YRKESHÖGSKOLAN
NOVIA

Pain Assessment Tools Used When Caring Through Cultural Boundaries

A Qualitative Systematic Literature Review

Mingzhi Jin

Degree Thesis in Health Care and Social Welfare, Vaasa

Education: Nurse, Bachelor of Health Care

Vaasa / 2017

BACHELOR'S THESIS

Author: Mingzhi Jin

Degree Program: Nursing

Supervisor: Maj-Helen Nyback

Title: Pain Assessment Tools Used When Caring Through Cultural Boundaries

A Qualitative Systematic Literature Review

Date 08.03.17 Number of pages 48 Appendices 5

Abstract

Caring through cultural boundaries in pain assessment is multidimensional. Ineffectual pain assessment would result in deficient pain management, which would have negative impacts on the clients' wellbeing. The aim of this study is to explore cultural boundaries in pain assessment between patient and nurse, and how the nurse uses pain assessment tools. This is a qualitative systematic literature review. In the theoretical background, the concepts of cultural boundaries, pain, and communication significant for this study will be presented. Orlando's Nursing Process Theory and Campinha-Bacote's Model of Cultural Competence will form the theoretical framework. The study indicates that there are cultural differences in responses to pain. Through striving the knowledge of cultural competence, a nurse would be able to choose proper pain assessment tools for cultural sensitive pain assessment when caring through cultural boundaries.

Language: English Key words: pain assessment, tools, nursing, culture, communication, pain, transcultural, cultural boundaries

Table of Contents

1 Introduction

The major interest of this study came from the respondent's clinical experiences as a nursing student. There were two cases that raised respondent's attentions. The first case was a thirty-year-old refugee patient who came to the local health care bed ward because of an injury from a car accident. He spoke his mother tongue and very limited English. He constantly called for nurses and behaved manically. He kept performing the same hand gestures on the nurses' arms. He would move his index finger and middle finger ahead of each other. Nurses in the ward were assuming the gestures suggested some form of pain as the result of his injuries. The pain killers were given and they did not seem to have any effect. Then, he was given a stronger pain killer there was no change in his behaviors. Later, his friend, who could speak both his mother tongue as well as English, told the nurses that he wanted to walk and rehabilitate his leg. The respondent together with the caring team was surprised to find out how incorrectly the message from the patient had been interpreted in pain assessment.

The second case was a Russian patient, who had a satisfying command in Finnish. He called nurses every five seconds and screamed at the pain in his legs. Unfortunately, medication was unable to reduce his pain. His reactions to pain were quite dramatic to the hospital staff. The caring team holds the opinion that Russians tend to react more dramatically than other patients. His vital signs were taken and the results showed little out of the ordinary, which indicated that his pain was not as strong as he had displayed.

In the first case, the misunderstanding occurred when there was language boundary together with the fact that hand gestures vary from culture to culture. In the second case, the misunderstanding on physical pain occurred when nurses and patients are from different cultural backgrounds. Although linguistically there was no boundary between nurses and the patient, culturally there obviously was. The two cases describe the pain assessment between nurses and patients when caring through cultural boundaries. The pain assessment in the above cases has some friction. The nurses did not properly interpret the messages on the pain that the patients intended to convey. The nurses, therefore, were not able to rate the patients' level of pain, which resulted in inappropriate pain assessments. Due to the insufficient pain assessment, the pain management was not adequate. Ineffectual pain management would have negative impacts on the patient's wellbeing and increase costs for the health care sectors. (Hutchinson, 2007)

The respondent raises the question of how culture influences responses to pain and how the nurse could interpret the message of pain in a more coherent manner. The respondent wanted to investigate tools that possibly contribute to pain assessment when caring through cultural boundaries.

2 Aim and Problem Definition

The aim of this study is to explore cultural boundaries in pain assessment between patient and nurse, and how the nurse uses pain assessment tools. The respondent will focus on how sane adult patients in different cultures respond to pain. The goal of this study is to increase the understanding of cultural boundaries in caring and pain assessment in a way that the negative complications of ineffective pain assessment would be reduced. A systematic literature review will be applied in this thesis.

The two research questions posed are:

1. How do different cultures respond to pain?

2. What tools are available for pain assessment?

3 Background

In this chapter, the respondent will concentrate on three concepts: Cultural Boundaries, Pain, and Communication. The aim of this study is to explore cultural boundaries in pain assessment between patient and nurse, and how the nurse uses pain assessment tools. Hence, by opening up the three concepts Cultural Boundaries, Pain, and Communication, readers would be able to comprehend the study more thoroughly.

3.1 Cultural Boundaries in Caring

In this section, the respondent concentrates on the definition of culture and cultural boundaries through the concepts of Culture Shock, Subculture, Cultural Blindness, Cultural Imposition, Transcultural Nursing and Cultural Sensitive Care.

Culture is a vast concept that contains a multitude of aspects. According to Leininger (1978) **culture** is the knowledge that is learned and transmitted into values, beliefs, rules of

behaviors and lifestyle practices. It guides a designated group with their way of thinking and acting in patterned ways. Munoz & Luckman (2005) describes that culture is the foundation of a racial, ethnic, religious, or social group. Culture is a term that is never fixed, it changes and evolves with time.

3.1.1 Culture Shock, Subculture, Cultural Blindness and Cultural Imposition

Culture shock is a key concept used in transcultural nursing. Nurses and clients experience cultural shock in many different settings, where they are unable to act appropriately in situations that are shocking to them because lifeways are so different. Culture shock leaves the feeling of helplessness, hopelessness, and confusion to the individual, e.g. an elder Amish client who has never been in hospital settings would possibly experience culture shock when suddenly taken into the emergency room with masked nurses, light, equipment etc. since the Amish are not used to the technological world. A nurse, on the other hand, would most likely be shocked when encountering an Anglo mother declining her child's crying until the child does severely harmful acts. Culture shock enormously limits an individual's ability to be around strangers in unfamiliar settings. Nonetheless, one can overcome and prevent certain cultural shock through studying people from a certain culture and acknowledging their lifeways before working with them. (Leininger & Mc Farland, 2002)

Subculture refers to a composition of people having distinct identities yet related to a larger cultural group. A subcultural group commonly shares ethnic origin or physical characteristics with the larger cultural group it's related to. (Berman & Snyder, 2012, 316) People are not only part of the major cultural group but also related to the subcultural groups. The classification of a subcultural group might be based on occupation, age groups, gender, socioeconomic class, sexual orientation etc. When a patient is charged into the hospital, he encounters a new subcultural group as a patient. Although the hospital is located within his major cultural group, there are many unfamiliar surroundings for him in the hospital. Therefore, this patient would still feel the cultural shock of the subculture. Accordingly, patients from another major cultural group entering this hospital would experience an intensified cultural shock since they must overcome both the major culture and the subcultures of the hospital (Munoz & Luckmann, 2005)

Cultural Blindness, sometimes called Cultural Blind Spot, refers to the care provider's assumption that the client, who is similar in the appearance and behavior as the care provider herself/himself, there would be no cultural differences or potential barriers to give appropriate care. Cultural blindness occurs when a person holds the perception that he/she understands the culture and has had similar cultural encounters, and as a result, the person would conclude that he/she has the culturally competent skills. Cultural blind spot occurs when there is a lack of awareness of differences. (Andrews & Boyle, 2012) **Cultural Imposition** refers to the health care professionals' tendency to impose their own beliefs on others because of their notion of superiority. (Sagar, 2012)

3.1.2 Transcultural Nursing and Cultural Sensitive Care

Transcultural Nursing focuses on the correlative study and analysis of divergent cultures and subcultures in the world while maintaining an attitude of respecting the caring values, expressions, health-illness beliefs and behavioral patterns of the cultures. Transcultural nursing is a formal area of humanistic and scientific knowledge and holistic culture care practice. It consists of the competence of helping individuals or groups to maintain or regain their wellbeing in a culturally congruent and beneficial way (McFarland, 2014) Transcultural nursing has significance for delivering culturally sensitive care. Nursing is a profession that is "culturally determined", which forms a conditional relationship between **cultural sensitive care** and cultural determination. A transcultural nurse would be trained to have the abilities to assess, diagnose, plan, implement and evaluate clients through their cultural significant information. Clients representing the same cultural group are as unique as there are many different cultural groups in the world. The purpose of transcultural nursing is to be able to collect culturally relevant information on the clients and give cultural sensitive and competent care. It is also the responsibility of each nurse to have a knowledge of transcultural nursing. (Giger & Davidhizar, 2004)

3.2 The Concept of Pain

In this section pain concepts as the definition of pain, pain assessment, and its association to cultural boundaries will be described. Suffering will be clarified briefly after the definition of pain because of the similarity of the concepts.

3.2.1 Definition of Pain

Pain is a universal concept, however, the experience is unique from person to person. Pain is a subjective term that an individual describes and experiences. Pain has its meaning and is produced out of the complex interactions of body, mind, and culture. Pain can be interpreted differently from individual to individual depending on the time and place where that person is. (Louise Hide, 2012). Pain is complicated since it concerns physical and emotional senses both in body and mind. Pain is a physiological signal that has an impact on the mind, body, and spirit. It is the response to an actual or potential tissue damage and a body warning signal. Some pain scientists have revealed that pain is a complex protective mechanism. (Moseley, 2015) Therefore, pain cannot always be identified from an abnormal lab result or a radiography report. (Berman & Snyder, 2012)

Pain is a sensation that is caused by our nervous system. The sensation gives a negative impact on the human body, which could be an unpleasant experience even harming our bodies. Pain impulses are carried by a specific kind of nerve fiber to the brain. Pain exists for a good reason as it helps to identify problems in our bodies. Pain can be serious or mild, it can stay for days, months and even years. Generally speaking, the pain dissipates when the problems in our bodies are solved. (Berman & Snyder, 2012)

There are four factors that commonly affect pain expressions: Location, Duration, Intensity and Etiology. Etiology means the reason for the pain. Etiology can be divided into nociceptive pain, somatic pain, and neuropathic pain. Nociceptive pain is experienced when a proper functioning nervous system sends a signal of a tissue damage requiring proper care. Somatic pain derives from the skin, muscle, bone or connective tissue. It is a sharp sensation or aching. Neuropathic pain occurs within malfunctioning nerves due to illness. (Berman & Snyder, 2012)

The location is the place where the pain occurs. Duration is the time that pain lasts, and is classified as chronic or acute. Intensity tells how severe the pain is. It is usually measured

through a pain scale from zero to ten. The patient's rate themselves. Usually, four to six is considered as a moderate level, and above seven is considered to be severe pain. (Berman & Snyder, 2012)

3.2.2 Suffering vs. Pain

The respondent is seeking to focus on pain through cultural boundaries. Suffering is related to pain and therefore included into the Theoretical Background. Nyback (2008) describes that pain could be an indirect symptomatic description within suffering, illness, anxiety, fear and loneliness. Hence, the respondent wanted to clarify the concept of suffering, in order to increase the understanding of pain.

The concept suffering is relatively broad and abstract; therefore, it is demanding to give it a plain definition. Suffering is seen as a central concept of the caring science since it relates to empathy, sympathy, and compassion. Suffering can be understood as a reaction to losses, e.g. loss of health, dignity, mobility, loved ones, and self. (Nyback, 2008)

In her book, Eriksson (2006) mentions that the concept of suffering and pain cannot be used interchangeably. Suffering can exist without pain, likewise, the existence of pain does not necessarily combine with suffering. Suffering has both negative and positive aspects. Negative suffering occurs when circumstances plague a person. Those circumstances could be pain and misery. Suffering is a part of life and subjected to every human being. Suffering becomes positive when a meaning behind it is found. Positive suffering is constructive and has its special meaning. (Eriksson K. , 1994)

Suffering could also be experienced when one lacks something desired. A person could suffer with or for another person, in this situation suffering could mean compassion. (Eriksson K. , 2006) Suffering has its phases. These phases make up the process of reconciliation. The suffering human being has to accept the suffering as part of life and gradually learns to manage and to endure it. The meanings behind suffering will be found when reconciliation is formed. (Eriksson K. , 1994)

3.2.3 Pain Assessment

Pain assessment is significant to the pain management. Therefore, many health care facilities consider that pain assessment as the fifth vital sign. Pain assessment is used as a routine check-up in health care, it is a fact that pain is subjective and pain experiences comprehensive. Pain experiences cover physiological, behavioral, sociocultural, and emotional aspects etc. (Berman & Snyder, 2012)

Pain assessment consists of two main steps: Pain History and Immediate Pain Observation of changes in behaviors, tissue damages or physiological responses. The purpose of pain assessment is to get an as objective as possible understanding of the pain as a subjective experience. (Berman & Snyder, 2012)

3.2.3.1 Pain History

Pain history is of great importance to the pain assessment in nursing. Since pain history would help nurses to understand what pain means to a patient and how he or she copes with it from before. As pain is subjective and it is an individual experience, the patient himself/herself is the best interpreter of it. Therefore, nurses should give the opportunity or space for the patients to express their pain experiences in their own words and ways. (Berman & Snyder, 2012)

For patients who are in severe acute pain, the pain history would be focusing on previous pain treatment, how the treatment worked, what kind of analgesics were taken latest, medications, and allergies in the records. For patients with chronic pain, nurses would be focusing on coping mechanisms, how those mechanisms work, the effectiveness of pain management used as well as the impact of pain experiences on the patients, e.g. body impact, emotional, mental and social impact. The data would be comprehensive on pain history and would include different pain components such as pain location, intensity, quality, patterns, precipitating factors, associated symptoms, alleviating factors, the meanings of pain, how pain affects daily basic activities, coping strategies and affecting responses. (Berman & Snyder, 2012)

3.2.3.2 Observation

Observation, in some occasions, takes place when the clients are not able to "self-report" their pain experiences adequately. This category of clients, called "nonverbal" patients, includes patients who are critically ill e.g. in a coma, disabled or in palliative care. (Berman & Snyder, 2012)

There are varied ways of responding to pain in the "nonverbal" patients. Facial expression is considered as one of the first signs of pain. Patients could also use vocalizations as crying, groaning, screaming, or moaning to respond pain. Behavioral changes would also indicate pain. There are certain different types of behavior changes: purposeless body movements like turning in bed many times, confusion and restlessness, body movements that a follow the certain rhythm or the immobilization of the body parts. However, behavioral changes do not necessarily indicate pain, since with time patients might have adopted a coping mechanism to deal with those behavioral changes caused by pain. As a result, the behaviors would be controlled and not as revealing as otherwise. (Berman & Snyder, 2012)

Physiological responses measured by nurses would also contribute the pain assessment data. In the stage of acute pain, the sympathetic nervous system would be stimulated causing a series of physiological responses, the blood pressure, pulse rate, pallor, respiratory rate, diaphoresis and pupil dilation would be increased. If the pain lasts for a longer period of time the physiological responses would not be as evident as in the beginning. Therefore, the physiological responses indicators are ineffectual for patients with chronic pain, (Berman & Snyder, 2012).

