

# **Pain Expression in Different Cultures**

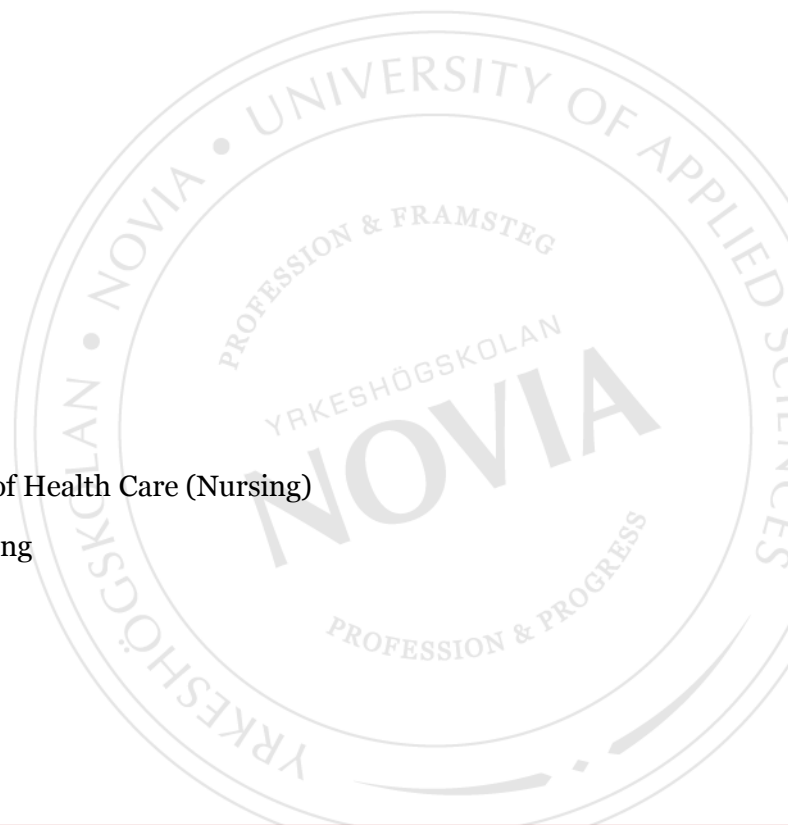
## **A Qualitative Study of the Analysis for the Cues of Pain in Different Cultures**

Grace Richardson

Degree Thesis for Bachelor of Health Care (Nursing)

Degree Programme in Nursing

Vasa 2012



## **BACHELOR THESIS**

Author: Grace Richardson

Degree Programme: Bachelor of Nursing

Specialisation: General Nursing

Supervisor: Irén Vikström

Title: Expression of Pain in Different Cultures

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Date: 8/4/2012

Number of pages: 71

Enclosures: 4

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### **Summary:**

The aim of this study was to describe the expression of pain in patients of different cultures, and to understand and interpret different cultures perceptions and expressions of pain. The theoretical framework used was Halldórsdóttir's *'Caring and Uncaring encounters in Nursing and Health Care: Developing a Theory'*, and Campinha-Bacote's *'The Process of Cultural Competence in the Delivery of Healthcare Services'*. The respondent employed a qualitative approach, with scientific articles.

The main result of this study shows that pain can be expressed in a multitude of ways, depending on the culture expressing it. The importance of cultural competence in caring was emphasized. Understanding different cultures is a dominant part of caring, and as a result the importance of cultural competence should be acknowledged. Despite evidence of cultural knowledge in the nursing education, it is apparent that there are characteristics specific to different cultures, such as expressions of pain, that are absent from the nursing education. As a result, cultural competence education in nursing could be expanded to further facilitate knowledge in cultural expressions of different aspects of illness, such as pain.

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Language: English

Key words: pain, culture, cultural competence, pain expression

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## 1. Introduction

As the world becomes smaller every day, due to the ever expanding ability to travel, every country is becoming more culturally diverse by the day. This ever changing diversity has challenged healthcare professionals with the need to provide more culturally coherent care. Throughout nursing education, students are taught to care for, and treat patients holistically. Providing holistic care means that the patient care should be carried out with a psychological, physiological, and social approach. It is about taking the whole patient into account, rather than just treating their diagnosed illness (Mc Ferran, 2008, 304).

Without being culturally competent nurses cannot care for their patient holistically. Their ability to value diversity, and in retrospect their given care, is or was limited by their inability to be dynamic. Understanding signals of pain in different cultures is therefore mandatory to evoke appropriate behaviours and responses (Llewellyn, 2008).

As nurses, it is our duty to respond pertinently to the cues of pain in our clients and patients. Nurses cannot achieve this without some understanding of how pain is portrayed or perceived in the patients' cultures (Morse, 1999, 1).

Nurses must strive to enhance and expand their ability to understand and interpret different cultures. This must be an ongoing quest to further their knowledge, as no culture remains static with the world's population continuously emigrating and progressing (Flowers, 2004).

The respondent chose to do a qualitative study on how pain is expressed in different cultures. The topic the respondent chose withholds interest to the respondent as it gives the opportunity to discover more comprehension on how to provide culturally competent care to patients in pain. The respondent feels that this study can provide infinite insights into the expression of pain in different cultures, as it is a component which is still absent from education for healthcare providers. The respondent will use articles, books, and journals as the data collection for the topic of choice.

The framework that will be used for this thesis is Halldórsdóttir's theory on caring and uncaring encounters in nursing and healthcare, and Campinha-Bacote's theory on the process of cultural competence in the delivery of healthcare services. All the data that is deduced from this thesis will then be analysed and examined against the framework.

The method for analysing throughout this thesis will be content analysis. At the end of this study the findings will be examined critically and discussed.

## **2. Aim and Problem Definition**

The aim of this study is to describe the expression of pain, in patients of different cultures. The aim is to understand, and interpret different cultures perception and expression of pain. This understanding embraces the multifarious needs of each patient, as with different cultures there are different approaches required for care. The understanding includes: cues of pain in different cultures, outlines for how different cultures express pain, and how a nurse can be culturally sensitive towards the different patients needs. As a result, in understanding different cultures, the respondent hopes to have a vastly crucial influence on the standard of care given to culturally diverse patients, as well as to expand the standards in delivery of pain management (Smith *et al.*, 2002, 27).

The questions of interest are:

1. How can nurses identify signals/expression of pain in a patient?
2. Do nurses need to provide culturally competent pain assessment?

These two questions have been chosen to better understand the diversity of pain in different cultures, and how a nurse can be culturally competent towards the different patients needs.

Culture is a main concept throughout this thesis, and therefore it is important that the respondent defines what culture is. Culture is crudely defined as a group of people sharing beliefs, values, norms, moral codes, lifestyle choices, characteristics, and mannerisms that they have learned through a member of this group/society (Galanti, 2008, 6).

Due to the extensive subject of pain, this study will not deal with suffering of patients, or social, economical or psychological pain.

### 3. Theoretical Framework

The respondent has chosen Halldórsdóttir's theory on '*caring and uncaring encounters in nursing and health care- developing a theory*' and Campinha-Bacote's theory on '*the process of cultural competence in the delivery of healthcare services*' for this thesis. The respondent chose Campinha-Bacote's theory as it gives a vivid outline of the crucial factors that enable nurses to gain the necessary skills to develop as culturally competent caregivers. Halldórsdóttir's theory was chosen as it describes the fundamental aspects necessary for a caring encounter during the interactions of the patient and the nurse.

#### 3.1 Caring and Uncaring encounters in Nursing and Health Care- Developing a Theory

Halldórsdóttir theory has many relevant aspects that contribute towards improving patient-nurse interactions. Within this theory there are two main concepts. These are the 'bridge' and the 'wall' (Halldórsdóttir, 1996, 5).

The caring encounter is considered to be the 'bridge'. The bridge is a symbol of open communication, and comfortable feelings of respect and compassion between the patient and the nurse. The 'bridge' is when the patient is given a sense of enhanced well-being, and health. As a result the 'bridge' causes a sense of empowerment. The patient can sense the nurse's competence through their caring attitude, and their connection to the patient's comfort and contentment. Halldórsdóttir (1996) expresses a caring encounter as being a competent one. This theory is about being competent in empowering the patient, and connecting with others. The theory also discusses how a caring encounter must accommodate the ability to be open, to be sensitive of the patient's needs, being genuinely concerned for the care of the patient, and being dedicated as a nurse. (Halldórsdóttir, 1996, 33-34).

The uncaring encounter is considered to be the 'wall'. The 'wall' is a symbol of incompetence in the delivery of patient care, absence of trust, shared forbearance of patient-nurse interaction, and disconnection in interactions. The 'wall' is when the patient is given a form of care that they believe diminishes their well-being, and overall health. As a result the 'wall' portrays a discouraging kind of care. The patient can sense that the nurse is incompetent or negative in respect to expressing communication

openly. The nurse is in no way genuinely concerned for the patients care, has no respect for the patients need for information, the nurse is disrespectful, inhuman or cold, not interested, and generally is insensitive and inconsiderate of the patients needs. Halldórsdóttir (1996) states that the 'wall' is a strong symbol of detachment and that the nurse is unwilling to communicate and engage with the patient (Halldórsdóttir, 1996, 35-36).

Throughout Halldórsdóttir's theory, she states how vulnerable and alienated patients can feel while receiving health care. She investigates how a patient only feels vulnerable or alienated when these feelings are put upon them. If respect is not shown to patients then they will feel disrespected. If a patient feels estranged, then his/her feeling of loneliness and isolation will only escalate. The theory states how all of these factors need to be taken into consideration when planning a patient's care. Halldórsdóttir (1996) outlines how societal factors and the hidden dimensions of each individual needs to be considered to avoid an uncaring approach to the delivery of care (Halldórsdóttir, 1996, 52-53).

### 3.2 The Process of Cultural Competence in the Delivery of Healthcare Services

The respondent has chosen Campinha-Bacote's model on culturally competent care delivery as it encompasses many mandatory components necessary to improve nurses cultural competency with respect to patient care. Each section of this theory is highly compelling as it vividly outlines compulsory factors in improving and further developing cultural competency.

Campinha-Bacote (2002) states that cultural competence should be an ongoing progress, and that no-one ever is fully culturally competent. The respondent understands this to be because cultures are constantly emigrating; therefore each culture is integrating and advancing. As a result, nurses need to constantly be advancing their knowledge of cultures. This theory affirms that nurses should view themselves as 'becoming', or growing into culturally competent individuals, rather than completing guidelines, and then 'being' culturally competent (Campinha-Bacote, 2002, 14).



The foremost concepts of Campinha-Bacote's theory are:

1. Cultural competence is a process, or journey, not a destination
2. There are five main elements in cultural competency: cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters
3. The main cardinal constitute of cultural competency is cultural desire
4. Cultural competence is a main factor in contributing towards culturally responsive and sensitive care for patients (Campinha-Bacote, 2002)

Cultural desire is viewed as the most affecting component of this theory. This is because it is considered the drive and motivation to become culturally competent. The desire to become competent is linked to having a humanistic regard of caring and respect for another human being. Having a desire to become more culturally competent is about being passionate, committed, and respectful to the practices of others (Campinha-Bacote, 2002).

Campinha-Bacote (2002) states that it is not always about liking or agreeing with how the patient behaves, it is more important that the nurse can respect the patient's individuality, and treat them with the upmost dignity and courtesy. It is the nurse's cultural desire and interest that fuels their ability to become culturally competent. The theory depicts desire as an erupting volcano that ignites the interest to explore cultures further (Campinha-Bacote, 2002, 16).

In aiming to fulfil the five categories of this theory, Campinha-Bacote (2002) believes that all nurses should expand their level of cultural competency and proficiency (Campinha-Bacote, 2002).

The respondent will now outline the five components involved in developing nurse's cultural competency.

1. Cultural Awareness: when a nurse becomes culturally aware they begin to respect and appreciate that each individual is unique. They understand that each culture has their own set of values, beliefs and practices. It is about the nurses setting aside their biases and prejudices, and moving forward in distinguishing that there are many different cultural ways of living. The nurse becomes aware that there are other cultures other than their own (Campinha-Bacote, 2001).

2. **Cultural Knowledge:** cultural knowledge is considered to be a strong competent in increasing cultural competency. It involves inquiring into different cultures. The concept involves an educational framework to build on. Obtaining this knowledge can be achieved in many ways. To gain knowledge about a culture, nurses can read literature, talk to people from different cultures and ask these people questions, or merely observe a different culture. All of these options will increase the nurse's knowledge on that culture (Campinha-Bacote, 2001).
3. **Cultural Encounters:** Campinha-Bacote (2001) outlines how it is important that nurses have cross-cultural interactions with their patients from various cultures. Interacting on direct face-to-face bases with diverse cultures diminishes previous stereotypes or preconceived ideas of a culture. Having cultural encounters enables the nurses to learn abilities they would otherwise not learn from literature. Examples of this can be the tone different cultures use to communicate, facial expressions, and body language (Campinha-Bacote, 2001).
4. **Cultural Skill:** developing the ability to be culturally sensitive or competent requires skill. The reason for this is because it is important relevant data be collected on the patient's culture. If the nurse is not skilful in data collection then they will collect irrelevant information that will not be helpful to the patient. The need to be skilful is imperative as it assists the nurse in culturally-precise assessments and delivery of care. If a nurse is skilful in collecting culturally sensitive data, then they will understand better: how the patient perceives their illness, what kind of treatment the patient is open to, what the patient can potentially fear, and what they may expect from the nurse (Campinha-Bacote, 2001).
5. **Cultural Desire:** According to Campinha-Bacote (2001), cultural desire is the main motivation to expand a nurse's cultural competency. The nurse must be inspired by their own interest to seek to advance the cultural abilities. Campinha-Bacote stated that patients do not care about how much a nurse knows about their culture, all patients are interested in is how much nurses long to know about the patients culture (Campinha-Bacote, 1999). This desire must not be feigned by the nurses. The nurse's words and actions must be in harmony

with each other. Without this authentic interest and desire, the nurse can never truly begin to develop and expand their cultural competency (Campinha-Bacote, 2001).

