

## **Experiences of patients during postoperative pain management**

Challenges for nurses when providing evidence based care to patients in a multicultural setting.

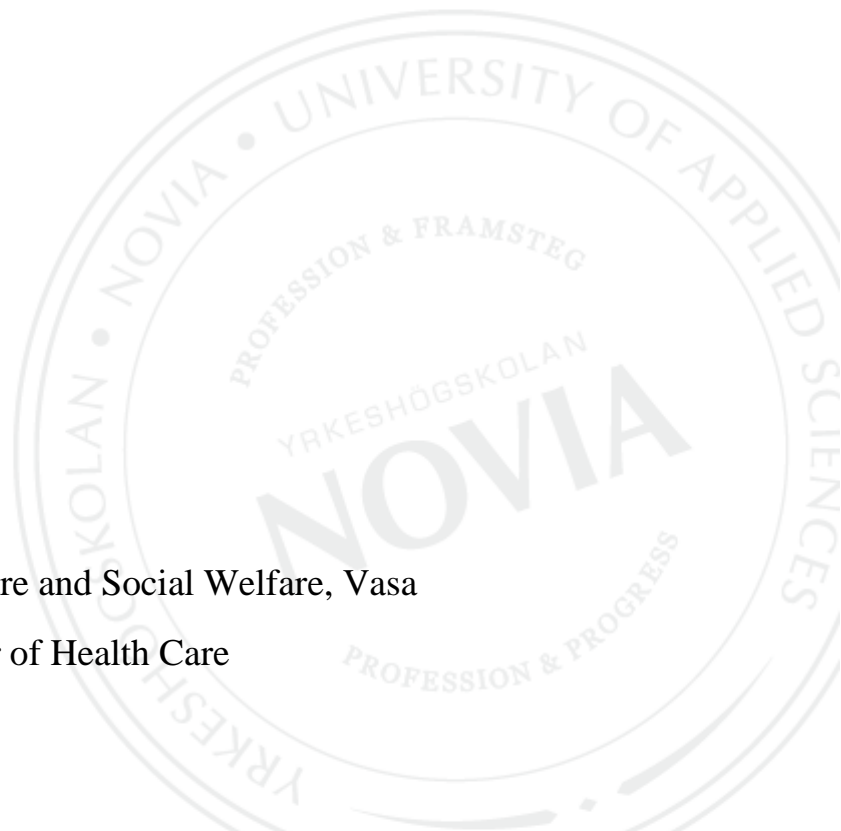
**A qualitative study**

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## **Summary**

Aim of this study is to explore patient's perceptions, experiences and meanings attributed to pain during pain behaviors. The study will also try to explain the role of cultural influences on pain perceptions and reaction by patients during postoperative phase. Postoperative phase time covers after surgery to period of discharge from healthcare setting. This is a qualitative study. Systematic Review was utilized in data collection; content analysis to analyze data while inductive approach was used to abstract themes. Three main themes emerged during abstraction process namely; cultural attributions towards pain, communicative pain behaviors and responses describing pain suffering. Theoretical frameworks used for this study are Leininger's Culture theory of diversity and universality; and Kolcaba's theory of comfort. Data collection was collected through Nelli portal database using inclusion/exclusion criteria as a guideline in study materials selection.

Results emerged from this study found that culture and beliefs system remains the most occurring themes influencing patients' pain behaviors during postoperative phase. Different interpretation, perception and meaning were attributed to pain based on patient's own cultural beliefs. To conclude this study, recommendation was made that nurses should be culturally competent when providing evidence based care because patients bring their own cultural expectation towards health outcome.

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**Language:** English    **Keywords:** postoperative, pain behaviors, culture, care and comfort

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## 1 Introduction

Postoperative pain affects millions of patients undergoing surgical procedures globally. Pain is a subjective experience, and every patient pain behavior is individualistic because pain behaviors are reported according to severity of painful stimulus, following emotional experience. Since various factors affect ways patient experience pain during nursing care delivery, the respondent chose to carry out this qualitative study on patients' experiences and perceptions with major focuses on interpretations through cultural beliefs and cultural shaping of pain behaviors in a multicultural setting. Provision of holistic care by nurses for patients within a different cultural background involves understanding congruent culture care, in order to eliminate bias and prejudices during nursing care. Furthermore, the study will point out other objective measurements used to evaluate pain when non-verbal communication exists between patients and nurses. Pain expressions involve verbal and non-verbal communications approach. Any underestimation of any of these two forms, results in wrong evaluation and poor pain management.

Evidence-based nursing care focuses on patient's experience, goals and values associated with better outcomes during nursing delivery, whereby the total outcome is to make the patient; disease free and regain his/her health. Though few times, these expectations can be short-lived during postoperative surgical procedure experiences as noticed in patients due to lack of clear understanding of pain rating scales and healthcare systems, communication barriers and cultural conflicts. During this phase of nursing care after surgical procedures, it is important that nurses have good knowledge of cultural competency care to evaluate and assess patients especially in multicultural settings.

This particular view gave to the respondent an upper lead to follow up and conduct this study. More also, the major interest was based on the fact that while working as a student nurse at the central hospital, the respondent came across multiple cases of negative feedbacks from most patients during post-operative admission despite getting the best nursing care from the nurses. There was a particular incident where a patient from Syria was shouting and hallucinating due to pain associated with surgical procedure (actually a first day postoperative pain) despite the effort to calm him down by the nurses, he kept shouting in his native language and the respondent came to a conclusion that the actual problem was that the nurses did not understand that his pain expression was based on his cultural background where patients can shout or call out names during episode of severe

pain. Emergence delirium was ruled out because through an interpreter, he mentioned that no one cared about his condition. Secondly while working as a student nurse at a certain placement, the respondent came across a middle age patient from a different cultural background where pain seems exaggerated. The vital signs were quite normal but the patient keep complaining about chronic pain and when the respondent asked him to identify his pain through pain assessment scale, he said he was at pain level 10. The third incident is about a Finnish patient who seemed to have been in pain, with an observation of the results from the vital signs reading; but when the respondent asked if he was in pain, he (the patient) said everything was fine! So, these major incidents rapidly raised the respondent's attention to conduct this study, to understand if cultural background determines how pain can be expressed. With these increasing numbers of patients with different cultural background, it is imperative that the healthcare system will periodically provide appropriate healthcare system that provides culturally congruent care to patients of different backgrounds.

## **2 Aim and Problem Definition**

The study aim is to explore patient's perceptions, experiences and meanings attributed to pain during pain behaviours. The respondent placed this study on multicultural patients in postoperative phase and pain management behaviours. This study intends to cover a more multicultural experiences and perceptions of patients during postoperative phase and about what ways can pain be shown during postoperative pain management. This study will elaborate competent ways to address this issue because patients from various multicultural backgrounds require different, unique, congruent and culturally competent care during nursing care. The study will also try to explain the role of cultural influences on pain perceptions and reaction by patients during postoperative phase. The questions are:

- How can pain be expressed or described during postoperative phase and if pain expression is culturally connected?
- How can a nurse provide competent care to patients during postoperative surgical procedures without facing challenges during nursing care?
- How can nurses communicate effectively through language when a cultural barrier exists with patients from different cultural background?

### 3 Theoretical background and previous studies

In this phase of study, the respondent will describe the theoretical background and previous studies carried out on postoperative surgical experiences. The respondent will lay emphasis on experience, Immigration, Culture and health, Cultural concept in healthcare, Finnish healthcare system, cultural concept in caring and pain definitions. It is worthwhile to understand the aforementioned terms because immigrant experiences resolve around these concepts.

Previous studies on postoperative experiences of patients during surgical procedure suggest that post-operative pain remains the most widely associated experience by patients (Ceyhan and Gulec, 2010, p.47-52). Further studies focused on surgical aspects and post-operative complications after surgery (Barthelsson, Lutzen, Anderberg and Nordstrom, 2003, p.253-259); Psychometric assessment of pain intensity between older and younger patients show that low score in McGill pain questionnaire (MPQ) with less self administered morphine were recorded in older patients compared to high score in younger patients following post-operative surgical procedure (Gagliese, Weizblit, Ellis and Chan, 2005,p.412-20).

#### 3.1 Culture and Health

Merriam-webster defined culture as '*beliefs, customs, norms and social value system of a society, group, place or time*'. World Health Organization (WHO) constitution (1946) definition of good health as not absence of disease but a condition of complete physical, social and mental well-being stability. Health determinants such as the individual's cultural behaviours affect patients during hospitalization either positively or negatively towards the patient's experience and perceptions about nursing care. Different cultural systems health related issues try to explain the causative agents of disease or illness and different understanding of health promotion. Some cultures explain or view illness from a different perspective than others such most health issues were attributed to supernatural phenomena or need spiritual interventions than seeking medical attention. In most cultures, patient's cultural beliefs affect the way healthcare delivery or beliefs on treatment options are delivered because patients sometimes bring their own values on health concepts and illness during nursing care (McLaughlin & Braun, 1998:116-126). McLaughlin et al. (1998) suggested some strategical requirements when working with multicultural patients and these were:

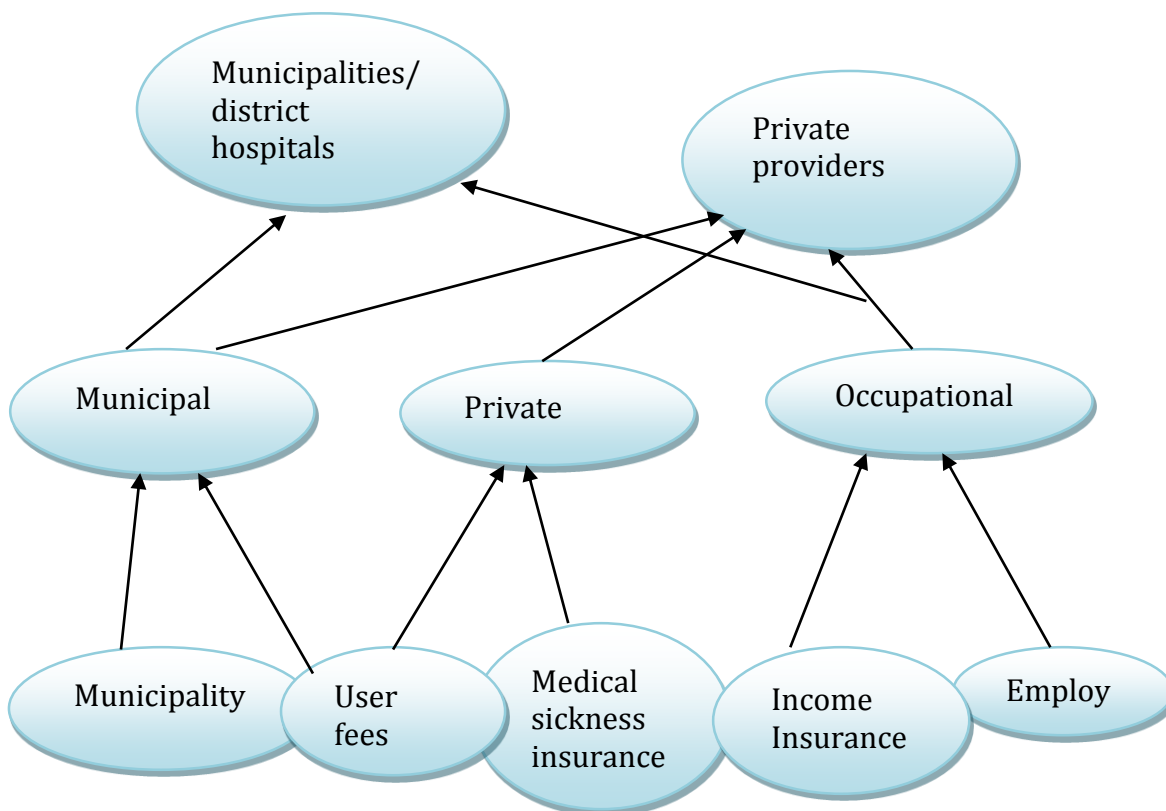
- Patients cultural systems should be taken into account during nursing delivery
- Body language, expressions of anxiety and state of responsiveness should be critically observed because it may lead to more nursing diagnosis
- Open-ended questions should be asked to understand patient/family perceptions about nursing care
- Biased assumptions should be avoided when values differ and use effective method of communication suitable for patients during care (McLaughlin et al. 1998:116–126).

