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Bachelor's Thesis

Cultural Competence of Nurses in Pain Assessments

A Literature Review

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Title: Cultural Competence of Nurses in Pain Assessments

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Abstract:

This thesis explores the cultural, religious, and social influences on the perception of pain and its expression, and emphasizes the importance of culturally competent pain assessment. The literature review shows that cultural differences significantly affect communication and interpretation of pain, which subsequently affects the effectiveness of pain management interventions. This literature review identifies some of the key difficulties in interpreting verbal and non-verbal pain cues in various patient groups and highlights how traditional pain assessment tools, such as the Numeric Rating Scale (NRS) and Visual Analog Scale (VAS), may overlook culturally subtle pain expressions. The study highlights the need for tools that are not only linguistically translated but conceptually adapted to reflect cultural expressions and pain beliefs. Culturally adapted and validated measures, including digital tools, substantially increase the validity and utility of pain assessment in diverse populations.The study is grounded in the Campinha-Bacote Model of Cultural Competence.

Keywords:

Cultural competence, pain assessment, nursing, cultural differences, pain expression, Campinha-Bacote Model, literature review, pain assessments tools.

Opinnäyte

Asmita Dahal
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Työn nimi. Sairaanhoitajien kulttuurinen osaaminen kivun arvioinnissa
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Tiivistelmä:

Tässä opinnäytetyössä tarkastellaan kulttuurisia, uskonnollisia ja sosiaalisia vaikutuksia kivun käsitykseen ja sen ilmaisuun ja korostetaan kulttuurisesti pätevän kivun arvioinnin merkitystä. Kirjallisuuskatsaus osoittaa, että kulttuurierot vaikuttavat merkittävästi kommunikaatioon ja kivun tulkintaan, mikä puolestaan vaikuttaa kivunhoitotoimenpiteiden tehokkuuteen. Tässä kirjallisuuskatsauksessa yksilöidään joitakin keskeisiä vaikeuksia, jotka liittyvät kivun sanallisten ja ei-sanallisten vihjeiden tulkintaan eri potilasryhmissä, ja tuodaan esiin, miten perinteiset kivunarviointivälineet, kuten numeerinen arviointiasteikko (NRS) ja visuaalinen analoginen asteikko (VAS), voivat jättää huomiotta kulttuurisesti hienovaraiset kivunilmaisut. Tutkimuksessa korostetaan, että tarvitaan välineitä, jotka on paitsi käännetty kielellisesti myös mukautettu käsitteellisesti siten, että ne heijastavat kulttuurisia ilmaisuja ja kipukäsityksiä. Kulttuurisesti mukautetut ja validoidut mittarit, mukaan lukien digitaaliset työkalut, lisäävät huomattavasti kivun arvioinnin validiteettia ja hyödyllisyyttä erilaisissa väestöryhmissä.

Avainsanat:

Kulttuurinen osaaminen, kivun arviointi, hoitotyö, kulttuurierot, kivun ilmaisu, Campinha-Bacote-malli, kirjallisuuskatsaus, kivun arviointivälineet.

Contents

1 Introduction

The world is becoming increasingly interconnected as people migrate to other countries for employment, study, or protection, forming diverse communities. Because of this, nurses must interact with patients from diverse cultures. To deliver the best care, nurses must study the effect of culture on health, communication, and pain, as this understanding helps them provide care that is relevant to each patient's needs, particularly in areas such as pain assessment where cultural competence is essential (Sharifi et al., 2019). Unless nurses fully understand how patients express pain, they will be unable to provide the right treatment. It causes undue suffering for patients and affects their health (Briggs, 2010).

In nursing schools, students are taught to provide holistic care (Purnell, 2002). This necessitates them to care for the whole person, not just their illness (Campinha-Bacote, 2002). Holistic care involves physical, emotional, and social aspects of health (Purnell, 2002). However, if nurses do not know about cultural differences in pain expression, they cannot provide holistic care. Different cultures express pain differently. Some scream or cry, while others are silent. Some cultures educate individuals to be strong and hide their pain, and some cultures need them to vent. If the nurse does not understand these cultural differences, they might mistakenly believe a patient is not in pain when they are, or assume a patient is in severe pain when they are not, leading to miscommunication, inaccurate pain assessment, and poor pain management (Briggs, 2010).There are real cases of these problems in nursing (Sharifi et al., 2019).

This literature review explores how people from different cultures express pain and the tools available for pain assessments. The study is based on a review of existing literature on the topic. The study also describes Campinha-Bacote's model of cultural competence. Theories describe why nursing care requires cultural competence (Campinha-Bacote, 2002).

2 Aim of the study

This study aims to explore different ways people from different cultures express pain and tools for pain assessments.

2.1 Research Questions

1. What are the ways people from different cultures express pain?
2. What tools can be used to ensure culturally competent pain assessments?

3 Background

Cultural competence is crucial in nursing, particularly in pain assessment and management (Purnell, 2002). Cultural competence for nurses is understanding and appreciating different cultural assumptions and practices (Campinha-Bacote, 2002; Purnell, 2002). Cultures perceive and express pain differently (Campinha-Bacote, 2002). If nurses are unaware of these differences, they will misestimate pain levels, which results in inadequate pain management (Williams & Craig, 2016). Pain is perceived differently across cultures (Treede et al., 2019). Being Nepali nurses working, residing, and studying in Finland, we found that in our own culture, silent endurance of pain is most often considered as a sign of strength. Being in contact with patients from diverse cultures, it is important that we become culturally aware of the manner in which patients express pain. This helps us to provide the appropriate and effective care each patient needs.
Nurses should be aware of these differences in order to provide appropriate care (Purnell, 2002). A patient's pain can be misinterpreted without cultural understanding (Campinha-Bacote, 2002). Treatment may be inappropriate if a nurse believes that an uncommunicative patient is not in pain or that a talkative patient is exaggerating their pain (Williams & Craig, 2016). Cultural competence education informs nurses about pain differences and prevents incorrect diagnoses (Purnell, 2002). Cultural differences education enables nurses to measure pain effectively and enhance patient outcomes (Campinha-Bacote, 2002).

3.1 Pain

Pain is a complex and subjective experience influenced by biological, psychological, and social factors (Treede et al., 2019). The International Association for the Study of Pain

(IASP) has defined pain as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" (IASP, 2020). Pain perception varies across individuals and is shaped by genetic, cultural, and psychological factors (Williams & Craig, 2016). It can be classified into acute and chronic pain, with acute pain being a warning symptom and chronic pain lasting more than normal healing time (Treede et al., 2019).

3.2 Culture

Culture is a shared system of values, beliefs, and practices that shape human behavior and social interaction. Culture influences how individuals perceive the world, communicate, and make choices, including health choices (Spencer-Oatey, 2021). The United Nations Educational, Scientific and Cultural Organization (UNESCO) defines culture as "the set of distinctive spiritual, material, intellectual, and emotional features of society or a social group" (UNESCO, 2022). Culture keeps on evolving with time due to globalization, migration, and technological advancements (Spencer-Oatey, 2021).