Throughout this theory Campinha-Bacote (2002) draws emphasis to the point that without cultural desire, nurses can never truly be considered culturally competent. Campinha-Bacote (2002) also stresses that no-one is ever fully culturally competent, as it is not an event or destination. Cultural competence should be considered a journey, or a continuous development within a nurse's career.

#### **4. Theoretical Background**

In this section the respondent will describe the theoretical background for this thesis. The respondent will firstly discuss the 'Definition of Pain', followed by the 'Definition of Culture'. After this, the respondent will define 'Types of Pain Assessment as a tool for pain management'. As this thesis is primarily based around cultural pain, the respondent feels it is important to define what pain is, and what culture is, followed by ways of accessing this.

After outlining the above topics the respondent will then describe 'Cultural Competence in Nursing', and then 'Pain Expression in Different Cultures'. The respondent chose cultural competence in nursing as a topic as it is most essential, out of all healthcare professionals, that nurses be culturally competent as they have the most frequent interactions with patients. The respondent chose pain expression in different cultures as another topic as it is important nurses be tuned into the various signs and expressions of pain in diverse cultures, so that they can assess this pain, and deal with it accordingly.

##### **4.1 Definition of Pain**

Pain is a universally experienced phenomenon. It is quite complex, and considered to be a very private issue. Pain is when the body becomes part of an evolving quest. Pain has been defined as a biopsychological phenomenon, meaning it is comprised of biological,

psychological, and social aspects (Merriam Webster). Therefore, pain is very much culturally determined (Lovering, 2006).

As it is a private experience, it can only be made public through communication, either verbally, or non-verbally. Pain is highly complex, and unfortunately not much nursing education has been dedicated towards education in this field. Even as pain is addressed, education on cultural perceptions, and expression of pain is not (Smith *et al.*, 2002).

To define pain crudely, it is a disagreeable state of discomfort, which can range in severity from mild to moderate, or even become agonising (Mc Ferran, 2008, 481). However, pain cannot be defined so coarsely when it has so many influencing factors on how it is apprehended, and expressed, culture being one of the most efficacious factors.

Pain is most commonly expressed by its location, continuance, how intense it is, and its etiology.

- ❖ Location is where the pain is on someone's body. It can also be described in proximity to something else. This is important as pain can also be deferred from another problem. For example, cardiac problems can be expressed as pain shooting down the left arm. Visceral pain can be another determinant to consider when evaluating pain. This is when pain is perceived in a non-connected part of the body from the organ it is originating from. An example of this is when a patient presents with right shoulder pain due to a liver problem.
- ❖ Continuance is often also called duration. This is subdivided into acute and chronic pain. Acute pain usually has an expected recovery span. Common colds, influenzas, and streptococcus (tonsillitis) would all have acute pain attached to them. Chronic pain is associated with indefatigable, and prolonged pain. Pain is classified as chronic when it lasts three months or longer, with no predictable or foreseeable end.
- ❖ Intensity is judged on a scale of zero to ten. Zero is considered to be no pain, and ten is considered to be the worst pain possible. When patients rate themselves between one to three on the pain scale, then the pain is considered to be mild. If patients rate themselves between four to six then the pain is considered to be moderate. Any pain rated seven and above is considered to be severe pain.

- ❖ Etiology is divided into nociceptive pain and neuropathic pain.
  - Nociceptive pain is when the nervous system is perfectly functioning it sends signals that tissue is damaged, or needs care, or attention. Once this attention is received the pain will quickly go away. An example of this is when someone has a broken arm.
  - Neuropathic pain is affiliated with affliction or malfunctioning nerves. This can be due to injuries, illnesses, and sometimes undetermined reasons. Neuropathic pain is commonly chronic and quite difficult to treat (Berman & Snyder. 2012, 1205-1206).

#### 4.2 Definition Culture

Culture is viewed as a bundle of practices that people commit to consciously, or unconsciously. These practices are continuously built and re-built by the associates who interact within this 'culture'. These shared practices, within the culture, embody a conditional structure that the members use as a framework to understand and interpret their social group. Culture is about a shared understanding between a group in society. Culture can be subdivided into macro-cultures and micro-cultures. A macro culture is about nationality, racial group, and ethnicity. Micro-cultures exist within macro-cultures. They consist of components such as age, gender, religion, and spiritual beliefs (Berman & Snyder. 2012).

Culture is a congregation of people who share the same beliefs, values, norms, moral codes, lifestyle choices, characteristics, and mannerisms. It is a learned behaviour from another member of this group/society (Galanti. 2008, 6).

When culture is learned, it can be achieved either actively or passively, or even both. It is relayed from generation to generation via formal or informal social interactions (Tharp, B. 2009).

For something to be classified as a culture, such as cultural behaviour, it must be shared and learned by other associates of the society (Galanti. 2006, 6).

Culture influences how pain is perceived, communicated, interpreted, and what meanings are attached to it. This is because people learn from their cultural group how they should understand, and delineate pain in health (Lovering, 2006).

#### 4.3 Pain Assessment as a tool for pain management

Pain assessment plays a crucial role in health care. It gives the nurse an opportunity to examine the patient, as well as collect valuable information for patient treatment, and care plans (Mc Ferran, 2008, 51).

The main aim of pain assessment is to identify the cause of the pain, interpret the impact of the pain, establish a suitable pain relief approach, and then evaluate the pain relief efficacy (Briggs, 2010).

Culture plays a crucial role in influencing how patients express pain. This is because pain perception and expression is very unique and individual in respect to how we have been raised. For example, when a patient has come from a stoical family or culture, they may have developed what appears to be a very high threshold for pain. This can be instilled in early childhood from hearing phrases such as 'boys do not cry', or for example after falling they are told 'get up, you are ok'. As a consequence, satisfactory pain assessment must be implemented to establish the needs of each culture. Pain is one of the most persistent reasons that patients seek health care treatment. Therefore, appropriate pain assessment is infallibly a mandatory skill in dealing with patient care (Briggs, 2010).

A major barrier to adequate pain assessment is stoicism. Patients who are stoic are said to still feel pain just as much as everyone else, however, they express it at a much lower level (Malvin, 1996).

There are many other barriers to sufficient pain assessment. The following is a list of barriers.

- Fear of analgesic addiction: a patient may suppress or hide symptoms of pain to avoid taking analgesia. Some patients fear they will become addicted to medication, so they diminish signs of pain to avoid treatment.
- Anxiety towards medication side effects: some patients can fear that the side effects that arise from medication can often be worse than the pain itself. For example, some medications might warn of side effects such as nausea. As a result, patients will portray their pain as lower than it is to avoid the medication.
- Fear of injections/suppositories et cetera: some patients dread the idea of receiving injections or suppositories or even oral medications. Their fear or anxiety overwhelms them, and as a result they rate their pain lower during assessment to avoid receiving treatment.
- Devotion to being a 'good patient': from time to time, patients desire to be good patients, and ensure they do not distract nurses from other tasks. As a result, the patient scales their pain low to insure the nurses are not distracted by them.
- Concern for health: when a patient is concerned that their pain could indicate a significant life-changing disease they might not often display signs of pain. These patients can be a barrier to adequate pain assessment as they themselves, consciously or subconsciously do not want to know what is causing their pain (Briggs, 2010).

Pain assessment is considered a fundamental component in designing the patients care plan. During pain assessment, the nurse or assessor asks questions in relation to the pain. Some examples include; location, intensity, quality of pain, onset and duration, previous management, and associated symptoms (Briggs, 2010).

Several mnemonics have been created to aid in the assessment of pain. According to the Oxford Dictionary (2012), mnemonics are patterns of letters devised to support the memory of different tasks or sequences. A common example of a pain assessment mnemonic is 'SOCRATES' (Briggs, 2010, 37).

**Site:** Where on your body is the pain

**Onset:** When did the pain first begin? Was it at rest? Was it sudden pain?

**Character:** What type of pain is it? Is it a burning, stabbing, sharp, or shooting?

**Radiation:** Does the pain come from somewhere else, or spread elsewhere?

**Associations:** Does the pain cause any associated symptoms such as nausea, change in mood or mobility or sleep or nutritional intake?

**Time:** How long has the patient had the pain? Does it get worse at certain times?

**Exacerbating/relieving factors:** Is there anything that increases or decreases the pain?

**Severity:** How severe or intense is the pain? (Briggs, 2010, 37).

Another example of a mnemonic for pain assessment is that of Kernicki (1993). Kernicki (1993) uses PQRST as a mnemonic model.

**Provokes:** What causes the pain or makes it worse?

**Quality:** What type of pain is it? Burning, stabbing, shooting?

**Region/radiation:** Where is the pain? Does it radiate elsewhere?

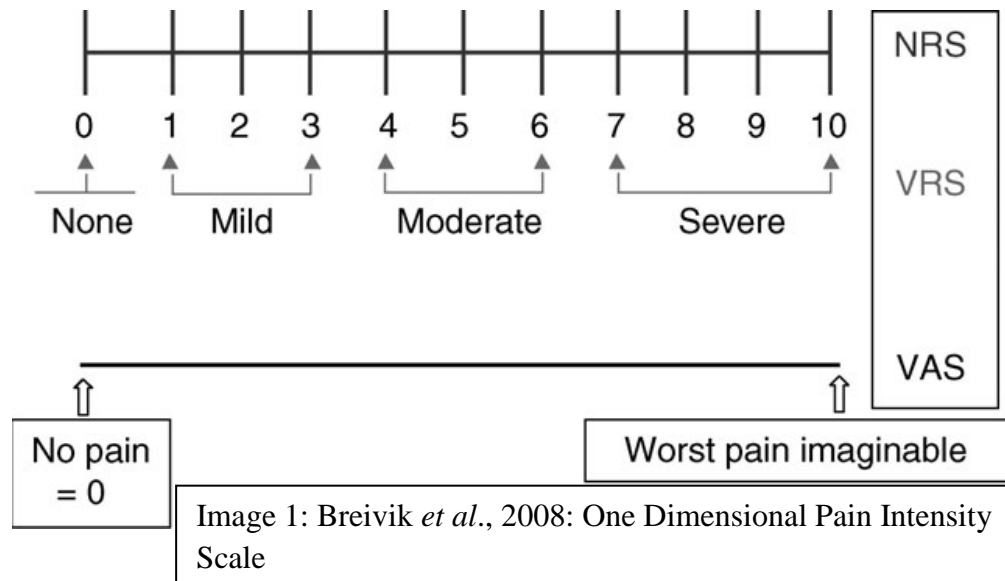
**Severity/symptoms:** How intense is the pain? Does it cause other symptoms?

**Timing:** When is it worst? Morning, evening, or night time? (Kernicki, 1993).

Pain assessment scales serve an important purpose in health care. Their significance is unyielding in the diagnoses of different conditions and treatments. This is because the information given during pain assessment, such as location and duration, can help healthcare professionals make their diagnoses. Pain scales always encompass visual, verbal, and numerical characteristics, and often all three combined (Aetna Inteli Health, 2012).

Visual pain scales are often abbreviated to VAS meaning visual analogue scale. Verbal pain assessments are abbreviated to VRS meaning visual rating scale. Numerical scales are abbreviated to NRS meaning numerical rating scale. Breivik *et al.* (2008) outlined a scale that combines all three of these scales.





The VAS is a ten centimetre line. The patient is asked to mark along the line between ‘no pain = 0’ and ‘worst pain imaginable’. After the patient marks it, it is then measured and documented. The VAS requires dexterity, the ability to be conceptual, and also concentration. Therefore this scale is not always advisable for older adults, or children (Briggs, 2010, 37).

These scales are considered to be unidimensional. This is because they deal very basically with factors such as intensity or duration (Briggs, 2010).

In the VAS section of the pain assessment, the assessor may also look for visual signs of pain. Visual signs of pain can be frowning, crying, the patient making worried shapes with their eyebrows, pale complexion, and possible sweating from intense pain. One commonly used visual assessing tool is the ‘Wong-Baker Faces Pain Rating Scale’. This is more generally used in the assessment of younger children who cannot always be as articulate as is needed in pain assessment (Aetna Inteli Health, 2012).



Image 2: Hockenberry *et al.*, 2005. Wong-Baker Faces Pain Rating Scale

When the assessor uses the VRS section of the assessment they will look for words such as moderate, severe, excruciating, stabbing, sharp, and shooting with respect to the type of pain being endured. This section of the pain assessment can be quite relevant in determining the quality of the pain, and also where the pain can be coming from. For example, if the patient describes a shooting pain down their left arm, then the assessor can immediately begin to consider cardiac problems (Aetna Inteli Health, 2012).

During the section of the pain assessment where the assessor judges the patient numerically (NRS), the patient is asked to set their pain on a scale of zero to ten. The assessor states in advance that zero is considered to be no pain, and ten is considered to be the worst pain possible conceivable. If a patient states their pain is between one to three on the pain scale, then their pain is said to be mild. If they rate their pain from four to six, then their pain is then considered to be moderate. Any pain rated seven or above is considered to be severe or excruciating pain (Berman & Snyder, 2012, 1205-1206).