3.2.3.3 Pain Assessment Tools

Pain assessment tools are used to quantify pain intensity due to the subjective nature of pain. There are four elementary assessment tools commonly used: a numeric scale, a word scale, a linear scale, and a picture scale. The level of pain is identified by the client through comparing the choices on the scale. (Timby, 2009) There are two pain scales for assessing chronic pain normally used: Brief Pain Inventory (BPI) (Appendix 2) and McGill Pain Questionnaire (SF-MPQ) (Appendix 1). These two pain scales include other aspects of chronic pain than the intensity rating, such as verbal descriptors, mood indicators and pictures where clients locate their pain experience. (Berman & Snyder, 2012)

Pain Intensity Scale is a numeric 0-10 scale (Figure 1). The number 0 represents No Pain, 5 represents Moderate pain and 10 stands for the Worst possible pain. It is commonly used for adult patients (Timby, 2009)

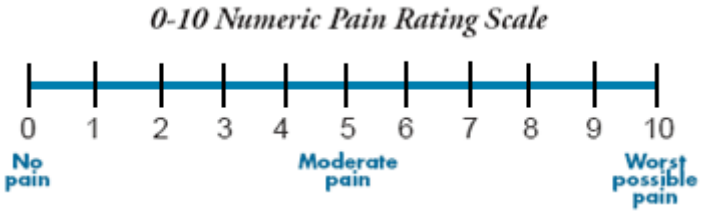


Figure 1: 0-10 Numeric Pain Intensity Scale

(https://understandingpain.wordpress.com/category/pain-assessment-tools/)

The Simple Descriptive Pain Intensity Scale is a word scale (Figure 2). It includes gradings from No pain, Mild pain, Moderate pain, Severe Pain, Very severe pain to Worst possible pain. (Timby, 2009)

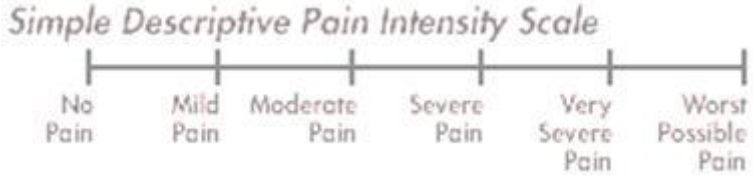


Figure 2: The Simple Descriptive Pain Intensity Scale

(http://course.sdu.edu.cn/G2S/Template/View.aspx?courseId=455&topMenuId=138555&action=view&type=&name=&menuType=1&curfolid=145857)

The Visual Analog Scale (VAS) is a linear scale (Figure 3). It consists of a line starting with "No pain" and ending up with "Pain as bad as it could possibly be". (Timby, 2009)

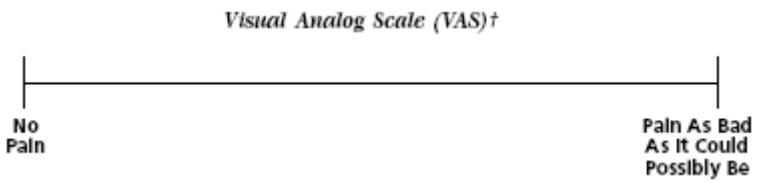


Figure 3: Visual Analog Scale

From http://www.physio-pedia.com/Visual_Analogue_Scale

Figure 4: Wong-Baker Scale

From *https://peerj.com/articles/37/*

The Wong-Baker scale is a picture scale (Figure 4). It shows six different facial expressions from No Hurt to Hurts Worst, which indicates the level of pain. Wong-Baker FACES scale is most applicable for children or clients having a different cultural background than the nurse or mentally challenging clients. (Timby, 2009)

3.2.4 Aspects of Pain Experience

Pain is an experience that consists of physiological, psychological as well as social aspects. Changes in behavioral, emotional, and cultural responses, would affect the understanding and expressions of pain. Patient's backgrounds determine pain. Backgrounds include education, place of birth, religion as well as language. (Flaskerud, 2015)

Ethnic background and cultural heritage are the recognizing factors that influence individual's reaction and expression toward pain. Some cultures might learn to express their pain, while other cultures tend to withdraw pain. Cultural backgrounds affect how

individuals experience the level of pain and how they are willing to tolerate it, e.g. in some Middle Eastern and African cultures, pain is considered as a sign of mourning or grief. Yet, in some cultures, the tolerance of pain is thought to be a strength. Studies prove that people from North Europe tend to be more stoic than the South Europeans. (Berman & Snyder, 2012)

Environment and support might affect how people experience pain. When a patient is admitted to the hospital, the unfamiliar surroundings of lights, noise and actives can worsen the pain. People without a supporting network might experience severer pain than others. One's expectations of significance to other people and family role can also be contributing factors to pain response, e.g. girls in some cases might express their pain stronger than boys. A single mom, on the other hand, might tend to ignore the pain in order to take care of her children. (Berman & Snyder, 2012)

Previous pain experiences trigger the patient's sensitivity to pain. People with previous pain experiences, either individual or from their close ones', would be more vulnerable than those without. The pain management methods used in the past would also affect the patient's view of pain experiences. (Berman & Snyder, 2012)

The interpretation of pain would in a way influence the experiences of pain. A client who connects the pain with positive outcomes would withstand pain well, e.g. a woman giving birth or an athlete going for a knee surgery to prolong his career. On the contrary, an unrelenting chronic and persistent pain would affect a client's life quality, both mentally and in daily activities. (Berman & Snyder, 2012)

3.2.5 Cultural Response to Pain

The symptoms detected in patients can also reflect their cultural backgrounds. According to research and studies, suffering in silence is considered to be the most valued response to pain, as people widely believe that controlling pain is better than expressing it. (AvMary A. Nies, 2013) These individual experiences are shown both through verbal as well as nonverbal communication. (Smith;Curci;& Silverman, 2002) As globalization progresses it is important for nurses to be culturally competent (Callister, 2003). It is essential for nurses to understand pain in a cultural perspective since this will contribute to the pain assessment.

Ethnic background and cultural values have to be considered when understanding, reacting and expressing pain. There are basically two cultural responses: stoicism and expressive or emotive behavior. (Berman & Snyder, 2012) The stoic response would be the refusal to admit pain. This group believes that pain is the punishment for sins done in the past and the punishment helps to guarantee a joyful future. They often act like "perfect" patients to avoid bothering others. The expressive group is usually in strong fear of pain and of helplessness. They consider that crying out relieves pain. (Munoz & Luckmann, 2005)

3.3 The Concept of Communication

Communication is described in this section since the aim of this study is to explore cultural boundaries in pain assessment between patient and nurse, and how the nurse uses pain assessment tools. Communication is significant when caring through cultural boundaries.

The forms of communication are verbal and nonverbal communication. The importance of communication in cultural nursing context and its effect on the nurse-patient relationship would be centered. (Timby, 2009)

Communication, in other words, is an exchange of information. It involves sending and receiving messages between two or more people. The feedback indicates if the information was understood or if there is a requirement for further clarification. The messages include both verbal and nonverbal communication. Relationships are based on communication, so is the therapeutic interactions between nurses and clients. Hence, nurses should develop their communication skills to enhance the therapeutic interactions with clients. (Timby, 2009)

3.3.1 Communication in General

There are two types of communication, one-way and two-way. In the one-way communication, the receiver gives no feedback to the message received. However, in the two-way communication, the receiver is actively involved responding to the message received. Although the two-way communication is considered superior by healthcare organizations, it is not often used in practice, since it requires more time. (Ellis;Gates;& Kenworthy, 1995)

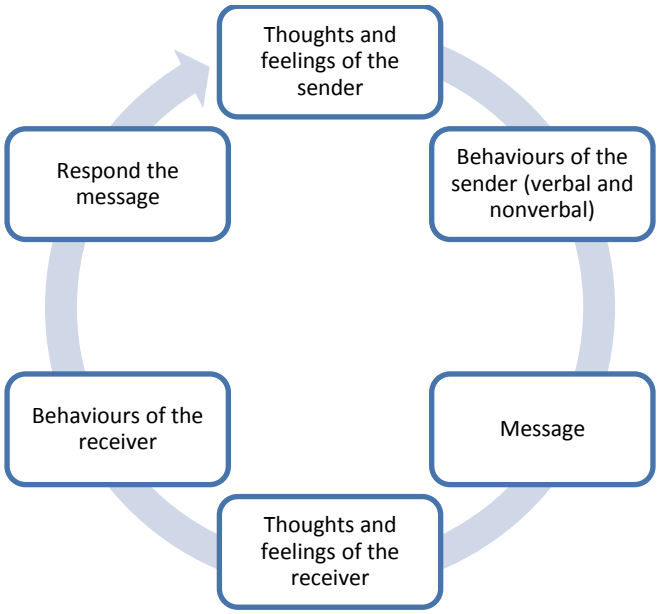


Figure 5. Communication model (Ellis;Gates;& Kenworthy, 1995)

In face-to-face communication, a language is a significant tool of ideas that are complex and abstract. Language is the carrier of the message. The spoken languages would be conveyed with different tones of emphasis and stress, depending on the sender's mood. Accent and dialect of the language would somehow indicate social class, religion, and culture of the sender. The words in a language make sense only when the receiver understands them. However, in some situations, the surface of the meaning is not that important if the sender consciously or unconsciously tries to decode the message behind the actual wording itself. For deaf people, there are sign languages available, where visional aspects and lexical contents would be more focused. (Ellis;Gates;& Kenworthy, 1995)

Body language, on the other hand, is a way of expression without lexical contents. Body language can reveal different emotional characters. Body language varies from culture to culture. Body language consists of gestures, facial expressions, gaze, posture, body space and proximity, touch and dress. (Ellis;Gates;& Kenworthy, 1995)

There are four types of message 1) message is conveyed simply and meaningfully in the surface 2) the sender consciously encodes the message behind the surface 3) the message is unconsciously encoded with feelings of the sender and 4) the sender is trying to dump his or her experiences and feelings into the message. (Ellis;Gates;& Kenworthy, 1995)

3.3.2 Communication in Caring

As the development of nursing is an ongoing process, the relationship between nurse and patient is no longer a disease-centered relationship but rather an individual-centered relationship. The patient is actively involved in the caring process. In order to involve the patient as an active participant in the caring process, it is necessary to inform her/him about the caring process. The quality of the relationship between nurse and patient is the criteria for professional nursing; a good communication is considered as a virtue of nursing. (Ellis;Gates;& Kenworthy, 1995) A study published in 2013 reviews cancer pain in elderly patients. The study includes the relationship between communication and expression of cancer pain. The result shows that good communication can reduce patient's fear of pain, which can reduce the feeling of pain. The way of communication can affect how elderly patients understand pain. (Dunham, et al., 2013) Caring is considered to be a meaningful and sensitive interpersonal communication between nurses and patients. (Ellis;Gates;& Kenworthy, 1995)

There are certain factors that influence the relationship between patients and nurses. The essence of a helping relationship is to able to create a surrounding that is warm, genuine, and empathetic. It is not a practical skill, rather a state of mind. It is an attitude of openness respecting individuals regardless of their backgrounds. (Ellis;Gates;& Kenworthy, 1995) A study done in 2013 indicates that the expression of pain could be influenced through trust. A trusting and loving relationship between the healthcare professional and the patient would contribute to a better understanding of pain. The patient's expression of pain would contribute to accurate disease diagnosis as well as its prognosis. (Dunham, et al., 2013)

It is important for patients to feel safe, that nurses understand them and are there to support them with their decisions concerning their welfare. However, nurses should have a reflective mind, since the nurses' understanding consists of both patient's perspectives and self-perception. The depth of understanding would affect the quality of the relationship between nurses and patients. However, nurses should also have the ability to encounter patients in a polite way, since this would enhance a positive attitude and motivate their recovery. (Ellis;Gates;& Kenworthy, 1995)

The core of any interpersonal relationship is communication, which also includes the caring relationship between the nurse, the patients, and their loved ones. (Ellis;Gates;& Kenworthy, 1995) The experience of cancer pain could be different when culture and language are

involved. Dunham et al. compared the cultures in Israel and America and found that the communication influences are apparent. Language, abstract emotional words or visible concrete symptoms of pain is used to describe the pain. (Dunham;Ingleton;Ryan;& Gott, 2013) Pain expression and language goes hand in hand. Those who cannot communicate could suffer. (Waddie, 1996)

