resident status owing to a well-founded fear of returning to their home country (Statistics Canada, 2019b).

Visible minority: They, according to the Employment Equity Act, are “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour” (Statistics Canada, 2018c, p. 151). I acknowledge that the term minority is vague and obscures the existence of multiple intersecting categories (Bowleg, 2012).

Appendix B: List of Key Health Determinants

WHO (2017a)	Wilkinson & Marmot (2003)	Public Health Agency of Canada (2020)	Mikkonen & Raphael (2010)	Raphael et al., (2020)
Income and social status	Social gradient	Income and social status	Income and income distribution	Income and its distribution
Social support networks	Social support	Social supports and coping skills	Social safety net	Social safety net
Education	—	Education and literacy	Education	Education
	Work	Employment and working conditions	Employment and working conditions	Employment and working conditions
	Social exclusion	—	Social exclusion	Social exclusion
Physical environment	—	Physical environments	Housing	Housing
		Healthy behaviours	—	—
—	Early life	Childhood experiences	Early childhood development	Early child development
Genetics	—	Biology and genetic endowment	—	—
Health services	—	Access to health services	Health services	Health services
Gender		Gender	Gender	Gender
—	—	Culture	Aboriginal status	Indigenous ancestry
—	—	—	Food insecurity	Food insecurity
—	Unemployment	—	Unemployment and job security	Unemployment and job security
—	—	—	Disability	Disability
	—	Race/Racism	Race	Race
	—	—	—	Globalization
	—	—	—	Immigration
	—	—	—	Geography
	Stress	—	—	—
	Addiction	—	—	—
	Transport	—	—	—

Appendix C1: Social Determinants of Health Conceptual Framework



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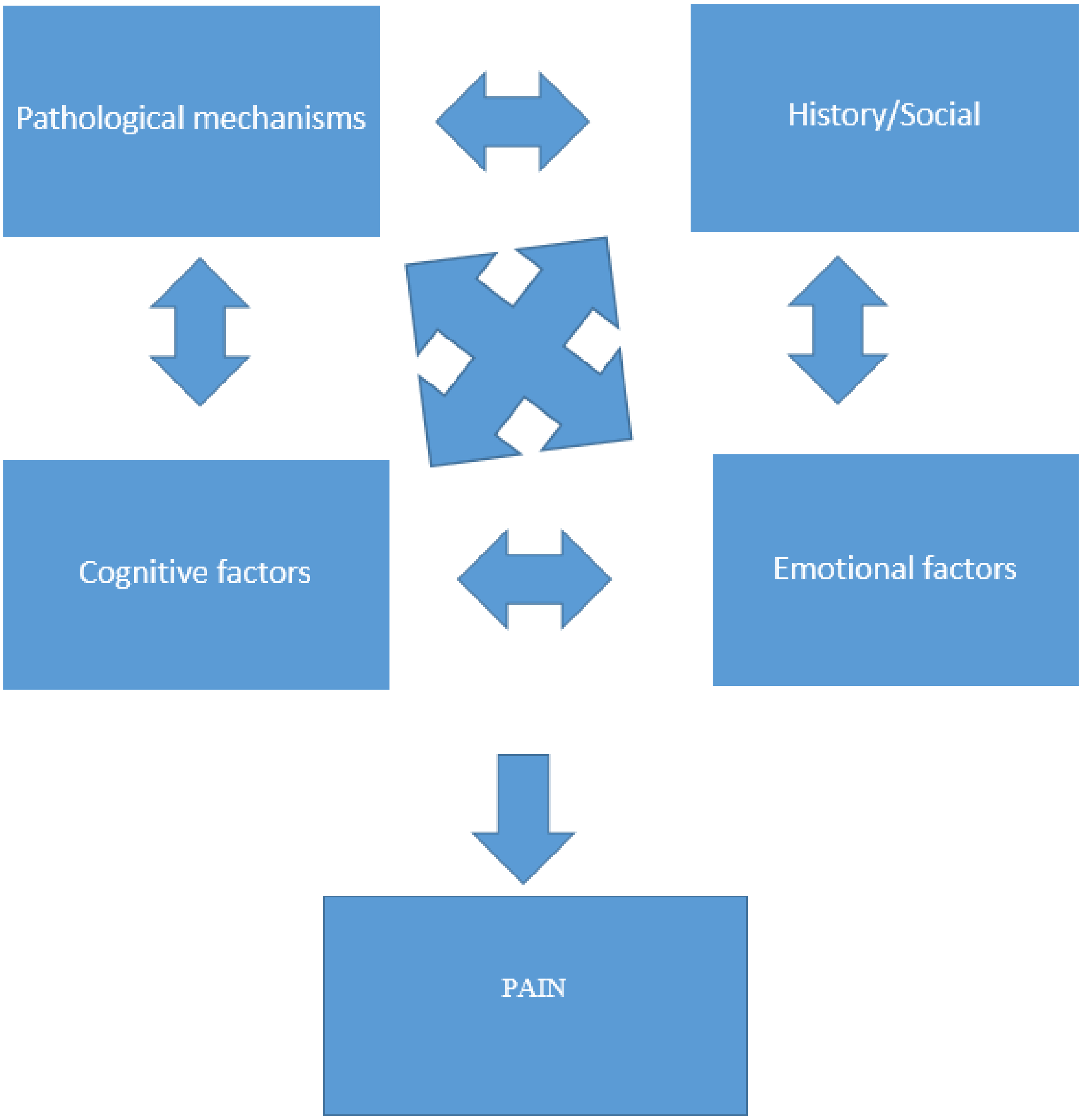
Appendix D: Biopsychosocial Model of Pain



Adapted from Turk et al., 2011

Appendix E: Demography of Participants

Demography of immigrant Women Living with Chronic Pain	
Age Group	Numbers
31 to 40	1
41 to 50	3
50 to 60	5
>60	4
Place of Birth	
Asia	10
Africa	2
South America	1
Level of Education	
Some high school	1
College	2
University degree (Undergraduate)	4
University degree (Postgraduate)	6
Annual Income	
Less than $20,000	3
$20,000 —$39,999	0
$40,000 — $59,900	2
$60,000 — $79,999	4
$80,000 and over	1
Prefer not to answer	3
Immigration Category	
Family Class	3
Refugee	6
Economic immigrants	4
Marital Status	
Married	7
Single (never married)	2
Divorced/ Separated	4
Having Children	
With children	9
Without children	4
Years Living in Canada	
5 to 10	2
11 to 20	4
21 to 30	7

Demography of Caregivers	
Age Group	**Numbers**
31 to 40	4
41 to 50	0
50 to 60	0
>60	1
Place of Birth	
Asia	4
Africa	1
Level of Education	
University degree (Undergraduate)	2
University degree (Postgraduate)	3
College	0
Some high school	0
Currently Employed	5
Years Living in Canada	
5 to10	1
10 to 20	0
20 to 30	4

Demography of Physicians	
Age Group	**Numbers**
31 to 40	3
41 to 50	1
51 to 60	1
>60	1
Number of years managing chronic pain	
<5	4
5 - 10	0
11 - 20	2

Appendix F1: Interview Guide - Immigrant Women with Chronic Pain

A. Rapport

1. Could you tell me a little about yourself? (Age, country of origin, length of residency in Canada and Ottawa)

B. General Description/History of pain

2. Could you tell me the story about your experience of pain? (When did it begin? What was going on in your life at the time? How the pain has changed over time?)

C. Origin of Pain/Determinants of pain

3. In your opinion why has pain happened? Which factors do you feel are responsible for your pain?
4. How and why do you think that certain issues contributed to the development of your pain?
    a. Probes if these issues do not come up:
        i. Do you think there is any relation between physical environment and/or weather and your pain? If so how?
        ii. What do you think about employment/working conditions?
        iii. What is your idea about income sufficiency?
        iv. What do you think is the role of stress?
        v. Do you have any family members who have/had chronic pain? Do you have a sense that this ‘runs in the family’?
        vi. Do you think that there are differences between men and women experiencing pain? If so how?
        vii. Do you think age affects pain? If so, how does it affect your pain?
        viii. Does the process of immigration or being an immigrant impact on your pain? If so what are the differences?
5. Do you experience an increase in pain as a result of some activities? If so, which activities?

D. Consequences/Effects of Pain on Everyday Life

6. What are some day to day challenges that you face in terms of being an immigrant woman living with chronic pain?
7. Does pain cause particular problems for you? If so how?
    a. Probes if these issues do not come up:
        i. Working issues and relationships with co-workers
        ii. Household chores
        iii. Relationships with friends
        iv. Social events
        v. Sleep problems
        vi. Relationships with children
        vii. Relationship with spouse, sexual problems
        viii. Feeling sadness or anxiety

E. Dealing and Coping with Pain/Pain Management

8. Please tell me what have you done to make pain go away? (From when it started until now) how have you decided where to go and who to see for relief/treatment of pain?
9. What is the most difficult to deal with pain?
10. Has anyone helped you to manage your pain and/or daily activity limitations? If so, could you explain more? (First time and then during the condition until now)
11. How does your family understand your condition? How they have provided support for you?
12. How about your friends, colleagues, and employers—if she was/has been working?
13. Could you tell me about your experiences with health care services? What have you been expecting/wanting from them? What have they told you about your condition? What do you see as barriers/facilitators to care?
14. What could be done to improve prevention/care for immigrant women with pain/limitations?

F. Ending Interview

15. What do you think pain means? How do you define it?
16. Is there anything else you would like to share with me?
17. How are you feeling right now? (Ensuring she is pleased with what was shared)

Thanks participant for her time and sharing her experiences

Appendix F2: Interview Guide - Caregivers

A. Rapport

- Could you tell me a little about yourself? (Age, country of origin, length of residency in Canada and Ottawa, relationship to the care-recipient)

B. General Description

- What do you think pain means? How do you define it?
- Where do you think that the pain of person for whom you have been providing care comes from?
- What makes your care-recipient's pain better or worse?

C. Consequences/Effects of Pain on Everyday Life

- How does the pain affect the life of the person you are caring for?
- What are some of the day to day challenges that you face in terms of caretaking?
- Does pain affect your life? If so how?

D. Pain Management

- Could you tell me about your experiences with health care services? What have you been expecting/wanting from them for yourself and for the person you are caring for? What do you see as barriers/facilitators to care?
- What could be done to improve prevention/care for immigrant women with pain/limitations?

E. Ending Interview

- Is there anything else you would like to share with me?
- Ensuring she/he is pleased with what was shared

Thanks participant for her/his time and sharing her/his experience

Appendix F3: Interview Guide - Physicians

A. Rapport

- Could you tell me a little about yourself? (Number of years in practice—how long have you been involved in managing chronic pain? Your position and responsibilities)
- Tell me about your experience in immigrants' health care (How long have you been involved in immigrant health issues?)

B. General Description

- What do you think pain means? How do you define it?
- What do you think are the major etiologies of pain amongst the patients you treat, in general? What about immigrant women?
- What do you see as factors that exacerbate or help alleviate pain of your patients in general? What about immigrant women?