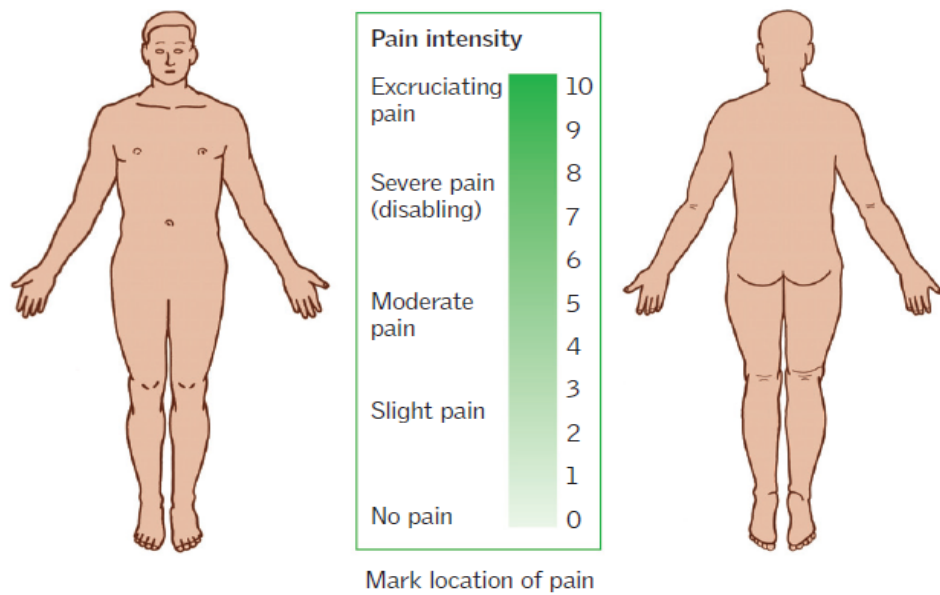
Several multidimensional pain assessment scales have also been developed. One of the most comprehensive multidimensional pain scales is that of Melzack (1975) which is still used today. It is called the Mc Gill Pain Questionnaire. This questionnaire divides pain into temporal, spatial, punctuate pressure, incisive pressure, constrictive pressure, traction pressure, thermal, brightness, dullness, sensory miscellaneous, tension, autonomic, fear, punishment, effective-evaluative-sensory, time, increase-decrease factors, severity, and pain interpretation. (See Enclosure 3).

The Mc Gill Pain Questionnaire is rated from 0 (the minimum) to 78 (the maximum pain score). After calculating the results of the questionnaire, the nurse will then have a much broader representation of the type of pain the patient is dealing with, and how it can be managed (Melzack, 1975).

Multidimensional scales are useful in evaluating patients who are suffering from a significant amount of pain, that cannot be merely assessed using the basic VAS, VRS, or NRS (Melzack, 1975)

An example of a pain assessment tool which incorporates all VAS, VRS, and NRS, and is based on the Mc Gill Pain Questionnaire is the pain assessment tool used by the Royal Brompton and Harefield NHS Foundation Trust. This pain assessment tool is used throughout many hospitals. This assessment focuses on different aspects of pain.

The patient can rate their pain on a scale of zero to ten. Zero is considered no pain, and ten is considered to be excruciating pain. After this the patient can rate the pattern of their pain; continuous, intermittent, or brief. The patient is then given a list of pain descriptors they can choose from, for example tender, dull, and cramping. The patient can then mark on the pain assessment tool where they have pain. This is a rather affective tool as it covers several aspects of pain assessment, including allowing the patient mark on the picture where their pain is (Cox, 2010).



Pattern of pain			
Continuous	Intermittent	Brief	

Description of pain			
Tender	Pressure	Aching	Cramping
Gnawing	Dull	Burning	Electric shock
Throbbing	Sharp	Stabbing	Like a weight
Squeezing	Crushing	Discomfort	Sore

Reproduced with permission from Royal Brompton and Harefield NHS Foundation Trust

Image 3: Cox, 2010: Pain Assessment Tool.

Determining what scale to use is dictated by factors such as age, language ability, cognitive capability, and patient preference (Briggs, 2010).

#### 4.4 Cultural Competence in Nursing

Throughout nursing education nursing students are thought to respect the rights, beliefs, and dignity of all of their patients. Living in such a multicultural environment, it is therefore imperative that nurses be culturally competent. This serves to meet every patients needs, in an individual way (Anderson. 2008-2012)

According to Davidhizar and Newman, being culturally competent is about viewing someone with a holism approach. This has many components such as politics, religion, health practices, and relationships. Cultural competence is the calculation of several of these components combined, and by understanding them, their value is infinite (Davidhizar & Giger. 2008). Therefore, without cultural competence, or even culturally sensitive care, a patient is then subjected to feelings of discrimination, stereotypes, prejudice, and possibly racism (Anderson. 2008-2012)

Being culturally competent means that a holistic approach to care is given. This is because all of the patients needs are being met, instead of in some cases excluded. A holistic approach allows nurses to care for the mind, body, physical, emotional, and spiritual characteristics of the patient. Therefore, it is crucial carers be culturally competent to meet these criteria. For this reason alone, culture competency is indispensable within nursing care (Perkins. 2007)

Cultural competence has a high significance in nursing as it assists with successful communication, both verbally, and non-verbally (Anderson. 2008-2012).

If a nurse cannot care for his/her patient with cultural competence then they are subjecting the patient to reductionism (Paley. 2010) Reductionism is when a rather complex issue is simplified to a point of minimisation. This is a problem in nursing when a patient is not dealt with holistically, and it can result in feelings of a patient being simplified down to an illness (Dictionary.com, 2012).

According to Halldórsdóttir, if you are not culturally competent, you subject the patient to feelings of reductionism. This will increase the patients suffering, and can be pigeonholed into a 'life-destroying' approach to care. Life-destroying mode is the transference of negative energy, thoughts, and an overall feeling of darkness and gloom (Halldórsdóttir, 1996, 89). Life-destroying mode increases a person's vulnerability, feelings of despair, and also elevates stress of an experience. (Gaut & Leininger. 1991)

According to the Campinha-Bacote and Munoz model for cultural competence in nursing, there are five key steps to becoming culturally competent.

1. Cultural Awareness: to begin with you must understand your own culture
2. Cultural Knowledge: you must search for information on different cultures to obtain new information
3. Cultural Skill: you must have a knowledgeable skill on how to collect information on diverse cultures
4. Cultural Encounter: you must engage with various cultures to modify/remove stereotypes you may already have
5. Cultural Desire: you must be eager to learn about, and understand new cultures. Your enthusiasm must be genuine (Campinha-Bacote, 2002).

Nursing is, as a career, often illustrated as a compassionate, sympathetic, and empathetic one. However, it would be impracticable to believe that a nurse could fulfil these criteria without understanding a patient's culture (Kimmel, 2008)

Cultural competence is resoundingly required in nursing. It will serve as a crucial tool in not only how a nurse should deliver care to a patient, but also what form of care should be provided. Cultural beliefs, values, and traditions all form how each individual views their illness, and health. If a nurse can have an understanding on a person's culture, then this knowledge is indispensable in planning this patient's treatment, and medical interventions (Kim-Godwin, Clarke, & Barton, 2001)

## **5. Earlier Research**

'Culture Based Nursing Knowledge from Education' was the topic of interest in the respondent's earlier research. The research for this section was found manually and electronically through the Novia University of Applied Sciences library, as well as through Tritonia's online library search. The respondent also searched for articles through the EBSCO database. Word searches such as 'culture and nursing', 'cultural care and nursing' and 'transcultural nursing' were used for this search.

The respondent chose the above topic to examine how much of nursing education is dedicated towards culture knowledge, as cultural understanding/competency is considered an imperative skill for nurses.

### 5.1 Culture Based Nursing Knowledge from Education

Culture has been a part of the nursing education for many years. Therefore, in one way or another all nurses should have knowledge on this subject. During the respondents search for culture based nursing knowledge from education, text books and literature including this topic can be found back as far as books published in 1980. Despite one book being thirty-two years old, it still contained many of the important aspects nurses should consider, for their cultural knowledge, to deliver a high standard of care.

Roper *et al.* (1980) defines culture as being a word society uses to describe different ways of life. These ways of life differ due to the communities and societies different people live in. They state how culture is the way people live their everyday lives. They also outlined that when different hospitals and healthcare settings around the world are examined, it is clear that the type of care that is delivered is highly influenced by culture. Therefore, it is mandatory nurses have a good knowledge on what culture is. Roper *et al.* (1980) highlights how perception of health and illness are deeply rooted in cultural beliefs from cultural societies where people have learned their mannerisms. This is evidence that culture has been a part of nursing knowledge for many years now. Roper *et al.* (1980) divides how culture is developed into the following subgroups: housing, role and status, and relationships and groups. I will now outline how they believe these factors contribute towards developing different cultures.

- Housing: it is believed this is a factor in developing a person's culture as the type of housing a person lives in is in direct relation to what type of society they live in. For example, if a person lives in bad housing with poor or no amenities, or if their housing is overcrowded, they may have developed a stoic culture because they are used to harder times. Or as a consequence of these conditions they may have developed a low tolerance culture due to hard conditions.
- Role and Status: if a person plays a central role in their family or community, or workplace, then they can develop a certain culture that comes with this role.

They may have developed a superior repertoire as their cultural approach to dealing with other people. This is due to the influence the culture they live in has imprinted on their character.

- Relationships and Groups: if a person has good relationships with friends, family, work colleagues, and their neighbours then they can develop an ability to continue this good communication with other people. This is the culture they have learned through their society. The opposite can also be said, if a person has negative encounters in their culture then they can continue these negative encounters with other people they meet too (Roper *et al.*, 1980).

Despite this book addressing the relevance of knowledge on cultures in nursing, it does not draw attention to the necessary skills a nurse should develop to deliver a high standard of care to culturally diverse patients.

The respondent found slightly newer literature from seventeen years ago. Despite still not being completely current, the respondent wished to view how far back in nursing education culture knowledge had been considered. This book was slightly more relevant than what had been found in the works of Roper *et al.* (1980). Long *et al.* (1995) addressed two main concepts in relation to nursing understanding, and having knowledge on cultural differences. These two concepts were: culture and pain, and culture and chronic illness. This literature focused very basically on each concept.

- Culture and Pain: How pain is conceived and understood is affected by culture. Long *et al.* (1995) explained culture is defined by mobility, age, living environment, sex and background, to name a few. Each culture can respond to pain in completely different ways. It is influenced by how one is taught to respond to pain. This teaching occurs through the society one lives in, and/or through their culture. Some cultures are thought to accept pain as a way of life, or be stoic, some other cultures are thought to be expressive and open with their pain. Therefore, understanding a person's culture will allow the nurse to understand the person's response to pain.
- Culture and Chronic Illness: Long *et al.*, (1995) addresses that commonly the western culture will not deal with chronic illnesses as well as other cultures. This is because the western culture is often focused on a 'cure'. Some cultures often consider chronic illness to have symbolic meaning, and that by being ill

that they, as individuals, have been chosen for an important task and their God is testing them. Other cultures can view chronic illness as a punishment. Depending on what type of culture a patient comes from, they may react differently, and it is therefore important a nurse be open to all the possible ways a patient will react to chronic illness (Long *et al.*, 1995).

Although the Long *et al.* (1995) text book covers many important aspects to consider when caring for patients of different cultures, it only highlights the importance of being open to different expressions. It does not educate the nurse on how to obtain this cultural nursing knowledge.

The respondent found another text book within a manual library search. This text book was printed in 2002. The book itself strictly covers concepts, ideas, and routines for dealing with patients of a culture other than the nurse's own culture. It focuses on transcultural nursing. In this book, Leininger and Mc Farland (2002) focus on the vastly broad practices of different cultures, and how nurses should deal with patients of these different cultures. This course book addresses not only culture as being influenced geographically, but also culture as being more than this definition. Leininger and Mc Farland (2002) focus on the culture of nurses, the culture of violence, the culture of medicine, and the culture of poverty, to name a few. This gave the respondent the opportunity to see culture as being something more than what ethnicity or geographical location can dictate (Leininger & Mc Farland, 2002).

This literature was highly informative as not only is there outlines of what a culture is, and different forms of cultures and subcultures, but there is also guidelines for what a nurse can do to improve their cultural competency. These guidelines are separated into ten different steps. The respondent will now outline the ten steps in Leininger and Mc Farland's (2002) guidelines.

1. Gain an insight into the patient's culture by obtaining literature, or by attending transcultural nursing seminars.
2. Have an understanding of your own culture, and out rule any possible biases that can interfere with the assessment of a patient of a different culture.
3. Use theoretical guidelines for assessing patients, such as 'The Sunrise Model' by Leininger. This strengthens the nurse's ability to be culturally sensitive.



4. If there is a language barrier between the patient and the nurse then the nurse should assign a qualified interpreter to help with a patient's assessment and care.
5. Be an active learner. It is important to show an authentic interest in the patient's stories, experiences, and suggestions.
6. The nurse should pay attention to the environment in which the assessment or care is taking place. An uncomfortable environment will make for an uncomfortable assessment.
7. When a patient expresses emic and etic data, the nurse should ensure they are understanding, and interpreting this information correctly. The nurse should take this information and delineate it appropriately into culturally competent holistic care.
8. The nurse should encourage the patient to participate actively in their assessment, decision making, and daily care given. This will give the nurse an opportunity to further understand how a culturally diverse patient requires daily tasks to be done.
9. After the nurse has identified certain cultural values, beliefs, and practices, they should re-check this data as often as possible to avoid stereotyping against other members of this culture.
10. When a nurse has attained information and knowledge on a culture, he/she should use these findings in a sensitive, considerable manner. Being sensitive and considerate will guarantee the most beneficial outcomes from this new knowledge (Leininger & Mc Farland, 2002, 128).

Leininger and Mc Farland's (2002) literature was undoubtedly highly beneficial in demonstrating not only what culture is, but also in educating nurses in the necessary knowledge to become culturally competent in care. The respondent found this literature very relevant in providing knowledgeable bases for cultural education in nursing.

The respondent found another text book during the manual library search. This text book was very current as it had been first published in 1992 and revised several times since then. The respondent worked from the ninth edition which had been printed in 2009.

In this literature Timby (2009) dedicated a whole chapter to addressing many important criteria to consider when caring for patients of different cultures. Timby (2009) also provided information which should be collected before attempting to deal with a patient of a different culture. Timby (2009) concentrated on the following aspects with regards to educating nurses on cultural knowledge: culture, race and ethnicity as definitions, cultural assessment, biological and physiological variations, and health beliefs and practices. The respondent will now outline the material covered in each of the above categories.