3.3 Culture Competence

Cultural competence means being able to become familiar and understand people of other cultures (Briggs, 2010). In the medical field, it allows employees to care for people with different backgrounds more (Campinha-Bacote, 2002). The culturally competent nurse or doctor knows how to communicate, listen, and help patients in a way that is respectful of their beliefs and values (Campinha-Bacote, 2002; Purnell, 2002). Cultural competence, as Campinha-Bacote (2002) defines, is a process whereby healthcare workers become educated on other cultures and attempt to provide care to each person in the best way for them.

3.4 Culturally Competent Care

Culturally competent care is giving care that suits the patient's culture, beliefs, and values (Campinha-Bacote, 2002; Purnell, 2002). It makes individuals feel secure, valued, and recognized. Physicians and nurses implement such care to build trust and give enhanced health aid (Campinha-Bacote, 2002). According to Campinha-Bacote (2002), culturally competent care is given when healthcare workers learn about various cultures and implement that knowledge to help each person in the best possible way.

3.5 Pain Assessment

Pain measurement is necessary because pain is subjective, and every individual feels pain differently. Poor treatment and suffering may occur unless pain is accurately measured (Treede et al., 2019). Pain measurement tools allow the quantification of pain intensity, location, and quality (IASP, 2020). Accurate evaluation of pain is crucial to administer proper treatment (Treede et al., 2019).

4 Theoretical Framework

We have chosen the Campinha-Bacote Model of Cultural Competence theoretical framework for our study on the Cultural competencies of the nurse in pain assessments due to its relevance.

4.1 The Campinha-Bacote Model of Cultural Competence

This model explains that cultural competence is a process that nurses must always improve. It helps nurses assess pain better by understanding cultural differences (Campinha-Bacote, 2002).

This model has five main parts:

1. Cultural Awareness – Nurses must know how their own culture influences their thinking.
2. Cultural Knowledge – Nurses should learn about different cultures and their views on pain.
3. Cultural Skill – Nurses should use the right pain assessment tools for each patient's culture.
4. Cultural Encounters – Nurses must interact with people from different backgrounds to gain experience.
5. Cultural Desire – Nurses should want to learn about different cultures and improve their skills.

These five components help nurses understand and manage pain in different cultural groups Culture affects pain expression and pain tolerance (Williams & Craig, 2019). Nurses must use cultural knowledge and skills to choose the right pain assessment tools (Campinha-

Bacote, 2002). This model helps nurses ask the right questions and avoid assumptions when assessing pain (Williams & Craig, 2019).

5 Methods

5.1 Literature Review

This study uses a literature review, which means that it looks at what others have published about the topic. The review includes journals, articles, online resources and books. A literature review helps to highlight what is already known and also what is missing in research (Elo et al., 2014).

A literature review is not simply a list of sources, but a way of working out what studies say, what they do well or poorly, and where they conflict. This helps the researcher to find out more about the topic and to work out where further research is needed. The benefit of utilizing secondary sources is that they give easily accessible information. A literature review in nursing is important because it helps to improve care by learning from existing studies (Polit & Beck, 2017).

5.2 Data Collection

Data gathering was conducted through a careful search of databases like PubMed, EBSCO, and SAGE Journals. The search was on nursing and cultural competence in pain assessment. Only peer-reviewed English articles published in the last ten years with few exceptions were used to keep the data as current and reliable as possible.

The search applied explicit criteria to identify the best studies. Terminology such as "pain”,” care," "culture," "cultural competence”, “pain expression” and “assessment" was used. Boolean logic such as "AND" and "OR" facilitated narrowing or expanding the search. For example, searches such as "nurse AND cultural competence AND pain assessment" facilitated identifying relevant studies. Articles were selected based on relevance to our study and those aligning with our theoretical framework.

Table. 1 Search Strategy and Results Across Databases for Literature

Database	Keywords Used	Filters Applied	Hits	Articles Selected
PubMed	(((Pain[Title]) AND (care)) AND (culture)) AND (assessments)	in the last 10 years, Free full text, English.	245	6
EBSCO	TI pain AND TI culture	"Peer Reviewed", "English", "Full Text"	67	4
CINAHL	pain expression AND culture	"Peer Reviewed", "English", "Full Text", "past 10 years", "research article"	165	5
SAGE	Cultural competence (In title)	"Nursing", "Research article"	142	3
Sciencedirect	Title, abstract, keywords: culture Title: pain	Year: 2015-2025 Publication title: Pain Management Nursing Article type: Reseach	26	3

In total, 21 articles were used in this literature review for results. The reference management program was utilized to store, organize, and reference the sources. Besides that, it was capable of removing duplicates and hence the data became clean and easy to utilize. This was in accordance with best research practice (Elo et al., 2014).

Exceptions in inclusion of articles: Some articles older than ten years were used because they are still very relevant and important. For example, Purnell's (2002) and Campinha-Bacote's (2002) models help to explain cultural competence. These are concepts that are used even now.

Table 2. Inclusion and exclusion criteria for articles selection

Criteria	Inclusion	Exclusion
Language	English-language publications	Non-English publications
Publication Type	Peer-reviewed journal articles	Editorials, commentaries, dissertations, conference abstracts
Date Range	Published within the last 10 years (2015–2025) with limited exceptions.	Published before 2015 unless deemed exceptionally relevant
Access	Full-text articles available	Abstracts only or articles with no full-text access
Database Source	Articles retrieved from PubMed, EBSCO, SAGE Journals	Articles from unverified or non-academic sources
Study Focus	Focused on nursing, cultural competence, pain assessment and pain assessment tools.	Articles unrelated to pain assessment, cultural competence, or nursing
Population	Studies involving nurses or nursing practice in pain assessment	Studies focusing solely on physicians or other health professionals
Relevance	Directly relevant to the research question and aligned with the theoretical framework	Articles with limited or no relevance to cultural competence in nursing
Geographic Scope	Any region, provided cultural competence in nursing pain assessment is addressed	None specifically excluded based on geography

5.3 Data Analysis

Data analysis in this literature review was conducted through content analysis. Content analysis involves examining existing data that helps authors gain insights from previous reports and studies (Elo et al., 2014). This was used in an effort to study systematically the ways cultures differently communicate pain and the available tools for pain assessment.

5.3.1 Step of content analysis

The content analysis process is composed of three steps: preparation, organization, and presentation of results. The preparation phase involed collecting relevant data and choosing the articles to be analysed for the literature review (Elo et al., 2014).