The professional caring relationship involves face-to-face interactions. In the scenario, communication skills are required. In nursing the skills required are mostly nonverbal, e.g. nodding and eye contacts. These nonverbal behaviors convey the message to the patient, that the nurse is paying attention to and giving confirmation to what the patient says. Listening is also a way of nonverbal communication and it would encourage patients to be more involved in their caring process through expressing their feelings and ideas. (Ellis;Gates;& Kenworthy, 1995)

3.3.3 Communication through Cultural Boundaries

Communication and culture go conjointly since they affect each other interchangeably. Culture has an impact on the expressions/communication in general on feelings. Culture determines appropriate verbal and nonverbal communication. Communication in different cultures affects the way people feel and how they make decisions. Communication pattern of an individual also indicates his or her culture. There are communication differences especially in small groups, for example in families. (Giger & Davidhizar, 2004)

In transcultural nursing, nurses should not generalize patients from the same cultural groups to have the same type of communication patterns, since communication patterns are unique from person to person. Therefore, communication patterns can’t be generalized by the patient’s cultural background. (Giger & Davidhizar, 2004)

According to Giger & Davidhizar (2004), sensitivity in communication in transcultural nursing can be achieved through proper communication techniques. They found that nurses who could not communicate and interpret a patient’s communication would feel helpless and stressful. The first step in achieving a proper communication technique is to assess the patients’ personal beliefs. The second step is to do a cultural communication variables assessment of the patient. The third step is to modify communication methods to fulfill the cultural needs. The fourth step is to respect the patients’ needs and consider them the essence of the therapeutic relationship. Then, it is suggested for nurses to use validation in the

communication, that is to give feedback on what the client said. For example, asking "Did I understand you correctly" to validate whether the patient's message was interpreted correctly. Within cultures, there are taboos, e.g. sexual matters, which the nurses should be cautious about and considerate of in their communication. In some cases, when there is a language barrier, it is suggested that nurses talk in a slow, simple and clear manner. If an interpreter is used, then the interpreter should also be culturally sensitive and know how to pass the client's message to the nurse. (Giger & Davidhizar, 2004)

4 Theoretical Framework

The theoretical framework provides guidelines for the study and it helps to interpret the result in a meaningful way. (LoBiondo-Wood & Haber, 2002) In this chapter, there are two theoretical frameworks selected: Orlando's nursing process theory and Campinha-Bacote's model of cultural competence. Orlando's nursing process theory is a patient-focused nursing theory. It suggests that care should be individualized. The nurse-patient relationship is a fair relationship where both partners participate willingly. The evaluation of patients' behavioral changes would be part of the pain assessment and would prevent misdiagnosis and ineffective caring plans. (Orlando, 1990) It could give the guidelines to explore cultural boundaries in pain assessment between patient and nurse. An individualized care is also required when caring through cultural boundaries. The Campinha-Bacote's model of Cultural competence is chosen since it gives guidelines for nurses to build their cultural competence in nursing interventions. The respondent intended to find out the how nurse uses pain assessment tools when caring through cultural boundaries. Cultural competence care enhances effective pain assessment in multicultural settings.

4.1 Orlando's Nursing Process Theory

According to Orlando the responsibility of a professional nurse is to help the patient with his or her needs. That is to say, a professional nurse should be able to ensure the patient's physical and mental comfort during medical treatment to the highest extent possible. The patients are depending on the nurse because the patients cannot independently fulfill their own needs. To be able to help patients with their needs, the nurse should recognize them. However, in many cases, those needs are not recognized due to the inadequate communication of the patients. In that scenario, the nurse should be able to observe the

patients and identify their needs. The observation determines the nursing plans. The documentation of observation is nursing data, which contributes to the process of caring. When the needs cannot be fulfilled, the patient would become distressed. If the needs are met, then the patient's immediate distress would be reduced and his or her immediate sense of well-being would be improved. Orlando believes that the needs of a human being are the core of nursing practice. According to Orlando, nursing is unique when caring for an individual's need in an immediate situation. It requires proper training for a nurse to develop his/herself to meet an individual's immediate needs in any situation in the nurse-patient relationship. (Orlando, 1990)

4.1.1 Nursing Process Discipline

The nursing process discipline is founded on the process of acts of an individual. It is made for the purpose of helping patients with their immediate needs in the nursing setting. The nursing process discipline includes four aspects: patient behavior, nurse reaction, nurse's action and professional function. (George, 2011) According to Orlando's principle of the nursing process, the interaction between the nurse and patient should occur in a time and place that is specific. The interaction should happen when the patient has the need for help; this can be shown by his/her behavior. The nurse is the one who plans and implements the caring actions. The nurse should then evaluate the caring actions with patient's behavioral changes. If there are no behavioral changes or the patient's behavior has degraded, the process should be repeated. (Schmieding, 1993)

There are two types of nurse-patient contact. The first one would be open, which means that nurse's understanding of the patient could be done through observation of behavioral changes. The other one would be in secret, which means that nurse's understanding of the patient would not directly be observed through their behavioral changes. (Orlando, 1990)

4.1.2 Patient Behavior

"The presenting behavior of the patient, regardless of the form in which it appears, may represent a plea for help" Patient behavior communicates the need for help when they themselves cannot meet the need. It is the patient's behavior that stimulates a nurse's reaction, which indicates the beginning of the nursing process (Orlando, 1990, 36) Patient behavior could be verbal or nonverbal, obvious or seemingly insignificant. Verbal behavior

could be questioning, complaining, requesting, refusing, demanding and commenting. Nonverbal behavior would consist of physiological manifestation and vocal behaviors. Physiological manifestation would be heart rate, urination, motor activity like eye contacting and smiling. Vocal behaviors would be such as sobbing, shouting, and laughing. (George, 2011) All patient behaviors should be taken into consideration regardless of the form of behavior since the behaviors have their meanings to the individuals in their corresponding situations. (Schmieding, 1993). Behaviors indicate the patient's distress. The distress could be the result of physical limitations. The distress could be caused by inadequate understanding of the setting, which results in a negative reaction against a beneficial therapeutic intent. A patient's disease, embarrassment, stating, and lack of trust could cause distress and be an obstacle for communicating the needs (Orlando, 1990) The problems in a nurse-patient relationship can arise when the patient behavior is not expressive enough. Indecisive patient behavior keeps nurses from engaging in patients' care. (George, 2011)

4.1.3 Nurse's Reaction and Action

Nurse's reaction and action are included in the nursing process discipline for undertaking the inadequate patient behavior and meet the patient's immediate needs. Nurse's reaction is stimulated by the patient behavior. (George, 2011) Firstly, the nurse receives the behaviors through her/his senses. Those behaviors cause an automatic and instinctual thought, which then leads to an automatic emotional response. (Schmieding, 1993) However, the nurse should make sure that all the nursing procedures are logical rather than automatic. Therefore, the nurse should not assume, rather validate the patient behavior. (Orlando, 1990) In the discipline, Orlando provides guidelines on how nurses can share their reaction to the patients. What the nurse says verbally to a patient, should be coherent with his/her immediate reaction, at the same time, also invite the patient to confirm the validity of her reaction. The nonverbal reaction and verbal reaction should be consistent. A nurse should be able to express herself in a way that encourages the patient to describe his or her need more effortlessly. The nurse's openness in sharing her/his reaction safeguards the patient's need resolution (George, 2011)

There are automatic and deliberative actions. Only the deliberative nursing actions achieve a professional function. The automatic action is based upon the purpose or reason rather than patient's immediate needs. The automatic action is focusing more on the following of routines, physicians' orders. The deliberative action is built upon the needs of the patients.

The deliberative action focuses on the purpose to help the patient and also confirm that the patient is helped. After the action the feedback from the patient is important. (George, 2011)

4.1.4 Limitation

However, the theory has its limitations. As it is based on immediate actions and situations, it is not appropriate for a long-term caring plan. Caring of an unconscious patient is also not included in this theory. (Schmieding, 1993)

The aim of the thesis is to explore pain assessment tools when caring through cultural bondaries concerning sane adult patients. Therefore, long-term caring patients, unconscious patients and patients with mental disorders are not in the range of research areas.

4.2 Campinha-Bacote's Model of Cultural Competence

As the second part of the theoretical framework, the respondent chose Campinha-Bacote's process of cultural competence in the delivery of healthcare services. The thesis is aiming at exploring cultural boundaries in pain assessment between patient and nurse, and how the nurse uses pain assessment tools. According to Orlando's theory, a patient's behavior changes could be both obvious and seemingly insignificant, and that is why all of the patient's behavioral changes should be taken into consideration (Schmieding, 1993). Reasonably, behavioral changes in patients relate to their cultural backgrounds. Being able to notice a patient's behavioral changes, requires cultural competence. Cultural competence is thought to be the fundamental requirement for giving effective and culturally responsive services to clients coming from different backgrounds. Campinha-Bacote's model of cultural competence in health care delivery is a framework that could be applied to the structure of culturally responsive health care services. The relationship between the ability to provide a culturally responsive health care service, and the level of culture competence of the healthcare personals, are considered to be directly connected. (Campinha-Bacote, 2002)

The volcano model was developed by Campinha-Bacote. Campinha-Bacote considered that the cultural desire is the source energy that stimulates the process of cultural competence. When the cultural desire goes off, it triggers the process of cultural competence that involves finding cultural exposure, gaining cultural knowledge, making a cultural assessment and being modest upon the progress of cultural awareness. (Campinha-Bacote J. , 2003)

In this model, the cultural competence represents the process, where healthcare professionals achieve effective results within the cultural context of clients: individuals, family, and community. This model requires health care professionals to see themselves as the ones becoming culturally competent rather than the ones, who already are. (Campinha-Bacote, 2002)

4.2.1 Cultural Desire

Campinha-Bacote (1998) defines cultural desire as the motivation of a health care professional to "want to" engage in the process of becoming culturally competent; not "have to". The cultural desire is based on transcendent love and care. The cultural desire is built on the humanistic value to love and care for others. Each individual has the same background, that is to say, belongs to the same human race and has the same primitive needs.

The commitment to personal sacrifice is the component of the culture desire. This sacrifice is also associated with the commitment of caring for all the patients, despite their cultural backgrounds and values. It could occasionally be challenging when a client's value is completely opposite of the healthcare professionals'. However, this doesn't mean that the healthcare professional should embrace all individual values, but respect each client. (Campinha-Bacote J. , 2003)

The pure passion and commitment to an open and adjustable attitude are also a value in the culture desire. This means that the healthcare professional is willing to accept the differences of others and learn from patients. Humanity is the by-product of cultural desire. (Campinha-Bacote J. , 2003)

4.2.2 Cultural Awareness

Campinha-Bacote (1998) claims that cultural awareness is the self-examination and in-depth exploration of one's own cultural background. Cultural awareness indicates distinct prejudice between individuals. Cultural awareness prevents an individual from putting cultural imposition to the other. Cultural imposition refers to the trend of putting one's beliefs and values into another culture. (Campinha-Bacote J. , 2003)

Lara (1997) presents seven questions for healthcare professionals to self-examine their cultural backgrounds (Appendix 4).

4.2.3 Cultural Knowledge

Cultural knowledge is the process of seeking and obtaining a profound educational base about culturally diverse groups (Campinha-Bacote J. , 1998) In the process of gaining cultural knowledge there is a mixture of three main issues that healthcare professionals should focus on 1) beliefs about health-related issues and values on practices and cultures 2) diseases incidents are popular in certain cultural groups and 3) treatment and its effects.

The beliefs about health-related issues and values on practices and cultures are about awareness of how a patient's perception of the health-related issues is essential to understanding a patient's worldview since worldview explains behaviors. Campinha-Bacote used the Nichols' theoretical model to explain the four aspects of worldview as figure showed below. (Campinha-Bacote J. , 2003)

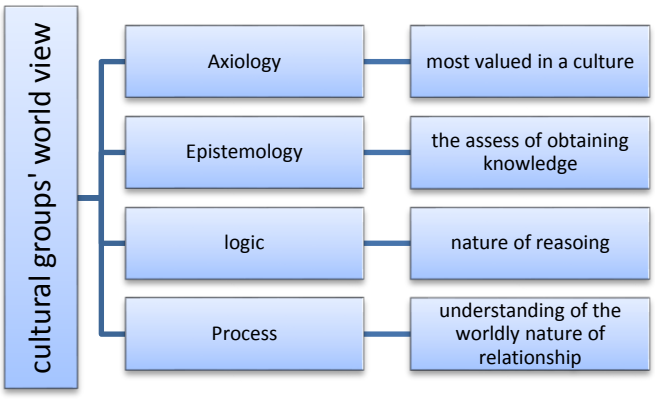


Figure 6. Nichol's theoretical model of a cultural groups' worldview (Campinha-Bacote J. , 2003)

Certain disease incidents are popular in certain cultural groups. Treatment and its effects involve the study of ethnic pharmacology, which concentrates on variation in drug metabolism among different ethnical groups. (Campinha-Bacote J. , 2003)

When obtaining cultural knowledge, it is significant to remember, that there would be variations within the same cultural groups. Therefore, it is important to not stereotype any cultural group, but rather recognize the uniqueness of each individual. In obtaining cultural knowledge healthcare professionals should not completely rely on textbooks and other

printed materials about culture, but learn directly from the clients as well. (Campinha-Bacote, 2003)

There are four stages that are identified by Purnell and Paulanka in gaining cultural knowledge. *Unconscious incompetence* illustrates that one is not aware of the absence of cultural knowledge. *Conscious incompetence* means that one is aware of the fact that the cultural knowledge is absence. *Conscious competence* means that the healthcare professional has a desire to actively learn from client's culture and want to provide a satisfactory culturally competent care. *Unconscious competence* states that the healthcare professional is able to give culturally competent care spontaneously. (Campinha-Bacote J. , 2002)

4.2.4 Cultural Skill and Encounter

Cultural skill is the ability to collect relevant cultural data concerning the client's current problem as well as accurately perform a culturally abased, physical assessment. (Campinha-Bacote J. , 1998) Cultural skill is about choosing the appropriate assessment tool and perform it in a culturally sensitive manner. (Campinha-Bacote J. , 2002)

The Cultural encounter is the process, which encourages the healthcare professional in a direct face-to-face interaction with clients from culturally diverse backgrounds. (Campinha-Bacote J. , 1998) Cultural encounter in some cases can be unpleasant since nurse might be having some verbal and non-verbal gestures that are offending to client's culture. (Campinha-Bacote J. , 2002)

5 Method

A qualitative systematic literature review, as well as deductive content analysis, will be selected as the method for this thesis.