- Culture, Race and Ethnicity: Timby (2009) defines culture as a set of beliefs, values, or practices. She outlines how culture is something that is learned from birth, shared with other group members, dictated by environment and resources, and that culture is ever changing. She explains how race is the biological variations within each culture. Race is determined by features such as eye colour and shape, skin colour, and hair texture, and that the most important thing for nurses to understand from race is that they should not connect it to a particular cultural group. Timby (2009) then defined ethnicity as type of bond or relationship a person feels for his/her country or ancestry.
- Cultural Assessment: in this section Timby (2009) subdivides assessment into firstly understanding and gathering the following prototypes of the patient:
  - Language and Communication: it is important to use a translator where possible. Despite a patient's ability to communicate through English, they might prefer to express themselves in their own language. Aspects such as eye contact, space and distance, touch, and emotional expression are important to comprehend also.
  - Hygiene and Clothing: certain cultures have different ways of performing their hygiene routines. For example some cultures consider one hand to be dirty and the other hand to be clean. A nurse must consider this when caring for the hygiene needs of each patient. Clothing is also important in different cultures. Some cultures require covering their hair, or certain parts of their bodies. Nurses must understand and respect these traditions (Timby, 2009, 71-81).
  - Religious and Spiritual practices: different cultures are required to pray or read from their spiritual texts at particular times of the day. To respect

the dignity of these patients cultures, the nurse must facilitate their wishes.

- Family and Gender roles: in various cultures a patient can play a different role which is dictated by their family position or gender, as a result this can influence their reactions and expressions when a nurse is assessing them. If a patient comes from a stoic background where they are in charge of their family they may appear expressionless or closed off during assessments.
- Greetings: understanding how a patient greets people is highly important. If a nurse does not understand a patient's greeting they are in threat of invading the patient's spacial and distance requirements. For example, the Shomer Negiah religion will avoid shaking hands with a member of the opposite sex.
- Food habits and restrictions: it is important that a nurse knows what food habits and restrictions a patient of another culture has. Serving a patient food they cannot eat can increase their anxiety, and possibly put them completely off eating in the hospital. For example practising people of the Jewish religion and Muslims will not eat any form of pork.
- Biological and Physiological Variations: different cultures will have different characteristics that are genetically and environmentally influenced. A nurse should be aware of these possible variations to avoid misinterpreting the variations for something they are not. An example of this is Mongolian spots in darkly pigmented children. This is hyperpigmentation on the lower back appearing to be dark-blue on inspection. This can often be confused with bruises inflicted through child abuse. Another example of a variation is yellowish sclera on darker pigmented people. This is caused by carotene and fatty deposits and should not be confused with jaundice.
- Health Beliefs and Practices: It is important to stay open-minded to the beliefs of these patients. Some patients can firmly believe in the power of herbal remedies, the Yin-Yang theory, and spiritual healing. If a nurse dismisses the idea that these practices can be beneficial then there is the possibility that they will offend, hurt, and even disrespect the patient's feelings (Timby, 2009, 71-81).

Timby (2009) appears to cover not only the possible differences from culture to culture, but also how nurses can improve their competency. She explains that ways of becoming culturally sensitive can include: learning a second language, becoming aware of possible physical differences in different ethnic groups, integrating culturally sensitive care into the patient's care plan, providing a diet that is customarily eaten, and even apologising for the lack of knowledge the nurse may have on a given culture. This literature was highly relevant in not only outlining what can be varied from culture to culture, but how a nurse can advance his/her knowledge on different cultures (Timby, 2009).

Despite only reviewing four text books, it is clear to the respondent that culture has had a role in nursing knowledge from education for many years now. The advancement of how in-depth the knowledge needs to be for nurses is evident throughout the texts. It is clear to the respondent that from Roper *et al* (1980) to Timby (2009) there is an obvious improvement in the quantity of material covered with respect to culture based nursing knowledge in education.

## **6. Methodological Discussion**

In this section the respondent will outline the methods that were chosen to conduct the thesis research. This will comprise of how the respondent collected research, analysed it, and what ethical considerations needed to be taken into account for study. The reason the respondent chose to do a qualitative thesis is because qualitative studies help researchers understand varieties of phenomena where there is little already known or explored. Qualitative studies allow the respondent to achieve new perceptions, and gain better insights into topics which would be too extensive to explore via quantitative research. Qualitative studies allow the respondent to derive a conclusion that has not come about through means of statistical analysis, or other forms of quantitative measures (Hoepfl, 1997).

## 6.1 Data Collection

There are many different methods for data collection with qualitative studies. The respondent decided to use previously published literature as the data source for this study. The data was collected manually through library searches of articles, and journals. The data for this thesis was also collected electronically through article, and journal search engines. Search engines such as EBSCO's academic search elite, and CINAHL were used for this. EBSCO is one of the world's leading databases for the finest online information. It is designed to give the latest and highest quality information to healthcare researchers. It provides articles, journals, and also eBooks (EBSCO Host, 2012).

The respondent used 'Key Words' to search for journals and articles. The chosen key words were: Pain, Pain and Culture, and Pain and Cultural Competence. Below is a table of the given findings for these key word searches.

<u>Key Words</u>	<u>EBSCO (Academic Search Elite)</u>	<u>CINAHL (With Full Text)</u>
Pain	36,133 found (search too broad)	18,660 found (search too broad)
Pain & Culture	476 found (8 selected)	209 found (4 selected)
Pain & Cultural Competence	5 found (1 selected)	19 found (3 selected)

### Criteria of included literature:

1. Empirical Studies: the respondent will only include articles and journals that are based on empirical studies. Therefore, the results of this thesis will have come about by means of observation, experiment, and experience (Dictionary.com, 2012).
2. Less than ten years old: the respondent will only select articles and journals which have been published in the last ten years. This will avoid the use of outdated materials.
3. Relevance: the respondent will only choose articles and journals that contain relevance to this thesis topic.

Criteria of excluded literature:

1. Meta-analysis Studies: the respondent will avoid using meta-analysis studies as literature. This is because meta-analysis is previous works that are then summarised. The respondent cannot summarise work that has already been summarised.
2. Literature that is too old: the respondent will not include literature that is older than ten years as this can be considered to be outdated.
3. Not relevant: the respondent will avoid using articles and journals that do not address this thesis topic.

The subtotal of articles selected was eleven, seven of these articles were from EBSCO Academic Search Elite, and four were from CINAHL With Full Text.

## 6.2 Data Analysis

For the respondent's thesis method, content analysis was used. During content analysis there are three main stages. These are preparing, organising, and then informing. During the preparation stage, material is collected, read, and interpreted. After this, the organising stage is about putting similar material into the one pile, thus dividing up the assortment of ideas from the articles, books, and journals. From this, the respondent must analyse these ideas to draw one's own conclusions, and thoughts, to convey ones understanding of the material. In the informing stage, the collected ideas, thoughts, and proposals are expressed. An advantage of content analysis is that it allows the researcher to condense large amounts of texts into a collaborated conclusion (Elos & Kyngäs, 2008).

For this the respondent researched as much information as possible to compile a comprehensive insight into the perception of pain in different cultures. During the content analysis the respondent found key words to separate different ideas, and concepts into different categories. The respondent used journals, books, articles, and any other resources found with relevance to understanding how different cultures express pain. The respondent used comparisons and contrasts to find similarities, and differences to draw conclusions from these works during the content analysis. Due to this being a qualitative study, the analysis was based on the dissection of pre-existing

studies and researches on similar topics to this study. The respondent collected data that was believed to be relevant to this study. From here, the respondent read, and began to wean away irrelevant and unhelpful data. After this, the respondent chose the most elite information, which can contribute the most towards a valuable study, and conclusion. Qualitative research is about analysing information. It is about taking the collected data, organising it, dividing it up into smaller controllable divisions, looking for patterns and similarities, finding out what can be learned from the research, and then choosing what is important to express from it to others (Hoepfl, 1997).

Qualitative studies are not based on numbers, or statistics, unlike quantitative research. Qualitative studies are about obtaining an understanding into values, norms, behaviours, motivations, cultures and/or lifestyle choices. It is about focusing on small amounts of material, or interviews, with in-depth scrutiny (QSR International, 2011)

### 6.3 Ethical considerations

Ethical considerations are put in place to ensure no-one is harmed during the duration of a study. There are many different types of ethics that need to be considered when planning a study. The main consideration is about voluntary participation. This means that all participants of a study must not be pressurised into partaking in the study/research. The next important ethical consideration is that the researcher obtains informed consent from all participants. This must outline all hazards and risks involved with the study. However, it is the researcher's obligation to avoid putting their participants into situations that might put them at risk of harm, either physically or emotionally. Another ethical consideration is to guarantee all partakers of the study confidentiality and/or anonymity. This requires that the participants remain anonymous (Social Research Methods, 2006).

There are a few ethical factors the respondent needed to consider when writing this thesis. The respondent needed to enter this research topic without any prior assumptions of the outcome. This thesis was about studying pain. As this is a broad issue, it has many influencing factors, and it is therefore important that ethically the respondent entered this analysis process without any biases. Keeping this an ethical consideration,

the respondent should have been able to avoid stereotyping, and ‘clichéing’ different cultures into generalised boxed groups.

Ethically, the respondent needs to be able to analyse, and interpret the given findings, without infringing on previous researchers conclusions. When necessary, the respondent must ask for the permission from certain researchers to use their work as references within this thesis. This eliminated the possibility of copyright, and accusable plagiarism.

Two other aspects the respondent needs to consider are fabrication, and misrepresentation. Fabrication refers to the respondent collecting data in a way other than how is outlined in the data collection section of their research. Misrepresentation refers to the respondent altering the original findings and results. To ensure the respondent avoids these concepts ethically, one must outline clearly and concisely how the data was collected, and then represent and report the given findings appropriately, without withholding any information (National Advisory Board on Research Ethics in Finland, 2011).

As the respondent is not interviewing anyone for this study, there was no need to consider the ethical issues such as participant consent, and participant confidentiality.

## **7. Conduction of the Study**

To be able to conduct this study, the respondent collect data. This data was collected over a period of approximately four weeks. Data was collected from a variety of sources such as online electronic resources, online libraries using keyword searches, and manually searching through libraries and books.

When analysing the collected data, the respondent used content analysis to catalogue it into necessary and unnecessary piles. Throughout the collected data keywords and phrases were underlined and highlighted to draw attention to these ideas as focal points of the literature.

These key ideas of each piece of data was then put together under new headings and writing sections to illustrate the respondents understandings of the data.



## 8. Presentation of results

In this section the respondent will present the results which have been found from the collected articles. These results have been collected through content analysis. The respondent has found different categories and subcategories within the analysed articles.

Each category will be supported using quotations from the collected articles. These quotations will appear between quotation marks, and also in italics. The contents of the quotations will be at times consisting of only one or two words which reinforce the respondent's findings.

In relation to the questions of interest in the aim of this study, the following head categories emerged from the analysed articles **communication of pain**, **religion**, and **sensory metaphors**. Each culture appeared to have different ways of signalling/expressing pain, and some cultures had the same ways of signalling/expressing pain.

### 8.1 Communication of Pain

Beginning with the head category communication of pain, the respondent found the following subcategories of non-verbal expression and verbal expression.

#### 8.1.1 Non-Verbal Expression

In the subcategory non-verbal expression, the respondent found the following results.

In the Somali culture, pain is often expressed by rest or through their body language. It is considered weak to express pain verbally through crying or moaning (Finnström & Söderhamn, 2006).

*“Crying and wailing are unaccepted ways of showing pain.”* (Finnström & Söderhamn, 2006, 422)

*“Pain can be communicated through body language or..... resting.”* (Finnström & Söderhamn, 2006, 422)

In the army culture, pain is very rarely expressed verbally as army recruits are trained to seldom express their pain verbally due to their ‘roughie-toughie’, and ‘no pain, no gain’ beliefs. Therefore, their pain expression tends to be non-verbal through body language (Harper, 2006).

*“Generally very quiet, saying very little.”* (Harper, 2006, 549).

*“They expressed their pain through limping or walking along rubbing the affected parts.”* (Harper, 2006, 549).

In assessing culturally diverse patients with chest pain, it was found that members of the Mexican American culture are likely to be non-verbal about pain expression (Sobralke & Katz, 2005).

*“Wincing, groaning, and grimacing.”* (Sobralke & Katz, 2005, 345)

In analysing the article on Hispanic expression of cancer pain, there was evidence also of *non-verbal expression* (Juarez *et al.*, 1998).

*“When in pain, the respondents would withdraw or moan.”* (Juarez *et al.*, 1998, 265).

*“I kind of grimace sometimes.”* (Juarez *et al.*, 1998, 265).

### 8.1.2 Verbal Expression

In the subcategory verbal expression, the respondent found the following results.

African American and Caucasian cultures tend to verbally express cancer pain through metaphors. This is to try signify where their pain is, and what it feels like. Using metaphors gives the healthcare professional an opportunity to try imagine what the patient’s pain feels like (Cleland *et al.*, 2005).

*“...Sharp, dull, hot, achy, stabbing, stiff, sore, tender, throbbing, and frozen.”* (Cleland *et al.*, 2005, 115).

There was a neuropathic pain symptom inventory carried out in the U.S., Brazil, Japan, China, Finland, and Spain. The participants from these countries verbally expressed their pain during focus groups. The participants expressed their pain through words, and also through scales (Crawford *et al.*, 2008).

*“Subjects in China typically used descriptive terms mild, moderate or severe.”*  
(Crawford *et al.*, 2008, 7).

*“The most common spontaneous descriptions were burning, electric shocks...”*  
(Crawford *et al.*, 2008, 4).

In Sweden, Swedes tend to be verbal with pain expression, either through verbally expressing how it feels, or moaning, and crying (Finnström & Söderhamn, 2006).

*“Participants working in the healthcare sector stated that Swedes complain more about their pain.”* (Finnström & Söderhamn, 2006, 422).

In the article on the study of pain in Black Caribbean and White British patients, both cultures expressed pain verbally. This expression, however, was not expressed at an equal ratio (Koffman *et al.*, 2010).

*“Nine Black Caribbean and four White British reported unabated pain.”*  
(Koffman *et al.*, 2010, 353).

*“More Black Caribbean than White British patients reported...pain.”* (Koffman *et al.*, 2010, 355).

Another example of *verbal expression* can be found in Sobralske & Katz’ (2005) article on acute chest pain. Here they found that Arab Americans are openly expressive with pain.