Table 3. Categorization

Themes	Generic categories	Subcategories	Unit of analysis
Pain Expression Across Cultures	Cultural expressions of pain	Communication of pain Verbal expresssion of pain Non verbal expression of pain General descriptors of pain	1, 2, 3, 6, 9, 10, 13, 14, 15, 16, 19
	Religious interpretation of pain	Religious explanation of pain Religious relief from pain	1, 3, 4, 6, 10, 13, 14
	Social and contextual factors	Family dynamics in pain reporting Cultural power dynamics in healthcare settings Historical factors affecting trust in pain reporting Cultural differences in healthcare expectations	1, 6, 8, 13, 14, 18
Culturally competent Pain Assessment Tools	Self-report	Numeric Rating Scale (NRS) Visual Analog Scale (VAS) Faces Pain Scale (FPS) Verbal Rating Scale (VRS)	1, 3, 10, 11, 12, 17, 20, 21
	Culturally adapted tools	Cross-culturally validated instruments Culturally adapted pain questionnaires	5, 7, 8, 17, 21
	Technology-assisted assessment	Translated and culturally validated scales Culturally adapted digital tools	8, 17, 21

Credible articles chosen during data collection were saved in a shared Word document that both authors could access. Organization phase involes organizing the collected data (Elo et al., 2014). The information was then divided into categories by implementing a coding system. General knowledge about pain expression in different cultures, culturally competent pain assessments tools and results were highlighted. The highlighted data were further grouped into two categories and their subcategories, respectively, and saved on a different Word document which was distinct from saved articles. Category 1 comprised articles regarding pain expression in diverse cultures and category 2 assessed culturally appropriate tools which were developed to be used for measuring pain. Finally content analysis was completed by presentation of results (Elo et al., 2014).

6 Ethical considerations

This study is guided by the Finnish Advisory Board on Research Integrity's ethical principles. Four broad areas of ethics are to be adhered to: fabrication, plagiarism, falsification, and misappropriation. Fabrication refers to the creation of fake research findings, while plagiarism refers to copying other people's work without crediting the author. Falsification is altering research results, and misappropriation is appropriating the work of another researcher without his or her permission (Finnish Advisory Board on Research Integrity, 2012).
The data is derived from existing studies and literature, and thus the rights and autonomy of research subjects are not directly involved. However, the ethical principle of non-maleficence is also relevant, particularly about privacy and data protection (Finnish Advisory Board on Research Integrity, 2012; Polit & Beck, 2017).

7 Results

This chapter is a compilation of all 21 articles selected for this literature review. Reading each article independently, they were constructed into themes, categories, and subcategories. These themes relate to the research question and aim, pain expression across cultures, and culturally competent tools of pain assessment.

7.1 Cultural Expressions of Pain

Cultural background significantly contributes to patients' pain experience and pain expression (15). The literature review has consistently demonstrated that individuals from various cultural groups express and perceive pain differently. For instance, there is a significant ethnic diversity in the expression of post-operative pain, a finding that suggests that cultural standards have the capability to alter the intensity as well as the mode of pain reporting (1). Similarly, (19) highlighted the role of ethnicity on pain behaviors that express themselves in a misunderstood manner by clinicians who are unfamiliar with non-Western culture. Facial features and body language also differ across cultures, as indicated by (9), which reported that cultural and ethnic influences affect how people express and perceive pain through visual means. In some societies, stoicism is valued and leads to pain underreporting, while in others expressiveness is valued or even encouraged, as highlighted by (13) and (6).

7.1.1 Communication of Pain

Some cultures use direct verbal communication, while others use indirect or subtle cues (3). Pain communication is significantly influenced by linguistic, social, and cultural factors, and therefore there are variations in the manner in which individuals explain their pain experience. For example, (2) noted that cultural differences in pain communication often arise from divergent expectations on emotional expressiveness since there are cultures that embrace stoic reserve while others encourage open declarations of suffering. Similarly, (3) also emphasized the importance of culturally suitable vocabularies when it comes to talking about pain, quoting those different linguistic depictions may be insufficient to articulate how pain diverges across cultures. This language barrier can disrupt communication between patients and healthcare providers, leading to pain assessment challenges. (6) further added that cultural beliefs can affect not just verbal reporting of pain but also willingness to report pain symptoms because some cultures may view open reporting of pain as weakness or

breach of social norms. On the contrary, in some cultures, pain is openly talked about, where verbal expression occupies the center of the pain experience, as witnessed by (14), who outline the difference in expressions of pain between Chinese and Indian cultures and Western models of pain.

Furthermore, cultural taboos regarding discussing pain freely occur in most cultures. The capacity of health care providers to manage the complexity of pain communication among multicultural populations depends on cultural competency (10) . Misinterpretation of pain communication has been forwarded by (16), who argue that pain expressions culture-specific should also be considered while assessing in clinical processes so that their needs are actually met.In addition, (9) discussed how cultural differences affect visual and non-verbal pain communication such as facial expression and posturing of the body, which further complicates cross-cultural pain communication.

Table 4. Non-Verbal Expression of Pain

Culture/Group	Findings	Source
Chinese Culture	Pain is often hidden or downplayed in social settings to maintain harmony and avoid burdening others.	14
Finnish Culture	Pain is often endured silently; stoicism is common, and verbal complaints are minimal.	3
Brazilian Culture	Pain is expressed through withdrawal or moaning; some use grimacing.	3
Indian Culture	Avoiding movement and facial expressions like grimacing, but dramatic displays are rare.	14
American Culture	Wincing, groaning, grimacing.	3
Somali Culture	Pain is expressed through rest or body language; crying and wailing are unacceptable.	6

Table 5. Verbal Expression of Pain

Culture/Group	Findings	Source
African American & Caucasian Cultures	Pain is expressed through metaphors (e.g., sharp, dull, hot, achy, stabbing).	3
Black Caribbean & White British Patients	Both express pains verbally, but Black Caribbean patients report pain more frequently.	13
Chinese Culture	Verbal expressions are indirect; pain is often described through bodily imbalance rather than specific pain words.	14
Finnish Culture	Pain is described in simple, factual terms rather than emotional expressions.	3
Brazilian	Some verbal expressions include telling family members about pain.	3
Indian Culture	Pain is verbally minimized in front of others, but may be described poetically in private settings.	14
Swedish Culture	Swedes verbally express pain (e.g., complaining, moaning, crying).	6
U.S., Brazil, Japan, China, Finland, Spain	Participants describe pain using words like "burning," "electric shocks," or scales (e.g., mild, moderate, severe).	3

Table 6. General Descriptors of Pain

Culture/Group	Findings	Source
African Americans, Caucasians, Koreans, Whites	Pain is described using sensory metaphors (e.g., "sharp," "hot," "heavy," "frozen").	3
Chinese Culture	Pain is often metaphorically linked to blocked energy channels or a sense of cold penetrating the body.	14
Finnish Culture	Pain is described in straightforward, concrete terms, avoiding dramatic metaphors.	3
Indian Culture	Pain is described as "burning like fire," or "like being pierced by thorns."	14
U.S, Brazil	Common descriptors: "burning," "electric shock," "pins and needles," and "stabbing."	3

7.1.2 Religious Interpretations of Pain

Pain is considered a religious experience by most cultures. Religious accounts of pain are an essential aspect of cultural knowledge since they influence the way individuals experience and cope with suffering. In every culture, religion plays a significant role in shaping the meaning that is attributed to pain, as well as influencing the experience and expression of pain. The religious dimensions of pain are deeply embedded in cultural contexts and must be accepted in holistic pain assessment and management plans. They demonstrate that religious beliefs can provide individuals with meaning or purpose in suffering, which can significantly alter their perception of pain. Pain in other cultures is at times viewed as spiritual testing or purification and may influence the reporting and management of pain (4).