### **3.2 Finnish healthcare system**

The Finnish healthcare system rose from rudimentary healthcare system to a world recognized healthcare system. Finnish healthcare care utilizes the value-based system as its main principle. The outmost core value remains effective and appropriate healthcare outcome for the patient as the final receiver. The different level of classification of healthcare system makes it possible for every permanent resident in Finland as a healthcare recipient regardless of race or ethnical background. Integrated practice units based on the level of value-based care gives each patient a sense of coverage to be part of the care delivery team because it is imperative so that patient can successfully participate in preventive care and self-care (Teperi, Porter, Vuorenkoski & Baron, 2009:28). The Finnish healthcare system makes use of highly and effective information technology automation thereby adding more cutting-edge values to its approach towards electronic medical documentation than any healthcare system around the world. Each municipality in Finland is legally bounded to provide basic healthcare services to its residents. Currently 348 municipalities exist in Finland (Teperi et al. 2009:37). Each municipality is responsible to make jurisdictions on how to provide healthcare services such as provision of vaccination against influenza and other specialties of medical care. Every resident person is entitled to healthcare services and most reimbursements for healthcare services are from the social services authority KELA if the resident qualifies for Finnish health insurance coverage (KELA, 2012). There are several protocols by which residents pass through before the can be go to any specialized healthcare settings. The patient starts from his/her own primary healthcare center such the General practitioner sends a referral to a higher centralized hospital or the person can go through the process of acute/emergency protocol directly to



the central hospital. The most common process is the referral letter from either patient's own primary healthcare center or through occupational healthcare clinic. Below diagram illustrates Finnish healthcare structure.



**Figure 1:** Structure of Finnish healthcare system

(Teperi et al., 2009:40).

### 3.3 Pain

Each individual experiences pain several times during one's lifetime but the level of pain intensity determines predisposing factors associated with it. Merskey et al' defined pain as "a sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage" (cited in Cambitzi et al, 2000, p.467). While Matteliano's definition of pain was that pain is the soul's experience of evolution (Matteliano, 2003). Matteliano's explanation of pain dominates most medical and cultural views about pain because the gradual progression of pain sensation in any part of the body system is a warning signal that an imminent attention is required. Culture has been a dominant force in the way most immigrants experience pain and it is important that nurses need knowledge based cultural experience to ascertain pain level and expression when working in a diversified healthcare setting. There are three main classification pains according to Kennedy (2007)

- Nociceptive pain is associated with somatic and visceral tissues as a result of normal response to injury. A typical example of nociceptive pain is that of a patient experiencing joint or ligament localized pain.
- Neuropathic pain is associated with somatosensory abnormalities as a result of lesions. An example of neuropathic pain can be experienced during post-operative phase of patients who underwent amputation surgical procedures such as amputation of limb.
- Inflammatory pain is associated with activation and sensitization of nociceptive pain due to inflammation of tissue by mediators. Rheumatoid arthritis pain is a typical example of inflammatory pain.

Pain can be attributed to time duration and this can be explained in the following categorized into the following: Acute, chronic and cancer-related pain. Acute pain is an onset pain to a specific injury and usually last from days to months, chronic pain refers to persistent pain lasting beyond the duration of disease and usually last more than three-six months while cancer related pain remains a complex situation because it can be acute or chronic as a result of cancer prognosis and procedural pain occurs as a result of short and intense sensation from diagnostic procedures (Paul and Williams, 2009, pg.256).

### **3.3.1 Pain Assessment**

Because pain remains a subjective experience, it is obviously important that pain assessment should be accurate and reliable during pain management so that an appropriate pain relief can be administered. Pain assessments of patients somehow remain a difficult problem when there is no common language between the nurse and patient. Without good communication channel, pain assessment appears to be ineffective because healthcare professional ability to assess pain is challenged and assessment result is altered. This may lead to a poor diagnose and the assessor may use his/her criteria to evaluate level of patient's pain.

According to Kehlet, Jensen and Woolf during their study state that post-procedural pain experiences can be attributed to two basic factors between patient and surgical factors (Kehlet H, Jensen T & Woolf C, 2006). But the disposing factors from patient's attributes such as genetic predisposition and cultural belief readily influences how these immigrant

patients experience pain therefore assessing pain by healthcare professionals often seems a difficult barrier. Communication remains an effective tool when assessing pain during post-operative nursing care. According to Briggs (2010) in his study about patient's individuality on pain expression and healthcare professional roles towards pain experience came to conclusion that the use of pain assessment tool is important when assessing cause of pain, understanding the impact and to determine what pain management enhances positive outcome and its effectiveness either negative or positive outcome (Briggs, 2010, pg.35-38).

Some barriers limit how these patients express pain during post-operative surgical procedures. Though cultural background influences pain expression among these immigrant patients, but some other major barriers mitigate against pain expression. These factors are outlined below.

- Stoicism is a major barrier because these immigrant patients express pain from a different point of view. Stoics are people who feel much pain but express less pain than others and distinguished from perseverance where a patient express less pain behaviours indirectly to pain related cases. (Janal, 1996, p.379). Stoic patients tend to avoid acceptance of pain during post-operative surgical procedures as in most multicultural settings in order to evade pain medications. This can be attributed to most factors such cultural belief, fear of injection needles and gender issue where some culture do not expect male gender to cry or shout as a way of expressing pain. Other barriers associated with wrong pain assessment are
- Addiction and side effects – Most patients hide do not want to express pain because of addiction issue to opioids or no steroidal anti-inflammatory drugs (NSAIDs) medications. The fear of this addiction problem and side effects as result of these medications tend to make them avoid reporting pain during nursing evaluation after post-operative surgical procedures. Literacy level among these immigrant patients plays important role because most of these immigrants are illiterate so understanding that certain medication alleviate their pain are countered by their rejection based on that side effects of these medications are far worse than its benefits.
- Lack of professional knowledge of basic principles of pain management – This barrier is on the part of healthcare professionals where lack of basic knowledge of

pain medications mitigates against pain management. Pain administration and management, use of adjunctive medications, anatomy and physiology of pain and non-pharmacological interventions contribute to numerous deficits lacked by nurses (Clarke, French and Bildeau et al. 1996). This is why current nursing curriculum includes basic and advance knowledge of drug administration to address these problems. Clarke et al. (1996) during their study pointed out advanced level of nurse's education in correlation to accurate pain recognition knowledge.

### **3.3.2 Pain Assessment Tools**

Pain assessment tools are important diagnostic tools used by healthcare professionals to evaluate nature of pain experienced by patients. Though useful and reliable during assessment of pain experience in self reporting patient based on locality, intensity and duration but in actual sense it does not really report the patient's actual pain because certain barriers limit patient's expression of pain during post-operative surgical procedure. Pain assessment makes use of basic characteristics of visual, verbal and numerical values where patients can report their pain experiences. Pain assessment tools includes pain intensity ratings such as numeric rating scale (NRS), visual analogue scale (VAS) which subjective response of pain experienced by patient, verbal rating scale (VRS) which is in the form of pain intensity ratings as mild, moderate or worst, visual rating scale is used when the patient has limited cognitive ability while pain assessment in advanced dementia (PAIN-AD) is a behavioral observation to evaluate pain intensity evaluation in advanced dementia patients (Wells, Pasero, McCaffery, 2008). Wong-Baker faces rating scale is a visual rating in numerical scale widely used in most healthcare settings (Wong, Whaley, 1986). It is widely used in pediatric, in some older patients and patients with poor communication problems due to poor articulation of pain evaluation (Wong et al. 1986).

McGill Pain Questionnaire (MPQ) is a multidimensional pain assessment tool developed in a questionnaire form consisting of major descriptive points – sensory, affective and evaluative responses (Melzack, 1975). Though a complex pain scale but it is highly sensitive when healthcare professionals need to evaluate differences among other pain management methods that cannot be evaluated using VAS, NRS, VRS (Melzack, 1975). See appendix 2. A newer version known as Short-form McGill Pain Questionnaire (SF-MPQ) comprising of eleven sensory and four affective responses.

This pain scale remains highly sensitive in evaluating present pain intensity (PPI) index of the standard MPQ and also visual analogue scale (VAS) (Melzack, 1987).

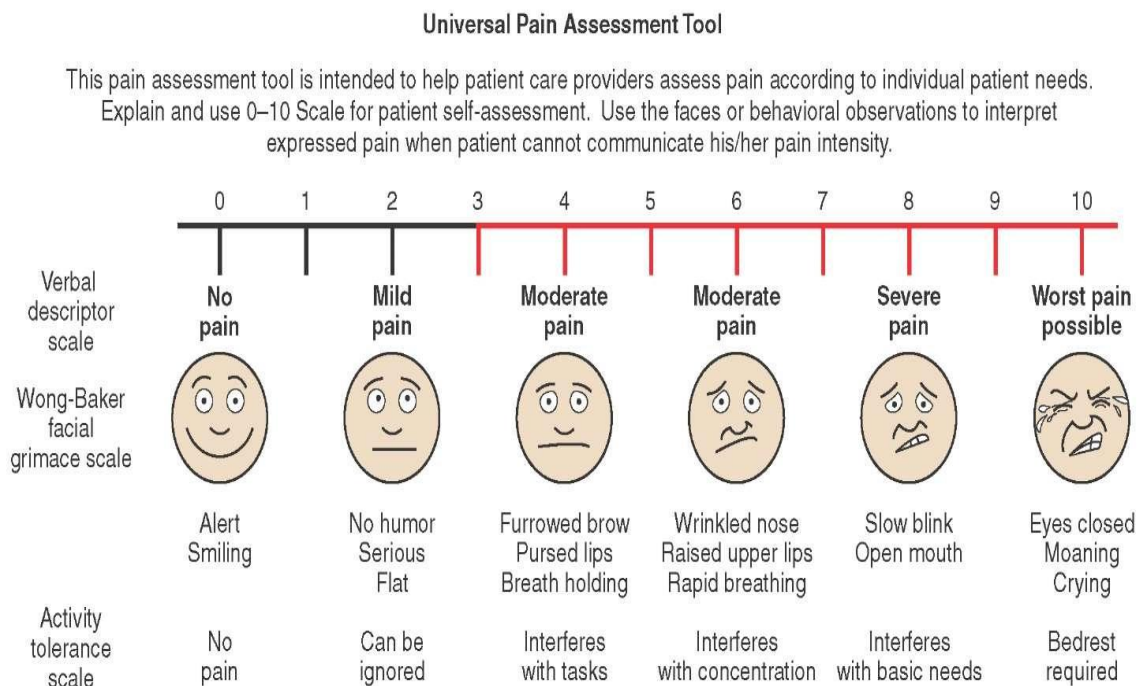


Figure 2: Universal pain assessment tool

(<http://what-when-how.com/wp-content/uploads/2012/04/tmp2637.jpg>)

### The Wilda approach to pain assessment

Five major components (words, intensity, location, duration and aggravating/alleviating factors) of pain assessment are documented into a process for pain evaluation and usually an open-ended question where healthcare professionals must take into account the patient's pain experience where it is worst located Fink (2000). The 5 major components of Wilda approach are:

- Words – Descriptive words explaining pain types aid healthcare professionals to make a proper judgment on specific intervention for pain management
- Intensity – Quantifying pain intensity is important during pain assessment
- Location – A specified location of pain aid healthcare professionals to evaluate best interventions required for the patient
- Duration – Occasional questioning about pain duration reduces transitory exacerbation of pain in patients

- Aggravating/alleviating – Descriptive factors on pain aggravation or alleviation during pain assessment helps in implementing the best possible outcomes for pain management.