5.1 Qualitative Systematic Literature Review

A qualitative research is scientific that follows a set of procedures systematically aiming at answering certain questions. A qualitative research is suitable for this thesis since it effectively answers questions about topics including values, opinions, behaviors that contain special information. A qualitative study is a flexible way to collect and analyze data.

Throughout the process of collecting and analyzing data, the researcher aims at finding a new perspective of knowledge based on previous studies. (Polite & Beck, 2008)

A systematic review would be the most appropriate choice. A systematic review is *"a review of the evidence on a clearly formulated question that uses systematic and explicit methods to identify, select and critically appraise relevant primary research, and to extract and analyze data from the studies that are included in the review*" A systematic review aims at finding out the synthesis of results of relevant studies on a well-formulated topic. Therefore, a systematic review should be systematic, explicit, and reproducible. The term systematic refers to literature being systematically searched. Explicit means that the description of methods, information and purposes should be coherent. (Booth;Rees;& Beecroft, 2015) A systematic review is an important part of practice that is based on current evidence and focuses on collecting and synthesizing the best available research to solve a specific area. (Hemingway & Brereton, 2009) A systematic review is thought to be the cornerstone of Evident Based Practice (called EBP in short) and it will play a more important role in the field of nursing as well as other health disciplines. It is said that the best clinical guidelines are usually based on this method. (Polite & Beck, 2008)

Figure 7: Systematic Review protocol (Booth;Rees;& Beecroft, 2015)

The respondent applied the systematic review protocol into the conduction of this study. The aim of this study is to explore cultural boundaries in pain assessment between patient and nurse, and how the nurse uses pain assessment tools. The research questions were produced accordingly. Keywords and inclusion criteria were made to select the qualified data using trustworthy databases. The data were collected using Systematically Searching the Literature Process (Figure 8). The selection of data was described as a process (Figure 9). Relevant data was carefully documented in the Overview of Articles Used in The Study in Appendix 3. The deductive content analysis (Figure 10) was selected to analyze the chosen relevant

data. Categorization matrix (Figure 11) the Model of Pain Assessment When Caring Through Cultural Boundaries (Figure 12) was made accordingly. The presentation of the study will be 16.3.2017 and the publication will be made in the theseus.fi. The respondent is working alone on this project. The opponent will be chosen in the presentation of this thesis. There is no proposed costing since the study is a systematic review using previous studies. Books and articles can be found through Tritonia Library services, which is free of charge for students of Novia Universty of Applied Sciences

5.2 Data collection: Systematic Literature Search

A systematic literature search would be adopted in the study since it would guide the respondent to get a list of primary studies that are all-inclusive. A systematic literature search follows a certain process displayed in the figure 8 below. (Booth;Rees;& Beecroft, 2015)

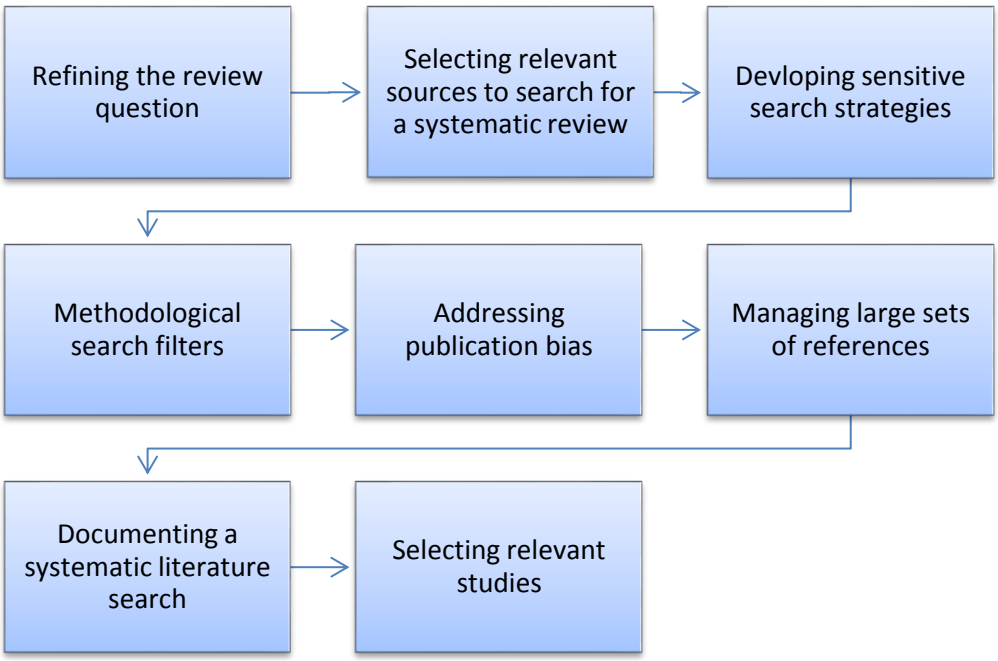


Figure 8: Systematically searching the literature process (Booth;Rees;& Beecroft, 2015)

The respondent applied the Systematically searching the literature process (Figure 8) into this study. The two research questions are 1. How do different cultures respond to pain? 2. What tools are available for pain assessment? The respondent then formulated the keywords,

inclusion and exclusion criteria for selecting the articles. The database used were EBSCO, CINAHL, and PubMed through Novia University of Applied Sciences Tritonia library FINNA search engine. The qualitative studies were carefully chosen. The selecting process of articles is demonstrated through the chart of data collection (Figure 9) below. The articles selected for this study were described in the Overview of Articles Used in The Study (Appendix 3). The systematic literature search is in this way well documented. There were 11 relevant articles selected for this study.

5.2.1 Inclusion Criteria.

Studies of qualitative approach would be selected since this thesis is using qualitative systematic literature review. Studies written in English will be chosen. Keywords include pain assessment, tools, nursing, culture, communication, pain, transcultural. The searching process would be using the combination of the keywords mentioned above. The full-text assessable material through Finna library database using Novia University of Applied Sciences username will be chosen.

The inclusion process will begin at putting keywords in the advanced search area. Then the respondent would choose in the match area “AND” or “OR” in order to combine the keywords. The respondent will next set limits on the material type to “E-article”, Language to “English”, Subjects to “Nursing” and Full text available. The title and abstract will be reviewed first by the respondent. All the relevant articles are selected

5.2.2 Exclusion Criteria

Languages that are not English are excluded from this thesis. Studies that are done through quantitative method are excluded from this thesis. Studies that can’t be assessed to full text will be excluded. Irrelevant material to the keywords mentioned in the inclusion criteria and the content of this thesis would be excluded.

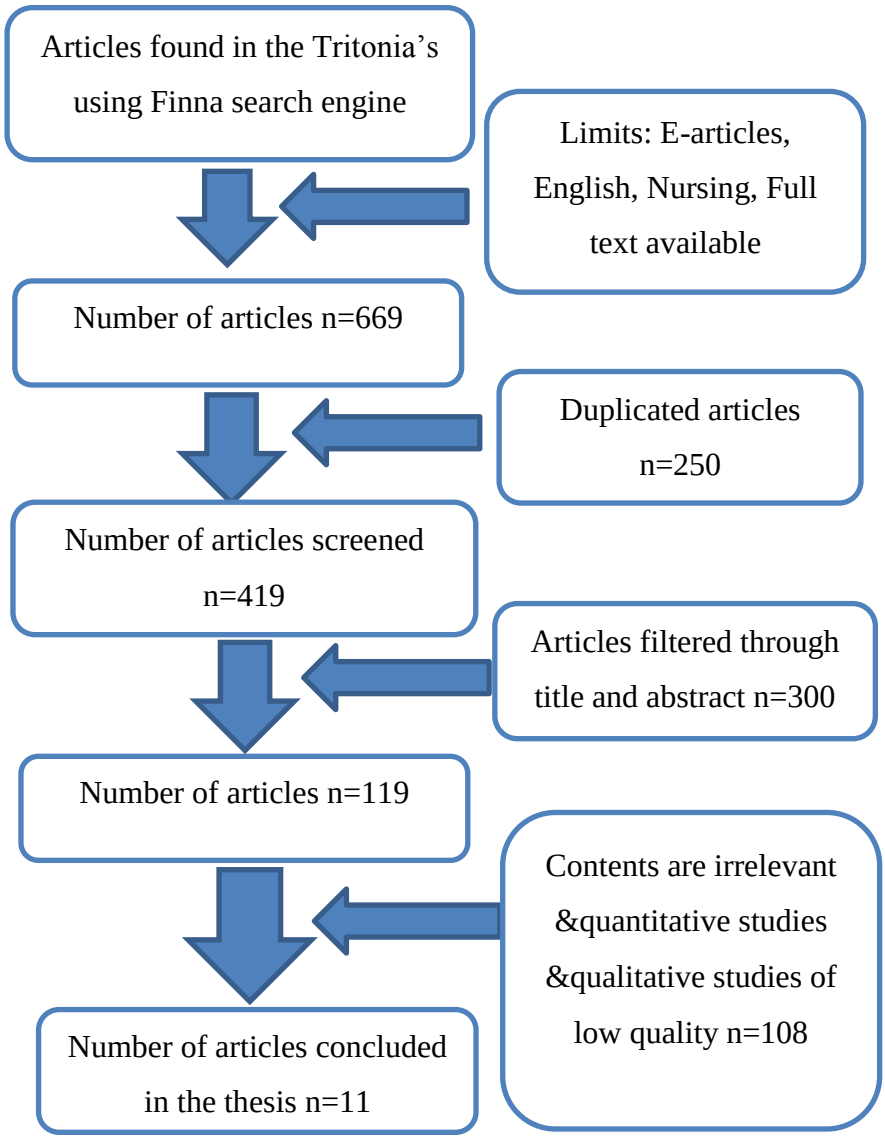


Figure 9: Chart of data collection result using inclusion and exclusion criteria.

11 articles selected are presented in Overview of Articles Used in The Study (Appendix 3). The name, year, authors, aim, and the result of articles was provided in the form.

5.3 Deductive Content Analysis

Content analysis is selected as a common method in the field of nursing studies. It is a method for analyzing written, verbal, or visual communication information. It is a systematic and objective description and phenomena quantification. By using content analysis, it is possible to condense words into fewer categories. Words and phrases with the same meaning will be placed in the same category. The aim is to find a condensed and broad description of the phenomenon and to make categories to illustrate the phenomenon. The categories would then be used to build up a model, a conceptual system etc. A content analysis provides new insights, knowledge, a representation of facts and a practical guide for action. It is used both in qualitative studies as well as in quantitative studies. (Elo & Kyngäs, 2008)

A deductive approach to the content analysis will be chosen. The deductive content analysis is based on previous studies and it helps the researcher to retest existing data in a new context. The aim of this study is to explore cultural boundaries in pain assessment between patient and nurse, and how the nurse uses pain assessment tools. The studies on cultural boundaries and pain assessment are conducted in the previous studies and the aim of this study is based on the previous studies. (Elo & Kyngäs, 2008) Therefore, the deductive content analysis is suitable for data analysis for this thesis.