Similarly, (13) highlight the cultural variations in the meaning attributions of pain, continuing to describe religious conceptions as influencing whether pain is seen as a test of one's spirituality, punishment for something engaged in in the past, or a sign of spiritual growth. They concentrate in their study on how individuals of different religious denominations experience pain within their different spiritual contexts, and this is something that can affect the coping strategies and receptiveness to medical care. Cultural understanding of pain, especially in Chinese and Indian cultures, is typically founded on religious beliefs, where pain might sometimes be seen as a natural part of suffering from life or a manifestation of karma. Such religious accounts not only shape people's experiences of pain but also the manner in which they seek to relieve it, which can include medical treatments to religious ritual or prayer (14).

Also, religious belief is able to become a source of relief and solace from agony. Prayer or religious rituals to heal can act as a mechanism of emotional comfort and acceptance upon experiencing pain (1). These religious actions, deeply grounded in certain culture traditions, have a parallel or complementary way of coping with medical pain. Based on these discoveries, it is important that clinicians acknowledge and incorporate religious beliefs in pain assessment and treatment planning, as this is likely to result in more effective, culturally appropriate care (10).

Table 7. Religious Explanation of Pain

Culture/Group	Findings	Source
Black Caribbean Culture	Pain is viewed as a trial of faith or punishment for sin.	13
Black Culture (Pain Perception)	Pain is attributed to wrongdoing or as a test of faith.	3
Chinese Culture	Pain is linked to imbalances in Qi (life energy, Yin-Yang imbalance) and disharmony in the body.	14
Finnish Culture	Pain is considered a natural part of life, endured with resilience rather than spiritual meaning.	3
Brazilian Culture	Pain is explained as part of God's plan ("God doesn't give you anything you can't bear").	3
Indian Culture	Pain is seen as karmic retribution or a means of spiritual growth.	14
Somali Culture	Pain is seen as a burden given by Allah; must be borne with dignity.	6

Table 8. Religious Relief from Pain

Culture/Group	Findings	Source
African American Culture	Prayer and religious coping strategies are used for pain relief.	3
Chinese Culture	Acupuncture and herbal medicine are used to restore balance and relieve pain.	14
Finnish Culture	Traditional sauna uses is common methods for pain relief.	3
Brazilian Culture	Prayer (e.g., rosary) is used to seek relief from pain.	3
Indian Culture	Meditation, yoga, and Ayurveda-based practices are used for pain relief.	14
Somali Culture	Reading the Koran is believed to relieve pain.	6

Pain is alleviated in different cultures with the assistance of religion or tradition. Somali patients believe that listening to the Koran can alleviate them (6). Indian patients may pray or meditate to alleviate pain. Chinese patients would receive herbal medicine, acupuncture, and massage instead of painkillers (14). Finnish patients may use medical pain alleviation techniques like medication or physiotherapy (3).

7.1.3 Social and Contextual Factors

Social and contextual factors play a major role in shaping how pain is communicated, interpreted, and managed across cultures. These factors encompass a wide range of elements including family dynamics, power dynamics within the clinical setting, history, and overall cultural expectations, all of which impact the experience of pain. Family involvement in pain reporting and decision-making can also vary significantly across cultures. In some cultures, the family can have the primary role in pain management decisions, while in other cultures, individuals are more likely to report pain or to see a physician on their own. Family dynamics may also determine whether or not a patient will report pain or, conversely, underreport pain to spare family members a burden. This implies that cultural knowledge of pain is strongly rooted within family relationships in which shared attitudes toward pain affect individual experiences (13).

Cultural power relationships within the healthcare environment may also affect the perception and treatment of pain. As an example, (8) describe how cultural power dynamics can lead to underreporting of pain among patients from marginalized groups, particularly in a setting where they believe they have no voice or are not believed by health professionals. This is compounded by historical factors such as colonialism or systemic discrimination that have created mistrust between certain communities and healthcare systems (18). These dynamics may lead to over-reporting or under-reporting of pain, depending on perceived treatment by healthcare providers or fear of stigma for reporting pain.

Healthcare expectations varying across cultures also complicate the pain experience, in that individuals of different cultural backgrounds have different ideas about appropriate pain expression and management. For example, the research by (14) illustrates that Chinese and Indian cultural models of chronic pain are very different from Western models, with pain sometimes being viewed as a normal part of life or a spiritual issue, rather than something

to be medically eliminated. This incongruence in comprehension has a tendency to foster varying expectations for pain relief and may generate resistance to engaging in pain management activities that are incongruent with cultural or social norms.

Moreover, (6) continue that the experience of pain and coping among Somali women are influenced by religious and cultural beliefs that are, in turn, shaped by historical and social circumstances. For these women, pain is also regularly treated in ways that are communicative of communal solidarity and cultural values, and it is thus necessary for medical professionals to be attentive to these contextual factors in assessing pain. Similarly, (1) highlight how ethnicity and cultural background strongly condition the way pain is conceived and treated in post-operative care.

7.2 Culturally Competent Pain Assessment

Culturally competent pain assessment utilizes tools and practices that are sensitive to the patient's values, culture, and experiences. Culturally responsive pain assessments value the fact that pain is not universally sensed and expressed, and that cultural forces profoundly influence how pain is perceived, described, and managed. Pain rating scales of general use have differential utility in various populations (20). As highlighted by studies such as those by (1) and (17), health professionals must be trained in cultural competence to adequately grasp pain behaviors and avoid biases that might lead to misdiagnosis or inappropriate treatment. Culturally adapted pain assessment tools, such as the ones discussed by (21) and (17), ensure that pain scales are validated across diverse cultural environments to achieve more accurate measurements and better clinical results. In addition, culturally responsive care, including the use of interpreters or family involvement, is also necessary to enhance the effectiveness and equity of pain evaluation in diverse populations and build trust and strengthen patient-provider relationships (10).

7.2.1 Self Report

Self-report pain measures, such as the Numeric Rating Scale (NRS), Visual Analog Scale (VAS), Faces Pain Scale (FPS), and Verbal Rating Scale (VRS), are frequently used in the clinical setting due to their simplicity and efficiency. When using these measures in culturally diverse groups, caution must be exercised with respect to cultural factors, as pain perception and communication can vary significantly among ethnic groups. Despite being commonly

applied, the scales may not be completely applicable across all situations due to cultural differences in comprehension as well as communication of pain (11, 12). For example, cultural background of the patients can determine their willingness to report the degree of pain since it has been noted through responses varying across different ethnic groups (1). Furthermore, the administration of self-report measures can be compromised by language discrepancies or pain vocabulary variation, as highlighted by studies like that by (3), which emphasizes the need for cross-cultural validation of such measures to ensure their conceptual fidelity. Thus, though self-report measures remain a staple of pain assessment, their effectiveness hinges upon the adaptation of such measures into various cultural contexts to avoid misinterpretation and guaranteeing that they reflect the true pain experience of patients from different backgrounds (7).