C. Describing good care for chronic pain prevention and management

- How would you describe a good chronic pain care?
- What are your views on the strengths of immigrant women for preventing and managing chronic pain?
- What are your views on the needs of immigrant women for preventing and managing chronic pain?

D. Factors influencing access to responsive preventive services

- What do you see as barriers to provide care for immigrant women with chronic pain?
- What facilitates the provision of care for immigrant women with chronic pain?
- What strategies/actions would help reduce barriers?
- What strategies/actions would help improve access to care for immigrant women? (Community level, organizational level, provider level, policy level)

E. Ending Interview

- Other comments/ suggestions
- Thanks participants for their time

Appendix G1: Demographic Questionnaire—Immigrant Women with Chronic Pain

Participant #: ______________________________________

1. Age (Please check one):
    - ☐ 18-20 years
    - ☐ 21-30 years
    - ☐ 31-40 years
    - ☐ 41-50 years
    - ☐ 51-60
    - ☐ More than 60 years

2. Where were you born? (Please print name of country) ___

3. How many years have you been living in Canada? ___ How many years have you been living in Ottawa? ___

4. How did you come to Canada—immigration status: (Please check one)
    - ☐ Family Class
    - ☐ Economic Immigrant
    - ☐ Refugee

5. What is your highest level of schooling?
    - ☐ Less than high school
    - ☐ Some high school
    - ☐ High school graduate
    - ☐ Some post high school education/training
    - ☐ College degree
    - ☐Under-graduate University degree
    - ☐ Post-graduate degree

6. What is your marital status? (Please check one):
    - ☐ Married
    - ☐ Living with partner
    - ☐ Separated
    - ☐ Divorced
    - ☐ Widowed
    - ☐ Never married

7. Do you have children?
   - ☐ No
   - ☐ Yes

8. If so, how many?
   - ☐ 1
   - ☐ 2
   - ☐ 3
   - ☐ 4
   - ☐ 5
   - ☐ 6 and more

9. How old are they? ___

10. Are you currently employed? (Please check one)
    - ☐ Yes
    - ☐ No

11. If you have ever been worked, has your work situation changed because of the pain? (Please check one)
    - ☐ No change in job status
    - ☐ Changed job
    - ☐ Reduced number of work hours
    - ☐ Temporary leave of absence
    - ☐ Quit job
    - ☐ Retired

12. If you had ever been worked before immigration, what was/were your job/jobs? ___

13. If you have ever been worked after immigration, what is/are your job/jobs? ___

14. Which describes your total household income (Please check one)?
    - ☐ Less than 20,000
    - ☐ 20,000 — 29,999
    - ☐ 30,000 — 39,999
    - ☐ 40,000 — 59,999
    - ☐ 60,000 — 79,999
    - ☐ 80,000 and over

Appendix G2: Demographic Questionnaire—Caregivers

Participant #: ______________________________________

1. Age (Please check one):
    - ☐ 18-20 years
    - ☐ 21-30 years
    - ☐ 31-40 years
    - ☐ 41-50 years
    - ☐ 51-60
    - ☐ More than 60 years

2. Where were you born? (Please print name of country) ___

3. If not born in Canada, how many years have you been living here? ___ How many years have you been living in Ottawa? ___

4. For whom have you been providing care? ___

5. How many years are you taking care of your care-recipient? (Please check one)
    - ☐ Less than 5 years
    - ☐ 5-10 years
    - ☐ 11-20 years
    - ☐ More than 20 years

6. What is your marital status? (Please check one)
    - ☐ Married
    - ☐ Living with partner
    - ☐ Separated
    - ☐ Divorced
    - ☐ Widowed
    - ☐ Never married

7. What is your highest level of schooling? (Please check one)
    - ☐ Less than high school
    - ☐ Some high school
    - ☐ High school graduate
    - ☐ Some post high school education/training
    - ☐ College degree
    - ☐Under-graduate University degree
    - ☐ Post-graduate degree

8. Are you currently employed? (Please check one)
    - ☐ Yes

  - ☐ No

9. If you have ever been worked, has your work situation changed because of caretaking? (Please check all that apply)
   ☐ No change in job status
   - ☐ Changed job
   - ☐ Reduced number of work hours
   - ☐ Temporary leave of absence
   - ☐ Quit job
   - ☐ Taken a second job
   - ☐ Retired

Appendix G3: Demographic Questionnaire—Physicians

Participant #: ____

15. Organization: ____

- Role: ____

16. Number of years in practice: (Please check one)
    ☐ Less than 5 years
    ☐ 5-10 years
    ☐ 11-20 years
    ☐ More than 20 years

17. Number of years managing chronic pain: (Please check one)
    ☐ Less than 5 years
    ☐ 5-10 years
    ☐ 11-20 years
    ☐ More than 20 years

18. Number of patients with chronic pain: per week ___ ; per month ___

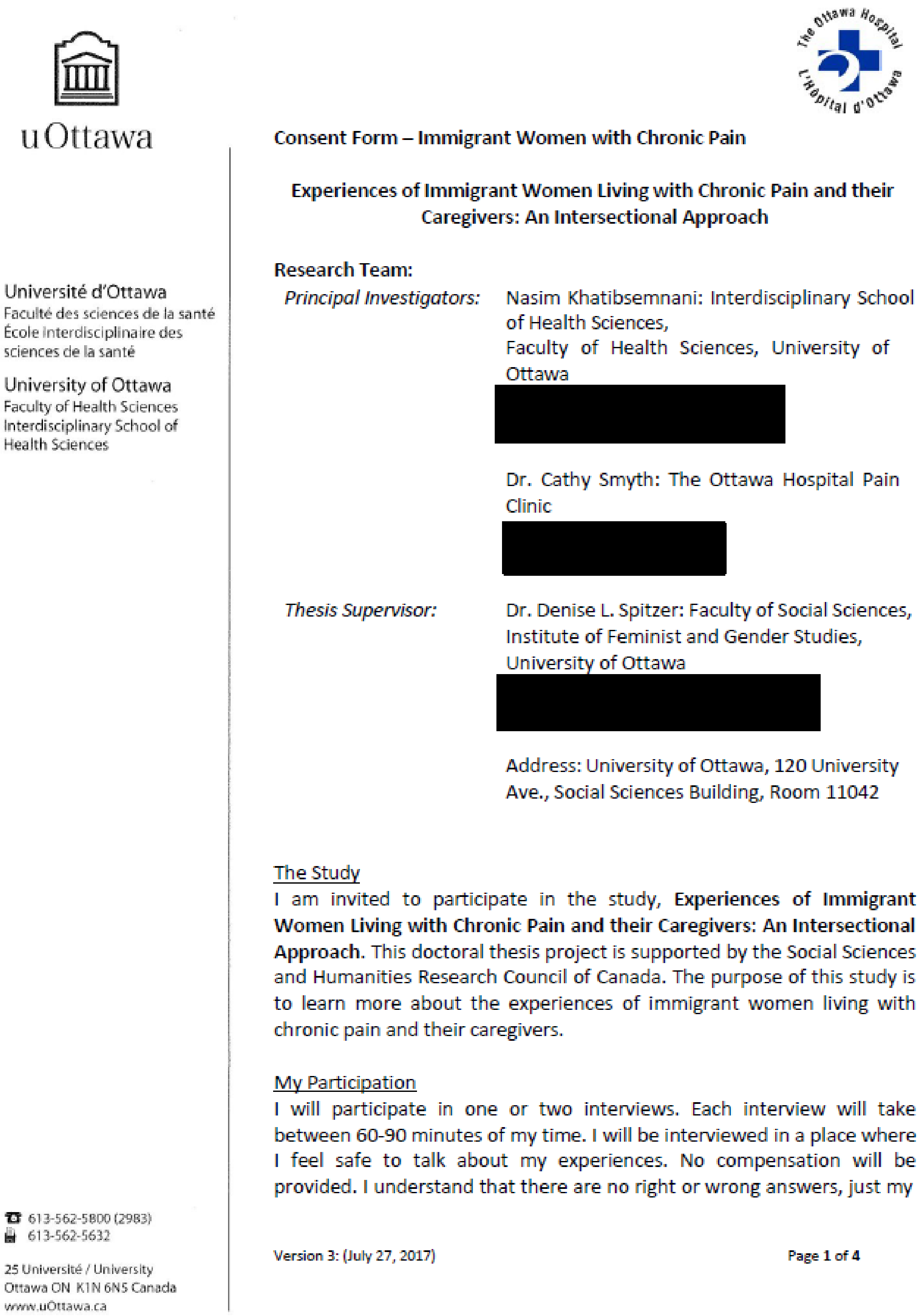
19. Number of years in immigrant health: (Please check one)
    ☐ Less than 5 years
    ☐ 5-10 years
    ☐ 11-20 years
    ☐ More than 20 years

20. Number of immigrant patients with chronic pain: per week ___ ; per month ___

21. Age (Please check one):
    ☐ 20-30 years
    ☐ 31-40 years
    ☐ 41-50 years
    ☐ 51-60
    ☐ More than 60 years

22. Self-identification: (Please check one)
    ☐ Immigrant
    ☐ Refugee
    ☐ Other (please explain)

Appendix H1: Consent Form – Immigrant Women with Chronic Pain



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Consent Form – Immigrant Women with Chronic Pain

Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach

Research Team:

Principal Investigators: Nasim Khatibsemnani: Interdisciplinary School of Health Sciences, Faculty of Health Sciences, University of Ottawa

[redacted]

Dr. Cathy Smyth: The Ottawa Hospital Pain Clinic

[redacted]

Thesis Supervisor: Dr. Denise L. Spitzer: Faculty of Social Sciences, Institute of Feminist and Gender Studies, University of Ottawa

[redacted]

Address: University of Ottawa, 120 University Ave., Social Sciences Building, Room 11042

The Study

I am invited to participate in the study, **Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach**. This doctoral thesis project is supported by the Social Sciences and Humanities Research Council of Canada. The purpose of this study is to learn more about the experiences of immigrant women living with chronic pain and their caregivers.

My Participation

I will participate in one or two interviews. Each interview will take between 60-90 minutes of my time. I will be interviewed in a place where I feel safe to talk about my experiences. No compensation will be provided. I understand that there are no right or wrong answers, just my

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Page 1 of 4

opinion. I will also answer a questionnaire. It will take between 5-10 minutes. The researcher may record the interview, so she can listen to me carefully. She may also take notes during the interview. I will have a chance to review the interview transcripts and give my feedback. The transcripts will be hand-delivered or will be sent via email; the decision is mine. If I choose email, the transcripts will be password protected. The password will be sent in a separate email or be provided by a phone call to me. I will be allowed to make any modifications to the transcript that make me comfortable with what I said.

Confidentiality and Anonymity

Members of the research team and a transcriptionist are the only ones who will listen to or read the transcripts of my interview. All persons involved with the project have signed an oath of confidentiality to keep my identity secret and my statements private. The researcher will select a different name for me. She will use this name on all material she keeps. She will also use this name in any public presentations, written or oral, of this project. She may change some details of my story, so I will not be personally identified in any public presentation of the research.