There are three stages that need to be considered in the content analysis: Preparation, Organization, and Report. (Figure 7) There is no obvious rule for data analyzing as the purpose is to classify texts into categories. The preparation starts from choosing the units for the analysis. The size of the units is very important since they affect the analysis process. The content in the units could be varieties of things like a letter, word, sentence, page and discussion etc. (Elo & Kyngäs, 2008)

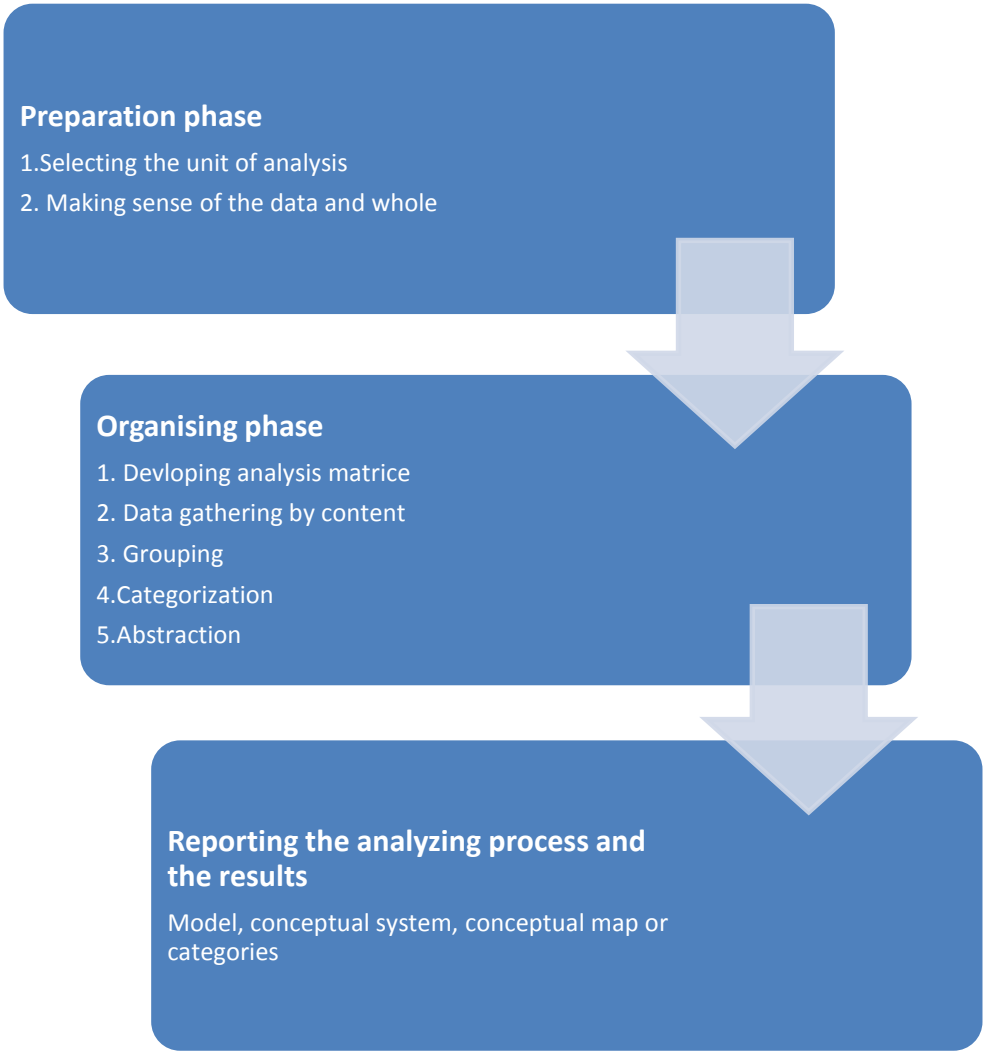


Figure 10: Preparation, organizing and resulting phases in the deductive unconstrained content analysis process (Elo & Kyngäs, 2008)

After a deductive content analysis is chosen, the categories will be made. The data selected for the study would be coded according to the different categories. There are two approaches to analyzing matrices in the deductive content analysis: Structured and Unconstrained. Selecting the approach is always dependent on the aim of the study conducted. The categories are made according to their bonds. Categories can also be called concepts, models, testing categories or hypotheses. (Elo & Kyngäs, 2008)

It is of great importance that the analysis process and the results are described in a way that the readers understand the strength as well as the limitations in the process of the analysis. That is to say that the reports on the result should be as detailed as possible in the analyzing process. (Elo & Kyngäs, 2008)

The categories are required to be grounded both conceptually as well as empirically. The results of the study should be in the contents of the categories. A successful content analysis is achieved when the readers, in a reliable way, are able to analyze and simplify the data from the categories. The reliable way means that the data collected should be valid and reliable. In order to increase the reliability of the study, it is important to show the connection between the data and the results. Accordingly, citations could be a way to increase the reliability. (Elo & Kyngäs, 2008)

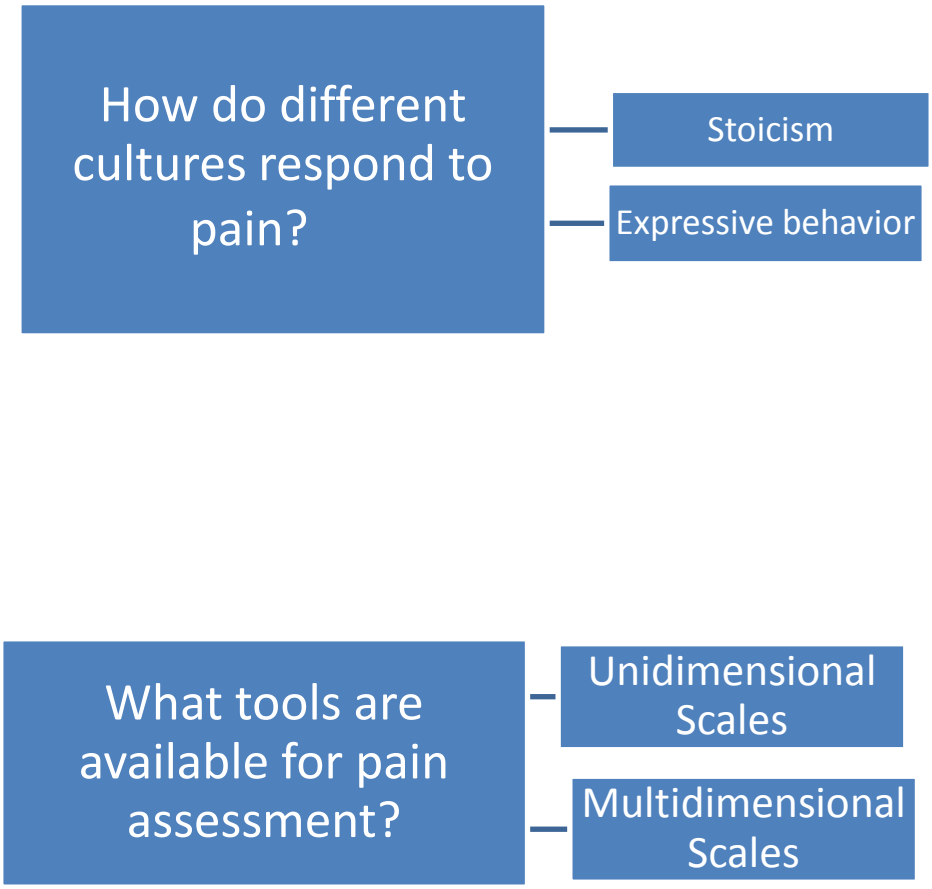


Figure 11: Categorization matrix for this thesis

The Categorization matrix was made according to the deductive unconstrained content analysis process (Figure 7) in the organizing phase. The categorization matrix for this thesis is answering the two research questions: 1. How do different cultures respond to pain? 2. What tools are available for pain assessment? The first theme is about the How do different cultures respond to pain. Stoicism, expressive behavior and were under the theme. The second theme is on the pain assessment tools available used. Multidimensional scales and Unidimensional Scales were under the theme.

6 Ethical Consideration

The ethical consideration of this thesis will be based on the Finnish Advisory Board on Research Integrity. As the aim of this thesis is to find out how different cultures respond to pain and how the nurse uses pain assessment tools, the content belongs to the humanities and social and behavioral sciences. (Neuvottelukunta, 2014)

There are four areas in the ethical considerations according to Finnish Advisory Board on Research Integrity: Fabrication, Plagiarism, Misappropriation, and Falsification. Fabrication means the research is done by making out unrealistic outcomes through inappropriate methods and observations. Plagiarism means that the content of the study is copied from previous research and there is no credit given to the previous researchers. Falsification is also called misrepresentation, it means deliberately changing the original research results. Misappropriation means an act that is against the law of presenting other researchers' studies to use as one's own work. (Finnish Advisory Board on Research Integrity, 2012)

The ethical principles in the field of the humanities and social and behavioral sciences are about the rights and autonomy of research subjects, prevention of harm as well as privacy and data protection. (Neuvottelukunta, 2014)

As this thesis is using qualitative systematic literature review of cultural boundaries in pain assessment and pain assessment tools available for the nurse, the research is based on previous studies and books. Therefore, there is no research subject directly involved in the study. The study is done through collecting data from previous studies. Hence, the autonomy of research subjects is not related to this thesis. Prevention of harm principle is also applied to the research subjects.

In consideration of data protection, the most concerning issue related to this thesis is the risk of identification. Within the qualitative data, the risk of identification is high and it should always be checked before the samples are published. (National Advisory Board on Research Ethics, 2009) In this thesis, there might be articles that include interviews that might reveal research subjects' names and information. Therefore, it is important to consider if it is acceptable to use their identifications in this thesis.

To sum it up, the study conducted has, in general, fit into all the ethical principles in the field of the humanities and social and behavioral sciences. Since the study is a qualitative systematic literature study, the research subjects are indirect.

As pain is viewed in a subjective way, the understanding of pain assessments could be influenced by emotions and bias. According to the article, principles of ethics should be followed by health care professionals. (Bernhofer, 2011)

The thesis is helping nurses to gain knowledge and understanding of cultural boundaries in pain assessment between patient and nurse. The study might result in nurses understanding patients better which might result in a better pain management and the relief of suffering.

The international council of nurses (ICN) has stated the ethical codes for nurses. The codes connect the profession to human rights and focus on the need and responsibility to improve health, prevent diseases, recover and relieve suffering. (Arman;Dahlberg;& Ekebergh, 2015)

Caring science should be understood as a caring value connected to human's existence as a base. Caring science is actualized in situations where human beings are dependent on basic needs of care. In practice, this should include respect and not judgment of other human beings. (Arman;Dahlberg;& Ekebergh, 2015)

7 Result

This chapter presents the result of the review. There are two main themes included: Cultural differences in responses to pain and Pain assessment tools in caring. Examples from cultures of Amish, Somalin, Swedish, Chinses, Hispanic-Latino, Arabian, and Ghanaian are selected within the articles to describe how cultures respond to pain differently. The pain assessment tools available in caring is presented in the last part of the Result.

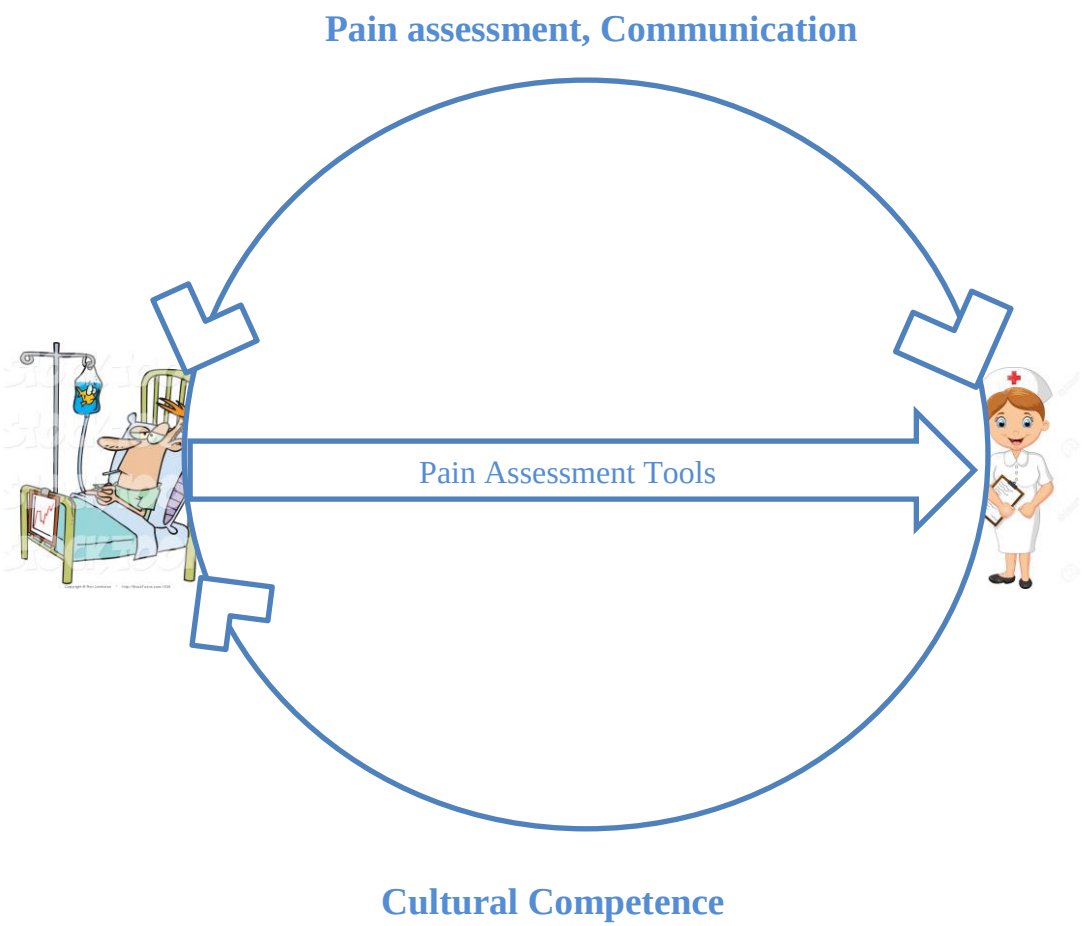


Figure 12: Model of Pain Assessment When Caring Through Cultural Boundaries

The Model of Pain Assessment When Caring Through Cultural Boundaries (Figure 12) is created according to the content analysis process (Figure 10) in the reporting phase. The model explained how pain assessment works when caring through cultural boundaries. The communication is a two-way communication between nurses and patients on the matter of pain assessment. The pain assessment tools are the bridge of pain assessment between nurses

and patients. They carry the message of pain in a way that nurses could understand. Cultural Competence helps nurses for selecting the appropriate pain assessment tools and communication when caring through cultural boundaries.