*“May tend to emphasize and exaggerate pain.”* (Sobralske & Katz, 2005, 345)

*“May repeat message for emphasis.”* (Sobralske & Katz, 2005, 345)

*“May use analogues or metaphors.”* (Sobralke & Katz, 2005, 345)

Despite the article on Hispanic expression of cancer pain exhibiting non-verbal pain expression it also contained *verbal expression* (Juarez *et al.*, 1998)

*“When I have pain I tell my daughter.”* (Juarez *et al.*, 1998, 265)

## 8.2 Religion

In the head category religion, the respondent found the following subcategories *explanation*, and *relief*.

### 8.2.1 Explanation

Taking explanation first, many cultures understood pain to be something their God had bestowed upon them. In the Somali culture, it is believed that Allah gives someone the burden of pain. (Finnström & Söderhamn, 2006).

*“Religion can help a person to accept pain.”* (Finnström & Söderhamn, 2006, 422).

*“If Allah has given you the burden of pain, you have to bear it with dignity.”* . (Finnström & Söderhamn, 2006, 422).

Religion was regarded as an *explanation* for pain among the Black culture in the article on pain perception (Cleland *et al.*, 2005).

*“Black patients were significantly more likely... to attribute their pain to something they had done wrong.”* (Cleland *et al.*, 2005, 117).

Religion is also an explanation for pain in the Black Caribbean culture. This is evident when they explain that being inflicted with pain is a type of test of faith (Koffman *et al.*, 2008).

*“Pain represented a trial or test of faith.”* (Koffman *et al.*, 2008, 354).

Within the Black Caribbean culture, religion was also expressed as an explanation in that pain is inflicted as punishment (Koffman *et al.*, 2008)..

*“The distress it caused them emanated from group sin.”* (Koffman *et al.*, 2008, 355).

*“An older Black Caribbean attributed his pain to that of justified punishment.”* (Koffman *et al.*, 2008, 355).

Religion as an explanation for pain was a common finding among Mexican Americans and Arab Americans in the article on chest pain (Sobralke & Katz, 2005).

First taking the Mexican American culture, they believe that pain is God’s doing.

*“Pain is God’s will.”* (Sobralke & Katz, 2005, 345).

In the Arab American culture, they believe pain can be explained by religion also.

*“Pain helps cleanse the soul.”* (Sobralke & Katz, 2005, 345).

*“Suffering shows courage and faith.”* (Sobralke & Katz, 2005, 345).

*“Pain may be seen as punishment to redeem sins.”*

In the Hispanic culture, religion is used as an explanation of pain (Juarez *et al.*, 1998).

*“The Lord wants it that way.”* (Juarez *et al.*, 1998, 265).

*“God doesn’t give you anything you can’t bear.”* (Juarez *et al.*, 1998, 265).

### 8.2.2 Relief

Under the head category religion, the subcategory relief emerged. The Somali culture believe that relief from pain can be achieved by reading religious material (Finnström & Söderhamn, 2006).

*“Some women would read from the Koran when they are in pain....believing that to relieve pain.”* (Finnström & Söderhamn, 2006, 422).

The African American culture was viewed as also using religion as a form of pain relief. The respondent found this during the analysis of the article on pain perception (Cleland *et al.*, 2005).

*“African Americans utilised more coping strategies, diverting and praying.”* (Cleland *et al.*, 2005, 117).

The Arab American culture was reported as using religion as a form of relief also (Sobralke & Katz, 2005).

*“Arab Americans may relinquish control of their pain to God or Allah.”* (Sobralke & Katz, 2005, 346).

The Hispanic culture demonstrated evidence of using religion as a form of relief for pain (Juarez *et al.*, 1998).

*“I pray the rosary daily because that makes me feel better.”* (Juarez *et al.*, 1998, 267).

*"I say 'My God help me...so that all of this will disappear..."* (Juarez *et al.*, 1998, 267).

### 8.3 Sensory Metaphors

The final head category that emerged from the respondent's analysis of the articles was sensory metaphors. Senses include sight, smell, taste, touch and hearing. Sensory metaphors will include sensations such as heat, light, and cold, typically experienced by one of our five senses. (Dictionary.com, 2012) One subcategory was viewed within this head category. This subcategory was sharp objects.

Sensory metaphors to signal/express pain occurred throughout many articles. In the article on perception of pain, African Americans, Caucasians, Koreans, and Whites were found to express pain using sensory metaphors (Cleland *et al.*, 2005).

*"Sharp, hot, stabbing, throbbing, frozen"*- African Americans and Caucasians (Cleland *et al.*, 2005, 115).

*"Heavy."*- Koreans (Cleland *et al.*, 2005, 116).

*"Sharp."*- Whites (Cleland *et al.*, 2005, 116).

Sensory metaphors are also evident in the study carried out in the U.S., Brazil, Japan, China, Finland, and Spain. Sensory metaphors were among the highest expressions of pain in these six countries (Crawford *et al.*, 2008).

*"The most frequently listed words to describe neuropathic pain were burning, electric shock, numbness, and tingling."* (Crawford *et al.*, 2008, 4).

*"Pins and needles."* (Crawford *et al.*, 2008, 4).

*"Stabbing, sharp."* (Crawford *et al.*, 2008, 6).

When reviewing the study on the army culture ‘No Pain, No Gain’, sensory metaphors were also used to signal/express pain (Harper, 2006).

*“A needle into muscle.”* (Harper, 2006, 550).

Arab Americans are quite often observed as using metaphors to express their pain in a more emphasised way (Sobralke & Katz, 2005).

*“Metaphors to express pain were seen in studies on Arab Americans.”* (Sobralke & Katz, 2005, 346).

*“A stone, a knife, a fire, and a piece of iron pulling.”* (Sobralke & Katz, 2005, 346).

Sensory metaphors to signal/express pain occurred in the article on the Hispanic culture (Juarez *et al.*, 1998).

*“Burning, pulling, sharp, strong, throbbing.”* (Juarez *et al.*, 1998, 266).

### 8.3.1 Sharp Objects

The subcategory sharp objects existed throughout the articles which had used sensory metaphors to begin with.

In Cleland *et al.*'s (2005) article on pain perception, there were examples of pain being metaphorically explained as a sharp object.

*“Sharp.”* (Cleland *et al.*, 2005, 115)

*“Stabbing.”* (Cleland *et al.*, 2005, 115)



In the study of pain symptom inventory in six countries, the subcategory sharp objects could be found throughout. Each of the six countries expressed the subcategory sharp objects at least once (Crawford *et al.*, 2008).

*“Pins and needles.”*–Japan (Crawford *et al.*, 2008, 5).

*“Heart stabbing.”*, *“Needle through heart.”* –China (Crawford *et al.*, 2008, 5).

*“Stabbing.”* –Finland (Crawford *et al.*, 2008, 5).

*“Stabbing pins on fire.”* –Spain (Crawford *et al.*, 2008, 5).

*“Sharp.”*– U.S (Crawford *et al.*, 2008, 5).

*“Piercing.”* –Brazil (Crawford *et al.*, 2008, 5).

The army culture also exhibited signs of metaphorical use of sharp objects (Harper, 2006).

*“A needle into a muscle.”* (Harper, 2006, 550).

Finally, in the Hispanic culture, there was evidence of pain being expressed metaphorically as sharp objects (Juarez *et al.*, 1998).

*“Penetrating, sharp, stabbing.”* (Juarez *et al.*, 1998, 266).

## **9. Mirroring Results**

In this section, the respondent will mirror and interpret the results of this research against the theoretical framework, theoretical background, and earlier research. The respondent will achieve this mirroring by using the categories that emerged from the analysis of the collected data as a guideline.

### 9.1 Communication: Verbal/Non-Verbal

During the respondent's research, communication (either verbally or non-verbally) emerged as a principle theme. This theme presented itself through the theoretical framework, theoretical background, and also in the respondent's earlier research. Communication is the exchange of information by means of speech, writing, or other mediums, such as body language (Oxford Dictionaries, 2012). Therefore, without communication, in any form, people would be unable to convey any form of message, feeling, or thought to one another.

Communication was addressed in Halldórsdóttir's theory (1996) on Caring and Uncaring Encounters. According to Halldórsdóttir, communication can be approached in two ways, either opening (the bridge), or in a closed negative manor (the wall). Halldórsdóttir's theory focuses on improving patient-nurse interaction. She believes that a caring encounter must be a competent one. As a result, competence of someone's choice of communication, due to culture is mandatory. If a nurse is caring for a stoic patient, they must be aware that although they do not communicate pain verbally the patient may have pain. Halldórsdóttir's theory is about connecting with others, and being open, and sensitive to patients needs. To mirror this against the finding, the respondent would draw the conclusion that the nurse should be aware, and connected to the needs that the patient does not communicate verbally, but rather non-verbally. This can be achieved by watching the patient's facial expressions for grimacing, or frowning, and also watching for other signals of pain, such as withdrawing from social interaction. Halldórsdóttir's theory outlines how societal factors and hidden dimensions of the patient, and their culture, must be considered to avoid an approach that could be considered 'uncaring' in care delivery (Halldórsdóttir, 1996).

In the theoretical background, the respondent outlined the definition of pain. In this section, the respondent described how pain can be expressed verbally through expressing to the nurse different characteristics of their pain, such as location, continuance, and intensity. This approach to care is only appropriate for patients that are verbal with their expression of pain. As the respondent has discovered through analysis of articles, not every culture will express pain verbally. The Somali culture was an example of this. In the Somali culture it is considered inappropriate to complain about pain, or express it verbally. As a result, people of the Somali culture are likely to give

inaccurate results with regards to pain characteristics. They believe pain can only be communicated to others through body language, or by resting (Finnström & Söderhamn, 2006).

In the theoretical background, the respondent included the definition of culture. In this section the respondent outlined that culture influences how pain is perceived, communicated, and interpreted. This is because a person will learn from their culture how to behave, and think in certain situation. This section of the theoretical background support findings in the analysis of articles. This was due to this definition highlighting how every aspect of a person's being is influenced by their culture. A person's choice of communication skills is one of these cultural aspects (Briggs, 2012).

In the section 'Pain Assessment as a tool for Pain Management', the respondent defined how culture plays a vital role in the influence of how a patient chooses to express their pain. In this section the respondent stated how pain expression is highly unique to how a person has been raised, or what type of culture they have been raised in. Their culture can be stoic, expressive, or in between the two. In the results of the article analysis, this point was very evident. Also, within the section on 'Pain Assessment as a tool for Pain Management', the respondent found certain criteria that can be considered barriers to sufficient pain assessment. If a person comes from a culture where it is considered inappropriate to express pain, then a pain assessment will be a barrier for them. This barrier can be found throughout many different cultures, the army culture being one. It is considered improper to express pain, therefore, during a pain assessment members of the army culture will score little or nothing as they are not allowed to communicate pain. Instead of communicating pain verbally, they are more likely to become quiet, and say very little (Briggs, 2010).

In the respondents earlier research, many aspects of communication in different cultures were addressed. An example of this was in Leininger and Mc Farland's (2002) ten step guidelines. The fourth step of these guidelines, communication of different cultures was addressed. The fourth step states if there is a language barrier between the patient and the nurse, then the quality of care will diminish. This also highlights the importance of understanding the different varieties on communication in different culture. Nurses need to remember that communication is not just what they witness verbally, but also what they see non-verbally (Leininger & Mc Farland, 2002).

Another section in the respondent's earlier research addressed how role and status can affect how a patient chooses to communicate pain, either verbally, non-verbally, or not at all. If a patient plays the role of the sole caregiver in a family, then this patient may choose to have a stoic approach to communication to avoid worrying their other family members (Roper *et al.*, 1980). The respondent found during the analysis that to help avoid the expression of pain, African Americans will divert their expression of pain by keeping busy with activities or by praying (Cleland *et al.*, 2005).

In the section in earlier research, the respondent found literature in Timby (2009) which referred to language and communication. This portion of the Timby (2009) literature was based on assessment. It discussed how language skills can affect assessment of pain. This literature covered how a nurse may analyse eye contact, space and distance, touch, and emotional expression to understand a patient's pain during assessment. This was highly relevant in relation to understanding a culture. As the analysis of the articles displayed, patients will not always express pain verbally. As Timby (2009) illustrates, a nurse must observe other aspects of a patient, not merely their vocalisation of pain. As the Mexican American culture demonstrated in the article analysis, they will not verbalise pain, they are more likely to wince, groan, or grimace. (Sobralске & Katz, 2005)

## 9.2 Religion: Explanation/Relief

During the respondent's research, religion either as an explanation or form of relief, emerged as a theme. This theme not only presented itself throughout the analysis of the collected articles but also in the theoretical framework, theoretical background, and in the respondent's earlier research. Being that culture can be defined as a group of people sharing the same beliefs, values, norms, moral codes, lifestyle choices, characteristics, and mannerisms according to Galanti (2008), it is inevitable that religion would emerge as a dominant theme throughout the respondent's research and analysis.

Religion first can to light as a theme in Campinha-Bacote's theory 'The Process of Cultural Competence in the Delivery of Healthcare Services'. In Campinha-Bacote's model (2001), she stated the importance of cultural awareness. Within this model she highlighted the relevance of the nurse being aware of their own values, beliefs, and

practice. This can heighten the delivery of care. If a nurse is aware of their own beliefs, for example spiritually or religiously, then they can be open and more aware of the practices of others (Campinha-Bacote, 2001).

In the section 'Definition of Culture', the importance of understanding that culture influences pain is emphasised. The respondent found this result due to discovering that culture can influence how pain is perceived, and what meanings are attached. This can influence whether or not a person would believe that God has inflicted this pain on them. During the article analysis, the respondent found that in the Hispanic culture, they perceive that God bestows pain upon them. People of the Hispanic culture often perceive that God gives them pain, and that God would not give them pain if He did not believe they could bear it (Juarez *et al.*, 1998).

In the section of this research on 'Pain Assessment as a tool for Pain Management', the respondent discovered that religion can affect how a patient will express their pain during an assessment. If a patient is from a culture where they believe God has given them pain, they are often quite stoical about their pain expression. This is because the patient feels it is not his/her duty to complain when this pain has been inflicted for a reason (Briggs, 2010). As the respondent identified in the analysis of the articles, some members of the Black Caribbean culture will not express their pain. This is because they believe pain is a test or trial of faith imposed on them by God (Koffman *et al.*, 2008).