Conservation of Data

The recordings or notes and transcripts will be kept for 10 years after completion of the study. They will be kept in a locked cabinet separately from consent form in the laboratory or office of Dr. Spitzer at the University of Ottawa. Only the research team will have access to the data. Another copy will be kept in a locked cabinet separately from consent form at Dr. Smyth's pain clinic office. The researcher will also use a password for her computer. After 10 years all written data will be shredded. The electronic data will also be securely deleted.

For audit purposes only, my original study records may be reviewed under the supervision of the researcher by representatives from:

- the Ottawa Health Science Network Research Ethics Board (OHSN-REB),
- The Ottawa Hospital

Risks and Benefits

Sometimes talking about the experiences of pain may be uncomfortable. The researcher will try to reduce this risk. At all times, I have the right to change the topic. I can also stop the interview or not answer questions.

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The researcher will respect my wishes. She will also provide some information about local resources that may be helpful.

I understand that taking part in this study may help others to learn more about the experiences of immigrant women living with chronic pain and their caregivers. At the completion of the research, I will also receive a summary of the research findings.

Voluntary Participation

At all times, I have the right to stop the interview and/or not to answer question. I also have the right to ask the researcher any question about any part of this study. I can withdraw from the study at any time. In this case, the researcher will only use the information I have given her with my permission. If I do not wish her to use this information, she will destroy it or give it to me.

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L'Hôpital d'Ottawa

Consent to Participate:

I, (please print)__________________________________, voluntarily agree to participate in the above research conducted by Nasim Khatibsemnani of University of Ottawa and supervised by Dr. Denise L. Spitzer.

Please initial one box:	I agree to audio-record the interview	☐
	I do not agree to audio-record the interview	☐
Please initial one box:	I would like to receive transcripts by email	☐
	I would like to receive transcripts by hand delivery	☐

If I have any questions about the study, I may contact the researcher or her supervisor using the contact information provided on page 1. If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, Tel: (613)562-5387, Email: ethics@uottawa.ca

The Ottawa Health Science Network Research Ethics Board (OHSN-REB) has reviewed the plans for this research study. The Board considers the ethical aspects of all research studies involving human participants at The Ottawa Hospital. If I have any questions about my rights as a study participant, I may contact the Chairperson at 613-798-5555, extension 16719.

There are two copies of the consent form. Keep one copy for your files.

____________________________ ________________
Participant's Signature Date

____________________________ ____________________________
Researcher's Printed Name Researcher's Signature

____
Date

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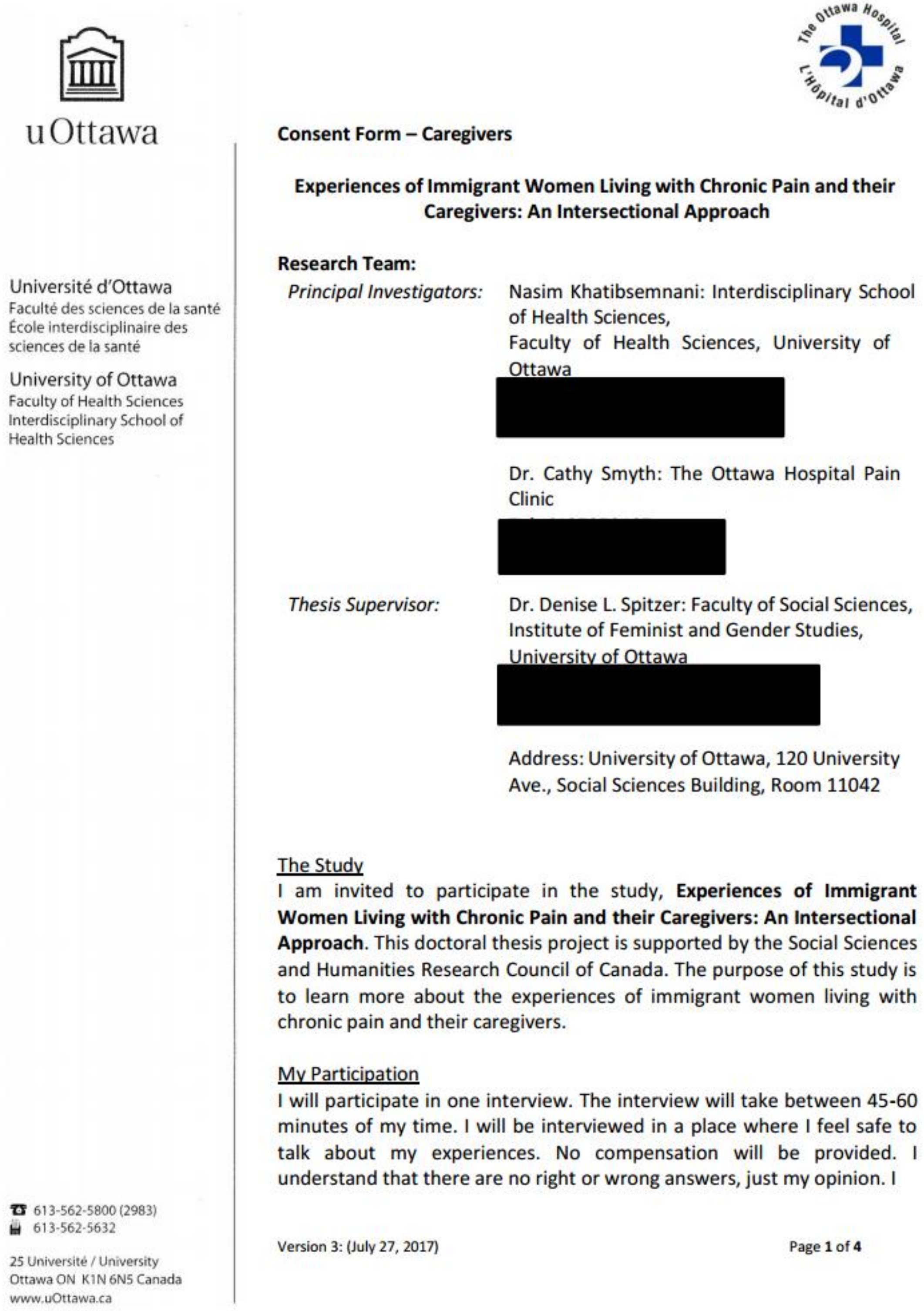
Appendix H2: Consent Form – Caregivers



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Consent Form – Caregivers

Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach

Research Team:

Principal Investigators:	Nasim Khatibsemnani: Interdisciplinary School of Health Sciences, Faculty of Health Sciences, University of Ottawa [redacted]
	Dr. Cathy Smyth: The Ottawa Hospital Pain Clinic [redacted]
Thesis Supervisor:	Dr. Denise L. Spitzer: Faculty of Social Sciences, Institute of Feminist and Gender Studies, University of Ottawa [redacted]
	Address: University of Ottawa, 120 University Ave., Social Sciences Building, Room 11042

The Study

I am invited to participate in the study, **Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach**. This doctoral thesis project is supported by the Social Sciences and Humanities Research Council of Canada. The purpose of this study is to learn more about the experiences of immigrant women living with chronic pain and their caregivers.

My Participation

I will participate in one interview. The interview will take between 45-60 minutes of my time. I will be interviewed in a place where I feel safe to talk about my experiences. No compensation will be provided. I understand that there are no right or wrong answers, just my opinion. I

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will also answer a questionnaire. It will take between 5-10 minutes. The researcher may record the interview, so she can listen to me carefully. She may also take notes during the interview. I might answer a few questions by phone after the interview, which will take about 15 minutes. I will have a chance to review the interview transcripts and give my feedback. The transcripts will be hand-delivered or will be sent via email; the decision is mine. If I choose email, the transcripts will be password protected. The password will be sent in a separate email or be provided by a phone call to me. I will be allowed to make any modifications to the transcript that make me comfortable with what I said.

Confidentiality and Anonymity

Members of the research team and a transcriptionist are the only ones who will listen to or read the transcripts of my interview. All persons involved with the project have signed an oath of confidentiality to keep my identity secret and my statements private. The researcher will select a different name for me. She will use this name on all material she keeps. She will also use this name in any public presentations, written or oral, of this project. She may change some details of my story, so I will not be personally identified in any public presentation of the research.

Conservation of Data

The recordings or notes and transcripts will be kept for 10 years after completion of the study. They will be kept in a locked cabinet separately from consent form in the laboratory or office of Dr. Spitzer at the University of Ottawa. Only the research team will have access to the data. Another copy will be kept in a locked cabinet separately from consent form at Dr. Smyth's pain clinic office. She will also use a password for her computer. After 10 years all written data will be shredded. The electronic data will also be securely deleted.

For audit purposes only, my original study records may be reviewed under the supervision of the researcher by representatives from:

- the Ottawa Health Science Network Research Ethics Board (OHSN-REB),
- The Ottawa Hospital