## **PAIN ASSESSMENT GUIDE**

### **TELL ME ABOUT YOUR PAIN**

#### **W**ords to describe pain

aching	throbbing	shooting
stabbing	gnawing	sharp
tender	burning	exhausting
tiring	penetrating	nagging
numb	miserable	unbearable
dull	radiating	squeezing
crampy	deep	pressure

#### **Pain in other languages**

itami	Japanese	dolor	Spanish
tong	Chinese	douleur	French
dau	Vietnamese	bolno	Russian

#### **I**ntensity (0-10)

If 0 is no pain and 10 is the worst pain imaginable, what is your pain now? ... in the last 24 hours?

#### **L**ocation

Where is your pain?

#### **D**uration

Is the pain always there?  
Does the pain come and go? (Breakthrough Pain)  
Do you have both types of pain?

#### **A**ggravating and Alleviating Factors

What makes the pain better?  
What makes the pain worse?

#### **How does pain affect**

sleep	energy	relationships
appetite	activity	mood

#### **Are you experiencing any other symptoms?**

nausea/vomiting	itching	urinary retention
constipation	sleepiness/confusion	weakness

#### **Things to check**

vital signs, past medication history, knowledge of pain, and use of noninvasive techniques

## Mnemonics used in pain assessment

Mnemonics, which are letters, intended to aid memory (Merriam-Webster dictionary). Pain assessment mnemonic tools used commonly to evaluate nature of patient's pain include 'SOCRATES'- a framework in asking major questions when assessing patient's pain experience. (Briggs, 2013:37). The following listed below are the eight major keywords of SOCRATES framework:

- **SOCRATES**

**Site:** Where is the pain located in the body?

**Onset:** When did the pain begin and how? Was it sudden, intermittent, fast progressing, etc.?

**Character:** What type of pain is it? Is it a dull, stabbing, sharp, tight?

**Radiation:** Does the pain spread to other body parts?

**Associations:** Does the pain cause any associated symptoms such as nausea, vomiting or change in mobility, jaundice?

**Time:** What specific activities activate the pain or get worse at certain times?

**Exacerbating/relieving factors:** Does it get worse during mobility, sitting or breathing?

**Surgical history:** Earlier surgery or interventions? (Berger, McLatchie, Borley and Chikwe, 2009).

- **PQRST** mnemonic model (Kernicki, 1993). This is another framework used to evaluate pain nature as seen in a patient. The five keywords stand for:

**Provokes:** What causes the pain or makes it worse (stress or position) / better?

**Quality:** Does the pain feel like? Burning, stabbing, shooting, nauseating, crushing, throbbing?

**Region/radiation:** Where is the pain located? Does it radiate elsewhere to some other body parts or stays at one point?

**Severity/symptoms:** How is intensity of the pain? Does it cause other symptoms or interfere with other daily activities?

**Timing:** What time does it get worst? What time do you normally experience pain? Is it seasonal or periodic? (Kernicki, 1993).

These mnemonic models evaluate patient's pain under the above headings. In order to get the actual pain assessment, healthcare professionals make use of this model. In evaluating pain, often-basic key points are important to understand in patient's pain history such as location, severity and time onset.

### 3.3.3 Appraisal of pain

Merriam-Webster dictionary defined appraisal as "*the act of judging the value, condition, or importance of something*" (Merriam-Webster dictionary). Appraisal of pain remains an objective and fundamental practice during patient's pain assessment. It is important to establish a formal assessment of pain in patients because without accurate assessment, a successful and effective relief from pain cannot be met (Thompson, 1989, p.149) and there exist no current objective measurement in pain determination among patients reporting pain (McCaffery and Pasero, 1999). Every individual attribute towards pain appraisal is generally shaped around his/her belief system and ideology based on learned experiences and observations. Belief system and appraisal of pain usually affects patient's perceptions about pain and these are major determinants towards pain experience. One study carried out on cancer patients undergoing physiotherapy found that patient's perception of pain sensation in relation to cancer feel more pain intensity than patients those who relate their pain to other factors outside the disease (Smith, Gracely, Safer, 1998). The transactional stress model illustrates a distinctive criteria between primary and secondary appraisal where the former is evaluation of pain significance such as threatening, irrelevance or benign while the later evaluates pain control and coping resources (Lazarus R, Folkman S, 1984). Appraisals of pain among patients remain an individualistic experience because each patient show distinctive approach towards pain and this can be either from a cultural perspective or an act of coping mechanism.



### **3.3.4 How previous pain experiences affects pain management care**

Post-operative pain remains a common complication associated with surgical procedure. An experience after surgical procedures differs from one patient to another. These experiences range from moderate to severity pain level. Certain knowledge gathered through nurse-patient relationship during hospital stay forms the basis of experience by patients. From gathered information, the patient makes either positive or negative assumptions toward nursing care, prevalence of risks associated with surgical procedures, cultural bias towards. Moreover, patient's experience during postoperative phase can be affected by sociocultural factors about pain behaviours. For example this can be noticed among patients from different culture who underwent same surgical procedure but pain level experiences were expressed differently.

Continuum of engagement refers to core integrated system of care developed to improve healthcare quality, decision-making actions necessary for patient's safety and comprehensive management (Carman et al., 2013). Since pain is a subjective experience, major influencers such as beliefs system, Culture and literacy level affects towards pain perceptions by patients. Pain assessment scales can be interpreted differently when there exists a gap between nursing care and patients' involvement during care delivery; because it is impossible for a patient who is unfamiliar with pain rating scale to describe how he/she feels pain, by using a pain scale. Continuum of engagement is important in the sense that patients' involvement in highly required such that their preferences are included during nursing care following total harmony with healthcare systems and patients' families. Though most healthcare policies made around the world is to improve healthcare quality and reduction of shortfall decrease in negative patients' experiences towards nursing care. For example in Australia, this framework was developed to include patients' cultural development and equip them to collaborate with their care plan (Australia council for safety and quality, 2003).

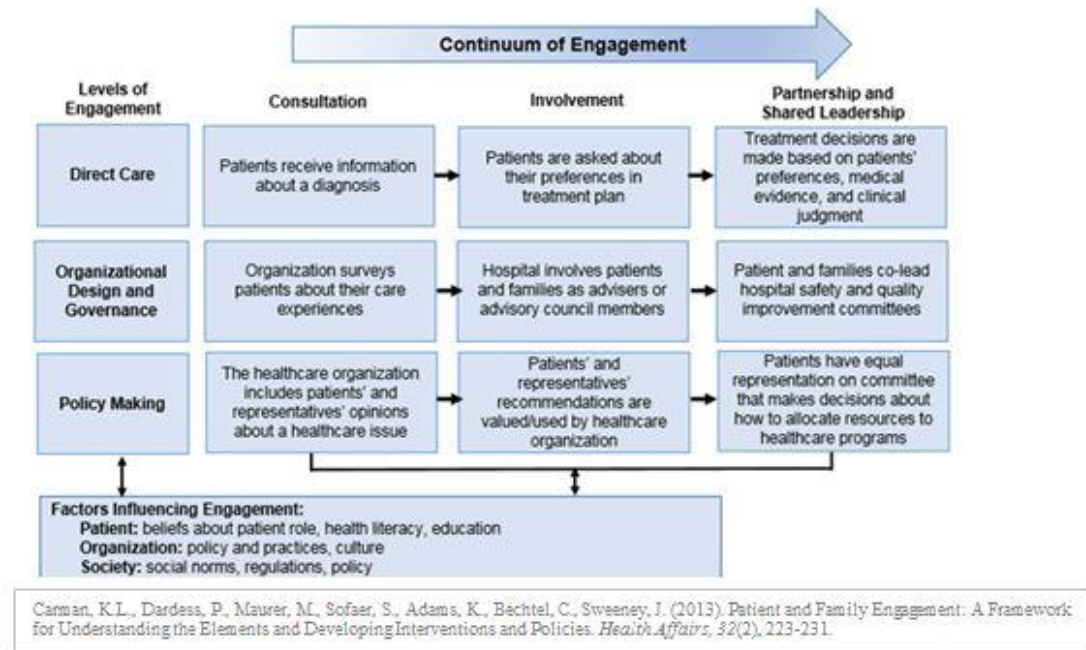


Figure 3: Continuum of patient's influence  
(c Carman et al. 2013:225).

## 4 Theoretical Framework

The respondent has chosen Katharine Kolcaba's theory on "comfort" and Madeleine Leininger's theory on 'culture care theory of diversity and universality' for this study. These theories were chosen because in Kolcaba's theory of comfort, she used an empirical evidence to point out important nursing actions to take care of each specific comfort needs. Leininger's theory on culture care, theory of diversity and universality describes specific measures that nurse need to acquire in order to be culturally competent when delivering nursing care.

### 4.1 Conceptual framework of Kolcaba's comfort theory

The main concept of Kolcaba's comfort theory is a holistic and humanistic theory focusing on patient's need.

*"In today's technological world, nursing's historic mission of providing comfort to patients and family members is even more important. Comfort is an antidote to the stressors inherent in health care situations today, and when comfort is enhanced, patients and families are strengthened for the tasks ahead. In addition, nurses feel more satisfied with the care they are giving"* (K. Kolcaba (personal communication, March 7,2012).

Health care needs was defined as comfort needs which arises from stressful healthcare conditions where the patient's traditional support systems failed to achieve an optimal healthcare needs. Though traditional support systems are part of holistic care providing comfort in nursing but in general if a holistic approach towards achieving comfort, it seems apparent that nurses should be equipped to monitoring patient's vital functions, give verbal and non verbal reports, gain adequate education and be able to counsel and provide proper intervention towards patient's pathophysiologic needs (Kolcaba cited in Alligood, 2014, p.659-660). Holistic comfort is described as a combination of normative and descriptive component necessity in nursing care (Kolcaba, 1994, p.1180). In the concept theory framework, negative tensions were triggered by situation stimulus when healthcare needs increases but these negative tensions illustrate the imbalance between obstructing and facilitating forces within the system. To achieve comfort for the patient, there arise need to weigh both internal and external health-seeking behaviors with comfort outcomes. At this point, the nurses toward patient's experience of comfort evaluate comfort outcomes either subjectively or objectively (Kolcaba, 1994, p.1180).

The major concepts of the theory are explained briefly: -

- Healthcare Need: Identification of best practice by patient/family within a specific practice setting.
- Comfort Interventions. These are nursing actions placed to achieve a desirable comfort needs for patient. They are interventions towards achieving a positive comfort level and desired health seeking behaviors on specific patient's physiological, social, cultural, financial, psychological, spiritual, environmental and physical interventions (Kolcaba, 2001).
- Intervening Variables: Refers to factors that influence patient's experience towards achieving total comfort. These variables include cultural background, prognosis, education, financial situations, social support systems or personal emotions etc. (Kolcaba, 2001).
- Comfort as the immediate experience of being strengthened by having needs for relief, ease, and transcendence met in four contexts – physical, psycho spiritual, social and environmental (Kolcaba, 2001).

- Health seeking behaviors involves institutional integrity where ethical values, wholeness of health care organization produce evidence-based practice and policies. Best policies include protocols and procedures carried by the healthcare organization to provide best patient and family healthcare outcomes (Kolcaba, 2001).

## **4.2 Metaparadigm Concepts of Comfort**

Over the years comfort has been the main goal of nursing outcomes and many activities has been promoted to achieve this fate. McIlveen & Morse (1995) stated that patient's recovery process could be achieved through comfort. McIlveen et al. (1995) further mentioned that emotional comfort was called mental comfort and this can be seen as a positive outcome only through modification of patient's environment and provision of physical comfort in the sense of psychological ease. Kolcaba's metaparadigm concepts falls into four distinctive groups namely nursing, patient, environment and health. The nursing represents all intentional evaluation of comfort needs, design of comfort measures to address specific needs and also evaluation of action plan towards comfort compared to previous baseline measurements. Assessment and reassessment is either intuitive or subjective or both and achieved through clinical or research (Kolcaba 2003,p.68). The patient include the individual, family and the immediate community in need health care and the nurse can be a patient when working conditions are improved thus gaining enhanced workplace comfort (Kolcaba, Tilton, & Drouin, 2006). The environmental aspect focuses on the external influences such as physical room, institutional settings, policies, family which can improve comfort when manipulated by nurses or institution while Health aspect focuses on family, community and patient's optimal functioning when nursing care is enhanced to bring comfort (Kolcaba 2003, p.68).