7.1 Cultural Differences in Responses to Pain

Different cultures experience and express pain in both symbolic and linguistic systems. (Sobralske & Katz, 2005) Culture shapes all the aspects of the cancer experience for patients, family members, and health professionals. Those aspects include the perception, manifestation, reaction, and treatment of pain. Culture affects communication, religious beliefs, and traditional and nontraditional forms of medicinal care. Ethnic groups experience and hold attitudes differently, which may affect neurophysiologic processes of pain perception and psychological and behavioral responses to pain. (Juarez;Ferrell;& Borneman, 1998)

Different cultures define and experience pain differently. Thus, the meaning of pain varies from culture to culture. Pain experience is stimulated by the environments and cultural values. The meaning of pain is affected also by the religious factors as well. Hispanics – Latinos view pain as a part of life and it has to be endured in order to enter heaven. They view pain as a form of suffering, punishment and only through praying, attending mass, anointment, and blessing by the priest can pain be relieved. These interventions on pain are closely linked with the Catholic beliefs and traditions. (Davidhizar, 2004)

Studies show that health care providers tend to communicate with patients from the same cultural backgrounds on pain rather than those from other cultures. Clients from other cultures adapt different terms in communicating pain and their languages skills might not be as fluent as the natives'. In such scenarios, the interpreter should use pain assessment tools in clients' own languages. Nurses have to be sensitive to the different communication styles in patients. (Davidhizar, 2004)

Elders (Irish, Italians, Jews) see pain as "useless" as defeated situation. However, Elders hold the positive attitude that health care professionals are able to cure the pain. People with Irish background would like to be left alone when they are in pain. They are proud of tolerating pain but holds that fear of the complication of disability caused by pain. The Jewish calls pain as "unbearable and terrific" as to call for help of others. People of Italian

backgrounds tend to use nonverbal gestures, crying and complaining of pain. They focus on the pain rather than the reasons that led to pain. (Sobralske & Katz, 2005)

There are two groups of cultural responses to pain: stoic and emotive. Stoic persons are less likely to convey their pain experiences and they would tend to "*grin and bear it"* on the contrary the emotive persons tend to express their pain through verbal communication. (Davidhizar, 2004)

7.1.1 Stoicism

A case indicates how Amish culture reacts to pain stoically and even for the children. The 3-year-old Amish patient was quiet in his bed. When the nurse was preparing to inspect his abdomen, he was winced and tightened up even before she touched him. However, when she palpated his stomach he didn't complain. The nurse asked many times if it hurts the patient answered: "I am ok". The mother was with the patient and she explained that her son does not report that he is in pain before his appendix burst that he needs surgery. In the Amish culture, they don't say much about pain and that's why the patient learned to be quiet and others did not get the chance to know that he is so sick. (Davidhizar, 2004)

Somalian culture considers that crying and wailing are not unacceptable concerning pain since *"There is no reason to exaggerate your pain. Everyone knows that childbirth is painful, and you are sort of ashamed of yourself if you cry, and the one who is there with you is ashamed as well. To cry is to be weak."* Somalian culture holds the stoic attitude towards pain. They consider that pain is a part of life and religion can help to relieve pain. They consider that Allah who chose to give you the pain then bear it with dignity. The value of endurance is highly praised in the Somalian culture since the one who has courage and toughness should be glorified. (Finnström & Söderhamn, 2006)

Swedes are encouraged to hold the attitude towards pain in their culture. It is reported that Swedes report more pain than the Somalis. Obviously, Swedes and Somalis have different approaches to the stoic behaviors towards pain. In Swedish society, it is individualistic and they tend to withdraw when in pain. However, Somalian society is collective. Collective means that people rely on groups or family in that sense. The group or family is considered more important than the individual himself or herself. Therefore, the Somalis would not tend to withdraw from the group when experiencing pain. Therefore, even though an interpreter

was provided for Somalis they are unlikely to express and describe their pain because of their stoic behavior. (Finnström & Söderhamn, 2006)

The Chinese value stoicism and they are influenced by Buddhism and Confucianism. These beliefs have significant effects on their understanding of pain. Stoicism is considered to be a positive lifestyle by Chinese people. As a result of this, the Chinese might avoid the verbal and non-verbal expression of their pain. They might suffer in silence until the level of pain is unbearable. Buddhism suggests that suffering goes hand in hand with living. Every human being has to overcome physical sufferings as well as psychological suffering. Buddhism also indicates that pain is the result of immoral actions in the past. People should accept their own karma by not receiving medical treatments. By this, many Chinese people would be unwilling to take pain medications. Confucianism focuses on the collectivism and familism. Goals of a group are always ahead of an individual. Physical or psychological distress is considered a family event. Therefore, Chinese patients consider it is a kind of loss of face if they seek help from outside of the family. The Chinese consider it better not to bother others or challenge them with their own emotions. Therefore, pain assessments of Chinese patients are usually inaccurate. (Tung & Li, 2015)

Culture influences the communication on pain. In some cultures, it might be rude to ask nurses for painkillers. Chinese clients might see that asking for pain killers would take away the nurses' time to do something more important. Some clients might understand that nurses know how to medicate without patients' self-report on pain. In some cultures, reporting pain might be considered as weakness. (Davidhizar, 2004)

In the Ghanaian culture, many patients do not consider post-surgical pain as pain that needs to be treated. Research still cannot identify if it is because the severity of post-surgical pain is less severe than the pre-surgical pain. Patients hold the opinion that post-surgical pain is "worry free" pain since the problem has been solved in the operation. *"There was pain, but I felt that whatever was in my stomach that was giving me the problem was no more, so I was not worried about the pain after the operation."* (Azoatp & Adejumo, 2015)

There is a sociocultural reason in Ghana to believe that talking about pain would increase the level of pain *"I couldn't talk, I was just lying there. I was in so much pain… I was so quiet because I didn't want to talk for it to give me more pain…I was also advised not to talk"* The social belief in Ghana is also that you should bear pain in quiet. Since it indicates that you are brought up in a strict environment. *I was quiet, maybe that was how we were*

taught at home, like our mothers will normally tell us that if we cry, especially during childbearing, if someone is giving birth and she cries, they will tell you that you will remain like that in all your deliveries. So whenever you are going to give birth and if you cry, it means that you are spoilt or something, so normally when you are in pain you just hide it and it will go." (Azoatp & Adejumo, 2015)

The effects of post-surgical pain in Ghana would be described as *"inability to sleep, walk, talk turn in bed and stretch in bed" "I was walking slowly and slightly leaned forward"* Post-surgical pain of ambulation was experienced differently. Some might think *"I was feeling the pain but by the time you walk around, the pain is a little better"* Some might not have many problems with the pain, *"I was able to get out of bed the next day by myself; I didn't have many problems with the pain"* (Azoatp & Adejumo, 2015)

The study on the influence of culture on cancer pain management in Hispanic patients indicates that Hispanic patients apply stoicism toward pain. There were eight themes were identified from a question on "family beliefs about pain" The first, they were taught not to complain of pain. The second, family medicine woman was the one for advice for patients. The third, they were taught to follow and believe God when in pain and not doubting his will. The fourth, folk healers were used before the conventional western treatment. Folk healers usually trying to cure the illness through using prayers, candles, herbs and message. The fifth, the fear of getting addicted to medication on pain. The sixth, the family is the most important thing when they are in pain. The seventh, advice from family/ neighbors were considered as the way of expressing their care and concern. The last, people tend to receive advice from the pharmacist on herbal medicines. (Juarez;Ferrell;& Borneman, 1998)

7.1.2 Expressive Behavior

In pain, Arab Americans would give up control of their pain to God or Allah. They see the suffering of pain as a chance to show courage, faith, and cleanse their sins from the past. Arab Americans express their pain experiences both verbally and non-verbally. They tend to repeat the same content to emphasize their pain. Around family members, they tend to be more expressive. They are in fear of pain and sometimes their responses might not be the true story of the pain. They would use comparisons and metaphors. *"a stone, a knife, a fire and a piece of iron pulling"* (Sobralske & Katz, 2005)

7.2 Pain Assessment Tools in Caring

The purpose of pain assessment tools is to objectify the subjective character of experiencing pain. (Fenwick, 2006) A successful pain assessment includes that the patient understands the pain assessment tools. The nurse would interpret the scores of the pain assessment correctly. (McLafferty & Farley, 2008)

A study done by the year of 2004 has given evidence that the use of pain assessment tools has proved its reliability and validity when caring through cultural boundaries. However, the use of pain assessment tools is not enough for pain assessment in nursing. The cooperation of relatives and friends are beneficial in assessing pain. In some cases, pain assessment tools are corresponding to the depression scales. The Brief Pain Inventory (BPI)(Appendix 2) has shown its reliability on pain intensity and the influence on daily activities when expressions of pain differed in different cultures outside of USA, especially in France, the Philippines, Singapore, and China. This tool has been translated also into the countries of use. The Numerical Rating Scale (NRS)(Figure 1) is considered better to be used in the cross-linguistic pain measurement and patients in critical conditions. There are three different variations of the scale of 0-5, 0-10 and 0-100. This tool is also translated into over 10 languages and used widely around the world. Faces rating scales like Wong-Baker Faces(Figure 4) are used commonly by children of age three. The Oucher scale shows a collection of different facial expressions. The Visual Analog Scale (VAS)(Figure 3) consist of two different variables. It could be vertical or horizontal line with words at each end of "no pain" and "worst pain". Chinese patients in a study showed that they tend to react to the vertical version of VAS more precisely since the tradition reading are done vertically. (Davidhizar, 2004)

7.2.1 Unidimensional Scales

Unidimensional scales aim to quantify the intensity of pain experienced. Common unidimensional scales that nurses would use would be Visual Analogue Scale (VAS) (Figure 3), Pain Faces Rating Scales, Numerical Rating Scale (NRS)(Figure 1) and Verbal Rating Scale (VRS)(Figure 2). The VRS uses a set of words that describe the intensity of pain. The common version of it could be *"no pain"," moderate pain" and "severe" or "excruciating pain".* Patients describe and express pain using concrete words rather than the numbers. For some patients, the score might be clearer, however, for some patients, it might be challenging

since it requires an understanding of the words. (McLafferty & Farley, 2008) . Unidimensional scales are commonly used in health care since those tools do not require extra instruments and they can be performed orally. (Fenwick, 2006)

A study done on the pain measurement in Older African Americans suggest that pain assessment tools like NRS and VRS are lacking sensitive in culture and language when used on older African American patients. However, the Facial Pain Scales are more suitable for the older African American patients, since many of them find it easier to relate their experiences of pain to facial expressions rather than numbers and words. The Brief Pain Inventory (BPI) (Appendices 2) has found its place among older African Americans. BPI measures multiple dimensions of pain: pain presence, intensity, location, functional interference across pain type. African Americans talk less about the impact of pain on functions when using open-ended questions. The consensus is important to be able to give more accurate and culturally appropriate pain assessment tools for different ethnicities. It is of great significance for clinicians to help older African American patients to increase their understandings of their clinical pain communication by explaining medical terminology and elucidating more accurate and vivid descriptions of pain. (Booker;Herr;& Tripp-Reimer, 2016)

Numerical Rating Scale (NRS) is a pain assessment tool that rates pain into 0-10. (Flaskerud, 2015) It is a tool that nurses like to use because it is very convenient. For central Australian Indigenous patients, it might be challenging because some of them might not have the conceptual identification of numbers that is above 5. Therefore, NRS might be challenging for them. (Fenwick, 2006) A study done on the central Australian Indigenous patients' pain assessment have shown the cultural safe pain assessment approaches for the non-Indigenous nurses. In Indigenous culture, patients give the power to the nurses, they usually fear to disagree with nurses and considered it as a kind of a shame. In the Indigenous language, numbers are rarely used or the concept of numbers are not that concrete, why the use of them wouldn't be accurate. In order to give cultural safe pain assessment, it is not of much significant to use the traditional type of pain assessment tools. The study suggests using verbal pain descriptors, Numerical Pain Assessment tools that range from 1-5 and health care workers from the same cultural background. (Fenwick, 2006)

A study done by Krebs and colleagues in the year of 2007 shows that almost one-third of patients with NRS of 0 have pain-related interferences with functioning. Nurses in most cases tend to assess pain level lower than the patients. NRS can fail to assess factors that

involve worries, functional limitation and so on. Studies showed that NRS cannot provide proper pain assessment for today's pain management. However, it is better than nothing. (Flaskerud, 2015)

7.2.2 Multidimensional Scales

With the help of Fitzpatrick et al's framework (Appendix 5), nurses should be able to identify the most appropriate pain assessment scales for the patient. However, it may require more than one tool for assessing a patient thoroughly. Therefore, it is important to prepare a selection of pain assessment tools to assess a patient fully. Multidimensional scales include many components of pain. The McGill Pain Questionnaire (Appendices 1) for example covers the intensity, type, and quality of the pain. The McGill Pain questionnaire consists of 78 words that are divided into 20 different groups, Present Pain Intensity (PRI) and a body chart. These 20 different groups of words, in turn, represent four different pain dimensions: Sensory, affective, evaluative and miscellaneous. PRI describes pain intensity on a verbal and numerical scale of 0-5. The body chart, in turn, could help the patient identify the location of the pain. Only healthy young men participated in the design process of the McGill Pain Questionnaire, therefore, it is not suitable for all circumstances. Accordingly, a shorter version of the McGill Pain Questionnaire was designed with 30 words and PRI of 0-3. The McGill Pain Questionnaire is time-consuming and it requires that the patient should have good language skills and it is quite complicated. (McLafferty & Farley, 2008)

A pilot study of evaluating the use of a pain assessment tool (body chart and pain ruler) and care plan was done in a 28-bed-mixed rehabilitation ward in the year of 1997 indicates that the pain assessment tools applied have an influence on communication between the nurses and the patients. The body chart got positive feedback because it creativity illustrated the locations of the pain. However, there is a need to educate nurses in using pain assessment tools to increase the effectiveness of pain management strategies. (Eloise, 1997)

8 Discussion

In this chapter, the respondent will concentrate on the result found of this thesis. The result would be illustrated and its relation to the aim, research questions, theoretical framework and theoretical background would be described. The aim of this thesis is to explore cultural boundaries in pain assessment between patient and nurse, and how the nurse uses pain assessment tools. The two research questions are 1. How do different cultures respond to pain? 2. What tools are available for pain assessment?