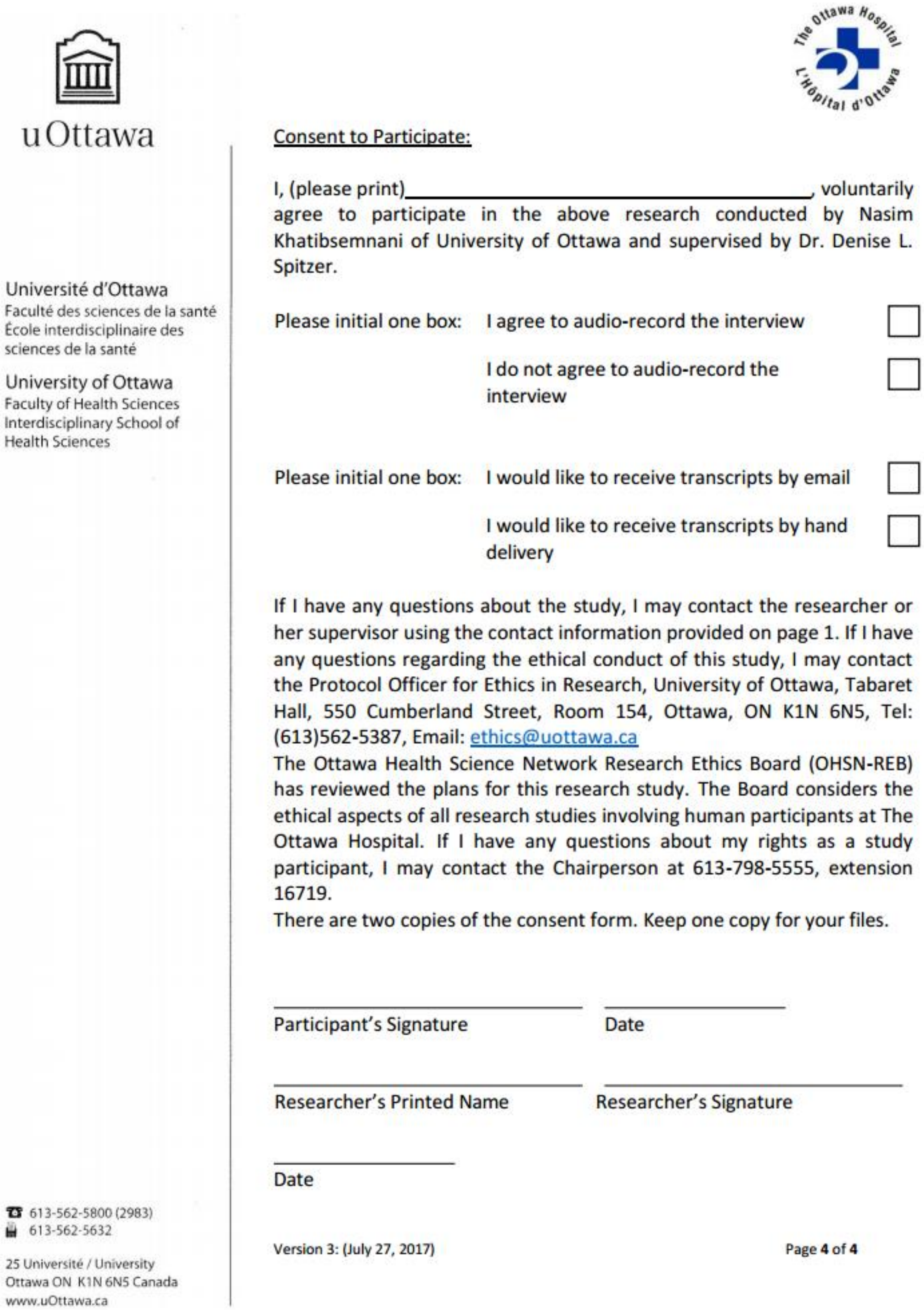
Risks and Benefits

Sometimes talking about the experience of providing care may be uncomfortable. The researcher will try to reduce this risk. At all times, I have the right to change the topic. I can also stop the interview or not answer questions. The researcher will respect my wishes. She will also provide some information about local resources that may be helpful.

I understand that taking part in this study may help others to learn more about the experiences of immigrant women living with chronic pain and their caregivers. At the completion of the research, I will also receive a summary of the research findings.

<u>Voluntary Participation</u>

At all times, I have the right to stop the interview and/or not to answer question. I also have the right to ask the researcher any question about any part of this study. I can withdraw from the study at any time. In this case, the researcher will only use the information I have given her with my permission. If I do not wish her to use this information, she will destroy it or give it to me.



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Interdisciplinary School of Health Sciences

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L'Hôpital d'Ottawa

Consent to Participate:

I, (please print)________________________________, voluntarily agree to participate in the above research conducted by Nasim Khatibsemnani of University of Ottawa and supervised by Dr. Denise L. Spitzer.

Please initial one box: I agree to audio-record the interview ☐
I do not agree to audio-record the interview ☐

Please initial one box: I would like to receive transcripts by email ☐
I would like to receive transcripts by hand delivery ☐

If I have any questions about the study, I may contact the researcher or her supervisor using the contact information provided on page 1. If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, Tel: (613)562-5387, Email: ethics@uottawa.ca

The Ottawa Health Science Network Research Ethics Board (OHSN-REB) has reviewed the plans for this research study. The Board considers the ethical aspects of all research studies involving human participants at The Ottawa Hospital. If I have any questions about my rights as a study participant, I may contact the Chairperson at 613-798-5555, extension 16719.

There are two copies of the consent form. Keep one copy for your files.

________________________ ______________
Participant's Signature Date

________________________ ________________________
Researcher's Printed Name Researcher's Signature

____
Date

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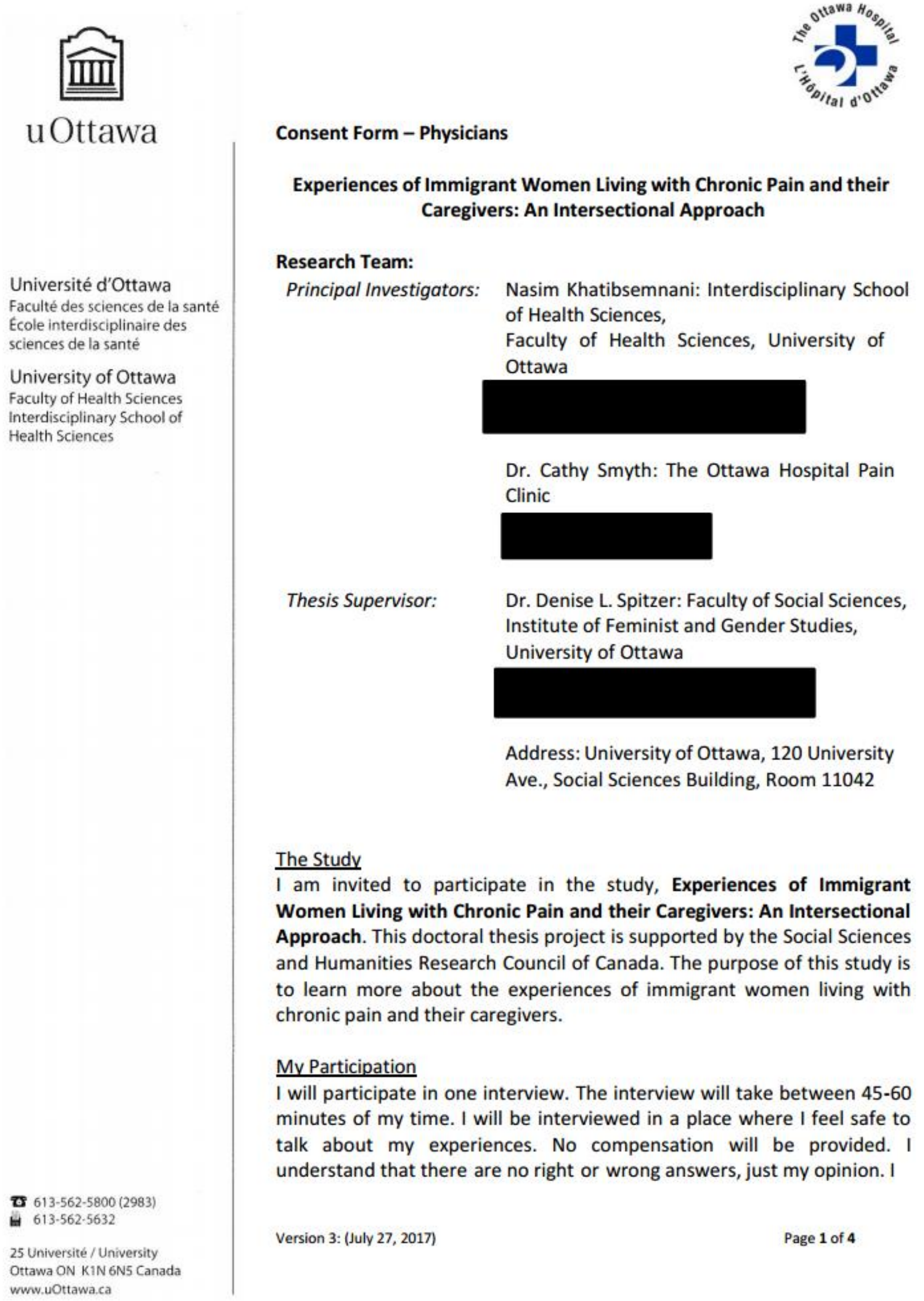
Appendix H3: Consent Form – Physicians



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L'Hôpital d'Ottawa

Consent Form – Physicians

Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach

Research Team:

Principal Investigators:	Nasim Khatibsemnani: Interdisciplinary School of Health Sciences, Faculty of Health Sciences, University of Ottawa [redacted]
	Dr. Cathy Smyth: The Ottawa Hospital Pain Clinic [redacted]
Thesis Supervisor:	Dr. Denise L. Spitzer: Faculty of Social Sciences, Institute of Feminist and Gender Studies, University of Ottawa [redacted]
	Address: University of Ottawa, 120 University Ave., Social Sciences Building, Room 11042

<u>The Study</u>

I am invited to participate in the study, **Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach**. This doctoral thesis project is supported by the Social Sciences and Humanities Research Council of Canada. The purpose of this study is to learn more about the experiences of immigrant women living with chronic pain and their caregivers.

<u>My Participation</u>

I will participate in one interview. The interview will take between 45-60 minutes of my time. I will be interviewed in a place where I feel safe to talk about my experiences. No compensation will be provided. I understand that there are no right or wrong answers, just my opinion. I

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will also answer a questionnaire. It will take between 5-10 minutes. The researcher may record the interview, so she can listen to me carefully. She may also take notes during the interview. I might answer a few questions by phone after the interview, which will take about 15 minutes. I will have a chance to review the interview transcripts and give my feedback. The transcripts will be hand-delivered or will be sent via email; the decision is mine. If I choose email, the transcripts will be password protected. The password will be sent in a separate email or be provided by a phone call to me. I will be allowed to make any modifications to the transcript that make me comfortable with what I said.

Confidentiality and Anonymity

Members of the research team and a transcriptionist are the only ones who will listen to or read the transcripts of my interview. All persons involved with the project have signed an oath of confidentiality to keep my identity secret and my statements private. The researcher will select a different name for me. She will use this name on all material she keeps. She will also use this name in any public presentations, written or oral, of this project. She may change some details of my story, so I will not be personally identified in any public presentation of the research.

Conservation of Data

The recordings or notes and transcripts will be kept for 10 years after completion of the study. They will be kept in a locked cabinet separately from consent form in the laboratory or office of Dr. Spitzer at the University of Ottawa. Only the research team will have access to the data. Another copy will be kept in a locked cabinet separately from consent form at Dr. Smyth's pain clinic office. The researcher will also use a password for her computer. After 10 years all written data will be shredded. The electronic data will also be securely deleted.