## **4.3 Taxonomic structure of comfort**

The taxonomic structure consists of the three types of comfort and the four contexts of comfort experience in a matrix sequence. It made provision of mapping out each content domain of comfort where utmost outcome is discomfort relief such as pain experience and social exclusion.

### 4.3.1 Types of comfort

Kolcaba came up with the classification of comfort according to different types by conceptualizing ideas from three earlier nursing theorists). She classified comfort into three distinct types as follows (Kolcaba cited in Alligood, 2014,p658-659).

- Relief was conceptualized from Orlando's work (1961). It was defined as the state where patient's specific need was met and relieved by nurses (Kolcaba cited in Alligood, 2014,p658-659)
- Ease defined as the state of calmness and contentment and it was conceptualized from Henderson's work (1966) where 13 basic human functions that should be maintained during nursing care (Kolcaba cited in Alligood, 2014,p658-659).
- Transcendence defined as the act of patient rising above his/her problems or during pain experience with the help of nurses. This was conceptualized from Paterson and Zderad's work (1975) (Kolcaba cited in Alligood, 2014, p658-659).

### 4.3.2 Contexts of comfort

Kolcaba (2003) states that contexts of comfort experienced by recipients originate literatures in nursing. These contexts of comfort experiences are in four distinct forms in which they occur – physical, psychospiritual, environmental and social context of experience. The physical context relates to sensations within the body functions, mechanisms put in place to achieve homeostatic functions and well functioning immune system. The psycho spiritual context relates to inward awareness of self, which includes self-worthy, sexuality, meaning of one's existence and one's spirituality. For some people this context can influence their consciousness to access comfort through some other tools such metaphor or through mediation. Environmental context of comfort experience relates to external surrounding or influences which stimulates the patient's rational behavior towards his immediate environment while social context relates to interpersonal relationship within one's nucleated or extended family and this can also be within societal circle (Alligood, 2014,p.659).

#### **4.4 Madeleine Leininger's theory of culture care diversity and universality**

Leininger in her book about the importance of transcultural nursing and human care defined transcultural nursing as:

*“a substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures with the goal of providing culture-specific and universal nursing care practices in promoting health or well-being or to help people to face unfavorable human conditions, illness, or death in culturally meaningful ways”* (Leininger, 1995, p. 58).

This aspect of nursing with comparative study and multicultural setting analysis places its major emphasis on values, caring, beliefs system, health-illness expressions and behaviors pattern (Leininger 1991b, 1995c; Leininger & McFarland, 2002b, 2006). She tried to find ways of promoting human care diversities and universalities in relation to worldview, social structure factors and other various dimensions when providing culturally congruent care in a multicultural settings, while appropriate health promotion and culturally meaningful end of life ways are been maintained.

Conceptualization and understanding of people are designed when promoting holistic care so that the best approach nursing care delivery can be maintained. More also, it is important to develop or have prior knowledge of culture and care because these are most effective tools when providing nursing care in a uniform or diversified cultural settings (Leininger, 1991b, 1995c; Leininger & McFarland 2002a, 2006). For effective decision-making and nursing actions when providing care by nurses congruent care competencies and knowledge are highly required to provide a better outcome because this knowledge will guide nurses to make the best utmost decisions and will enable nurses also to provide a well-organized nursing plan based on the patient's cultural background (Leininger, 1991b, 1995c, 1996a; Leininger & McFarland, 2002a, 2006). Leininger (1996a) postulated a modified theory about nurses being creative in understanding people with diversified cultural settings with respect to their values, expressions, beliefs system and caring process in order to promote more effective outcomes culturally congruent care, because without their values and beliefs being taken into account, the resultant outcome will remain bias on part of the individual or group (Leininger, 1991b, 1995a, 1995c, 1996a; Leininger & McFarland, 2002a, 2006).

#### 4.4.1 Theory of culture care diversity and universality

Leininger (1991b) postulated this theory based on the opinion that understanding diversity and universality of people's culture is important during nursing care because it forms a basic guided information to promote and provide specific care to that specific culture. For example when providing nursing care for a patient from a different cultural background experiencing pain, without prior understanding how pain is expressed in that culture; it seems difficult to assess and evaluate the patient's pain level. Thus this creates a strong barrier to effective nursing care because the patient will feel biased based on poor management of his pain because either the culture exaggerates pain or endure such pains during hospital stay.

##### Some major concepts of the theory

- Human care and caring: Relates to abstract or indicating factors with affirmative ways where expressions were promoted for health improvement situations, disabilities phase and for a successful end of life.
- Culture: Relates to sum of ways, values, beliefs system, customs and practices learned or shared which differentiate people from each other and often transmitted over generation through language, material and folk tales.
- Culture Care: Refers to culturally supportive pathways, which are focused on patients' well being through whole process of living, disability phase and end of life situations.
- Culture Care Diversity: Refers to culture differences in certain beliefs system, values and meanings within a diversified cultural background and associated human beings.
- Culture Care Universality: Refers to culture similarities within a certain culture. These similarities are based on culture care values, customs, beliefs and truths that reflect universality of care in human beings (Leininger, 1991b, 1995c; Leininger & McFarland, 2002a, 2006).

##### Empirical evidence

Merriam-Webster defines care as "*responsibility for or attention to health, well-being, and safety*" (Merriam-Webster dictionary). From the above definition, care remains a complex,

elusive with social structure values and remains the main focus in nursing care (Leininger, 1991b; Leininger & McFarland, 2006). With few similarities or differences among care such that some are universally held beliefs while some are professed differently among cultures (Leininger, 1991b; Leininger et al.2002a, 2006). As the main focus in nursing care delivery, understanding and documentation of culturally based care should be the main principle in transcultural nursing therapy and therefore be utilized for future development and in forecasting nursing based practices (Leininger, 1991b).

### **Major assumptions of Leininger's culture care theory**

- Nursing: Distinct feature of care.
- Person: Relates to the context of values, customs, beliefs and practices.
- Health: Refers to values and expressions for realization of satisfiable outcomes towards the person based on culturally congruent care.
- Environment: Refers to interpretation of emic and etic values learned or shared over a period of time thus overcoming cultural conflicts when promoting congruent care.

#### **4.4.2 Sunrise Enabler**

Leininger developed the sunrise enabler so that valuable diverse elements of her theory were fully represented and also making valuable clinical assessment based on culturally congruent. It reflects care as rising sun. The upper half of the circle illustrates social structure dimensions and a worldview of understanding values and life of the people while the center part illustrates other factors influencing nursing systems and the full sun focuses on care considerations in relation to health by nurses (Leininger, 1991b, 1995c; Leininger et al.2002a, 2006). The point of view is that nurses should acts as connection between generic and professional system during nursing care while focusing mainly on the patient/s health outcomes when working in a diversified settings. The major facets of care, actions and decision making exemplified in Leininger's theory were culture care preservation/maintenance, culture care accommodation/negotiation and culture care repatterning/restructuring. This explains that humans are indissoluble but interwoven with their culture, social structure and other dimensional features (Leininger, 1991b, 1995c; Leininger et al.2002a, 2006).



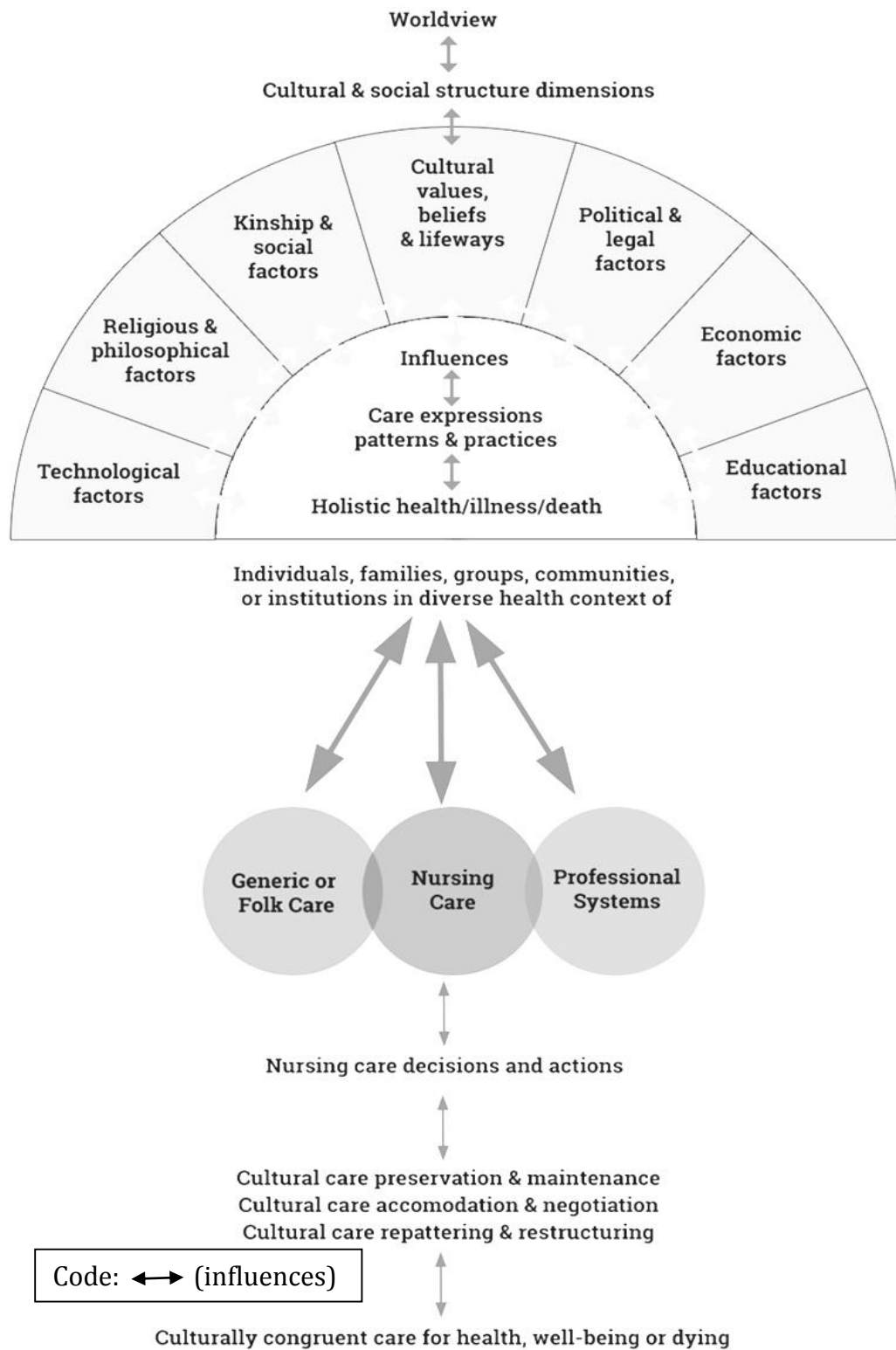


Figure 4: Leininger's Sunrise Enabler to discover culture care

(c M.Leininger, 2004 in M.Alligood, p.426)

## **5 Research methodology**

The respondent will apply qualitative research approach for this study. Qualitative study materials collected will be analyzed with ethical consideration taken into account. The respondent chose qualitative approach because the respondent intends to use a naturalistic method to tell about the lived experiences of people by capturing and communicating them in their own words (Patton, 2002:47). Communicating in their own words is by quoting their words, as it will be shown in the result interpretations.

Qualitative methods applied to this study will consist of systematic review of articles and inductive content analysis approach which is a major strength of qualitative research because its understanding originates from observed experiences through data collected rather than predetermined hypotheses. The study data collected were from qualitative articles dealing with the respondent's main objectives for the study. The respondent's way of inquiring or addressing a deeper fundamental questions of what these individual or group of people lived experience seems like and its social context, where language and communication structure leads new insights and a good conclusion.