Another section of 'Pain Assessment as a tool for Pain Management' that the respondent believed to be mirrored quite well was the Mc Gill Pain Questionnaire. This question is divided into many sections, two of these sections being fear, and punishment. This questionnaire serves as a highly relevant tool in assessing what meanings a patient attaches to pain. The Mc Gill Pain Questionnaire gives the patient an opportunity to divulge possible reasons as to why they express or hide their pain (Melzack, 1975). In the analysis of collected articles, the respondent found that Arab Americans connect their pain with religion and punishment. They believe that pain is a form of punishment to redeem oneself from sins (Sobralke & Katz, 2005).

In the section 'Cultural Competence in Nursing', the respondent focused on the importance of the nurse understanding that each culture expresses illness and health in a

different way. This is because illness and health are highly dictated by culture as culture is beliefs, values, and traditions. In respect to this, religion will be an assured constituent to pain expression as religion is a form of a belief, or value (Kim-Godwin *et al.*, 2001).

In the respondent's earlier research, Roper *et al.* (1980) highlighted how expression of pain is deeply rooted in cultural beliefs, such as religion. This is because cultural beliefs and expression are learned mannerisms. A patient will learn how to explain or relieve pain through how other members of their culture explain or relieve pain. The Somali culture have utilised a pain relief strategy that they believe works as they have watched other members of their culture use it. This strategy is reading from the Koran to relieve their pain (Finnström & Söderhamn, 2006).

In the earlier research the respondent discovered a mirroring result in Long *et al.* (1995). Long *et al.* (1995) believed that some cultures believe that chronic illness is linked to God testing them. This religious idea was thematic throughout the respondent's research. The Somali culture declare that if Allah gives them pain then they should bear it with dignity (Finnström & Söderhamn, 2006).

### 9.3 Sensory Metaphor: Sharp Objects

In the respondent's analysis, sensory metaphors emerged as a theme. This theme presented itself predominantly in the article analysis. Despite this, the reason behind different cultures using sensory metaphors to express pain was addressed in the theoretical background, and earlier research.

In the section on the 'Definition of Culture', the respondent found that culture influences how pain is communicated and interpreted. This denotes that each culture will choose different words, and expressions to illustrate their pain (Lovering, 2006).

In the respondent's earlier research, it was found that Mc Farland's work (2002) focused on drawing attention to avoiding stereotypes in different cultures pain expression. An example of this was given in Crawford *et al.* (2008) study. The Chinese culture

described their pain as a ‘needle through heart’ (Crawford *et al.*, 2008). It is important that nurses not take this interpretation literally, or consider their patient to be highly expressive. Crawford *et al.* (2008) pointed out that the Chinese culture refers intense pain to the heart. This is because the Chinese culture believes the heart to be the most sensitive part of the body, and therefore, the most susceptible to pain, and pain expression (Crawford *et al.*, 2008).

In the section ‘Definition of Pain’, the respondent noted that pain is a complex, and private issue (Loving, 2006). Therefore, pain can only be made public through communication. Since a nurse cannot understand fully what type of pain a patient is experiencing, or the quality of the pain, it is possible that certain culture will use sensory metaphors to try exemplify the pain they are experiencing. Every person in every culture can experience senses, such as smell, touch, and taste etcetera (unless they are born without one of these senses). When a patient chooses to express oneself using sensory metaphors, it maximises the chances of the nurses understanding what the patient is experiencing. When the army culture, for example, describes pain as a needle into their muscle, they are using needle to imply the pain is sharp. Being pricked by a needle is an experience many nurses can relate to.

## **10. Critical Review**

In the following section critical review, the respondent used the guidelines for credibility, auditability, and fittingness outlined in the Streubert and Carpenters book ‘Qualitative research in nursing: advancing the humanistic imperative’.

When a researcher is writing a qualitative study, his/her phenomenon of interest must be unmistakably defined. The researcher must distinguish why a qualitative approach is required to understand and evaluate this phenomenon. It is imperative that the researcher also make his/her purpose for conducting this study distinctive. The researcher must also outline the projected importance of the study to the nursing profession (Streubert & Carpenter, 1999, 118).

The aim of this study was to describe the expression of pain in patients of different cultures. The respondent also wished to discover how nurses can provide culturally

competent pain assessment. This study was carried out with respect to learning more about the expression of pain in different cultures. A qualitative approach was taken in order to achieve a more thorough understanding of this phenomenon. The respondent's research was based on Halldórsdóttir's theory about 'Caring and Uncaring Encounters in Nursing and Health Care', and Campinha-Bacote's theory on 'the process of cultural competence in the delivery of healthcare services'. The conclusion of this research can be helpful in distinguishing possible expressions of pain in patients of different cultures.

Streubert and Carpenter (1999) outlined that the chosen method, for data collection during research, must correspond with the intended purpose of the study. The chosen method must also address the research topic appropriately. The method of research must guide the study accordingly, and following the research process as described by these guidelines (Streubert & Carpenter, 1999, 118).

The purpose of this research was to understand cues of pain in different cultures, outline how different cultures express pain, and outline how nurses can be culturally sensitive towards different patients needs. The respondent chose articles to analyse through content analysis as the method for data collection of the study. These articles were selected from the article search engines EBSCO Academic Search Elite, and from CINAHL with full text. During sample collection, the respondent must select samples which are considered to be the most purposeful to the study. The sample must aim to inform the respondent appropriately on his/her given topic. The respondent must outline the procedure used for data collection. When the respondent analyses the collected data, the respondent must state the strategies used to analyse the data. During data analysis, the respondent must remain truthful to the data. The respondent must address the findings from the analyses, and then assess the data's credibility, auditability, and fittingness (Streubert & Carpenter, 1999, 66).

The respondent focused on the analysis of collected articles. Data was collected through the search engines EBSCO Academic Search Elite, and from CINAHL with full text. The respondent searched these search engines using the keywords; pain, pain and culture, and pain and cultural competence. A total of 54,793 articles were found, 36,133 from EBSCO, and 18,660 from CINAHL. These articles were then further narrowed down into a total of eleven articles. The selection of 11 articles from 54,793 was achieved through using including and excluding criteria. The including criteria was



empirical studies only, articles less than ten years old, and articles of relevance to the study topic. The excluding criteria was meta-analysis studies, literature that was more than ten years old, and articles that were not relevant to the chosen study topic. The eleven articles consisted of seven articles from EBSCO Academic Search Elite, and four articles from CINAHL with Full Text. The main reason that only eleven articles were chosen was because the respondent wished to focus on the topic of culture as a group of people sharing beliefs, values, norms, moral codes, lifestyle choices, characteristics, and mannerisms that they have learned through a member of this group/society (Galanti, 2008, 6). Many of the articles originally found through EBSCO Academic Search Elite, and from CINAHL with full text focused on culture with respect to skin colour, or geographical location.

The respondent input all the articles onto the computer. This was made into spread sheets in Microsoft Word, and each article was categorised under the follow headings; bibliography, method used, data, and results. The respondent then analysed these findings inductively. During the analyses of the collected data, the respondent noticed that some of the articles didn't correlate whatsoever with the aim of the study. Another problem the respondent incurred during the data analysing was that some of the articles had very different interpretations of what culture is. This often made it difficult for the respondent to make categories, or draw conclusions which would combine the eleven articles collectively. As a result, the respondent could not make a direct incorporation of all the articles merged into one category. If the respondent had found a larger supply of relevant articles, then the categories may have been denser, with more conclusive findings.

Streubert and Carpenter (1999) declare that the researcher must assess the credibility, auditability, and fittingness of the collected data when analysing for a study. Credibility is defined as how trustworthy the findings of qualitative research are. It can be displayed when the participants can familiarise themselves with the reported findings. Auditability refers to another researcher having the ability to comprehend the methods and conclusion of the original researcher. Fittingness is a term that is used in qualitative research to testify the probability that the research results have relevance and meaning to other people in similar situations. Fittingness refers to how meaningful a study can be to someone outside of the research (Streubert & Carpenter, 1999, 329, 330).

During the respondent's analyses of the collected data, the credibility of this study has not been fully addressed. To fully address the credibility of this study the respondent would have needed to have face to face interviews with the participants of the studies from the collected articles. This would have given the participants an opportunity to reflect on the material and confirm if it correctly represented how they feel about pain, and if the participants could familiarise themselves with the results. Due to the small selection of data, the respondent's results are not completely credible. This is because this data is only a minor representation of the larger population.

The respondent aimed to distinguish categories, represent, and analyse the collected data in the most appropriate way to ensure the original data would persist intact, without alterations. As a result, the collected data has been represented, and referred to in its authentic state. The respondent has not included anything that did not exist in the collected data. After the respondent drew categories from the collected data, quotations have been used to illustrate, and support these results.

The respondent created the results of this study by calculating one main theme from the analysed data, which was addressed from the aim of the study. There were three head categories that emerged from the selected articles, and five subcategories. The respondent aimed to describe these categories in such a way that the reader can clearly comprehend the results. The data was analysed, keeping in mind the respondent's questions of interest 'how can nurses identify signals/expression of pain in a patient?' and 'do nurses need to provide culturally competent pain assessment?'.

The results of this study can be used within the context of understanding the variation in signals/expression of pain in a patient of a different culture to the nurses own culture. This research is significant in understanding the importance of diversity in expression of pain among patients of different cultures, and for developing a variety of approaches to care of culturally diverse patients. Further studies of signals/expression of pain in different cultures may serve a meaningful purpose to nurses caring techniques for patients of different cultures. Overall, further studies of the signals/expression of pain in different cultures may be meaningful in the advancement of cultural competence, and culturally competent care.

## 11. Discussion

The aim of this study was to describe the expression of pain, in patients of different cultures. The aim was also to understand, and interpret different cultures perception and expression of pain. The understanding aimed to embrace the multifarious needs of each patient, as with different cultures there are different approaches required for care. This was carried out to understand the cues of pain in different cultures, outline how different cultures express pain, and illuminate how a nurse can be culturally sensitive towards different patients needs. The study aimed to enhance understanding of different cultures, in order to have a vastly crucial influence on the standard of care given to culturally diverse patients. The questions of interest were: how can nurses identify signals/expression of pain in a patient, and do nurses need to provide culturally competent pain assessment?.

The respondent chose online search engines to collect the data for this study. The respondent felt this was the most appropriate way to collect data, as excluding criteria could be applied to the search to find the most relevant literature. Limits were put on the searches. An example of one limit put on the searches was that the articles could not be more than ten years old.

The respondent analysed the collected data using content analysis. Content analysis was used to gain a better understanding of the articles, and the cultures that were being expressed through these articles. The results of the content analysis can be correlated to the theoretical framework, theoretical background, and earlier research of the respondent. As a result, the respondent's findings can be considered meaningful in the recognition of the importance of understanding that each culture expresses pain uniquely.

In the results of the article analysis, the respondent found that pain can be communicated verbally, and non-verbally. Depending on the type of culture a patient comes from, they may have learned to express pain either expressively and open, or stoically and privately. Within the respondent's results, the communication of pain was generally divided equally between verbal and non-verbal expression. The respondent believes this proves that there is need for increased knowledge in the nursing education, on how different cultures can express pain. This finding also indicated that nurses need to provide culturally competent pain assessment as with each culture comes a different

expression of pain, such as verbal or non-verbal. A nurse's pain assessment must accommodate this. It is required that a nurse delivers a high quality of care, but if she/he cannot identify pain in a non-verbal stoic patient, then her/his care cannot be delivered at a high standard.

Within the respondent's results, religion emerged as a characteristic related to pain in certain cultures. Religion was used as an explanation for why some culture believed they were experiencing pain. Religion was also used as a form of relief of pain. The spiritual choices, and beliefs of some of the cultures in the analysis, demonstrated how important it is for a nurse to have a level of cultural competence towards different cultures. The nurses must have cultural awareness, cultural knowledge, cultural encounters, cultural skill, and cultural desire to obtain this cultural competency. Without this understanding, it is inevitable that nurses will not be caring for their patients in a holistic manner.

As the world is becoming more multicultural every day, every country is becoming more culturally diverse. This changing diversity challenges nurses with a need to provide culturally competent care. Nurses must expand their knowledge on cultures, and their practices, and how different cultures express pain. Without this understanding, nurses are likely to misdiagnose certain situations. The respondent's results indicated how some cultures will not express pain verbally, but merely by grimacing. The respondent also found that certain cultures will also not express pain verbally when they believe that the pain they are experiencing has been inflicted by their God, for one reason or another. As a result, the respondent found that nurses need to embrace education on different cultures in order to expand their ability to interpret different culture's cues of pain. Concurrent with this, there is substantial evidence in the respondent's findings that indicates that nurses must provide culturally competent pain assessment.

Outgoing from these findings, the respondent believes that there is not enough education on the variance of expressions of pain in different cultures, in nursing. This lack of education will inescapably lead to discrimination, stereotypes, and reductionism in certain nurse-patient encounters.

A dominant finding of this study for the respondent was that the nursing education should be more open, and willing to change the curriculum inclusions to further

improve the knowledge of the nurses, and thus improve the quality of their care. Pain assessment should not be generalised for every culture, as with each culture comes unique pain expressions.

As a result of this study, the respondent feels that alterations could be made to the nursing education, to offer more culturally directed studies. This would expand the scope of a nurse's understanding of a patient's culture. As a finding of the respondent's analysis, this small alteration to the nursing education would vastly improve the quality of care given to patients of many different cultures. With this improvement in the nursing education, nurses would be able to identify signals/expression of pain in a patient, and in return they would be able to provide culturally competent pain assessment. This study has provided an insight into the perception of pain in different cultures, which the respondent believes is a component which is still absent from education for nurses.