For audit purposes only, my original study records may be reviewed under the supervision of the researcher by representatives from:

- the Ottawa Health Science Network Research Ethics Board (OHSN-REB),
- The Ottawa Hospital

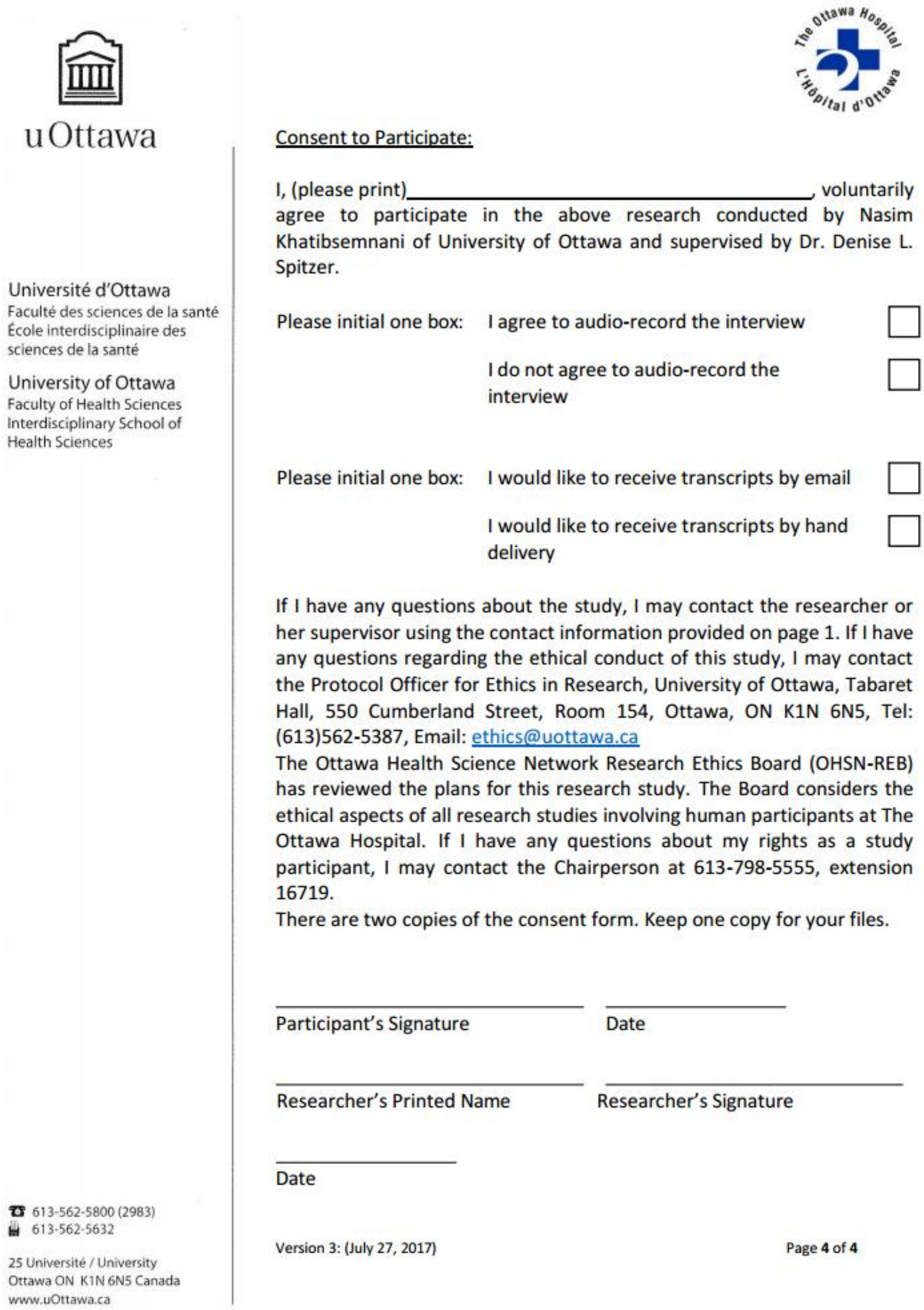
Risks and Benefits

Sometimes talking about the experience of providing care for patients with chronic pain may be uncomfortable. The researcher will try to reduce this risk. At all times, I have the right to change the topic. I can also stop the interview or not answer questions. The researcher will respect my wishes. She will also provide some information about local resources that may be helpful.

I understand that taking part in this study may help others to learn more about the experiences of immigrant women living with chronic pain and their caregivers. At the completion of the research, I will also receive a summary of the research findings.

Voluntary Participation

At all times, I have the right to stop the interview and/or not to answer question. I also have the right to ask the researcher any question about any part of this study. I can withdraw from the study at any time. In this case, the researcher will only use the information I have given her with my permission. If I do not wish her to use this information, she will destroy it or give it to me.



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Faculty of Health Sciences
Interdisciplinary School of Health Sciences

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L'Hôpital d'Ottawa

Consent to Participate:

I, (please print)______________________________________, voluntarily agree to participate in the above research conducted by Nasim Khatibsemnani of University of Ottawa and supervised by Dr. Denise L. Spitzer.

Please initial one box:
- I agree to audio-record the interview ☐
- I do not agree to audio-record the interview ☐

Please initial one box:
- I would like to receive transcripts by email ☐
- I would like to receive transcripts by hand delivery ☐

If I have any questions about the study, I may contact the researcher or her supervisor using the contact information provided on page 1. If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, Tel: (613)562-5387, Email: ethics@uottawa.ca

The Ottawa Health Science Network Research Ethics Board (OHSN-REB) has reviewed the plans for this research study. The Board considers the ethical aspects of all research studies involving human participants at The Ottawa Hospital. If I have any questions about my rights as a study participant, I may contact the Chairperson at 613-798-5555, extension 16719.

There are two copies of the consent form. Keep one copy for your files.

__________________________ ________________
Participant's Signature Date

__________________________ __________________________
Researcher's Printed Name Researcher's Signature

____
Date

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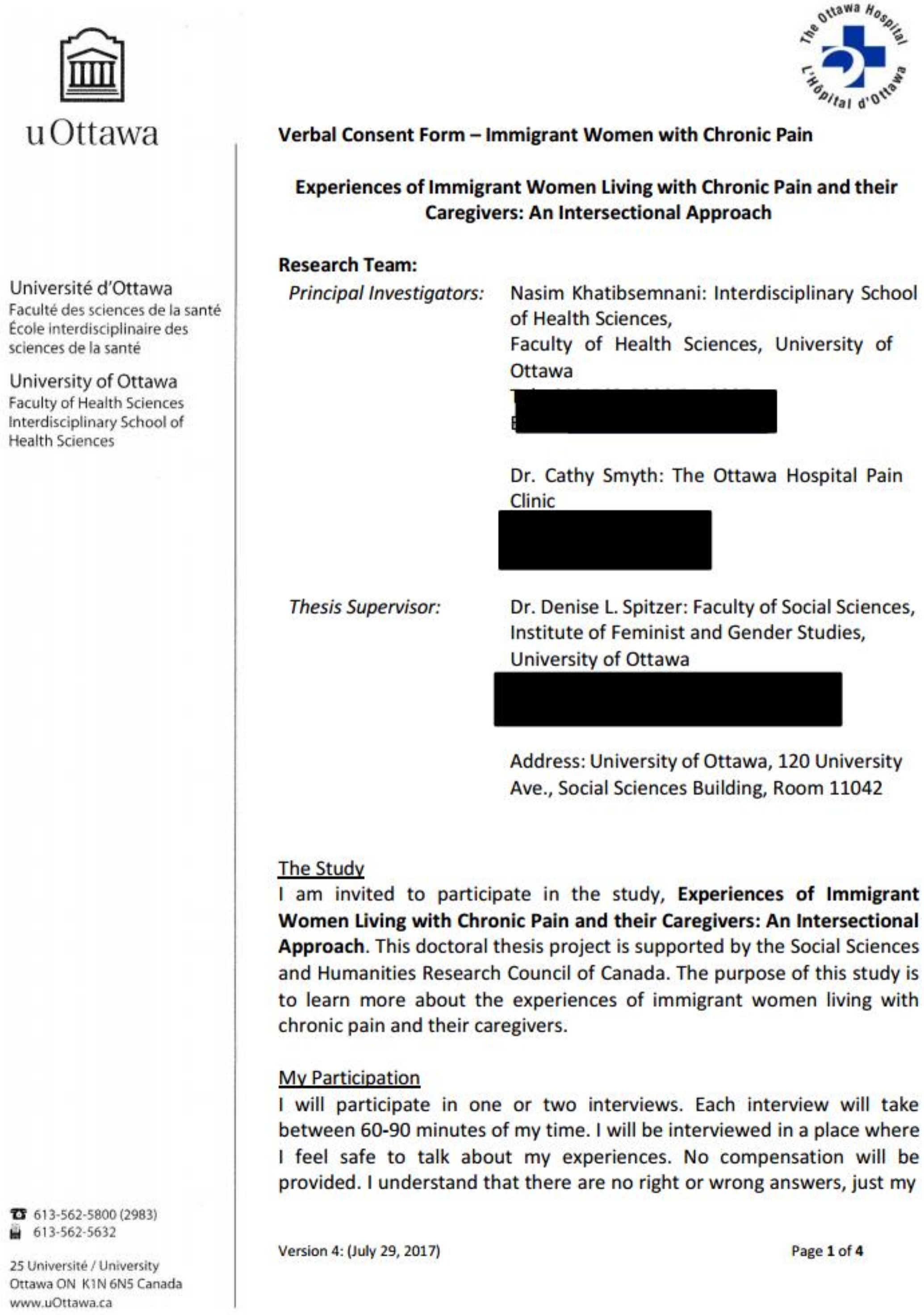
Appendix H4: Verbal Consent Form – Immigrant Women with Chronic Pain



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University of Ottawa
Faculty of Health Sciences
Interdisciplinary School of Health Sciences

Verbal Consent Form – Immigrant Women with Chronic Pain

Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach

Research Team:

Principal Investigators: Nasim Khatibsemnani: Interdisciplinary School of Health Sciences,
Faculty of Health Sciences, University of Ottawa

[redacted]

Dr. Cathy Smyth: The Ottawa Hospital Pain Clinic

[redacted]

Thesis Supervisor: Dr. Denise L. Spitzer: Faculty of Social Sciences, Institute of Feminist and Gender Studies, University of Ottawa

[redacted]

Address: University of Ottawa, 120 University Ave., Social Sciences Building, Room 11042

The Study

I am invited to participate in the study, **Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach**. This doctoral thesis project is supported by the Social Sciences and Humanities Research Council of Canada. The purpose of this study is to learn more about the experiences of immigrant women living with chronic pain and their caregivers.

My Participation

I will participate in one or two interviews. Each interview will take between 60-90 minutes of my time. I will be interviewed in a place where I feel safe to talk about my experiences. No compensation will be provided. I understand that there are no right or wrong answers, just my

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Version 4: (July 29, 2017) Page **1** of 4

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Interdisciplinary School of Health Sciences

opinion. I will also answer a questionnaire. It will take between 5-10 minutes. The researcher may record the interview, so she can listen to me carefully. She may also take notes during the interview. I will have a chance to review the interview transcripts and give my feedback. The transcripts will be hand-delivered or will be sent via email; the decision is mine. If I choose email, the transcripts will be password protected. The password will be sent in a separate email or be provided by a phone call to me. I will be allowed to make any modifications to the transcript that make me comfortable with what I said.

Confidentiality and Anonymity

Members of the research team and a transcriptionist are the only ones who will listen to or read the transcripts of my interview. All persons involved with the project have signed an oath of confidentiality to keep my identity secret and my statements private. The researcher will select a different name for me. She will use this name on all material she keeps. She will also use this name in any public presentations, written or oral, of this project. She may change some details of my story, so I will not be personally identified in any public presentation of the research.

Conservation of Data

The recordings or notes and transcripts will be kept for 10 years after completion of the study. They will be kept in a locked cabinet separately from consent form in the laboratory or office of Dr. Spitzer at the University of Ottawa. Only the research team will have access to the data. Another copy will be kept in a locked cabinet separately from consent form at Dr. Smyth's pain clinic office. The researcher will also use a password for her computer. After 10 years all written data will be shredded. The electronic data will also be securely deleted.

For audit purposes only, my original study records may be reviewed under the supervision of the researcher by representatives from:

- the Ottawa Health Science Network Research Ethics Board (OHSN-REB),
- The Ottawa Hospital

Risks and Benefits

Sometimes talking about the experiences of pain may be uncomfortable. The researcher will try to reduce this risk. At all times, I have the right to change the topic. I can also stop the interview or not answer questions.