### **5.1 Systematic Review**

The respondent chose to use systematic review for the study because systematic review integrates collected data from different sources and then follows the pattern of identification, selection and synthesizing important research available in order to achieve a desired review. The respondent use of systematic review is to gather all relevant materials for this study, thus making use of inclusion and exclusion method during data collection as explicit criteria to arrive at a better conclusion.

Application of systematic review during sampling and data collection process makes the study in question raises the standard of critical appraisal of this study's quality, thus making the methods applied open for external scrutinization (Polit & Beck, 2012:653). Inclusion criterion is imperative in every well appropriate systematic review because it will avoid or eliminate bias when extracting and synthesizing findings thus promoting decision-making from reliable rationale assumptions from study findings (Polit & Beck, 2012:653).

## 5.2 Data collection

Qualitative data are inexpensive with great sense of meaning and observation thus making data collection a systematic approach of information gathering from different sources and its analysis very simple to arrive at an accurate conclusion of the respondent's study interest; through an extensive process because it requires appropriate scrutiny in order to find relevant materials by applying explicit criteria to include or exclude some materials (Polit & Beck, 2012:534). The respondent chose to use previous published materials dealing with the particular topic being studied. The respondent searched for electronic materials comprehensively through Nelli-portal database using the meta-search engine. Various databases were searched; EBSCO's academic search elite and CINAHL with full text and few qualitative materials were found. Online journals were searched, and the respondent also searched materials manually from Tritonia library.

Systematic review based on the explicit criteria of inclusion/exclusion approach was applied to eliminate irrelevant materials, which are not required for the respondent area of interest. Materials dealing with quantitative studies were entirely excluded from this study. The respondent search for articles using 'Key Words' such as *Expressions of pain/qualitative study*, *Expression of pain in post-operative*, *Cultural expressions of pain in postoperative*, *postoperative pain/culture*, *pain/culture and postoperative pain/care*. In all, 12 articles were included for qualitative content analysis. See appendix 1.

### **Inclusion criteria**

Studies which are relevant to the study, scientific materials with full text with no log in, studies including all cultures, gender and age group, studies within 20 years, published journals in English language, involving nursing fields, scholarly (peered reviewed) journals. Articles on children's pain experience were also included because it is of the respondent's interest to understand how children experience pain; and one article reporting childbirth pain experience was included in order to establish, - if pain is culturally connected or attached to other sources rather than postoperative pain conditions.

### **Exclusion criteria**

This included; studies of more than 20 years, Non-English language, undocumented reports or materials. Meta-analysis studies and non-relevant articles, non-scientific articles.

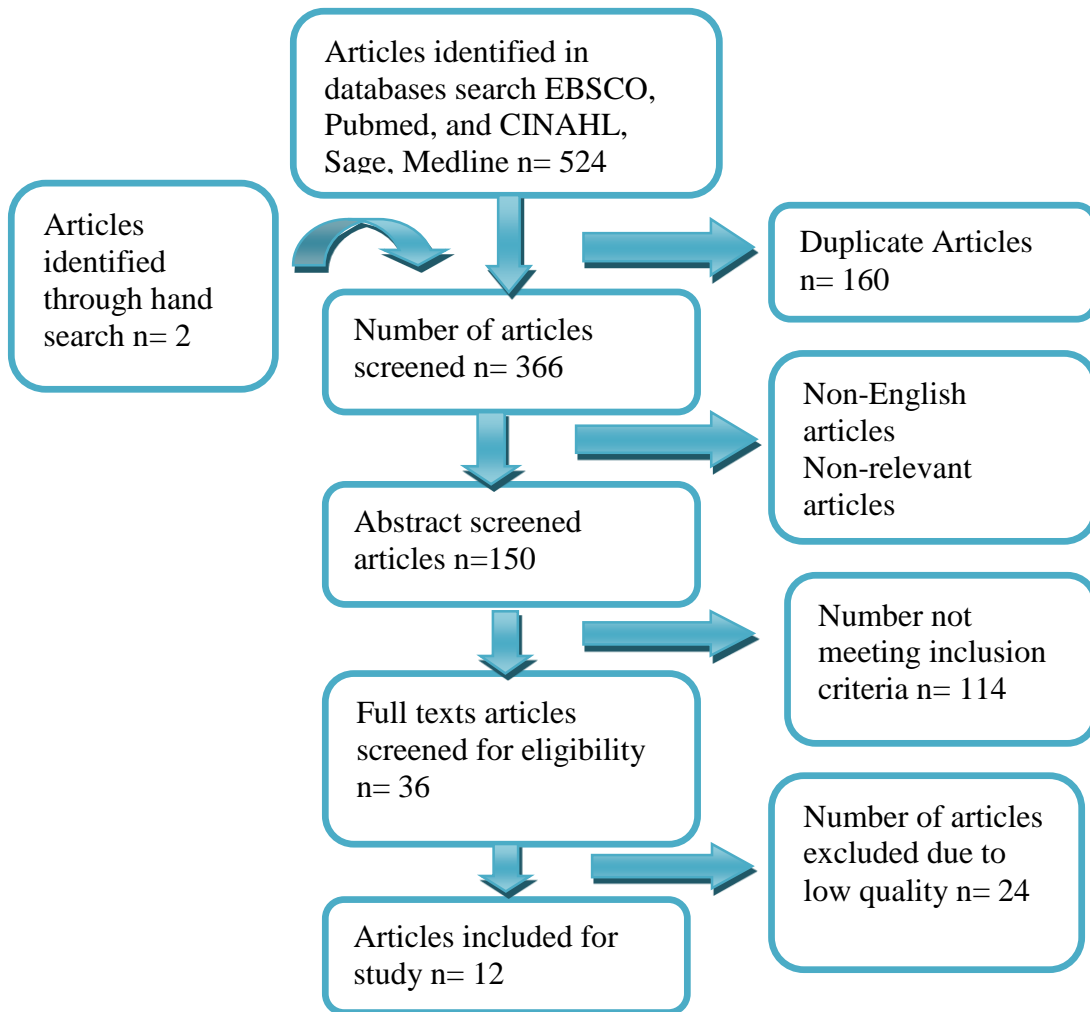


Figure 5: Flow chart of search criteria using inclusion/exclusion approach.

Twenty-four articles were excluded because some of the articles' results were presented in numeric and quasi statistics method. This would make it difficult to analyze them.

### 5.3 Qualitative Content Analysis

The respondent chose to use content analysis as a data analysis choice. Analyzing data within this study will be conducted using inductive approach because it this method will integrate the three major approaches in analyzing qualitative data. Since content analysis is a process of analyzing visual, written and verbal communication data into a more meaningful descriptive phenomenon (Elo & Kyngäs, 2007:107). Content analysis process involves three major approaches/stages which are employed to arrive a meaningful phenomenon, these three includes preparation stage where the respondent chose either a latent or manifest content way to analyze his data based on the type of data and detailed data materials collected (Elo et al.2007). At this stage collected materials were read thoroughly and few interpretations were made based on the content meaningful

information. Furthermore, meaningful information were integrated into similar key concepts thus making it easier to categorize data gathered into smaller units. Qualitative data are usually voluminous so the main point at this stage is to making sure that information from data remains of good quality and a good sense is made when organizing it.

Polit and Beck (2012) in their book defined content analysis as “*the process of organizing and integrating material from documents, often narrative information from a qualitative study, according to key concepts and themes*” (Polit & Beck, 2012:723). Elo et al. (2007) argued that no precise or generally accepted rule for qualitative data analysis but at times content analysis involves searching for the most recurring texts whereby core contexts are usually identified during data preparation. In order to arrive at a core meaning known as theme when using content analysis, qualitative information need to be clustered/organized, coded/grouped, categorized into themes they belong. Inductive content analysis revolves within the collected data where themes are discovered and then categorized into one’s data and result findings usually spring up from the data (Patton, 2002:453).

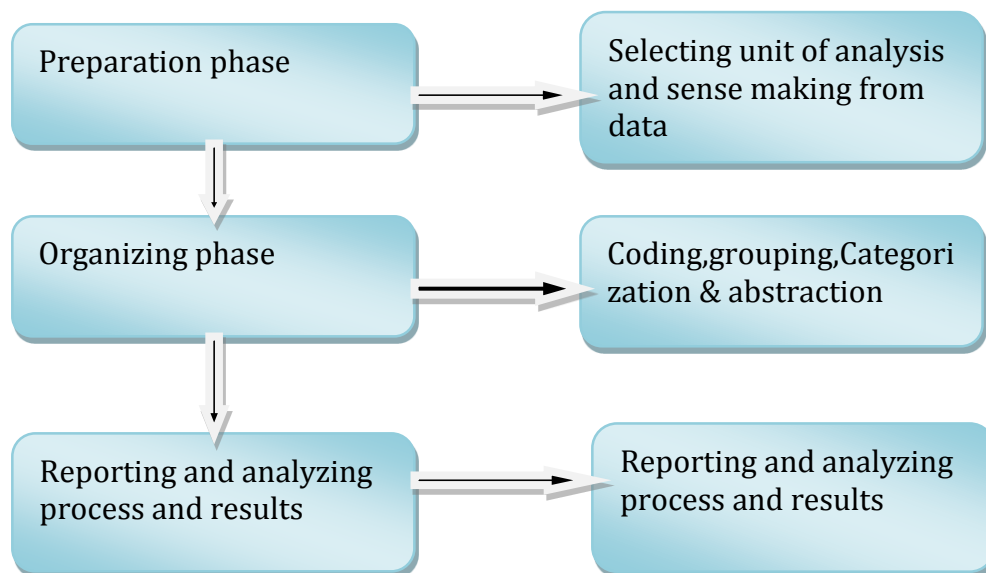


Figure 6: Inductive content analysis approach

(c Elo & Kyngäs, 2007:110).

## 5.4 Ethical considerations

The respondent paid important attention towards ethical considerations during this study because it is imperative that ethical issues are maintained. For this study to be credible and adhere to standard ethical evaluation, accurate and quality study materials should be sourced from well-recognized electronic databases.

Polit and Beck (2012) defined ethics as "set of concerned system which includes moral values regarding to research procedures in correlation with professional, legal and social coverage of study participants" (Polit & Beck; 2012:727). Data collections for this study were sourced through electronic databases and this method remains a great risk for most researchers. Though a qualitative study using content analysis for data analysis, careful observations and ethical issues regarding material selections were seriously considered so that copyright infringements were maintained throughout this study.

The respondent maintained absolute adherence to four major ethical considerations contexts relating to quality standards. The four contexts being considered are Fabrication, plagiarism, misappropriation and falsification. Fabrication means that the respondent should not make out unrealistic outcomes from wrong observation through unrelated methods used. Plagiarism means that the respondent should not copy word-to-word of other selected researchers works without giving proper credit to them. Misappropriation means that respondent should not lay dishonest and unmerited claims to other researcher's work in an unauthorized manner while falsification means that respondent should not falsify or altering important points useful for the study such that observational evidences are not verifiable (Finnish Advisory Board on Research Integrity, 2012, 32-33).

## 6 Results

During this stage, the respondent will interpret results from articles collected and analyzed through content analysis. Based on the themes and collective categories emerged through this method of analysis, it is imperative that these results will be in accordance with research aim and questions. Twelve qualitative articles were collected, analyzed and labeled Q1-Q12 (refer to appendix 1). Three major themes were identified namely: *communication barriers, figurative expression of pain, and influence of culture & beliefs system towards pain*. The figure below illustrates abstraction process where themes emerged.