Figure 1. Wong-Baker Faces Pain Rating Scale, (Karcioglu et al., 2018)

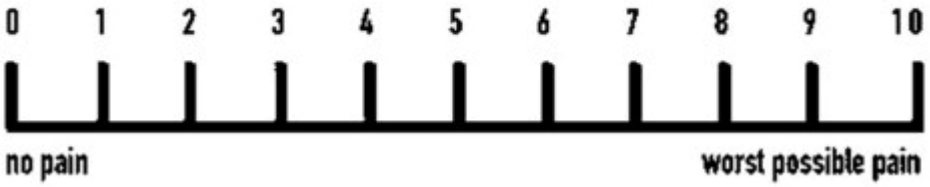

Figure 2. Numerical Rating Scale, (Karcioglu et al., 2018)

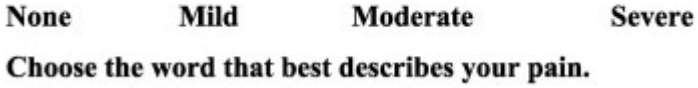

Figure 3. Visual Rating Scale, (Karcioglu et al., 2018)

7.2.2 Culturally Adapted Tools

Culturally sensitive instruments of pain assessment are required to ensure proper pain assessment in various populations (7). They are designed to be aware of variations in pain expression, perception, and coping among different cultures that can significantly influence the reliability and validity of assessments (21). For instance, (17) explain the necessity of tedious translation and cross-cultural adaptation of pain assessment tools to make them valid in multiple linguistic and cultural contexts. The role of cross-cultural adaptation in creating instruments like the Pain Medication Questionnaire and making questions on pain both culturally relevant and important are highlighted by (8). Furthermore, such measures as the Chronic Pain Cognition Scale, developed by (21), are specifically designed to pick up on the cultural nuance of pain experience in Chinese participants, demonstrating how culturally adapted measures can elicit unique characteristics of pain in specific cultural contexts. By controlling for cultural variation, these translated measures enhance the accuracy of pain measures, leading to more effective and targeted pain control interventions. Adding cultural dimensions to pain treatment calls for such changes, through which healthcare professionals are able to recognize and deal with pain better among various populations of patients. Such culturally translated instruments play an essential role in eliminating disparities in pain assessment as well as in ensuring equitable healthcare outcomes (5).

7.2.3 Technology-assisted Assessment

Technology-enabled pain assessment has now been accepted as a valuable tool in the overcoming of cultural and language barriers to pain management. Use of digital platforms and advanced technologies enables health care providers to offer more accurate and effective assessments of pain, particularly in multicultural environments (17, 8). The necessity of translation and cultural validation of pain assessment tools to provide them in various linguistic populations, something that can be readily performed with the help of technology is stressed by (17). Culturally adapted online tools, as underscored by (8) present a means to enhance the accessibility and cultural sensitivity of pain assessments, especially among non-Western populations. Such systems could include features such as graphical user interfaces or multimedia features that bridge language gaps and increase perception of pain experience, as noted by (5). Further, AI-directed systems are capable of detecting cultural patterns in pain expression and can help clinicians tailor tests according to individual patient needs. Through the incorporation of culturally appropriate features in digital pain measurement tools,

technology allows for more customized care to ensure pain is quantified and managed both clinically effective and culturally sensitive. These advances in technology in pain measurement are crucial to forestalling inequalities and improving the quality of pain management for all patients irrespective of their different cultural backgrounds (21).

8 Discussion

This literature review was carried out to understand how people from different cultures express pain and what tools can be used for culturally competent pain assessments. The 21 articles reviewed for this aim, highlighted how people of different cultures express their pain and the tools that can be used to measure pain in culturally appropriate way.

The literature review reports that pain expression, both verbal and non-verbal, is culturally conditioned by expectations and norms (Campbell & Edwards, 2012). An example is that some cultures expect stoicism and may even encourage patients to minimize their pain, while others promote more expressiveness and openness in communicating pain. These cultural differences have profound consequences in the healthcare setting, where practitioners may misdiagnose pain expressions if they are not culturally sensitive (Koffman et al., 2008).

One of the most significant outcomes of this study is the different ways in which individuals of different cultural backgrounds perceive and express pain. Pain, although a shared human condition, is not necessarily communicated or interpreted uniformly. Cultural values, beliefs, norms, and language play a significant role in whether, how, and to what extent individuals express pain. These differences create a dilemma for nurses and healthcare professionals in terms of effective and empathetic pain assessment and management.

In the majority of non-Western societies, pain is not necessarily expressed openly, and cultural expectations primarily dictate whether or not expressing pain is appropriate or acceptable. For instance, Somali patients have been reported to express pain non-verbally. Somalis may believe that revealing pain openly is a sign of weakness or shame. Hence, they may choose to suffer in silence or protest non-verbally through such cues as grimacing, posture change, or decreased activity (Finnström & Söderhamn, 2006). This makes it critical for nurses to be culturally aware and attentive to such guarded, non-verbal cues.

Similarly, in Chinese culture, pain is minimized or suppressed to uphold social harmony and not burden other people. Lewis et al. (2023) cite that Chinese patients may not necessarily describe their pain or may not mention it in clinical assessments. In these cases, silence cannot be taken as absence of pain. Nurses must be proactive in asking respectfully, and gently inquiring and seek changes in behavior that can indicate unease. These changes in behavior may be in the form of change in sleep pattern, appetite, or mood. The cultural sensitivity of the nurse to such differences is paramount for appropriate pain management.

Indian patients also present a clear cultural pattern of reporting pain. As Lewis et al. (2023) have pointed out, Indian patients may describe their pain using metaphors or symbolic language. For example, they may say that their pain is "like a burning fire" or "like being hit with a hammer." These descriptions convey the subjective and emotional nature of pain and may be misunderstood by nurses who are not accustomed to such descriptions. Here, cultural competence includes the ability to interpret metaphoric language and use it in clinical pain intensity measures. Nurses must also consider how Indian patients' native beliefs, for instance, karma or religious motives, can influence their experience of pain and coping with pain.

On the other hand, Finnish patients verbally express pain in a straightforward manner. According to Crawford et al. (2008), Finns have a tendency to describe their symptoms openly with exact medical or technical language. This may make it simpler for medical professionals to assess pain because patients disclose more about where, how severe, and of what type of pain they suffer. However, even in direct-communication cultures, variations exist. Not all Finnish patients will talk the same, and the nurses should not think that there is only one way to them all.