The researcher will respect my wishes. She will also provide some information about local resources that may be helpful.

I understand that taking part in this study may help others to learn more about the experiences of immigrant women living with chronic pain and their caregivers. At the completion of the research, I will also receive a summary of the research findings.

Voluntary Participation

At all times, I have the right to stop the interview and/or not to answer question. I also have the right to ask the researcher any question about any part of this study. I can withdraw from the study at any time. In this case, the researcher will only use the information I have given her with my permission. If I do not wish her to use this information, she will destroy it or give it to me.

Do you have any question?

Is your participation in this study voluntary? ☐

Do I have your permission to begin the interview? ☐

Do I have your permission to audio-record the interview? ☐

(Please print participant's name) ______________________________,
voluntarily agrees to participate in the above research conducted by Nasim Khatibsemnani of University of Ottawa and supervised by Dr. Denise L. Spitzer.

Please initial one box:	I would like to receive transcripts by email	☐
	I would like to receive transcripts by hand delivery	☐

If I have any questions about the study, I may contact the researcher or her supervisor using the contact information provided on page 1. If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, Tel: (613)562-5387, Email: ethics@uottawa.ca

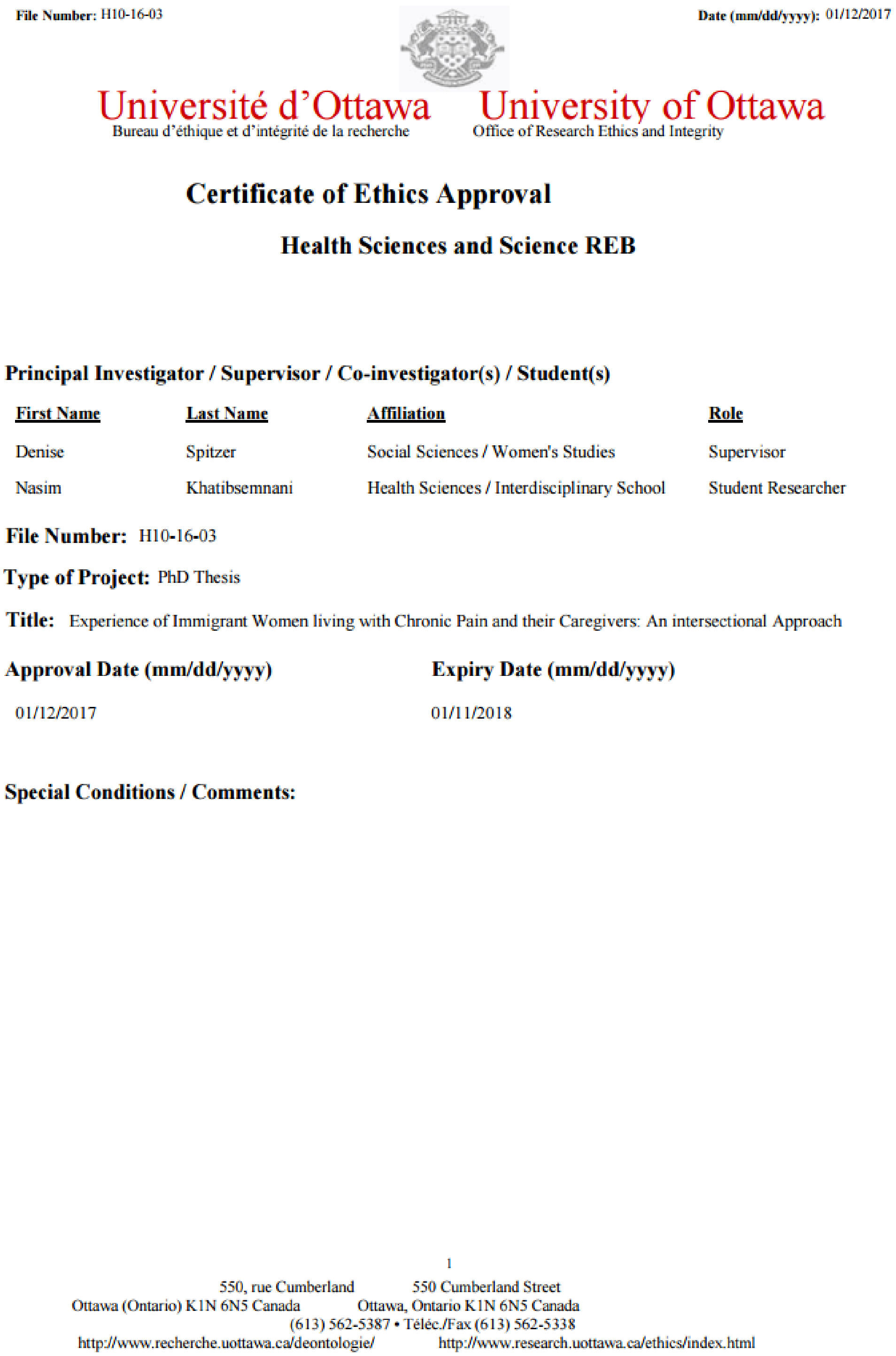
The Ottawa Health Science Network Research Ethics Board (OHSN-REB) has reviewed the plans for this research study. The Board considers the ethical aspects of all research studies involving human participants at The Ottawa Hospital. If I have any questions about my rights as a study participant, I may contact the Chairperson at 613-798-5555, extension 16719.

There are two copies of the consent form. Keep one copy for your files.

______________________________ ______________________________
Researcher's Printed Name Researcher's Signature

____
Date

Appendix I1: Certificate of Ethics Approval - University of Ottawa



File Number: H10-16-03

Date (mm/dd/yyyy): 01/12/2017

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Certificate of Ethics Approval

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

First Name	Last Name	Affiliation	Role
Denise	Spitzer	Social Sciences / Women's Studies	Supervisor
Nasim	Khatibsemnani	Health Sciences / Interdisciplinary School	Student Researcher

File Number: H10-16-03

Type of Project: PhD Thesis

Title: Experience of Immigrant Women living with Chronic Pain and their Caregivers: An intersectional Approach

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)
01/12/2017	01/11/2018

Special Conditions / Comments:

1

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Ottawa (Ontario) K1N 6N5 Canada

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Ottawa, Ontario K1N 6N5 Canada

(613) 562-5387 • Téléc./Fax (613) 562-5338

http://www.recherche.uottawa.ca/deontologie/
http://www.research.uottawa.ca/ethics/index.html

File Number: H10-16-03 **Date (mm/dd/yyyy):** 01/12/2017

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

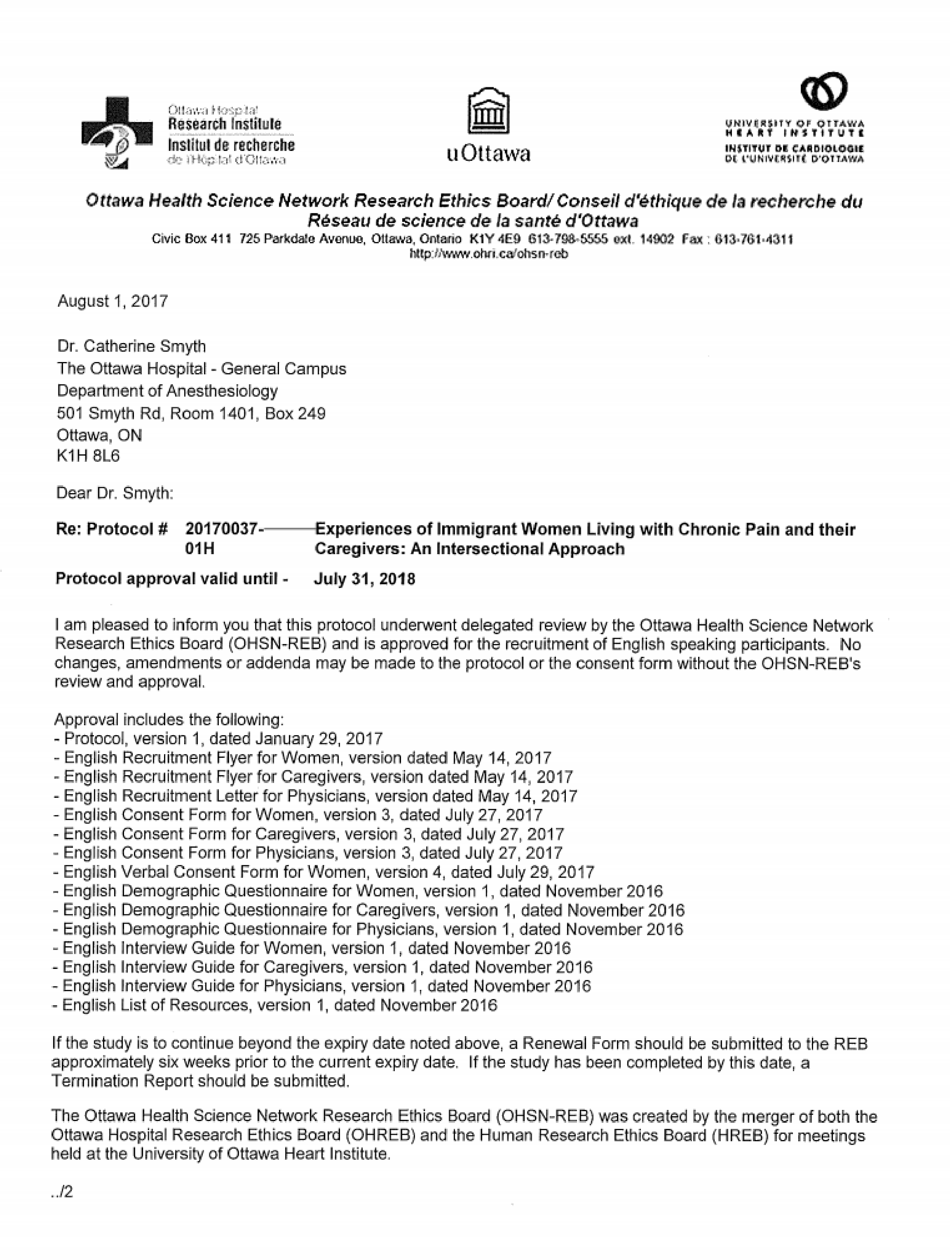
During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: http://research.uottawa.ca/ethics/submissions-and-reviews.

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: http://research.uottawa.ca/ethics/submissions-and-reviews.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Germain Zongo
Protocol Officer for Ethics in Research
For Daniel Lagarec, Chair of the Sciences and Health Sciences REB

Appendix I2: Certificate of Ethics Approval - OHSN-REB



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Ottawa Health Science Network Research Ethics Board/ Conseil d'éthique de la recherche du Réseau de science de la santé d'Ottawa
Civic Box 411 725 Parkdale Avenue, Ottawa, Ontario K1Y 4E9 613-798-5555 ext. 14902 Fax : 613-761-4311
http://www.ohri.ca/ohsn-reb

August 1, 2017

Dr. Catherine Smyth
The Ottawa Hospital - General Campus
Department of Anesthesiology
501 Smyth Rd, Room 1401, Box 249
Ottawa, ON
K1H 8L6

Dear Dr. Smyth:

Re: Protocol # 20170037-01H Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach

Protocol approval valid until - July 31, 2018

I am pleased to inform you that this protocol underwent delegated review by the Ottawa Health Science Network Research Ethics Board (OHSN-REB) and is approved for the recruitment of English speaking participants. No changes, amendments or addenda may be made to the protocol or the consent form without the OHSN-REB's review and approval.