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Enclosure 1

03/03/2012

Hello,

Thank you for your kind comments regarding my works. Please do feel free to quote from my book on my model of cultural competence or use it as a framework, by referencing it with my name and textbook title, year per APA guidelines of referencing. If you are requesting to copy my pictorial/graphic or mnemonic models of cultural competence, please note that they are copyrighted and I do not grant permission to copy them, but rather you can put my website's link in your paper, for my models appear on my website at [www.transculturalcare.net/Cultural\\_Competence\\_Model.htm](http://www.transculturalcare.net/Cultural_Competence_Model.htm).

Thank you for your understanding and I wish you the best in your thesis. Please do not hesitate to contact me if you have any further questions about use of my works.

Blessings,

Josie

Contact Information:

Josepha Campinha-Bacote, PhD, MAR, PMHCNS-BC, CTN-A, FAAN

President, Transcultural C.A.R.E. Associates

11108 Huntwicke Place

Cincinnati, Ohio 45241

Ph: 513-469-1664

Fax: 513-469-1764

Email: [meddir@aol.com](mailto:meddir@aol.com)

Website: [www.transculturalcare.net](http://www.transculturalcare.net)

Enclosure 2

02/03/2012

Dear Grace,

Thank you for your e-mail. Please find attached a copy of the tool in pdf format for use in your thesis. You have my permission (as the original author) to reproduce this image in your thesis on behalf of the Royal Brompton & Harefield NHS Foundation Trust. Please use the following wording in your thesis: **Reproduced with permission of Royal Brompton & Harefield NHS Foundation Trust 2009.**

This is the standard tool that we use to assess and document nociceptive pain after surgery. I would suggest that you read the following chapter: Brown D (2009) Pain assessment. In Cox F (Ed) Perioperative Pain Assessment. Wiley-Blackwell, Oxford

You can also access pain tools in a variety of scripts and languages at:  
[http://www.britishpainsociety.org/pub\\_pain\\_scales.htm](http://www.britishpainsociety.org/pub_pain_scales.htm)

With best wishes

Felicia Cox

Felicia Cox - Lead Nurse in Pain Management

Head of Pain Services

Royal Brompton and Harefield NHS Foundation Trust

Harefield Hospital, Hill End Rd, Middx UB9 6JH

Telephone: (0)1895 828 538 or (0)1895 82 3737 bleep 6144

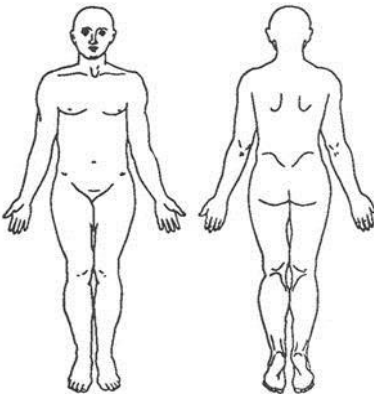
Email: [f.cox@rbht.nhs.uk](mailto:f.cox@rbht.nhs.uk)

Enclosure 3

The McGill Pain Questionnaire. The descriptors are divided into four main categories: sensory (S), 1–10; affective (A), 11–15; evaluative (E), 16; and miscellaneous (M), 17–20. The value for each category is based on the word set position. The sum of all the values is the pain rating index (PRI). The present pain intensity (PPI) is ranked on a scale of 0–5. Copyright 1975 Ronald Melzack.

McGILL PAIN QUESTIONNAIRE		
RONALD MELZACK		
Patient's Name _____ Date _____ Time _____ am/pm		
PRI: S _____	A _____	E _____
(1-10)	(11-15)	(16)
M _____ PRI(T) _____ PPI _____		
(17-20) (1-20)		

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<u><b>Bibliography</b></u>	<u><b>Method Used</b></u>	<u><b>Data</b></u>	<u><b>Results</b></u>
<p>Chakravarty, A., Mukherjee, A., &amp; Roy, D. (2007) Migraine Pain Location at onset and during established headaches in children and adolescents: a clinical-based study from eastern India. <i>Cephalalgia</i> 27(10): 1109-1114</p>	<p>-Interview on 262 participants between 7-15 years.</p> <p>-One or both parents must attend.</p> <p>-<u>First visit</u>: consultant evaluates to confirm migraine, and exclude underlying conditions.</p> <p>-<u>Second visit</u>: approx. 1 week later, evaluated with a loose structured questionnaire. This assesses location/onset.</p> <p><u>Third visit</u>: approx. 1 month later, same questions asked by a trainee interviewer.</p> <p>After these 3 visits an opportunity to review each answer was given to the patient.</p>	<p>-Neurology out-patient clinic in Calcutta, India.</p> <p>-262 subjects (age 7-15years).</p> <p>-Two migraine attacks/month for 6 months.</p> <p>-On no form of prophylactic medication.</p> <p>-First 200 subjects with repeated consistency of location and onset were chosen.</p>	<p>-Ratio of male to female was 118:82. ∴ in India migraines appear to be a male dominant disease.</p> <p>-Migraine was diagnosed if the headache lasted &gt;1hour.</p> <p>-Migraine aura was very rare in India, in comparison to Western studies.</p> <p>-Ethnicity showed adequate evidence in studying migraines in India compared to western studies.</p>
<u><b>Bibliography</b></u>	<u><b>Method Used</b></u>	<u><b>Data</b></u>	<u><b>Results</b></u>
<p>Cleland, J., Palmer, J., &amp; Venzke, J. (2005) Ethnic Differences in</p>	<p>-Literature research.</p> <p>-Pain assessments used: McGill</p>	<p>-CINAHL &amp; MEDLINE databases.</p> <p>-&lt;20years old sources.</p>	<p>-Ethnic difference in pain descriptors, &amp; quality.</p> <p>-African-American and Caucasian: cancer pain= sharp, hot, dull, achy, sore, stiff.</p>

<p>Pain Perception. <i>Physical Therapy Review 10(2): 113-122</i></p>	<p>Pain Questionnaire, Word lists, McGill-Melzack Pain Questionnaire, List of descriptors, Pain rating scales, surveys.</p>	<p>-Keywords: pain, culture, ethnicity, race, clinical trials.</p> <p>-Primary sources, original data. -42 articles under the given keywords were limited to 22 by suitability.</p> <p>-Excluded: studies investigating effect of stimuli.</p> <p>-Included: data relevant to clinical pain.</p> <p>-Categories (Pain=p): p. Quality, p. Intensity, p. Prevalence, p. Behaviours, patient/caregiver estimate of pain.</p>	<p>-A.A and Cau. most often use ‘nagging’ for hip/knee osteoarthritis.</p>
<p><b><u>Bibliography</u></b></p>	<p><b><u>Method Used</u></b></p>	<p><b><u>Data</u></b></p>	<p><b><u>Results</u></b></p>
<p>Crawford, B., Bouhassira, D., Wong, A., &amp; Dukes, E. (2008) Conceptual Adequacy of the Neuropathic Pain Symptom Inventory</p>	<p>-Data was collected from 132 subjects in 6 countries.</p> <p>-Qualitative research methods used.</p> <p>-U.S, Brazil, Japan, China, Finland, &amp; Spain.</p>	<p>-Inclusion criteria: 18years or above, diabetic peripheral neuropathy, post-herpetic neuralgia, trigeminal neuralgia, or sciatica.</p> <p>-Exclusion criteria: mental illness, cognitive impairment, severe mental retardation, schizophrenia, and clinical</p>	<p>-U.S: 72% Caucasian, 8% African American, 11% Hispanic/Latino, 3% other.</p> <p>-Ethnicity not collected in other countries.</p> <p>-Most frequently used words: “burning”, “electric shock”, “pins and needles” &amp; “tingling”.</p> <p>-Least used words: “squeezing” (only in</p>

<p>in six countries.</p> <p><i>Health and Quality of Life Outcomes 6 (62):</i> 1-8</p>	<ul style="list-style-type: none"> <li>-All suffered from neuropathic pain from nerve lesions or nerve damage.</li> <li>-Each filled out a neuropathic pain symptom inventory (NPSI).</li> <li>-Focus groups were carried out after the NPSI's. 8-10/group.</li> <li>-Subjects were recruited through pain specialists &amp; recruitment agencies.</li> <li>-Informational letter sent to all.</li> </ul>	<p>depression.</p> <ul style="list-style-type: none"> <li>-Before the study began informed consent was given, background demographics, &amp; pre-focus group questionnaires.</li> <li>-Each participant was asked to list 5 terms to describe their pain.</li> <li>-Trained moderators conducted the groups, semi-structured discussions.</li> <li>-Focus groups were audio/video recorded.</li> <li>-Groups consisted of concentrating on concepts, and content validation.</li> <li>-Transcripts were produced from audiotapes, verbatim sections were analysed.</li> <li>-Japanese, Spanish, Portuguese, and Chinese: transcribed to native language, and then into English.</li> </ul>	<p>Finland), &amp; “pressure” (never mentioned in Brazil).</p> <ul style="list-style-type: none"> <li>-China used: “heart stabbing”, “needle through heart”, “tremble”, and “bursting”. None of these are literal, but pain is linked to the heart because the Chinese believe this to be the most sensitive part of the body.</li> <li>-Spain used a combination of pins and needles, and stabbing= “stabbing pins on fire”.</li> <li>-U.S was the only place to mention “sharp”.</li> <li>-China had difficulty expressing pain as they do not express it on a numerical scale.</li> <li>-Numbness was mentioned but this should be a non-pain as it is linked to paresthesia.</li> <li>-Itchiness was mentioned but is not a true pain descriptor.</li> <li>-Subjects across different etiologies have described their pain slightly differently.</li> <li>-The study suggests there is only a small impact on how different cultures express neuropathic pain.</li> </ul>
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<b><u>Bibliography</u></b>	<b><u>Method Used</u></b>	<b><u>Data</u></b>	<b><u>Results</u></b>
<p>Finnström, B. &amp; Söderhamn, O. (2006) Conceptions of Pain among Somali Women. <i>Journal of Advanced Nursing</i> 54 (4): 418-425</p>	<p>-Conversational interviews.</p> <p>-Qualitative content analysis.</p> <p>-Interviews were taken with nine Somali women from 2002-2003.</p> <p>-The researches needed to consider how these women were probably integrated into the Swedish society/culture as they had lived in Sweden for 6 years or more.</p> <p>-The researches needed to keep in mind that their own cultural beliefs and values can influence their findings.</p>	<p>-Nine Somali women (S.W) took part in focused conversational interviews.</p> <p>-The nine Somali women lived in western Sweden for 6 or more years.</p> <p>-3 S.W=recruited while their children were in hospital. 2 S.W=members of the S.W network. 3 S.W were friends/relatives of others recruited. 1 S.W worked as a cultural interpreter in Sweden. (9)</p> <p>-Including criteria= each</p>	<p>-Study concluded that the NPSI is effective in measuring neuropathic pain in different cultures.</p> <p>-Pain was difficult to explain, even when an interpreter was involved.</p> <p>-Some S.W believed pain is a physiological matter, not connected to emotions. Other S.W believed it involves body and mind.</p> <p>-S.W related pain to physical sources: childbirth, cuts, sores, infections, and poisoning.</p> <p>-In Somali, pain (“xanuun”) means discomfort and illness, <u>not</u> just pain.</p> <p>-Answering healthcare professionals questions about pain can be difficult because of this.</p> <p>-When asked to give a pain example only 2 S.W mentioned female circumcision. This can be because it is too difficult to acknowledge.</p> <p>-Some S.W described sadness and worry as a source of pain.</p> <p>-All S.W dismissed emotions as causing pain.</p> <p>-The S.W believed can be communicated by: 1.Body language. 2.Resting.</p>



		<p>women needed to have at least 1 child, enough language to have a flowing conversation in Swedish.</p> <p>-The age group obtained was 28-38 years.</p> <p>-Interview topics: cause of pain, pain behaviour, and how pain can be alleviated.</p> <p>-Example question: ‘what does pain mean to you?’.</p> <p>-Interviews were 60-90minutes and recorded. Then transcribed verbatim and analysed.</p> <p>-Quotes were translated into</p>	<p><u>-S.W agreed they are taught to be stoical about pain.</u></p> <p>-S.W believed: crying or moaning is weak, and one should control themselves and tolerate pain.</p> <p>-Religion can help people accept pain.</p> <p>-S.W endure pain=their culture/society says they should be brave, have courage, and value endurance.</p> <p>-S.W observed Swedes complain about their pain more than Somalis.</p> <p>-From 6yrs+ Somalis should hide procedural pain. Ex: pain from blood tests should be tolerated.</p> <p>-Relieving pain= 1.Read from Koran. 2.Rest to relieve. 3.Keep family close. 4.Use red-hot needles or herbs.</p> <p>-Tolerating procedural pain makes you strong and brave. This makes them highly valued in their opinions.</p> <p>-If an injury is not dangerous then it is not painful.</p>
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		<p>English.</p> <p>-Written consent: after oral and written information was given. Participation was voluntary, and confidential. Identity numbers were used to report.</p>	<p>-Culture plays an important role in a person's attitude towards pain.</p> <p>-S.W believed that nurses need to improve their cultural competency so they can understand and interpret cues of pain more accurately.</p> <p>-Family is a strong source of pain relief for Somalis.</p>
<b><u>Bibliography</u></b>	<b><u>Method Used</u></b>	<b><u>Data</u></b>	<b><u>Results</u></b>
<p>Harper, P. (2006) No Pain, No Gain: pain behaviour in the armed forces. <i>British Journal of Nursing</i> 15(10): 548-551</p>	<p>-Ethnographic data collected via individual and group interviews.</p> <p>-Confidentiality, and opportunity to opt out, none did so.</p>	<p>-8 British Royal Armed Force personnel.</p> <p>-Interviews were carried out after training, such as: navigational exercises, and timed orienteering.</p> <p>-Most interviews were carried out at night after the days training was over.</p>	<p>-Verbally expressing pain was rare.</p> <p>-Descriptions was more about pain intensity: 'my feet are really sore'.</p> <p>-Tiredness/ exhaustion more expressed than aches or pains.</p> <p>-After physical activity, participants were very quiet.</p> <p>-No verbal complaining but limping was observed.</p> <p>-Males used metaphors: 'a needle into the muscle'.</p> <p>-Tasks were expressed as distracting from the pain.</p>