Being aware that pain communication varies across cultures is at the heart of providing effective care. This is in line with the observation that patients are likely to describe their pain using forms acceptable to their culture, which then influences their treatment outcome. Health care providers who know about these differences and who possess cultural competence in terms of identifying various expressions of pain will be will be better equipped to respond appropriately. Health care providers must obtain cultural awareness, knowledge, skills, encounters, and desire in order to deal and react to pain expressions in a culturally competent manner (Campinha-Bacote, 2002).

Religion and spirituality are very good predictors of the way people perceive and conceptualize pain. Integrating religious beliefs into pain management, particularly in multicultural settings, is vital to improving patient care. As per De-Diego-Cordero et al. (2024), spiritual dimensions of pain are heavily influenced by cultural and religious backgrounds, and pain management strategies must be modified to incorporate these beliefs. For example, some patients may be able to link pain to punishment or testing of spirituality, but other patients may gain comfort and solace from religious activity during experiences of pain.

The pain and suffering are particularly relevant from a cultural context when working with individuals who may understand pain through spiritual or religious belief. For instance, in the research conducted by Lewis et al. (2023), it was found that the cultural constructs of Chinese and Indian cultures regarding pain are quite different from Western constructs, with religious constructs providing individuals with meaning and purpose when hurting. Health care professionals with an understanding of such meanings will be better able to integrate spiritual aspects into pain management such that patients' beliefs are not abandoned but included within their plans of treatment. Pain is widely viewed among Somali patients as a test from Allah. Pain, to the majority of Somali patients, is something one must endure with patience and dignity. Exhibiting pain or seeking pain relief might be viewed as a sign of weakness or a lack of religiosity. Due to this, Somali patients might downplay their pain or decline certain treatments (Finnström & Söderhamn, 2006). Nurses should be aware of this belief and respect the patient's religious beliefs while still providing options for pain management. It might be helpful for nurses to broach the subject in a tactful way, for example by explaining how pain relief can aid in healing and maintaining strength, not merely removing discomfort.

Pain is also associated with karma in Indian society, a belief that actions in the past lives influence the course of events in the current. Pain in this case may then be interpreted as a spiritual cleansing or punishment that must be humbly endured by the individual. Because of these belief, Indian patients may not view pain as something to be eliminated immediately, but as something meaningful. This acceptance can lead to delayed seeking of treatment or poor adherence to pain medication (Lewis et al., 2023). However, when such patients do seek treatment, they may be more open to natural or spiritual treatments such as prayer, meditation, or Ayurvedic treatments. Nurses should be aware of this attitude and collaborate with patients to find a line of treatment that respects both medical and spiritual principles.

For Chinese patients, traditional medicine is at the center of how pain is perceived. In traditional Chinese medicine, pain is often considered the result of an imbalance in the body's energy systems, that is, the yin and yang or the flow of qi (energy) through the meridians. Chinese patients may prefer treatments like acupuncture, herbal medicine, or cupping, sometimes as an alternative to or in conjunction with western pain management (Lewis et al., 2023). While this is new for some nurses, learning and understanding these preferences can help to establish trust. Where possible, incorporating biomedical practices with the patient's preferred traditional practices can promote better outcomes and patient satisfaction.

Finnish patients, on the other hand, have a more biomedical or scientific understanding of pain. Pain is largely seen as a physiological issue to be treated medically. Finnish patients would be more inclined to expect alleviation from mainstream sources like painkillers, physio, or surgery (Crawford et al., 2008). Perhaps this would make the nurses' job easier by being able to stick to established routines for pain management. It is still significant, however, to handle each Finnish patient on a personal level since personal beliefs, prior experiences, and emotional states are also factors that contribute to how pain is experienced, even within a scientifically-oriented cultural group.

Campinha-Bacote's (2002) places emphasis upon cultural knowledge and abilities and reveals that health care professionals must recognize and act according to religious forces during pain assessment. By means of cultural exchanges and expressing a genuine interest in learning about a patient's religious beliefs regarding pain, clinicians are able to provide more complete and empathetic care. Moreover, practitioners who specifically seek to incorporate religious beliefs into their practice may enhance trust, which is generally a critical element in achieving better health outcomes.

Social and contextual factors like family relationships, power dynamics in healthcare, and historical factors play a significant role in shaping pain experiences and reporting. Pain reporting can be done by family members on behalf of the patients in the majority of cultures, particularly in collectivist cultures where the opinion of the family has a great deal of influence (Givler et al., 2025; Koffman et al., 2008). This is best exemplified in societies where relatives have to speak on behalf of the needs of the patient, such as pain management and reporting.

In addition, past experiences such as negative encounters with health systems can influence how individuals belonging to marginalized groups report pain. Rogger et al. (2023) note how cultural framing influences pain services and patient willingness to report pain. Historical mistrust, especially among racial and ethnic minorities, can shape how individuals communicate with healthcare providers and complain of pain. For example, Flannery et al. (1980) explored how ethnic variations in pain complaint are based on historical trauma and the degree to which healthcare providers are seen as trustworthy.

Addressing these social and contextual factors entails healthcare professionals adopting a culturally competent approach, outlined by Campinha-Bacote (2002), whereby one not only becomes aware of cultural difference but also strives to work intentionally at building patient trust and rapport. This includes acknowledging power imbalances within the health environment and creating an environment where patients can feel at ease and openly describe their pain experiences.

Cultural competence plays a critical role in choosing the most appropriate pain assessment tools, especially in multicultural healthcare environments. Since pain is a subjective experience, its expression and interpretation are heavily influenced by cultural background, language, and individual worldviews. As such, the one-size-fits-all approach to pain measurement can often lead to misunderstanding or underreporting, ultimately compromising patient care. Therefore, nurses must also consider cultural competence in the selection of pain assessment instruments so that the tools utilized are not only linguistically accessible but also culturally meaningful and relevant to the patient.

Application of culturally sensitive pain measurement tools is key to guaranteeing pain is accurately interpreted and effectively managed among multicultural populations. Pain measurement tools such as the Numeric Rating Scale (NRS) or Visual Analog Scale (VAS) are not sufficient to depict the subtle way people in different cultures express pain (Hawker et al., 2018; Williamson & Hoggart, 2005). As the literature review points out, pain assessment tools should be translated and validated for use in multiple cultural environments. The work of Pudas-Tähkä et al. (2014) and Wu et al. (2023) testifies to the importance of cross-translating and culturally adapting pain measurement tools to attain conceptual validity among the population of interest. Without such adaptations, health professionals will likely misjudge patients' pain and offer second-best treatment and care.

Cultural matters could also affect patients' words used in explaining pain and thereby also affect the validity of pain assessment. For example, some cultures may use metaphorical explanations ("my pain is burning," or "it feels like someone is stabbing me") rather than clinical explanations like "throbbing" or "sharp." Standardized pain tools may not always account for such variation, causing patient-caregiver misunderstanding. Health care professionals need to be cognizant of such differences and introduce more open-ended or culturally variable tools where necessary.