Approval includes the following:
- Protocol, version 1, dated January 29, 2017
- English Recruitment Flyer for Women, version dated May 14, 2017
- English Recruitment Flyer for Caregivers, version dated May 14, 2017
- English Recruitment Letter for Physicians, version dated May 14, 2017
- English Consent Form for Women, version 3, dated July 27, 2017
- English Consent Form for Caregivers, version 3, dated July 27, 2017
- English Consent Form for Physicians, version 3, dated July 27, 2017
- English Verbal Consent Form for Women, version 4, dated July 29, 2017
- English Demographic Questionnaire for Women, version 1, dated November 2016
- English Demographic Questionnaire for Caregivers, version 1, dated November 2016
- English Demographic Questionnaire for Physicians, version 1, dated November 2016
- English Interview Guide for Women, version 1, dated November 2016
- English Interview Guide for Caregivers, version 1, dated November 2016
- English Interview Guide for Physicians, version 1, dated November 2016
- English List of Resources, version 1, dated November 2016

If the study is to continue beyond the expiry date noted above, a Renewal Form should be submitted to the REB approximately six weeks prior to the current expiry date. If the study has been completed by this date, a Termination Report should be submitted.

The Ottawa Health Science Network Research Ethics Board (OHSN-REB) was created by the merger of both the Ottawa Hospital Research Ethics Board (OHREB) and the Human Research Ethics Board (HREB) for meetings held at the University of Ottawa Heart Institute.

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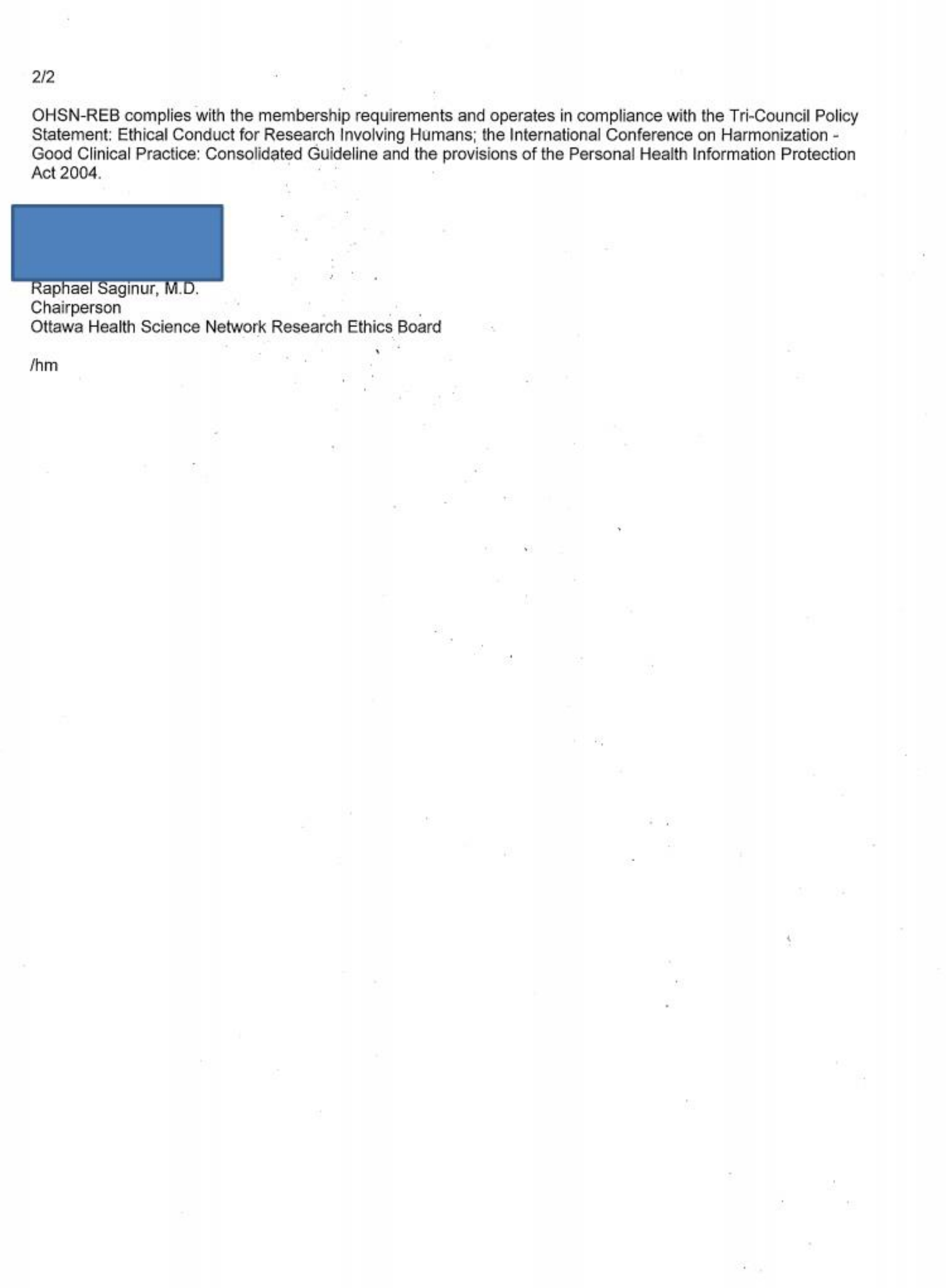

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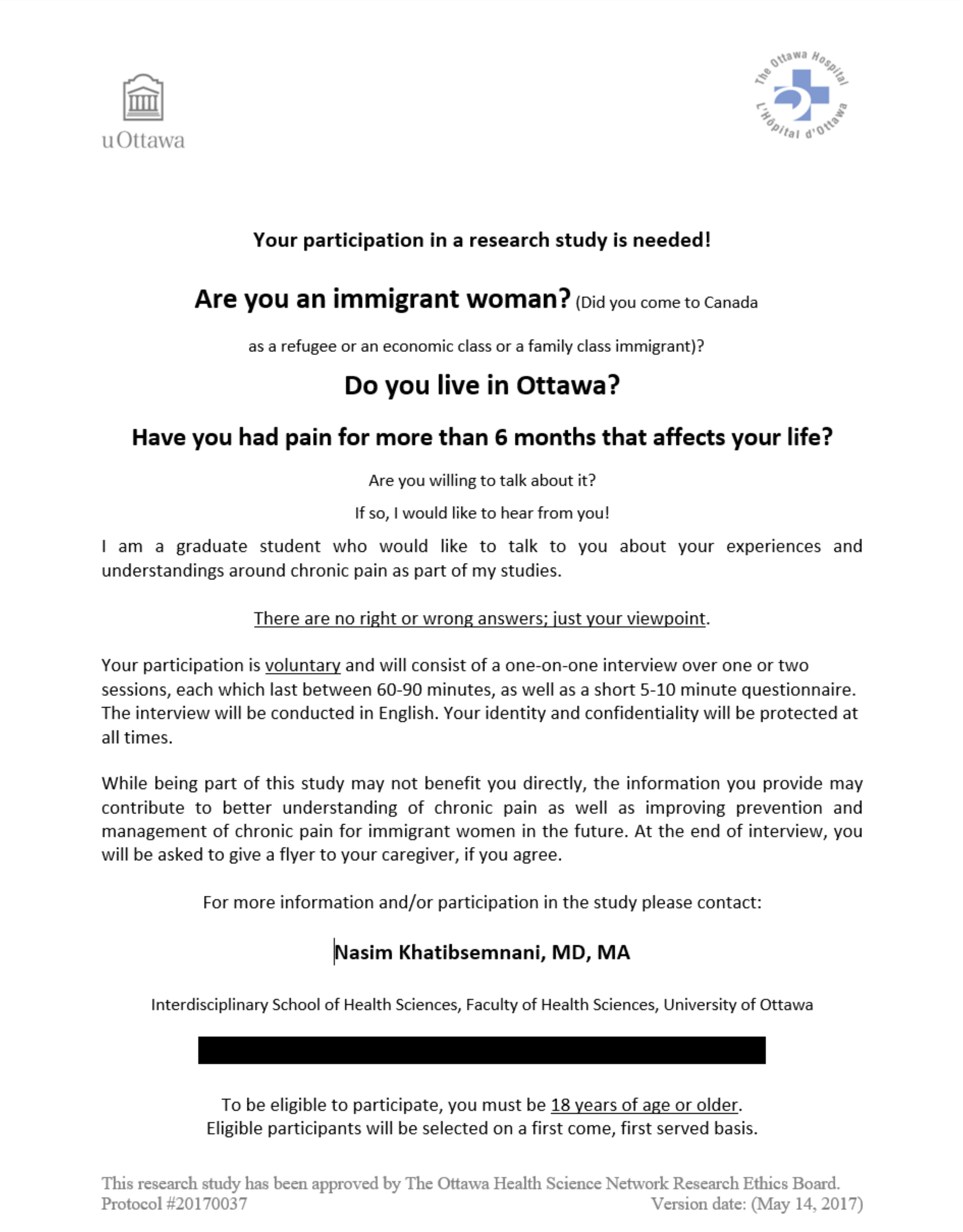
OHSN-REB complies with the membership requirements and operates in compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans; the International Conference on Harmonization - Good Clinical Practice: Consolidated Guideline and the provisions of the Personal Health Information Protection Act 2004.

[redacted]

Raphael Saginur, M.D.
Chairperson
Ottawa Health Science Network Research Ethics Board

/hm

Appendix J: Flyer - Immigrant Women Living with Chronic Pain



Your participation in a research study is needed!

Are you an immigrant woman? (Did you come to Canada as a refugee or an economic class or a family class immigrant)?

Do you live in Ottawa?

Have you had pain for more than 6 months that affects your life?

Are you willing to talk about it?

If so, I would like to hear from you!

I am a graduate student who would like to talk to you about your experiences and understandings around chronic pain as part of my studies.

There are no right or wrong answers; just your viewpoint.

Your participation is voluntary and will consist of a one-on-one interview over one or two sessions, each which last between 60-90 minutes, as well as a short 5-10 minute questionnaire. The interview will be conducted in English. Your identity and confidentiality will be protected at all times.

While being part of this study may not benefit you directly, the information you provide may contribute to better understanding of chronic pain as well as improving prevention and management of chronic pain for immigrant women in the future. At the end of interview, you will be asked to give a flyer to your caregiver, if you agree.