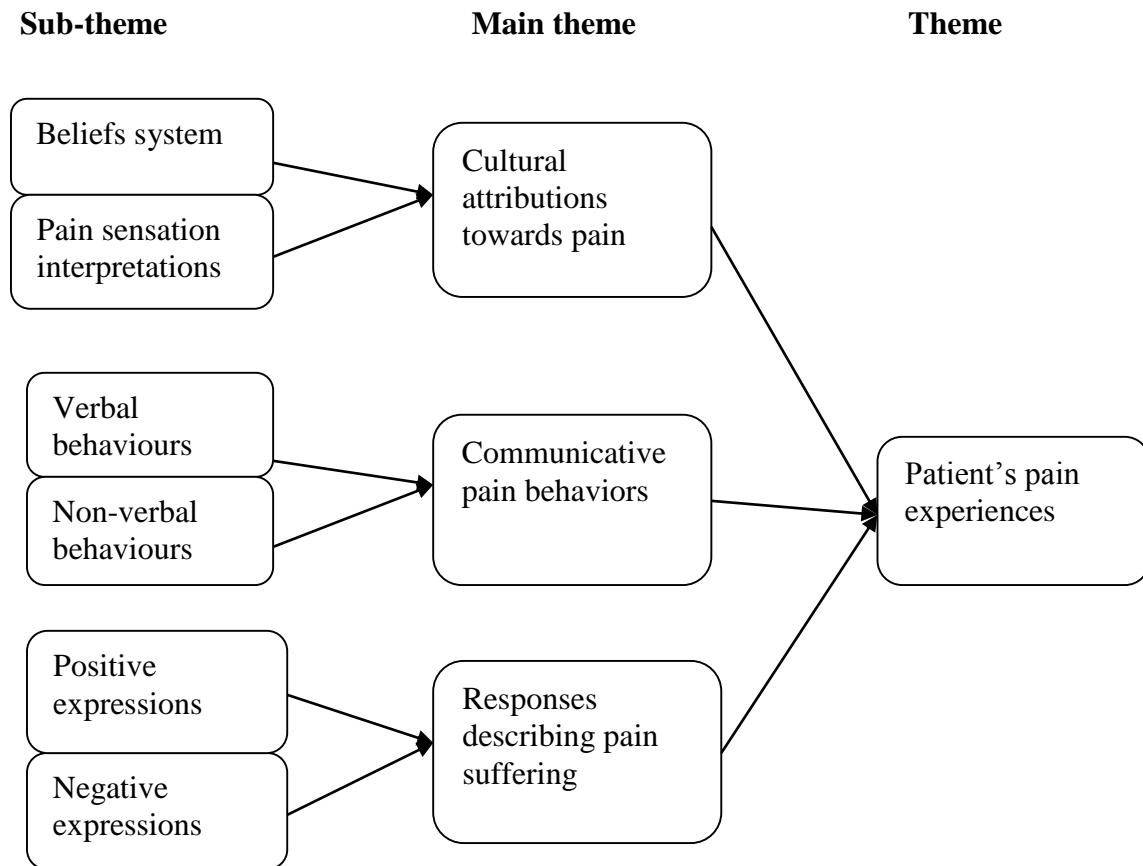


Figure7: Abstraction process of themes

## 6.1 Cultural attributions towards pain

Interpretations of pain experience by patient are readily influenced by patient's own cultural behaviours. This major issue has been a dominant role in communication and expression of pain experiences during nursing care.

### 6.1.1 Beliefs system

This sub-theme emerged because certain religious beliefs or ritual influences patient's pain experience such as in reporting pain. For example in one study about black Caribbean cancer patients, pain was perceived as a test of faith because of their religious beliefs (Koffmann et al; 2008:355).

*"Sometimes at night time I go to bed and when the pain is so much I turn everywhere in the bed and the pain is the same, I say, "Why the good Lord keeping me here? Why don't he take me?" Yeah, I've all those feelings, I say, "Why are you keeping me? Why don't you take me?" Because I'm in pain"* (Koffmann et al; 2008:355).

In another study about Somali women conceptions of pain, it was found that beliefs system plays a crucial role in determining pain expression. They rely on Koran when they experience pain (Finnström & Söderhamn; 2006:423).

*"We are Muslims, and when we are ill or in pain we read from the Koran. We are not familiar with psychologists. I never saw a psychologist's nameplate in Somalia. Most Somalis think that psychologists are for mentally ill people"* (Finnström & Söderhamn; 2006:423).

In certain cultures, patients are biased when using western pain medication so they tend to utilize their local alternative towards pain management. In one study on Hispanic cancer patients, most patients chose herbs and plants for cancer pain alleviation (Eun-Ok et al.; 2007:6)

*"Some people use their own remedy for the pain. I use some herbs that I got from Mexico. I put herbs in the microwave then put the herb paste on my leg and this helps me. I also sometimes go to the health food store and buy some herb"* (Eun-Ok et al.; 2007:6)

### **6.1.2 Pain sensation interpretations**

Cultural notations regarding the state of emotional, physical and bio psychosocial effects as experienced by most patients usually influenced pain sensations.

In one study on patient's experiences of chronic pelvic pain, male patients described their experiences in terms of physical and emotional impact (Toye et al; 2014:2722)

*"Relentless and overwhelming pain"* (Toye et al; 2014:2722)

Pain can be triggered when certain medications are administered to patients. Namnabati et al. (2012) in their study on pain management in Iranian children highlighted that gender differences and child's mood influences signs and behaviors coming from pain.

*"Some children are so quiet and do not show off their suffering and pain, but others especially girls with seeing a needle or venset makes screaming and crying"* (Namnabati et al.; 2011:224).



## 6.2 Communicative pain behaviours

Communication remains an important factor in pain expressions because without communication, pain assessment is usually underestimated and this can lead to improper pain evaluation. Communication can be either verbal or non-verbal communication approach. In certain situations where a child experiences pain, their parents are certainly the decision-makers. In one study about deaf patients' experience of pain using pain scales, it was found that using sign language at certain levels of pain assessment makes pain communication effective (Palese et al.; 2011). *"Someone has to explain that the faces relate to the amount of pain and for what reason"* (Palese et al., 2011:96). This calls for nurses to be effective and competent when reading and interpreting sign/body language.

### 6.2.1 Verbal behaviours

Verbal behaviours involve communication of pain whereby pain is interpreted through orally by the patient. In certain cultures, pain is rather expressed verbally than keeping mute while some cultures prefer being stoic in nature than speaking out.

At times verbal communication do not necessary for only the patient at one part but verbal communication involves both parties where the healthcare will ask questions about pain situation and the patient responds. But where one part is lacking due to certain barriers like language differences or using sophisticated language hard for the patients to comprehend, then it becomes a problem to pain assessment.

In one study analyzing using one-dimensional pain scale to evaluate pain in deaf patients, it was seen as a big barrier to pain expression (Palese et al.; 2011:98). In such a situation, nurses need to establish a more detailed explanation and sometimes a well-presented attitude towards entering into conversation with patients is important.

*"In the first instance in an oral conversation, they tend to confirm that they have understood but, in reality, they nod without understanding"* (Palese et al.; 2011:98).

Bergh et al. (2005) found that verbal communication is important to describing pain by objectification approach (Bergh et al., 2005:354). Verbal communication approach remains the key important explanation in establishing a clear view of pain location as was reported by most patients.

*"It's not only my hip, it's also my knee"* (Bergh et al.; 2005:354).

Verbal communication is imperative during nurse/patient interaction when assessing pain because lack of interactive phase creates vacuum where patient can be poorly assessed or pain report poorly understood by nurses. Cultural conflicts and ineffective communication were seen when analyzing pain expression among aboriginal women in Australia (Fenwick & Stevens, 2004:26).

In the aboriginal culture of Australia expect nurses to respect their own cultural preferences and follow their traditional pattern of healing (Fenwick & Stevens, 2004:26).

*”to see within’ and to ‘just know”* (Fenwick & Stevens, 2004:26).

Communication is important in every healthcare setting and this aids nurses to creatively provide quality care during care delivery. Despite language barriers experienced, verbal communication creates more avenues for critics so that further quality care can be improved and makes the patient’s voice to be heard. Where language barriers exists, use of translators are more commonly used in most healthcare settings.

### **6.2.2 Non-verbal behaviours**

Non-verbal behavior approach towards pain involves using of body language, facial gestures to express pain severity or experience.

In Somali culture, pain can be communicated through by body language and it was seen as a taboo to cry or wail while in pain (Finnstöm & Söderhamn; 2005:422). This study also examines Somali women experiencing childbirth pain. Being stoic is not generalized among Somali culture but it was reported that men are expected to exhibit stoicism.

*”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”* (Finnstöm & Söderhamn; 2005:422).

In describing postoperative pain among women who underwent cardiac surgery, results show that none of these women critically complained about pain experience rather pain was expressed in terms of characteristics, consequences, cognitive aspects and sites (Leegaard et al., 2008:480).

*”You feel the wound when you’re breathing, that confirms something is wrong with your body”* (Leegaard et al., 2008:479).

Non-verbal communication was identified as a barrier in pain experience among Iranian children. This non-verbal communication can be compared to adult patients at certain extent because non-verbal communication is not attached to a specific group or culture. (Namnabati et al., 2012:224).

*"Unfortunately, they cannot say about their pain due to we don't know what do we for them? Or what part of her body is in pain? . . . Of course, children those who are experienced LP, virtually; they have more fear than pain"* (Namnabati et al., 2012:224).

In one study, using non-verbal communicative pattern such as the facial scale rating should be explained carefully to patients because it can literally mean something else to some patients who are cognitively impaired or with low educational level (Palese et al., 2011:96).

*"Someone has to explain that the faces relate to the amount of pain and for what reason"* (Palese et al., 2011:96).

During analysis of one article, the respondent found out that among the Iranian culture, it is forbidden for men to hold on to their pain expression even when they were weakened by pain medication. (Rejeh & Vaismoradi; 2010:71).

*"Men never cry for pain"*(Rejeh & Vaismoradi; 2010:71).

### **6.3 Responses describing suffering with pain**

Most patients' pain expressions were reported during analysis of materials used for the study. The responses were directly from patients' physiologic experiences or perceptions about healthcare systems being put in place during pain management. The respondent classified this main theme into positive and negative expressions. This is influenced by past and present knowledge of pain experiences, attitudes of healthcare professionals, lack of understanding of assessment tools and social support systems. (Idvall et al., 2008; Qian Wen-Sng et al., 2012, Eun-Ok et al., 2012 & Palese et al.; 2011).

#### **6.3.1 Positive expressions**

Positive responses from patients' pain experiences were mainly due to healthcare professionals protocols and attitudes, support system from family and friends during hospitalization.

Analyzing one article for this study, the respondent noticed that positive and negative experiences were influenced by two different approaches namely personal and healthcare strategies (Idvall et al., 2008).

*"I thought they did a lot to relieve pain, got pills, and so forth. I didn't need to convince anyone. They just stopped by and asked, "Do you want a pain pill?"* (Idvall et al., 2008:134).

In this study, one can see how adjusting position thereby prompting her to positively express her feelings during nursing care as comfortable relieved a patient's expression of pain. It can be noted that nurses need to be culturally sensitive when providing evidence based care.

*"She adjusts my positions and makes me feel more comfortable"* (Qian Wen-Sng et al., 2012:963).

The Somalia culture and beliefs evidently attach their positive expression during pain management in the form of praying and reciting the Koran. This was reported that this strategy provides a source of comfort for them. And this strategy relates only to Somali culture and cannot be generalized to other Muslim cultures.

*"We are Muslims, and when we are ill or in pain we read from the Koran"* (Finnström et al.; 2006:423).

Finally, in every culture, it is often noted that positive experiences result from cultural sensitivity attachment on part of the nurses because patients' remain sensitive towards nursing care and this can be interpreted in different ways.

### **6.3.2 Negative expressions**

When the healthcare professionals fail to recognize patients' pain expression either verbally or non-verbal communication approach, the resultant experience and perception feedbacks are usually in negativity.

It can be noted in this article, that nurses' attitudes towards patients precede negative expressions. This patient felt neglected and this in turn creates prejudice from the nurses towards to the patient's pain behavior.

*"I say, no one paid attention and took it seriously. They thought that I only had normal pain and that I was just whining. You shouldn't treat a person like that"* (Idvall et al., 2008:134).