Cultural awareness and assessment skills must be used to determine which tool most appropriately fits the patient. The culturally competent nurse will begin by asking: "Is this patient comfortable with numbers?" ."Does this patient understand the descriptors on this scale?" or "Does this tool reflect the way this patient would typically describe discomfort? " Such inquiries, guided by Campinha-Bacote's Model of Cultural Competence, urge nurses to tailor their practice to the patient's cultural reality rather than using a predetermined approach to assessment. The use of culturally tailored instruments also makes a valuable contribution to improved patient outcomes and satisfaction. Programs such as the Chronic Pain Cognition Scale (Wu et al., 2023) and pain questionnaires tested in an appropriate cultural setting (De-Diego-Cordero et al., 2024) are structured for utilization within specific cultural contexts, allowing practitioners to assess pain in a manner that is culturally relevant within patients' practice. Development of these instruments aligns with Campinha-Bacote's emphasis on cultural competencies, advocating for the building and use of instruments that are sensitive to cultural considerations that affect pain experience and expression.

Technology use in pain assessment is a promising direction for enhancing cultural competence. Galindo et al. (2019) state that technology-supported assessment and the application of digital technologies can cross cultural and language barriers and enable accurate assessment of pain even among underserved and diverse populations. For example, the development of visually/graphic interfaces that transcend language boundaries (Gingras et al., 2023) allows patients who come from diverse linguistic backgrounds to give more valid pain descriptions, improving pain assessment quality. In addition, AI-enhanced software that is pain pattern-sensitive has the potential to offer more accurate and culture-appropriate recommendations about pain management (Wu et al., 2023).

Use of translation technology, as noted by Pudas-Tähkä et al. (2014), is also crucial in providing pain assessment tools for use by non-native speakers. Use of technology in culturally sensitive pain assessment, healthcare professionals can better treat diverse populations beyond the constraints imposed by cultural and linguistic differences. Campinha-Bacote's model prioritizes knowledge and skills related to culture, and technology use falls within this by empowering clinicians with instruments to enhance their ability to assess pain in culturally sensitive ways.

8.1 Implications for Nursing Practice

The findings of this study have significant implications for nursing practice, especially with more multicultural health settings. Nurses often serve as the first point of contact for patients and are instrumental in assessing and managing pain. Consequently, they must possess a firm understanding of cultural competence in order to identify, understand, and react suitably to a range of different expressions of pain. As has been illustrated in this literature review, culture affects the manner in which people perceive, describe, and respond to pain, and failure to take note of these differences could lead to miscommunication, misdiagnosis, and improper management of pain (Givler et al., 2025).

One of the most significant implications is that cultural sensitivity should be observed when evaluating pain. Nurses need to take note that other cultures may not express pain as verbally as ours. Whereas some may verbalize their pain in straightforward and direct terms, others may do so indirectly through metaphors, non-verbal communication, or even silence. For example, Chinese or Somali patients may underreport or suppress pain due to religious beliefs, cultural stoicism, or the reluctance to burden others (Finnström & Söderhamn, 2006; Lewis et al., 2023). A nurse who is not knowledgeable about such tendencies may misread that the patient does not have pain and therefore under-treat.

To counter this, the nurses need to be trained not only in clinical competencies but also in observational and communication competencies that are culturally sensitive. This involves acquiring the ability to interpret non-verbal cues like body position, facial expression, and change in behavior that may indicate pain in patients who are not verbally expressive. Nurses also need to learn active listening and use open-ended questions in a manner that allows

patients to describe pain in their own terms without endangering misinterpretation or dismissal (Givler et al., 2025).

Of similar importance is the understanding of how religious and spiritual beliefs are connected to the experience of pain. As defined in this study, the majority of patients frame their experience of pain within their religion. For example, Somali patients will perceive pain as a trial of faith or Allah's will, whereas Indian patients will perceive pain as karmic in origin and an opportunity for purification (Koffman et al., 2008; Givler et al., 2025, Lewis et al., 2023). Chinese patients may perceive that pain is related to an energy imbalance and will likely seek mainstream treatments such as acupuncture. In contrast, Finnish patients tend to bank on scientific approaches, expecting pharmacological or physiotherapeutic interventions (Crawford et al., 2008). These worldviews influence patients' willingness to report pain and to undergo treatment. Nurses therefore need to respect such beliefs and incorporate them in the care plan, providing holistic and individualized care that is aligned with the patient's values and preferences.

The Campinha-Bacote Model of Cultural Competence is particularly relevant in this case as it is concerned with how nurses ought to progress five primary aspects: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural competence, according to this model, does not occur once but is a process of learning with time. Nurses should be encouraged to be sensitive to their own cultural assumptions, learn about the cultural background of their patients, and engage willingly in culturally diverse clinical practices. This model is a benchmark to ensure that pain measurement and treatment are not only clinically appropriate but also culturally sensitive and empathetic (Campinha-Bacote, 2002).

Moreover, healthcare organizations have a responsibility to support culturally competent nursing care. This encompasses provision to make devices used to assess pain culturally accessible and available to all. For instance, nurses are to be availed with diverse devices to be used to assess pain, such as the Visual Analog Scale, Verbal Rating Scale, and Wong-Baker FACES scale, which will best suit certain populations. In addition, the instruments need to be translated into a variety of languages and made available with interpreters when necessary. Institutions should also ensure the availability of cultural liaisons or patient

advocates who are able to work as a buffer between patients and healthcare providers based on communication.

Additionally, ongoing education and training in cultural competence should be included in the professional growth of all nurses. It can include workshops, seminars, simulations, and reflective exercises on learning how cultural perspectives of health, illness, and pain differ. With ongoing knowledge construction, nurses can feel confident in their ability to work with patients from diverse backgrounds and provide equitable, competent care. Having a clinical environment that values cultural variations encourages patients to express their pain in any form that comes easily to them. This involves bringing about an environment that is free and open to where patients will feel secure, respected, and non-judgmental. When patients sense that their pain will be listened to and valued—however they choose to describe it—they are more likely to be fully involved in their care, with improved outcomes and greater patient satisfaction (Givler et al., 2025)). Nurses must also avoid stereotyping or assuming on the basis of cultural origin only; rather, each patient should be viewed as an individual whose needs and values are worth respecting in themselves.

Implications also extend to nursing leadership and policy-making. Nurse educators and nurse managers need to promote institutional policies in favor of culturally competent care. This includes modifying clinical protocols to account for cultural diversity in the evaluation of pain and having staff assessment and quality improvement activities include cultural competence as an important indicator. Moreover, collaboration with multidisciplinary teams, including social workers, chaplains, and cultural consultants, can provide a more integrated approach to pain management for diverse patients.

9 Conclusion

Cultural competence is very much needed in nursing, especially in evaluating and taking care of pain. People from other cultures feel and communicate pain differently. If the nurses are unaware of this, they can misinterpret the patient's pain or give the wrong treatment.

There are cultures that freely express pain in words, and others that remain silent or express it through symbols and body language. For example, Indian or Somali patients may use non-

verbal communication, while Finnish patients may describe pain in detail. Nurses must be aware of these differences to offer the best care.