The result was based on the deductive content analysis method (Figure 10). In the preparation phase, the respondent gathered the data from online on FINNA. Databases used were EBSCO, CINAHL, and PubMed. Search words as "communication, transcultural nursing, pain assessment, culture" were used. The selection of data was based on the inclusion and exclusion criteria mentioned in Chapter 5 Methodology. The data was then condensed to the categorization matrix (Figure 11). Then the Model of Pain Assessment When Caring Through Cultural Boundaries (Figure 12) was made. The result of this thesis was divided into two parts: 1. Cultural Differences in Responses to Pain. 2. Pain assessment tools in Caring.

The first part of Result answers the first research question: How do different cultures respond to pain? Through analyzing the process, two subcategories were found. There are two major cultural responses to pain: Stoicism and Expressive Behavior. Examples of stoicism were found among Amish culture, Somalian culture, Swedish culture, Hispanic-Latino culture and Chinese culture. Cultures that represent the stoic behavior tend to *"grin and bear it"* (Davidhizar, 2004). An example of expressive behavior was found among Arabs. Cultures that represent the expressive group tend to express their pain verbally as well as in their behaviors.

Cultures representing the stoicism group react differently to pain. Examples were found in the Somalian culture and Swedish culture. Although Somalian culture and Swedish culture are stoic, Swedes report more pain than Somalis. Swedish culture is an individualistic culture, while the Somalian culture is a collective culture. Thus, it might not be wise to make assumptions about stoic cultures defining, experiencing, and communicating on pain in like manner. Stoic cultures have their similarities, at the same time, their differences.

The respondent noticed that in studies among culture and pain, there are many descriptions and examples on stoicism. The respondent found only one example of expressive behavior: Arab culture. There might be more cultures with expressive behavior, however, the keywords used did not give other matches. The keyword matches also indicate that there are more patients from the stoic cultures than the expressive cultures. The nature of bearing pain in the stoic cultures together with the subjective experience of pain brings more challenges in pain assessment in transcultural nursing. The nature of emphasizing pain in the expressive cultures is also demanding in pain assessment when caring through cultural boundaries.

The second part of the result: pain assessment tools in nursing answers the second research question: What tools are available for pain assessment? Pain assessment tools, in general, are proved to help the communication on pain between nurses and patients. The respondent found multidimensional scales like The McGill Pain Questionnaire and the unidimensional scales such as VAS, NRS, and VRS. Each tool has its advantages and limitations. Many of them have shown to have a lack of cultural sensitivity. The individual's culture affects his/her understanding of pain assessment scales, e.g. studies found that the Australian Indigenous patients have difficulties in understanding numbers greater than 5. In such cases, the NRS was adjusted from 0-10 to 0-5 for this patient. Different cultures comprehend number, word, and facial expression scales individually. In addition, communication styles differ from culture to culture. Therefore, it is important to use an interpreter for patients if needed.

The Orlando's Nursing Process Theory was chosen to be part of the theoretical framework. Orlando advocates that the needs of a human being are at the center of nursing. A professional nurse should be able to ensure the patient's physical and mental comfort as much as she can during the medical treatment. Orlando views that a patient's behaviors express her/his needs and that these behaviors stimulate the nursing reaction and implementation. (Orlando, 1990)

This thesis is focusing on the needs of pain relieving based on Orlando's Nursing Process Theory. Pain could be expressed/communicated both verbally and nonverbally. Changes in patients' behaviors indicate their needs for pain relief. To relieve the pain, a professional nurse should be able to react to behavioral changes in the patients. However, as mentioned before, cultures affect the ways pain is expressed. The stoic cultures tend to withdraw when expressing pain. Their behavioral changes towards pain can be ambiguous to the nurses. The expressive group emphasizes pain, but might not show the authentic level of pain. Pain is a

subjective concept and could be defined as *"Pain is whatever the person says it is and exists whenever he says it does"* (McCaffery & Pasero, 1999, 17). Orlando considers that the source of the nursing action is the stimulation of the patients' behavioral changes and that the nurses' reaction to them. All the patient's behavioral changes should be taken into consideration, both obvious and seemingly insignificant ones. (Schmieding, 1993). Hence, being able to understand patients' behavioral changes is essential in nursing practice.

The previous studies have proved that pain assessment tools are of great help in pain assessment. Through these tools, nurses would able to objectify the subjective pain (Fenwick, 2006). However, further studies found that many pain assessment tools are lacking cultural sensitivity. Only the pain assessment tools that patients are able to understand would be successful tools. The nurse would determine what pain assessment tools would be the most appropriate for the patient. Actually, there are frameworks e.g. Appendix 5 for selecting the most appropriate pain assessment tools for different groups of clients in nursing, however, when caring through cultural boundaries, it requires cultural competence.

The Campinha-Bacote's Model of Cultural Competence was selected as the second part of the theoretical framework. Cultural competence in nursing is thought to be the base requirement for effective and culturally responsive services for clients from different backgrounds. The higher level of cultural competence the better ability to provide culturally responsive health care services. Campinha-Bacote's volcano model suggests that health care professionals should have the cultural desire. The cultural desire is the source of the whole cultural competence, involving cultural exposure, cultural knowledge, and cultural awareness. Cultural Competence guides nurses' decision towards selecting suitable pain assessment tools for patients from certain cultural backgrounds and helps the nurses get to know the patients better. It increases the nurses' cultural awareness to see the individual as unique and not to unconsciously impose their own values on the clients. It enhances when caring through cultural boundaries. It is beneficial for nurses to understand patients' behavioral changes to maintain an effective pain managements and meet the needs of the patients.

The respondent is still curious if there are more guidelines available when caring through cultural boundaries for nurses to determine suitable tools for pain assessments. Are there pain assessment tools specially designed for the stoic culture group and for the expressive culture group?

9 Critical Review

Lincoln and Guba's Framework is used in this chapter. The framework consists of four aspects: credibility, dependability, confirmability and transferability. Credibility refers to confidence in the truth of the data and being able to interpret them. There are two steps of credibility. The first step is to carry out the study in such a way that it enhances the credibility of the findings. The next step is to show credibility in the research report. Dependability refers to reliability or stability of data that endure through times and conditions, which means that the findings of the research would be the same if conducted again in other settings. Credibility and dependability rely on each other. Confirmability refers to objectivity, findings must reflect the participants' voice rather than the researcher's perception. Transferability refers to the responsibility of the researcher to describe the data sufficiently so that users of these data can evaluate the applicability of the data into other contexts. (Polit & Beck, 2017)

The respondent applied the systematic literature review for conducting a qualitative study. Relevant data for the study was collected through trustworthy databases. The deductive content analysis was implemented following certain steps. The categorization matrix (Figure 8) was made in the organizing process and a model (Figure 9) was made for reporting the results. In the chapter of discussion, the respondent presented the result and compared the result with the theoretical framework, background, and aim of the study. However, the data found for the expressive culture group was minimal. The study did not reveal pain assessment tools distinctly tailored for stoic or expressive cultures. This could possibly affect the result of the study.

Reference

Andrews, M. M. & Boyle, J. S., 2012. Transcultural Concepts in Nursing Care. 6th ed. s.l.: Wolter Kluwer.

Arman, M., Dahlberg, K. & Ekebergh, M., 2015. *Teoretiska grunder för vårdande.* Stockholm: Liber AB.

AvMary A. Nies, M. M., 2013. *Community/Public Health Nursing: Promoting the Health of Populations.* s.l. Elsevier saunders.

Azoatp, L. & Adejumo, O., 2015. An Ethnographic Exploration of Postoperative Pain Experience Among Ghanaian Surgical Patients. *Journal of Transcultural Nursing,* 26(3)(301-307).

Berman, A. & Snyder, S., 2012. *Koziers & Erb's Fundamentals of Nursing: Concepts, Process, and Practice.* New Jersey.: Pearson Ltd.

Bernhofer, E., 2011. Ethics: Ethics and Pain Management in Hospitalized Patients. *The Online Journal of Issues in Nursing,* p. Vol. 17 No. 1.

Board, F. A., 2012. *Responsible conduct of research and procedures for handling allegations of misconduct in Finland.* [Online] Available at: http://www.tenk.fi/sites/tenk.fi/files/HTK_ohje_2012.pdf

Booker, S. Q., Herr, K. A. & Tripp-Reimer, T., 2016. Culturally Conscientious Pain Measurement in Older African Americans. *Western Journal of Nursing Research,* Volume 38, pp. 1354-1373.

Booth, A., Rees, A. & Beecroft, C., 2015. *The Research Process In Nursing.* s.l. Wiley Blackwell.

Callister, C. L., 2003. HOME HEALTH CARE MANAGEMENT & PRACTICE / April 2003. *HOME HEALTH CARE MANAGEMENT & PRACTICE,* pp. 207-211.

Campinha-Bacote, J., 1998. *The process of Cultural Competence in the Delivery of Healthcare Services.* 3rd ed. s.l.: Transcultural C.A.R.E. Associates Press.

Campinha-Bacote, J., 2002. The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care. *Journal of Transcultural Nursing,* p. 13; 181.

Campinha-Bacote, J., 2003. *The process of Cultural Competence In the Delivery Of Healthcare Sevices.* s.l.: Transcultural C.A.R.E. Sddovisyrd.

Cleeland, C. S., 1991. [Online] Available at: http://www.healthcare.uiowa.edu/igec/tools/pain/briefpain.pdf [Accessed 2017 2 26].

Davidhizar, R., 2004. A review of the literature on care of clients in pain who are culturally diverse. *International Council of Nurses. International Nursing Review,* Volume 51, pp. 47-55.

Dunham, M., Ingleton, C., Ryan, T. & Gott, M., 2013. A narrative literature review of older people's cancer pain experience. *Journal of Clinical Nursing,* pp. 22(15/16): 2100-2113. (14p).

Ellis, R. B., Gates, R. J. & Kenworthy, N. eds., 1995. *Interpersonal communication in Nursing Theory and Practice.* New York: Churchill Livingstone.

Eloise, C. J., 1997. Evaluating the use of a pain assessment tool and care plan: a pilot study. *Journal of Advanced Nursing,* Volume 26, pp. 1073-1079.

Elo, S. & Kyngäs, H., 2008. The qualitative content analysis process. *Journal of Advanced Nursing,* pp. 62(1), 107–115.

Eriksson, K., 1994. *Den lidande människan.* s.l.:Liber Utbildning.

Eriksson, K., 2006. *The Suffering Human Being.* s.l.: Nordic Studies Press.

Fenwick, C., 2006. Assessing pain across the cultural gap: Central Australian Indigenous people's pain assessment. *Contemporary Nurse,* 22(2), pp. 218-217.

Finnström, B. & Söderhamn, O., 2006. Conceptions of pain among Somali women. *Journal of Advanced Nursing,* 54(4), pp. 418-425.

Flaskerud, J., 2015. Pain, Culture, Assessment and Management. *Issues in mental Health Nursing,* Volume 36, p. 74.77.

George, J. B., 2011. *Nursing Theories the base for professional nursing practice.* 6th ed. New Jersey: Pearson Education.

Giger, N. J. & Davidhizar, E. R., 2004. *Transcultural Nursing Assessment & Intervention.* St.louis: Mosby.

Health, O. o. M., 2001. *National standards for culturally and linguistically appropriate services in health care,* Washington, DC: Department of Health and Human Services.

Hemingway, P. & Brereton, N., 2009. *What is a systematic review.* s.l.: Hayward Group Ltd.

Holland, K. & Hogg, C., 2010. *Cultural Awareness in nursing and health care.* 2nd ed. London: Edward Arnold Ltd.

Hsieh HF1, S. S., 2005. Three approaches to qualitative content analysis. *Qual Health Res,* pp. 15(9):1277-88.

Hughes, R. G. & Rockville, 2008. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses.* s.l.: Agency for Healthcare Research and Quality (US);.

Hutchinson, R., 2007. Challenges in acute postoperative pain management. *Am J Health Syst Pharm,* 15 march.

Integrity., F. A. B. o. R., 2012. *Responsible conduct of research and procedures for handling allegations of misconduct in Finland.* [Online].

Juarez, G., Ferrell, B. & Borneman, T., 1998. Influence of Cultre on Cancer Pain Management in Hispanic Patientsq. *CANCER PRACTICE,* Volume 6, p. 5.

Langs, R., 1983. *Unconscious communication in everyday life.* New York: Jason Aronson.

Lara, G., 1997. *Cultural competence of Certified Nurse Practitioner.* Michigan, s.n.

Leininger, 1978. *Transcultural concepts, theories, and practices.* ed. ed. New York: John Wiley and Sons.