These are all pain expression by patient, metaphorically classified with a negative attribution as being unbearable.

*"Well, of course it hurts...it hurts...yes, it does...it's, like, not unbearable"* (Bergh et al., 2005:355).

In one study on cancer pain patients, negation response was as a result of unfair treatment due to cultural differences and the patients felt like prisoners (Eun-Ok et al., 2007:865).

*"But, when it was my turn, she was very short and curt with me and she treated me very differently"* (Eun-Ok et al., 2007:865).

Poor understanding of pain rating scales is a major barrier in pain assessment, often this leads to poor evaluation because in verbally communicative patients where pain is subjective; nurses upon patients proclamation of pain even when other objective routine procedures can be observed.

*"Yes. I used them, but I did not know whether I was expressing my evaluation by comparing it to the worst pain I had ever had in my life"* (Palese et al.; 2011:96).

According respondent conclusion of the below statement, this is evidently seen when patients literacy level are at low ebb such that they understand the pain medication guidelines or pharmacological effects. Some patients can call more often-needing pain medications.

*"Nurses don't understand how much pain there is. Nurses do what they want to do regardless of how I feel"* (Rejeh & Vaismoradi; 2009:70).

During pain management, some patient attribute their pain experience in negations often describing it according their own interpretations.

*"It goes up, it flattens out and then it goes down"* (Leegaard et al.; 2008:479).

In one advanced cancer study analysis, cultural meanings of pain was conducted among black Caribbean and White British patients, one patient with negative experience of her pain reported feeling of death than suffering with pain (Koffman et al.; 2008:354).

*"I feel sometimes, well...what am I living for? I'd better die, instead of suffering with all this pain. That's how I feel. ...Well, when you die, no more pain"* (Koffman et al.; 2008:354).

Though, patients' satisfaction and health outcome is the prime focus of holistic care delivery by nurses. Most patients complain originates from poor understanding of assessment tools or from nurses insensitive towards them during nursing care.

## **7 Discussion of the findings from this study**

The respondent will discuss result implications thereby interpreting the main themes and comparing and contrasting against theoretical background, framework and previous research chosen for this study. For this study to be interpreted and discussed qualitatively, respondent will focus that the aim of the study that is to explore patient's perceptions, experiences and meanings attributed to pain during pain behaviors did not deviate from the main objective of conducting this study. For the respondent to effectively interpret these results analysis of main theme will be mirrored separately in other words, important expressions were not missed out. With the aim being specified at start of this study, discussion results will be if the main aim and research questions were answered by study findings. The questions raised earlier were:

- How can pain be expressed or described during postoperative phase and if pain expression is culturally connected?
- How can a nurse provide competent care to patients during postoperative surgical procedures without facing challenges during nursing care?
- How can nurses communicate effectively through language when a cultural barrier exists with patients from different cultural background?

The respondent focused on finding if pain behaviours are affected by culture and beliefs and how nurses can provide evidence based care when communication mitigate in nurse-patient interaction phase during nursing care. Moreover, the main focus was not to propose

a new hypothesis but to point out what these patients' experiences are during pain management and how they assimilate these differences when coming from a different culture. Through study findings, recommendations were suggested so that its application can be of great importance when dealing with patients from different backgrounds. Recommendations are well explained in the conclusion section.

## **7.1 Discussion of findings from the theoretical background**

From result interpretations, evidence shows that the study focused its findings from multicultural settings. To explore patients' experiences, perceptions and meanings of pain behaviours in multicultural settings were analyzed and interpreted with direct quotations from literature examined, these include Somali culture, Hispanic patients, Iranian patients, Swedish patients, white British and Caribbean patients' perceptions' so that study's aim is fulfilled. Based on empirical evidence gained during qualitative content analysis by inductive approach, the study answered each research question raised earlier thus fulfilling criteria for study quality during critical reviewing of this study. The major weakness is that of timing. Moreover, it was easier to get information because previous studies and respondents' findings were almost the same, and carried the same conveying information.

Culture plays an important role in shaping patients' orientation towards understanding, experience and perceptions of pain. Cultural acknowledged set of values influences patients' perceptions towards pain expression, mutually held beliefs and interpretation of pain sensations. In some cultures, pain endurance through stoicism was shown in the theoretical background as one barrier limiting effective pain assessment and this was as a result of cultural beliefs that certain gender need to endure pain severity or show no expression towards pain sensitive (Janal, 1996).

Barthelsson et al. study reported that patients' postoperative pain experiences cannot be quantified and predictions of pain behaviors seem so difficult (Barthelsson et al., 2003). Ceyhan & Gulec (2010) study on postoperative pain suggests that patients' experiences of pain are always geared towards negative feedbacks (Ceyhan & Gulec, 2010). Gender or age do not have much impact on pain experience as was stated in Gagliese et al. (2005) study when comparing pain measurement among younger and older adults. The findings from previous studies when compared are correlations with study findings. It was found in one of the previous studies that Numeric rating pain scale was the preferred choice among

its study participant while visual analog scale should be discouraged among elderly patients in postoperative care (Gagliese et al., 2005). Previous studies show that experiences of pain behaviors were either positive or negative assumptions based on healthcare systems put in place, nursing care during pain management, cultural conflicts and absence of continuum of engagement. Further studies show that it remains important that patients receive information and were involved during nursing care plan so that preventive care and self care can be effectively utilized (Teiperi et al., 2009 & Carman et al., 2013). McLaughlin et al. 1998 suggested considerations when working with patient from diverse background, the made these considerations based on the following factors – patient's culture, body language, expression of anxiety, responsiveness state observation and use of open-ended questions to understand patient/family perceptions towards care and avoidance of bias (McLaughlin, 1998).

During analysis of some articles used for this study, some conflicting problems were recorded which suggest that most patients culturally attribute their pain experiences towards beliefs system and religious affiliation. In some studies, patients attribute their pain experience towards religion beliefs such that pain was described as a test of faith or retributive justice for their previous sins (Koffmann, 2008); Hispanic patients undergoing cancer treatments prefer use of local herbs and plants to alleviate their pain (Eun-Ok, 2007) while in Somali culture, reading the Koran was recorded as coping mechanism to endure pain (Finnström & Södermann, 2006).

From previous theory, major cultural concepts and patient's perspective during nursing care were reported. McLaughlin & Braun (1998) in their study reported that patients bring their own culture, beliefs about health concepts during nursing care. It was further suggested that nurses should consider all these facts such as body language; expressions and beliefs when providing evidence based and culturally congruent care (McLaughlin & Braun, 1998). When nurses fail to put patient's cultural beliefs and values into consideration during nursing care, usually healthcare outcomes, decisions and actions are biased and irrational.

Communication remains an important barrier in pain experience and perceptions. This requires cultural knowledge of the patient's background because it affects what kind of nursing intervention, care plan and evaluation for the patients. Communicative behaviors of pain can be in the form of verbal and non-verbal behaviors. Verbal behaviors involves use of writing and words in pain expression while non-verbal behaviours involves use of



gestures, body language, eye contact, crying, moaning and teeth grinding as reported in some cultures.

Communication is imperative to care provision. Leininger's theory of culture care diversity and universality was applicable to this study because nurses were required to be culturally competent during nursing care (Leininger, 1991b, 1995c, 2002a, 2002b, 2002c).

Communication barrier has been a major problem between nurses and patients when cultural and language differences exist. This major constraint influences nurse-patient interaction, patients' experience of pain and under-assessment of pain severity during postoperative period. In previous studies on pain assessment, communication barriers limit nurse's action such as in appraisal of pain assessment where patient's pain assessment remains subjective (McCaffery et al., 1999). Pain and pain assessment tools were carefully explained in the theoretical background, it is clearly understood why pain remains subjective rather than objective experience because no two patients experience same level of pain.

From most analyzed articles used for this study, culture has been another major influence to poor communication. For example in using pain assessment tool in deaf patients, results showed that poor verbal communication between nurses and these deaf patients were recorded when using face pain scale (Palese et al.; 2011). In this situation, Leininger's theory is applicable so that nurses can use prior knowledge gained through transcultural approach to provide culturally congruent care for these patients. While this has been applicable, a positive comfort care can be achieved through health-seeking behaviours (Kolcaba & Kolcaba, 1991). Pain expressions maybe exaggerated or stoic in certain cultures while infants pain experience are usually marked with crying, wailing. Since pain experience and behavior remains inconsistent, pain expressions by patients usually corresponds to level of injury associated with the pain (Craig, 1994). In Somali culture stoicism is practiced during pain experience (Finnstöm & Söderhamn; 2005) while crying is a sign of weakness in men during pain experience (Rejeh & Vaismoradi; 2010). In one study on meanings of pain, patients used several metaphors to communicate their pain experiences such that it was comparable to fight/defend mechanism; pain was described as an enemy, challenging and test of faith (Koffmann et al., 2008).

Different cultures express pain through different forms either verbally or non-verbal, it is imperative that nurses need to acquire cultural knowledge and understanding of culture care because certain pain behaviours or gestures may have a different meaning from the

nurse's own culture. This usually led to misinterpretations thereby leading to wrong evaluation or over or under medicated of opioids administration to patients.

Despite verbal communication chosen as the gold standard for pain expression but in impaired cognitive patients where communication is limited such as in dementia, autism, impaired speech and conscious patients; assessment of pain through subjective method for patients are not obtainable except by objective strategy where physiologic signs monitoring and behavioral observations for pain evaluation. Such physiologic signs monitoring include elevated blood pressure, temperature, pulse rate, pupil dilation, pallor and increased glucose while behavioral observations include facial expressions, vocalizations, body language, changes in mental status and interpersonal communication (Snow & Shuster, 2006).

Patients through numerous responses can express pain being a subjective experience. Patients responses during postoperative nursing care were reported either through negative or positive experiences. The respondent categorically differentiates these responses into two distinct parts in order to analyze if the findings from previous studies and theoretical background show some similarities or contradictions.

Analysis from study findings show that patients positive emerged from positive attitudes of nurses towards patients, support systems and some patients rely on their cultural beliefs interpretations of pain behaviors. In Somali culture, it emerged that reading the Koran was seen as a relief mechanism when experiencing pain (Finnström & Södermann, 2006) while pain was figuratively expressed as feeling of death, unbearable by some patients (Bergh et al., 2005 & Koffmann et al., 2008). Responses describing pain suffering were mainly in negative affirmation except some patients that appreciated nursing care, pain management interventions being put in place and those who receive proper information during care.

## **7.2 Reflection on using the chosen theoretical framework**

The use of Leininger's culture care theory of diversity and universality concepts can be applicable to this study because provision of nursing care in a diversified cultural settings involves knowledge of cultural congruent care, so nurses should be equipped with prior knowledge of tenets of culture care theory (Leininger, 2002c, 2006). Various articles collected dealing with pain during postoperative or other pain related conditions utilize these tenets. These tenets concept will help nurses to solve problems of social structure

factors, generic emic and professional etic care in certain environment, culture care differences, and unguided decisions during congruent care provision and during nurse-patient interactions (Leininger, 2002b, 2002c, 2006; Leininger & McFarland 2002a). Leininger's culture care theory of diversity and universality remains important in this aspect because for nurses to make the best effective decisions and actions in a multicultural setting, it is imperative that nurses need culture care competency and cultural knowledge of the patient such that an organized nursing plan including patient's cultural beliefs can be established (Leininger, 1991b, 1995a, 1995c; Leininger & McFarland, 2002a, 2006). In Leininger's sunrise enabler model, nurses can guide their actions and decisions in a cultural congruent care by utilizing the core elements of the model in order to provide a well-tailored nursing care with consideration of major influencers from nurses' predictions of cultural care preservation or maintenance, accommodation or negotiation and repatterning or restructuring (Leininger; 1991b, 1995c; Leininger & McFarland, 2002a, 2006). Integrating Leininger's theory into this study involves the four major cultural assumptions postulated by her, which comprises of nursing, person, health and environment (Leininger, 1991b). This is applicable because holistic care is required in all its entity which agrees with Kolcaba's theory of comfort where the four contexts of comfort is required to provide a holistic care and making sure that the patient's comfort is attained (Kolcaba, 2003). One major study where both theories were submerged try to provide comfort need for patients while being culturally sensitive can be seen in the study of Smith et al., where cancer patients from different cultural background relate their cancer pain to other positive attributes than its severity. This comfort needs involves ease, relief and transcendence whereby relief can be through therapy like music listening. Comfort care actions and intervention are important for monitoring such as vital signs, medications and treatments, patients assessment of pain for both verbal and non-verbal communicative patients. Coaching and comfort for the soul as postulated by Kolcaba's theory provides evidences other forms of care actions can be a source of comfort for patients. An application of these actions and interventions from comfort needs theory takes care of the patient's physical, psychospiritual, and environmental and sociocultural needs.