For more information and/or participation in the study please contact:

Nasim Khatibsemnani, MD, MA

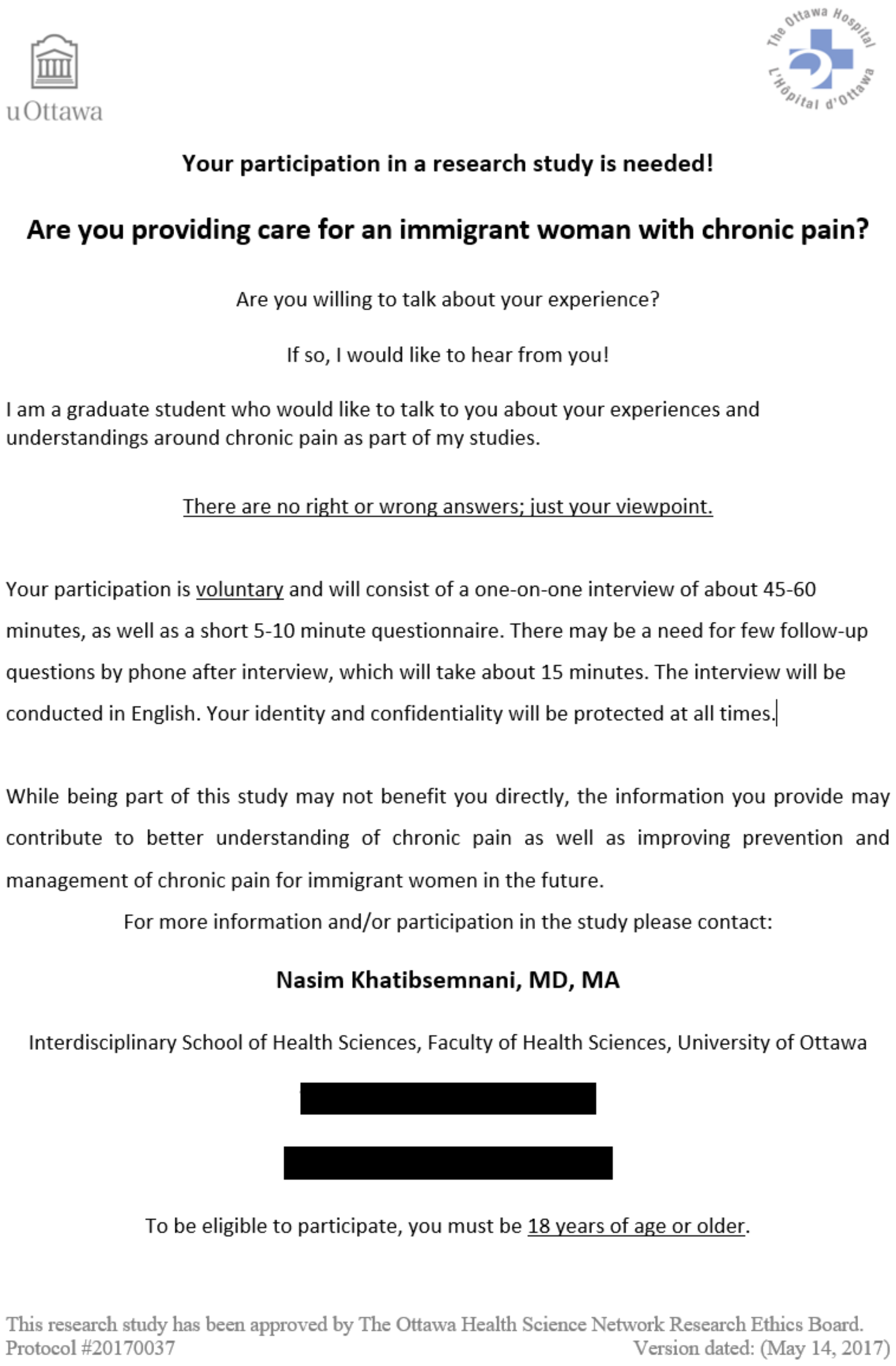
Interdisciplinary School of Health Sciences, Faculty of Health Sciences, University of Ottawa

[redacted]

To be eligible to participate, you must be 18 years of age or older.
Eligible participants will be selected on a first come, first served basis.

This research study has been approved by The Ottawa Health Science Network Research Ethics Board.
Protocol #20170037 Version date: (May 14, 2017)

Appendix K: Flyer - Caregivers



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Your participation in a research study is needed!

Are you providing care for an immigrant woman with chronic pain?

Are you willing to talk about your experience?

If so, I would like to hear from you!

I am a graduate student who would like to talk to you about your experiences and understandings around chronic pain as part of my studies.

There are no right or wrong answers; just your viewpoint.

Your participation is voluntary and will consist of a one-on-one interview of about 45-60 minutes, as well as a short 5-10 minute questionnaire. There may be a need for few follow-up questions by phone after interview, which will take about 15 minutes. The interview will be conducted in English. Your identity and confidentiality will be protected at all times.

While being part of this study may not benefit you directly, the information you provide may contribute to better understanding of chronic pain as well as improving prevention and management of chronic pain for immigrant women in the future.

For more information and/or participation in the study please contact:

Nasim Khatibsemnani, MD, MA

Interdisciplinary School of Health Sciences, Faculty of Health Sciences, University of Ottawa

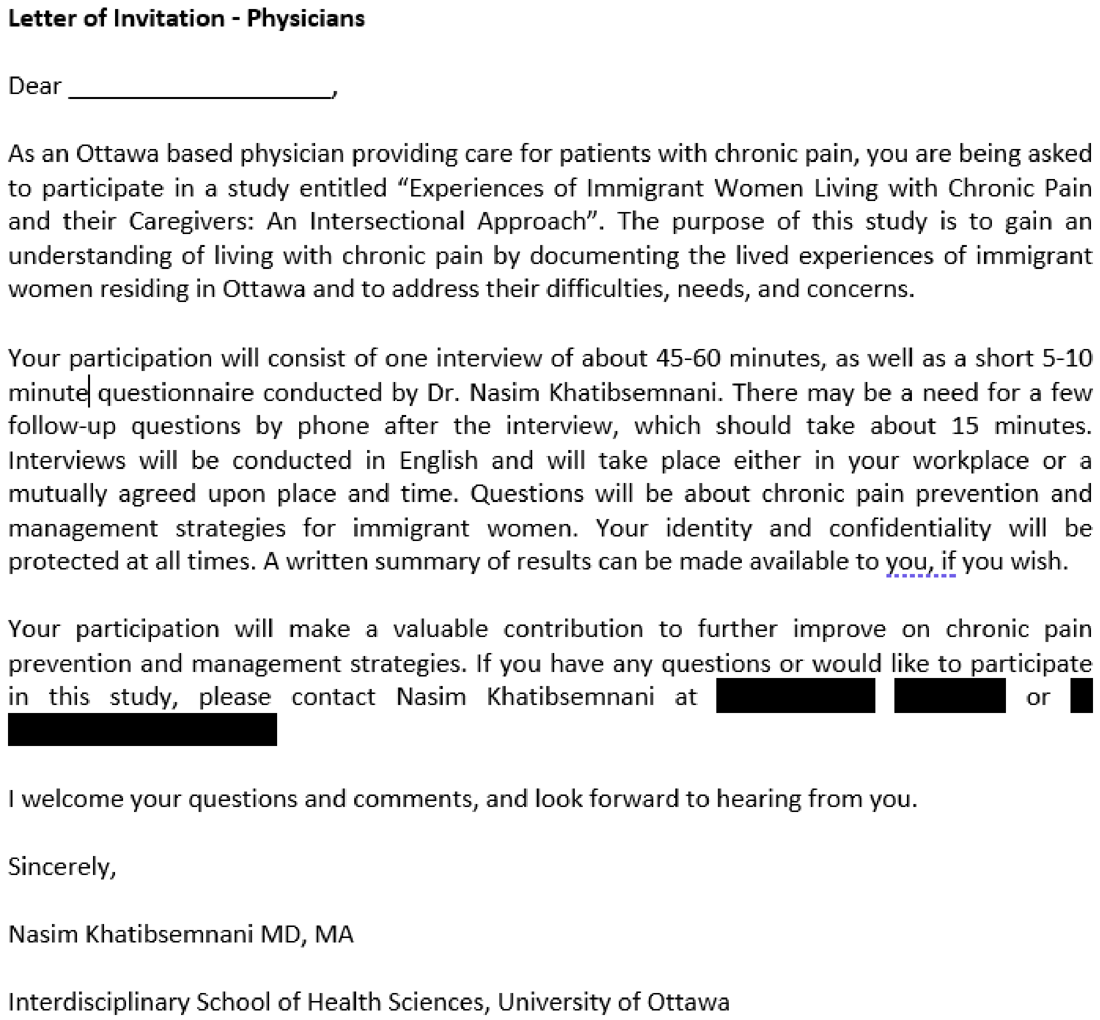
[redacted]

[redacted]

To be eligible to participate, you must be 18 years of age or older.

This research study has been approved by The Ottawa Health Science Network Research Ethics Board.
Protocol #20170037 Version dated: (May 14, 2017)

Appendix L: Letter of Invitation - Physicians



Letter of Invitation - Physicians

Dear ____________________,

As an Ottawa based physician providing care for patients with chronic pain, you are being asked to participate in a study entitled “Experiences of Immigrant Women Living with Chronic Pain and their Caregivers: An Intersectional Approach”. The purpose of this study is to gain an understanding of living with chronic pain by documenting the lived experiences of immigrant women residing in Ottawa and to address their difficulties, needs, and concerns.

Your participation will consist of one interview of about 45-60 minutes, as well as a short 5-10 minute questionnaire conducted by Dr. Nasim Khatibsemnani. There may be a need for a few follow-up questions by phone after the interview, which should take about 15 minutes. Interviews will be conducted in English and will take place either in your workplace or a mutually agreed upon place and time. Questions will be about chronic pain prevention and management strategies for immigrant women. Your identity and confidentiality will be protected at all times. A written summary of results can be made available to you, if you wish.

Your participation will make a valuable contribution to further improve on chronic pain prevention and management strategies. If you have any questions or would like to participate in this study, please contact Nasim Khatibsemnani at [redacted] [redacted] or [redacted]

I welcome your questions and comments, and look forward to hearing from you.

Sincerely,

Nasim Khatibsemnani MD, MA

Interdisciplinary School of Health Sciences, University of Ottawa

Appendix M: Good Thematic Analysis Criteria Checklist

NO	Process	Criteria
1	Transcription	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for ‘accuracy’.
2	Coding	Each data item has been given equal attention in the coding process.
3		Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
4		All relevant extracts for all each theme have been collated.
5		Themes have been checked against each other and back to the original data set.
6		Themes are internally coherent, consistent, and distinctive.
7	Analysis	Data have been analysed / interpreted, made sense of / rather than just paraphrased or described.
8		Analysis and data match each other / the extracts illustrate the analytic claims
9		Analysis tells a convincing and well-organized story about the data and topic.
10		A good balance between analytic narrative and illustrative extracts is provided.
11	Overall	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
12	Written report	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
13		There is a good fit between what you claim you do, and what you show you have done- i.e., described method and reported analysis are consistent.
14		The language and concepts used in the report are consistent with the epistemological position of the analysis.
15		The researcher is positioned as active in the research process; themes do not just ‘emerge’.

Adapted from Braun & Clarke, 2006, p. 96