		-Continually assessed.	<p>-No real pain behaviour was witnessed or expressed that would be considered unacceptable in the military.</p> <p>-Behaviour supported the ‘no pain, no gain’ culture of RAF.</p> <p>-‘Roughie-Toughie’ culture was also witnessed.</p> <p>-Personnel were rather stoic, expressing pain rarely.</p>
<b><u>Bibliography</u></b>	<b><u>Method Used</u></b>	<b><u>Data</u></b>	<b><u>Results</u></b>
<p>Juarez, G., Ferrell, B., &amp; Borneman, T. (1998) Influence of Culture on Cancer Pain Management in Hispanic Patients. <i>Cancer Practice Journal</i> 6(5): 262-269.</p>	<p>-Qualitative methodology</p> <p>-Systematic collection</p> <p>-Content analysis of subjective materials</p> <p>-Semi-structured interviews</p> <p>-Interviews transcribed verbatim.</p>	<p>-Subjects collected from 3 home health &amp; hospice agencies.</p> <p>-17 interviews.</p> <p>-Criteria: Spanish as main/only language, cancer diagnoses, cancer pain more than 2 weeks, living at home, self-identified as Hispanic/Latino.</p>	<p>-Hispanics believe pain to be: (1) predetermined by God. (2) your obligation to endure it. (3) accepted and anticipated. (4) accepted stoically. (5) alleviated by balance. (6) a consequence of bad/abnormal behaviour.</p> <p>-Hispanics seek advice about pain from: healers, family, friends, neighbours, pharmacists, &amp; God.</p> <p>-Hispanics express pain:  (1) Anatomically: ‘in my foot’.  (2) Through other symptoms: nausea  (3) Using pain scales: 1-10  (4) Telling loved ones  (5) Behaviour: stop socialising  (6) Through God: Praying</p>

	<p>-Interviews were transcribed from Spanish to English.</p> <p>-1125 pages of data was collected from 17 participants.</p>	<p>-Written consent obtained.</p> <p>-Interviews conducted at home, with a family member present.</p> <p>-Hispanic Pain Experience Questionnaire (HPEQ) was also used (open end questionnaire).</p>	<p>(7) Descriptions: burning, stabbing, aching, severe, intense, sharp, prickly, penetrating.</p> <p>-Hispanics often seek nondrug interventions first: prayer, home remedies, ointments, vitamins, herbs, tea.</p> <p>-Hispanics consider pain to be God's will, and it must be endured.</p>
<b><u>Bibliography</u></b>	<b><u>Method Used</u></b>	<b><u>Data</u></b>	<b><u>Results</u></b>
<p>Koffman, J., Morgon, M., &amp; Higginson, I. (2008) Cultural Meaning of pain: a qualitative study of Black Caribbean and White British patients in advanced cancer. <i>Palliative Medicine</i> 22(4): 350-359</p>	<p>-Qualitative interviews.</p> <p>-26 Black Caribbean (B.C) and 19 White British (W.B) cancer patients interviewed.</p> <p>-Patients that might be provoked/distressed/unable to give informed consent were excluded.</p> <p>-Oncology outpatients clinics, lung clinics, and palliative care clinics are where the participants were selected from in London.</p>	<p>-Informal/loosely structured interviews and discussions were used.</p> <p>-29/45 interviews were carried out in the participants homes, 16 were carried out at in-patient hospital settings.</p> <p>-Interviews were tape recorded, ranging from 20-60minutes.</p> <p>-Names of participants were changed.</p>	<p>-23/26 B.C and 15/19 W.B had cancer pain.</p> <p>-7 B.C and 9 W.B reported moderate to significant improvements with medication.</p> <p>-9 B.C and 4 W.B reported persistent pain even with medication.</p> <p>-3 B.C and 1 W.B described pain as a challenge.</p> <p>-3 B.C and 4 W.B viewed pain as an enemy that they described as something they needed to 'fight'.</p> <p>-3 B.C described pain as a test or trail of faith.</p>

			<p>-4 B.C described pain as a type of punishment. They believed the pain arose from sin. However, this isn't always perceived negatively.</p> <p>-More B.C than W.B reported pain.</p> <p>-Biomedical model of conceptualisation and assessing pain does not appropriately illustrate the participants amplitude of pain.</p>
<b><u>Bibliography</u></b>	<b><u>Method Used</u></b>	<b><u>Data</u></b>	<b><u>Results</u></b>
<p>Konteh, F., Mannion, R., &amp; Davies, H. (2010) Understanding Culture and Culture management in English NHS: a comparison of professional and patient perspectives. <i>Journal of Evaluation in Clinical Practice</i> 17(1): 111-117</p>	<p>-National Health System NHS England.</p> <p>-Mixed qualitative &amp; quantitative approach.</p> <p>-Quan. approach was postal survey sent to clinical governance leads and patient representatives.</p> <p>-Qual. approach was group discussions with 8 clinical governance leads, and 18 healthcare professionals and patient representatives.</p>	<p>-Postal survey: 77% return rate from clinical governance and 37% from patient representatives.</p> <p>-Survey: open structured.</p> <p>-Group discussions: semi-structured.</p> <p>-Organisations drawn at random.</p> <p>-Statistics analysed through SPSS (statistical package for the social sciences).</p> <p>-Discussions: transcribed &amp; analyses using atlas.ti.</p>	<p>-90% stated 'culture' is the way they do things in their workplace.</p> <p>97% of reps &amp; 100% of clinical governance said 'culture' is shared beliefs, attitudes, norms, behaviours in their workplace, for example their routines, ceremonies, and environment.</p> <p>-Reps focused on the importance of patient safety and involvement in healthcare decisions.</p> <p>-Clinical governance focused on the aspects of 'culture' connected to staff satisfaction, performance and standards of service delivery.</p> <p>-97% of clinical governance said understanding cultures is a key idea in their organisation.</p> <p>-90% of all involved in research said local 'cultures' can cause barriers in healthcare.</p>

			<p>-87% of clinical governance &amp; 76% of patient reps felt ‘local cultures’ are <u>unhelpful</u> in good quality healthcare delivery.</p> <p>-Ideas included that ‘cultures’ cause <u>self-centredness, cliques, and tribes</u>.</p> <p>-80% clinical governance &amp; 95% reps felt <u>patient centredness</u> and <u>quality focus</u> are <i>very important</i>.</p> <p>-Three quarters of clinical governance believed ‘culture’ requires a <u>blame-free</u> environment.</p> <p>-Healthcare professionals and patient reps don’t always agree on the importance of ‘culture’.</p> <p>-Altogether ‘culture’ is considered part of the everyday language of the NHS organisations in England.</p>
<b><u>Bibliography</u></b>	<b><u>Method Used</u></b>	<b><u>Data</u></b>	<b><u>Results</u></b>
<p>Kvarén, C. &amp; Johansson, E. (2004)</p> <p>Pain Experience and Expectations of Physiotherapy from a Cultural Perspective.</p>	<p>-Physiotherapy centre in Northern Sweden.</p> <p>-Questionnaires, oral information, and written information was given prior to the study.</p> <p>-Result of the research project was also given to the participants.</p>	<p>-74 subjects from Sweden, Iran &amp; Iraq.</p> <p>-Patients born &amp; living their first 18years in Sweden, Iran &amp; Iraq were used.</p> <p>-McGill Pain Questionnaire, and Margolis Pain and Scoring</p>	<p>-Swedes rated <u>sensory pain</u> significantly lower than Iran &amp; Iraq. Iran &amp; Iraq didn’t differ much.</p> <p>-Swedes rated <u>affective pain</u> significantly lower than Iran &amp; Iraq. Iran &amp; Iraq didn’t differ much.</p> <p>-Swedes rated <u>pain intensity</u> significantly lower than Iran &amp; Iraq. Iran &amp; Iraq didn’t differ much.</p>

<p><i>Advances in Physiotherapy Journal 6 (1): 2-10</i></p>	<p>-Assistance from relatives/friends was permitted.</p> <p>-85 people approached.</p>	<p>system used.</p> <p>-Inclusion criteria: 18years or over, musculoskeletal pain for 3months+, no need for interpreter.</p> <p>-Exclusion criteria: suspected neuropathic pain, pain from cancer, fracture pain, post-operative pain, &amp; torture pain.</p> <p>-Convenience sampling was used.</p> <p>-SPSS was used for analysing statistics.</p> <p>-ANOVA (analysis of variance) and Turkey's HSD post hoc systems were used for analysing differences.</p> <p>-91% responded to the questionnaire.</p> <p>-All participants were judged as having musculoskeletal pain.</p>	<p>-No major difference noted regarding pain distribution.</p> <p>-Positive belief in physiotherapy: 96% Swedes 83% Iranians 67% Iraqis</p> <p>-Other pain relief methods suggested: Sauna (Iraqi) Massage or Reducing Weight (Swedes)</p> <p>-Why Seek Physiotherapy? Reduce stiffness Get mobile Remove discomfort (all Swedish answers)</p> <p>-Pain experience differs between cultures.</p> <p>-No real differences between Iran &amp; Iraq noted.</p> <p>-Swedes had the lowest pain rating despite having the longest pain duration.</p> <p>-Iraqis were the least positive towards physiotherapy.</p> <p>Iranian and Iraqi had not been to physiotherapists before ∴ could be unsure of the method.</p>
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		-All participants lived in the same area.	-Relatives/friends were allowed to assist and ∴ could have obscured results.  -Dropout rate was 12%. 60% continuance rate is considered sufficient.  -Only 1centre was used ∴ it is difficult to generalise to the larger population.  -No differences were noted in pain distribution.
<b><u>Bibliography</u></b>	<b><u>Method Used</u></b>	<b><u>Data</u></b>	<b><u>Results</u></b>
Lewén, H., Gardulf, A. & Nilsson, J. (2010) Documented assessments and treatments of patients seeking emergency care because of Pain. <i>Scandinavian Journal of Caring Science</i> 24(4): 764-771	-Qualitative study using 698 patient records from a Swedish hospital.  -Excluding patients <15 years old.  -Collected 1 <sup>st</sup> week in March, and 1 <sup>st</sup> week in November.  -Records were selected consecutively.	-Records Collected: 94 Medical E.R, 94 Surgical E.R, 81 Neurology E.R, 95 Infectious Disease E.R, 39 e.n.t E.R, 100 ward A, & 100 ward B.  -Nurses reviewed the records manually.  -Data was registered into 9 sections: unit, age, gender, reason for coming to E.R, diagnoses, pain rating, treatment to achieve pain relief, follow-up pain assessment, & pain assessment at discharge.	-In 698 records: 363 were male (52%) & 336 were female (48%).  -53 years was the mean age.  -No significant difference between gender and mean age.  -Three most common pain reasons for coming to E.R were: abdominal pain, dyspnoea, & chest pain.  -Four lesser common reasons were: injuries, headaches, diarrhoea, & infections.  -25women:7men came for headaches.  -Only 52% (361) of records had notes stating if the patients had pain on arrival (p.o.a). In only



		<p>-ANOVA, chi-squares, and SPSS was used to analyse statistics.</p>	<p>17% (54) of these there was notes regarding pain treatment.</p> <p>-In 88% (319) of these 361 there were pain assessments: intensity, duration etc.</p> <p>-48% (337) did not have any records stating if they had/hadn't pain on arrival.</p> <p>-With notes on pain on arrival= 42% E.R, 37% ward A, 74% ward B.</p> <p>-3 Ward A &amp; 12 Ward B had used VAS (visual analogue scales). All of these contained assessment &amp; treatment notes.</p> <p>-Using pain scales appears to increase administration of analgesia, &amp; documentation of pain.</p> <p>-Various barriers such as culture &amp; language were identified as reasons pain scales may have been avoided.</p> <p>-Lack of routine in nurses pain assessments.</p> <p>-Reasons for lack of documentation: lack of time, lack of knowledge, short care episodes, lack of routine.</p>
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<u>Bibliography</u>	<u>Method Used</u>	<u>Data</u>	<u>Results</u>
<p>Sobralke, M., &amp; Katz, J. (2005) Culturally Competent Care of Patients with Acute Chest Pain. <i>Journal of the American Academy of Nurse Practitioners</i> 17(9): 342-349</p>	<p>-Content Analysis of selected clinical articles, &amp; research articles. -Phenomenological expertise of the author's clinical experiences.</p>	<p>-The author searched for articles and research related to acute chest pain in culturally competent patients. -30+ articles were collected and analysed. -Three different cultures were chosen to compare: Mexican American, Native American, &amp; Arab American.</p>	<p>-Result was lack of pain assessment, treatment, &amp; follow ups</p> <p>-Culture, health, and illness are firmly connected. -Cultural competence allows nurses delivery care effectively in any culture. -Chest pain is one of the strongest motivators in every culture for seeking medical care. -The ability to communicate appropriately is essential in pain assessment. -‘Sharp’ chest pain is linked to Acute Myocardial Infarction (AMI). If a culture doesn't use this word then AMI's can be misdiagnosed. -Pain response is directly linked to what a culture deems appropriate. -Nurses are fully educated in symptoms of AMI's, but not of the cultural influences on these symptom expressions. -Culture dictates how people should respond to pain, and what is ‘normal’.</p>

			<ul style="list-style-type: none"><li>-Little research has been devoted to understanding acute pain in different cultures.</li> <li>-Mexican American: show non-verbal pain behaviours, are less inclined to complain of pain (they are stoic), &amp; usually wince, groan, and grimace.</li> <li>-Native Americans: <i>may</i> regard pain as a way of life, usually have a high tolerance for pain, &amp; more commonly describe pain as they are ‘just not feeling right’.</li> <li>-Arab Americans: usually very expressive, <i>may</i> tend to exaggerate their pain and over emphasize it, &amp; can expect rapid pain relief.</li> <li>-Pain assessment tools, such as VAS, &amp; VRS etc do not measure affecting qualities of pain.</li> <li>-Assessing someone’s face for pain can reflect social biases: no facial expression in stoic patients.</li> <li>-Invalid cultural assumptions about pain can obstruct effective pain expression and care.</li> <li>-To avoid stereotyping when dealing with pain it is important to understand different variations exist within a culture.</li></ul>
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