Religion also plays a crucial role in how one feels about pain. Some patients view pain as a test of life or religion. For this reason, they may not require medication. Nurses must respect such beliefs and offer care that addresses physical and spiritual needs.

Pain tools must also be compatible with the patient's culture. Number or face scales can be difficult for some to comprehend. Under these circumstances, words or tools in the patient's language can be utilized. Nurses must choose the correct tool to ensure that pain is measured correctly.

The Campinha-Bacote Model does make nurses culturally competent. It is a five-step process that includes awareness, knowledge, skills, encounters, and desire. Nurses taking these steps are capable of understanding patients more and offering compassionate, safe, and respectful care.

In short, culturally competent care yields effective pain management, happier patients, and greater trust between nurses and patients. As the globe becomes increasingly diverse, nurses must learn from other cultures in order to take good care of all people.

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Appendices

Table 9. Presentation of choosen articles

No	Title	Author, Year & Journal	Method	Conclusion
1	Influence of ethnicity on the perception and treatment of early post-operative pain	Al-Hashimi et al., 2015, British Journal of Pain	Retrospective analysis of post-operative pain scores and analgesic requirements	There are considerable differences in pain perception and treatment across ethnic groups in post-operative care; cultural factors should be considered by healthcare providers when managing post-operative pain
2	Ethnic differences in pain and pain management	Campbell & Edwards, 2012, Pain Management	Review article	There are significant ethnic differences in pain perception, assessment, and treatment outcomes; these are shaped by biological, psychological, and social factors and require tailored approaches to pain management
3	Conceptual adequacy of the neuropathic pain symptom inventory in six countries	Crawford et al., 2008, Health and Quality of Life Outcomes	Cross-cultural validation study across six countries	Cross-cultural validation of pain assessment tools is required to ensure their conceptual adequacy across linguistic and cultural settings
4	The Spiritual Aspect of Pain: An Integrative Review	De-Diego-Cordero et al., 2024, Journal of Religion and Health	Integrative literature review	Spiritual dimensions of pain are culturally mediated and must be incorporated into comprehensive pain assessment and

				management approaches
5	Delivering transformative action in pediatric pain: A Lancet Child & Adolescent Health Commission	Eccleston et al., 2021, The Lancet Child & Adolescent Health	Expert commission report	Comprehensive pediatric pain therapy requires consideration of cultural context; reformatory approaches must overcome cultural variation in pain assessment and treatment
6	Conceptions of pain among Somali women	Finnström & Söderhamn, 2006, Journal of Advanced Nursing	Qualitative interviews	Somali women's pain complaints and coping strategies are strongly influenced by cultural beliefs and values; health professionals must grasp these cultural variables in order to provide appropriate care
7	Validity of four pain intensity rating scales	Ferreira-Valente et al., 2011, PAIN	Experimental validation study	Different intensity scales of pain have different validity across populations; cultural influences may affect scale preference and interpretation
8	Cross-cultural adaptation of the Pain Medication Questionnaire for use in Brazil	Galindo et al., 2019, BMC Medical Research Methodology	Cross-cultural adaptation and validation study	Pain assessment instruments require rigorous cross-cultural adaptation to ensure validity in new cultural contexts
9	Pain in the eye of the beholder: Variations in pain visual representations as a function of	Gingras et al., 2023, British Journal of Psychology	Experimental study examining how face ethnicity and culture influence visual representations of pain	Cultural and ethnic factors significantly impact how pain expressions are perceived and interpreted across different populations,

	face ethnicity and culture			highlighting the need for culturally sensitive pain assessment approaches
10	The importance of cultural competence in pain and palliative care	Givler et al., 2025, StatPearls Publishing	Literature review	Cultural competence is essential in pain and palliative care; practitioners must be aware of how cultural matters affect pain expression, treatment options, and end-of-life care decisions in order to deliver appropriate patient-centered care
11	Measures of adult pain: Visual Analog Scale, Numeric Rating Scale, and Verbal Rating Scale	Hawker et al., 2018, Arthritis Care & Research	Review of pain measurement scales	Standard pain assessment tools have limitations in diverse populations; cultural considerations are important when selecting appropriate pain measures
12	A systematic review of the pain scales in adults: Which to use?	Karcioglu et al., 2018, The American Journal of Emergency Medicine	Systematic review	Several pain scales vary in utility depending on clinical context and patient population; cultural factors must inform scale selection
13	Cultural meanings of pain: a qualitative study of Black Caribbean and White British patients with advanced cancer	Koffman et al., 2008, Palliative Medicine	Qualitative study comparing cultural meanings of pain	Pain meanings differ significantly between cultural groups; these differences influence how patients report, cope with, and seek treatment for pain
14	Chinese and Indian interpretations of pain: A	Lewis et al., 2023, Pain Practice	Qualitative evidence synthesis	Chinese and Indian cultural interpretations of pain differ markedly

	qualitative evidence synthesis to facilitate chronic pain management			from Western conceptions; understanding these cultural frameworks is essential for effective chronic pain management
15	Cultural influences on pain perception and management	Miller & Abu-Alhaija, 2019, Pain Management Nursing	Editorial/commentary	Cultural background shapes how patients experience and express pain; nurses must develop cultural competence to effectively assess and manage pain across diverse populations
16	Cultural Influences on Pain	Peacock & Patel, 2008, Reviews in Pain	Review article	Cultural factors influence every aspect of the pain experience, from perception and expression to coping strategies and treatment preferences
17	Translation and cultural adaptation of an objective pain assessment tool for Finnish ICU patients	Pudas-Tähkä et al., 2014, Scandinavian Journal of Caring Sciences	Translation and cultural adaptation study	Pain assessment tools require careful translation and cultural adaptation to maintain validity across different linguistic and cultural contexts
18	Cultural Framing and the Impact On Acute Pain and Pain Services	Rogger et al., 2023, Current Pain and Headache Reports	Review/perspective	Cultural framing significantly impacts acute pain experiences and utilization of pain services; healthcare systems must address cultural barriers to equitable pain management
19	Ethnicity as a factor in the expression of pain	Flannery et al., 1980, Psychosomatics	Observational study	Ethnicity significantly influences pain expression patterns; healthcare providers must be aware of cultural variations in pain behavior to

				avoid misinterpretation
20	Pain: a review of three commonly used pain rating scales	Williamson & Hoggart, 2005, Journal of Clinical Nursing	Review of pain assessment tools	Common pain rating scales have varying utility across different populations; cultural considerations are important when selecting and interpreting pain measures
21	Development of the Chronic Pain Cognition Scale: A Culture-Sensitive Pain Measurement in Chinese	Wu et al., 2023, Journal of Pain Research	Scale development and validation study	Pain assessment tools specific to particular cultures are necessary to measure distinct features of pain experience in different cultures; the Chronic pain Cognition Scale was developed to target certain Chinese cultural dimensions of pain