Leininger, M. & Mc Farland, M., 2002. *Tran cultural nursing. Concepts,* New York: Mc Grew-Hill.

LoBiondo-Wood, G. & Haber, J., 2002. *Nursing research: Methods and critical appraisal for evidence-based practice (5th ed.).* St. Louis: MO: Mosby.

Louise Hide, J. B. C. M., 2012. Perspectives on Pain: Introduction. *19: Interdisciplinary Studies in the Long Nineteenth Century.*

McFarland, M. R., 2014. *Nursing Theorists And Their Work.* 8th ed. St. Louis: Elsevier Mosby.

McLafferty, E. & Farley, A., 2008. Assessing pain in patients. *Nursing Standard,* 22(25), pp. 42-46.

Moseley, L., 2015. *Explainer: what is pain and what is happening when we feel it?.* [Online] Available at: https://theconversation.com/explainer-what-is-pain-and-what-is-happening-when-we-feel-it-49040

Munoz, C. C. & Luckmann, J., 2005. *Transcultural Communication in Nursing.* 2nd ed. s.l.: Thomson Delmar Learning.

National Advisory Board on Research Ethics, 2009. *Ethical principles of research in the humanities and social and behavioural sciences and.* [Online] Available at: http://www.tenk.fi/sites/tenk.fi/files/ethicalprinciples.pdf

Neuvottelukunta, T., 2014. *Ethical review in human sciences.* [Online] Available at: http://www.tenk.fi/en/ethical-review-human-sciences [Accessed 26 4 2016].

Nyback, M.-H., 2008. *Generic and professional caring in a Chinese setting: an ethnographic study.* s.l.:Oy Tibo-Trading Ab.

Orlando, I. J., 1990. *The Dynamic Nurse-Patient Relationship: Function, Process, and Principles (Nln Classics in Nursing Theory).* s.l.: Natl League for Nursing.

Polit, D. F. & Beck, C. T., 2017. *Nursing Research Generating and Assessing Evidence for Nursing Practice.* 10th ed. s.l.: Wolters Kluwer.

Polite, D. F. & Beck, C. T., 2008. *Nursing research: generating and assessing evidence for nursing practice.* second ed. s.l.: Lippincott Williams&Wilkins.

Sagar, P. L., 2012. *Transcultural Nursing Theory and Model.* New York: Springer Publishing Company.

Schmieding, N. J., 1993. *Ida Jean Orlando: A Nursing Process Theory (Notes on Nursing Theories).* s.l.: SAGE Publications.

Smith, R., Curci, M. & Silverman, A., 2002. Pain Management Global connection. *Nursing Management,* pp. Vol.33(6), 16-30.

Sobralske, M. & Katz, J., 2005. Culturally Competent Care of Patients with Acute Chest Pain. *Clinical Practice,* 17(9).

Society, A. P., 2008. *Principles of analgesic use in the treatment of acute pain and cancer pain,* s.l.: Glenview.

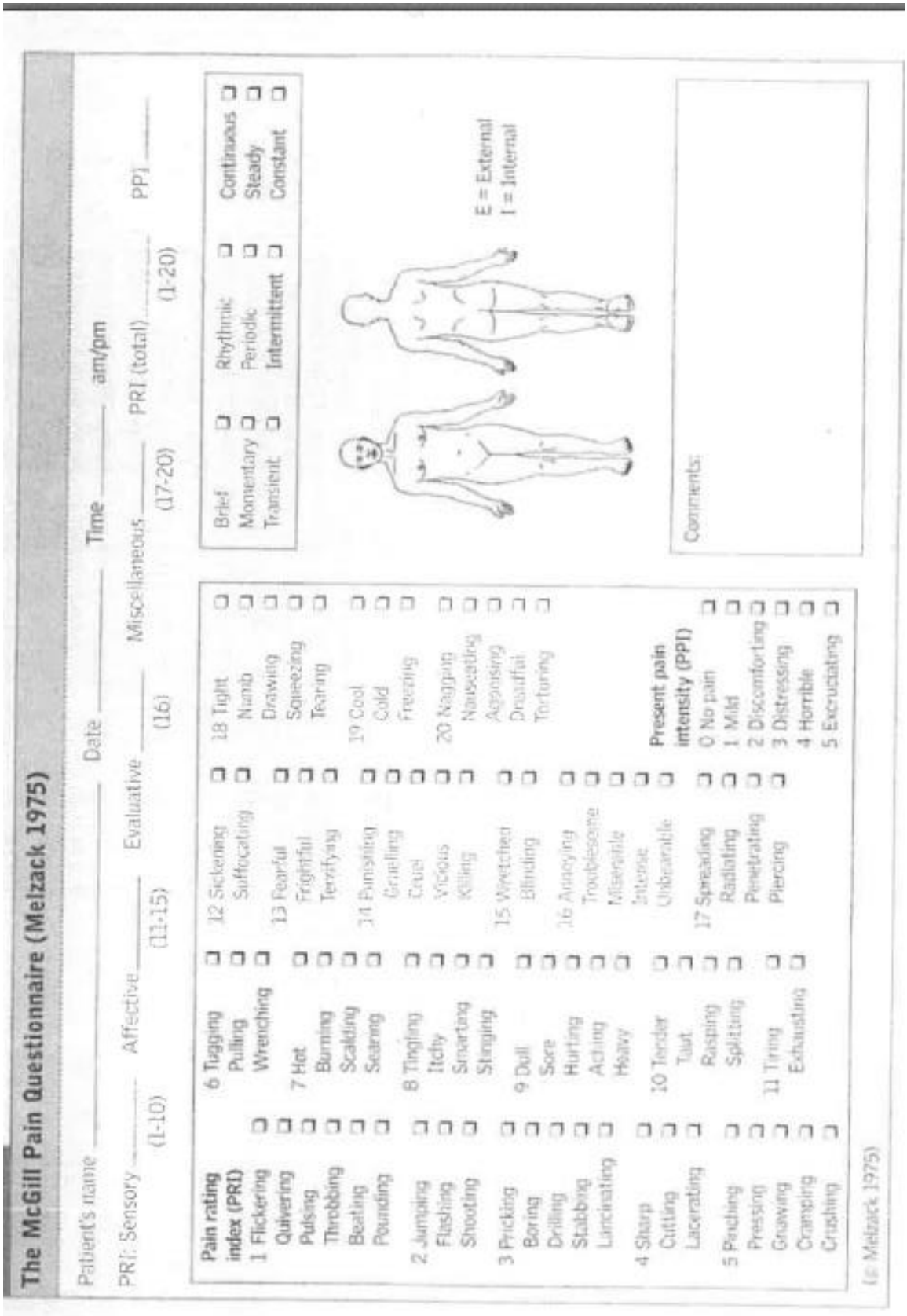
Timby, B. K., 2009. *Fundamental Nursing Skills and Concepts.* 9th ed. s.l.: Wolters Kluwer Health.

Tung, W.-C. & Li, Z., 2015. Pain Beliefs and Behaviors Among Chinese. *Home Health Care Management& Practice,* 272(2)(95-97).

Waddie, 1996. Language and pain expression. *Journal of Advanced Nursing (J ADV NURS),* pp. 23(5): 868-872. (5p).

Watzlawick, P., Beavin, J. & Jackson, D., 1967. *Pragmatics of human communication.* New Yorks: Norton.

Appendix 1: The McGill Pain Questionnaire (McLafferty &Farley,2008)



Appendix 2: Brief Pain Inventory (Cleeland, 1991)

STUDY ID# _____ HOSPITAL # _____

DO NOT WRITE ABOVE THIS LINE

Brief Pain Inventory (Short Form)

Date: _____/_____/_____ Time: _____

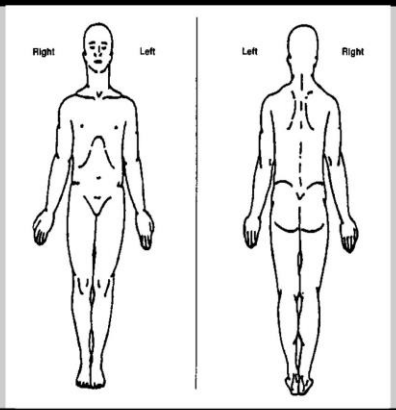
Name: _____ _____ _____

Last First Middlle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4. Please rate your pain by circling the one nuimber that best describes your pain at its least in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

Appendix 3: Overview of Articles Used in the Study

Title	Author/year	Aim	Method	Result
A review of the literature on care of clients in pain who are culturally diverse A1	R.Davidhizar&J. N. Giger 2004	literature review on the care of clients from diverse cultures who are in pain and provides strategies for care	Literature review	Seven strategies can assist in culturally appropriate assessment and management of pain

Assessing pain across the cultural gap: Central Australian Indigenous people's pain assessment A2	Clare Fenwich 2006	change the way non-Indigenous nurses approach to pain assessment and to critically analyze practices of assessing pain in Indigenous people	Grounded theory study	The trust relationship is important for giving a cultural safety care in the pain assessment between nonindigenous and indigenous people

Culturally Conscientious Pain Measurement in Older African Americans A3	Staja Q.Booker, Keela A.Herr, and Toni Tripp-Reimer 2016	Discuss the status of pain measurement and factors that affect knowledge on pain measurement in older African Americans and provide guidance for culturally conscientious pain measurement	Literature review	Four different pain measurements were discussed thoroughly and it is important for clinicians to consider the best possible pain measurement for people of different cultural backgrounds and giving education.
Evaluating the use of a pain assessment tool and care plan: a pilot study A4	Eloise C.J 1996	how clinicians might continue to improve pain management at a district general hospital	a pilot study	The pain assessment tool has the potential to improve communication of pain between the patient and the nurse but there is an urgent need for education to enable this information to be used effectively and develop pain management strategies which reflect the multidimensional nature of pain

Assessing pain in patients A5	McLafferty E, Farley A 2008			This articles defines pain and discusses options for pain assessment. Nursing skills required to carry out pain assessment are identified and discussed
Pain Beliefs and Behaviors Among Chinses A6	Wei-Chen Tung& Zhizhong Li 2015	How cultural factors influence response to pain beliefs and behaviors among Chinses Americans and present culturally appropriate strategies.	literature review	An understanding of the impact of culture on the pain among Chinese immigrants is important in assuring effective and culturally sensitive pain management interventions

Culturally Competent Care of Patients with Acute Chest Pain A7	Mary Sobralke & Janet Katz 2005	To inform nurse practitioner(NPs) about the influence of culture on patients' responses to pain using the example of acute chest pain	literature review	There is very little written and even fewer studies on the connection of culture and the response to acute chest pain. This topic needs more attend by nurse researchers.
An Ethnographic Exploration of Postoperative Pain Experiences Among Ghanaian Surgical Patients A8	Lydia Aziato & Oluyinka Adejumo 2015	This study focused on patients' experiences of postoperative pain (POP) and factors that affect POP	qualitative ethnographic approach	The study highlighted the need for patient education and the importance that health care professionals understand context-specific factors that influence POP management

Influence of Culture on Cancer Pain Management in Hispanic Patients A9	Gloria Juarez, Betty Ferrell &Tami Borneman 1998	Describe the influence of culture on cancer pain management in Hispanic (Mexican and Central American) patients	qualitative study	Responses suggest that culture, family beliefs, and religion contribute significantly to management and expression pain by the patient and caregiver. Pain may be approached with stoicism, therefore, lack of verbal or behavioral expression of pain does not indicate a lack of pain itself.

Conceptions of pain among Somali women A10	Berit Finnström & Olle Söderhamn 2006	Reports a study of a group of Somali mothers' views on pain, the causes of pain, pain behavior and pain treatment concerning themselves and their family members	Conversational interviews and qualitative content analysis	Nurses must strive for increased cultural competence and explore ways to make healthcare services sensitive and culturally diverse groups. Nurses have an educational role in educating parents and children about pain and the importance of sufficient pain relief. All healthcare providers should be aware of their own cultural values and the risk of serotyping people

Pain, Culture, Assessment and Management A11	Fluskerud, Jacquelyn H 2015		Literature review	The author reflects on the assessment and management of **pain** and discusses the challenges which medical professionals face when treating **pain** due to its complex nature. A discussion of several research studies which have investigated **pain**, **pain** prevalence, and **pain** assessment

Appendix 4 Lara's Seven Question in Cultural Awareness (Lara, 1997)

1. *What cultural/ethnic group, socio-economic class, religion, age, and community do you belong to?*
2. *What experiences have you had with people from cultural groups, socioeconomic classes, religions, age groups, or communities different from yourself"*
3. *How did you fell about them?*
4. *When you were growing up, what did your parents and significant others say bout people who were different from your family?*
5. *What about your cultural/ethical group, religion, socio-economic class, age or community did you feel embarrassing or wish you could change?*
6. *What personal qualities do you have that will help you establish interpersonal relations with persons from other cultures?*
7. *What may personal qualities be detrimental?*

Appendix 5: Framework for Selecting the Most Appropriate Pain Assessment Tool (McLafferty & Farley, 2008)

Framework for selecting the most appropriate pain assessment tool	
Criteria, that is, how effective is the assessment tool for use in your area?	**Characteristics, that is, these explain how the criteria are met**
Appropriate	Appropriate to the purpose and setting
Reliable	In terms of consistency
Valid	Measures patients' perceptions of pain
Responsive	To changes of importance to patients
Precise	Accurate and discriminating
Interpretable	Meaningful information is produced
Acceptable	Acceptable to those completing the pain assessment
Feasible	The degree of burden and effort involved in using it is acceptable

(Fitzpatrick *et al* 1998)