Kolcaba's theory of comfort was applicable to nursing interventions for patients experiencing pain; this is geared totally towards complete positive health outcomes whereby the level of patient's satisfaction depends on provision of comfort needs. According to studies, patient's satisfaction is directly proportional to quality of care because effective quality nursing care brings forth better satisfaction (Kolcaba, 1992).

From theoretical background, clear description of taxonomic structure comprising of Ease, Relief and Transcendence act as professional guide for nurses during pain assessment, measurement and evaluation based on patient's comfort need (Kolcaba, 1991). Using this structure as a guide takes care of the patient's nursing care plan during postoperative phase because it provides relief and ease through pharmacological and non-pharmacological mechanism and transcendence. Utilizing this approach help nurses in assessing both physical and mental comfort of patients thereby achieving an effective health outcome when relief and transcendence specific needs were completed while attaining ease as the final outcome (Kolcaba, 1992). Addressing key concepts in pain assessment, Kolcaba's theory of comfort needs can be applicable during assessment and evaluation of pain by using subjective questions to inquire of possible pain behaviors and severity. Nurses can make use of the conceptual framework proposed by Kolcaba in providing holistic nursing interventions and assessments of degree of comfort needs specifically required by specific patient in a multicultural settings (Kolcaba & Fox, 1999).

Kolcaba's comfort theory and Leininger culture care theory of diversity and universality are applicable to respondent's findings in the studies conducted by Namnabati et al.; 2011). In Namnabati et al., 2011 study on Iranian children undergoing pain management due to postoperative procedures, Kolcaba's comfort theory can be applicable because it can be a platform for relief and ease when nurses follow the taxonomic structure when providing nursing care therefore maintaining culturing sensitive. In the study of Swedish patients during postoperative pain management, Idvall et al., 2008 highlighted important patient's perceptions during nursing care. Both theories can be applicable by nurses because while providing congruent care, patient's physical, psychosocial and environmental factors were never neglected. If any of the above aspects misses during provision of care, then the perceptions and pain experiences swift to negative feelings.

The theoretical framework applied to this study makes it easy to answer those questions raised earlier. Pain can be culturally connected in the sense that, culture shapes patient's perceptions towards pain. As observed in verbal and non-verbal communication, patients try to bring in their culture during nursing care delivery. This is the major reason why nurses need to understand congruent culture care and should be culturally sensitive when caring for patients from different backgrounds. Moreover, nurses can communicate effectively when language barrier exists by understanding cultural awareness of the patient. Also the use of interpreters is readily employed to establish comfort.

## 8 Critical review

The respondent will make use of Lincoln and Guba's guidelines on critical evaluation of qualitative studies to review this study. Qualitative content analysis was used in analyzing collected data so it will be important that the trustworthiness of this study be critically evaluative under the following criteria's namely: credibility, dependability, conformability and transferability (Lincoln & Guba, 1985). Dependability refers to how consistent data used in this study directly reflects in the findings. Conformability refers to evaluation of compatibility level when analyzed by different researchers in order to find if data accuracy and study serves a relevant purpose to the society or specific group being studied without personal interference. Credibility of the study is to make sure that findings should be of trustworthiness such that objective, subjective components and investigative reference made should be found reliable. Transferability refers to this study findings being able to be transferred to other groups and it can be generally acceptable when applied to settings if need be (Lincoln & Guba, 1985; Polit & Beck, 2012).

The aim of this study was to explore patient's perceptions, experiences and meanings attributed to pain during pain behaviours. Being a qualitative study and respondent's use of content data analysis in analyzing data, it is important to judge the quality of this study under strength, weakness and notable features. Qualitative methods give comprehensive information and understanding over a smaller group but then generalizability of the study is being reduced (Patton, 2002:14). Objectivity has been considered a regulative strength, which guides scientific inquiry (Patton, 2002:51). The respondent applied objectivity approach in this study in order to remain biased, openness and precise in reporting and interpreting results thereby eliminating subjectivity approach where "my own thoughts", hinders results. This objectivity approach led to conformability and credibility of the findings and result interpretations. Credibility and dependability was applied during the choice of research theories Leininger's culture care: diversity and universality theory & Kolcaba's theory of comfort needs (Leininger, 1991b; Kolcaba, 1994). The use of theoretical framework remains the fact that referencing literatures are comprehensive and consistent with the current trend of required information. This ensured use of valid, well researched and evidence-based nursing theories that reflects to respondent's main aim and research questions raised. Credibility and dependability were ensured during data collection method by applying inclusion and exclusion criteria when sourcing articles needed for the study. In order to make sure that valid and quality articles were selected

source publication were streamlined to eliminate articles that do not meet the criteria and finally a total of 12 articles were chosen. Though it was difficult to find these articles over electronic sources but engaging in trustworthy databases through Nelli-portal as a great source of proving that all collected articles were of credible sources. Main themes emerged from data analyses were fully interpreted and coded in a reliable context according to similarities of ideas generated from analyzed articles, thereby making use of conformability and dependability criteria's to evaluate respondent's judgment.

Since this study was analyzed with inductive content analysis, the respondent analyzed its credibility through use of data representativeness (Thomas & Magilvy, 2011). The study was crosschecked in order to find if there is any uncertainty that may lead to subjectivity on part of the respondent. In order to avoid bias and prejudice during selection and choice of articles, the respondent made use of critical appraisal tools and checklists in evaluating research aims, research methodology and design, data collection, ethical issues, data analysis, findings and relevance of study (Critical Appraisal Skills Program, 2013). The critical appraisal checklist for qualitative study evaluates this study under the following headings namely: Are the results of the review valid? What are the results? Will the results help locally? (Critical Appraisal Skills Program, 2013). Structure of concepts, use of figures to explain results, presentations of themes was justifiable and thereby ensuring conformability. The Harvard-system has been used as source referencing method and this was important to make this study fall into quality academic writing; otherwise oxford-referencing style can be used for citation. Study weakness remains that of time constraints to conduct a structured interview because findings from literatures were easier to abstract, thus making the respondent's work less time consuming. Since generalizability remains an internal characteristic of qualitative studies, it's aim does not typically generalize (Polit & Beck, 2012:180), this study is transferable to an extent of other settings where similar beliefs and culture exists but with cultural competence; similar cases can be solved in all generality.

## **9 Conclusion**

The respondent chose to conclude this study by pointing out most important concepts observations necessary for transferability of this study in other settings and further future studies. Limitations of the study will be pointed out. The findings from the study highlighted salient themes which emerged from qualitative content analysis such that

patients' expressions of pain were affected by various factors such as Culture and beliefs, communicative behaviors and responses coming from subjective or objective experience of pain. Cultural beliefs and communication are the two most occurring factors associated with pain experiences and perceptions among patients during pain management care. Communication being an important issue in pain assessment, measurement and evaluation, remains imperative that patients are more sensitive towards nurses especially in non-verbal communication behaviours; so nurses are obliged to show good attitudes towards patients (Nyback, 2007). Furthermore, considerations should be provided when assessing patients with impaired cognitive conditions where verbal communication is void or limited, nurses assessment of pain can be evaluated through objective approach by assessing vital signs; such as high body temperature, high/low blood pressure, high/low pulse, saturation, breathing/respiratory rates, etc., body language or physical movement, immobility, and facial expressions such as crying as seen in infants. Study findings indicate that pain-rating scales remain a cultural sensitive issue when assessing patients from a different cultural background with low literacy level. Patients from a different cultural background either exaggerate pain or exhibit stoicism during pain experience. Verbal expressions of pain behaviors in some patients as seen in the findings, were mostly through attributing their pain using metaphors like pain is an enemy, unbearable or whining while non-verbal expressions mainly use body language or crying.

In establishing a good approach towards assessment or evaluating pain rating in culturally sensitive patients, Leininger's culture care theory of diversity and universality was applicable to the findings so that nurses can create an effective congruent care without prejudice and bias feelings. Leininger's theory was important because patients bring their own healthcare expectations during nursing care and it is expected that nurses acknowledge these expectations when planning and evaluating pain.

Kolcaba's theory of comfort needs was applicable to the findings where patients' pain behaviors were seen as unbearable. For example in cancer patients, nurses make use of the theory by applying the taxonomic structure approach in creating ease once relief and transcendence parts have been completed.

Furthermore, in caring for stoic patients as was established in Somali culture where patients try to suppress their pain through cultural beliefs by reading the Koran (Finnström & Söderhamn, 2005). It has been reported in many previous studies that culture plays very important role in shaping patients' perceptions and experiences because most patients tend

to preserve their cultural values and norms during nursing care. Using of orthodox medications as a supplement to relieve cancer pain in some Hispanic Mexicans came as a result of their beliefs therefore defying pharmacological interventions for cancer pain (Eun-Ok, 2007).

Patients, who lack self-care reporting of pain, remain the most vulnerable group where pain is under-assessed or being less evaluated. Nurses should be guided by ethical obligations in providing care for these vulnerable groups and patients from different cultural background. Through transcultural studies, nurses gain more knowledge on culturally based care and how to be culturally sensitive when providing congruent care to patients in a multicultural setting. Nurses should be culturally sensitive when using Mnemonics pain assessment tools such as SOCRATES and PQRST, because some patients may not be able to differentiate or tell about pain sites. For example, in asking sensitive questions to a patient from different culture, like, “where is the pain located in your body?” In Somali culture, where religious beliefs precede, a patient may not answer that question from a male nurse if the pain is located around the groin area.

Limitations to this study were a result of not being able to conduct a quantitative study as was earlier proposed. Another major factor limiting this study coverage was the fact of not finding enough studies conducted on the respondent’s own culture.

In conclusion, the respondent accepted the fact that this study is far from being conclusive as future research studies should be conducted in a well structured face to face qualitative interview of patients in postoperative pain management, so that an exploratory phenomenological study focusing on lived experience of a specific culture from pain experience, perceptions and meanings, and how these lived experience are interpreted. Suggested recommendations based on this study recommends that nurses should be culturally sensitive towards patients’ beliefs and culture attributions; because patients bring their own health perceptions during nursing care. Patients should be allowed to participate in their own healthcare outcome despite communication barriers, thus use of interpreters being a recommendable option.



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Title	Aim	Method	Result
<p>Q1: Ways of talking about experiences of pain among older patients following orthopedics surgery.</p> <p>Bergh et al. 2005</p>	<p>Description of older patients pain experiences.</p>	<p>Face-to face interview.</p> <p>Descriptive qualitative content analysis</p>	<p>Findings include patient's experience in four main themes-objectification, compensating, explanation and existentialization.</p>
<p>Q2: The pain experience of Hispanic patients with cancer in the United States.</p> <p>Eun-Ok Im et al. 2007</p>	<p>Exploration of pain experiences in Hispanic patients in relation to inadequate pain management.</p>	<p>- Qualitative study through online forum.</p> <p>-Thematic analysis</p>	<p>Cultural barriers and marginalization limits pain expression/management among these patients.</p>



<p>Q3: Cultural meanings of pain: a qualitative study of black Caribbean and white British patients with advanced cancer.</p> <p>Koffmann et al. 2008</p>	<p>Comparison of pain meanings between 26 Black Caribbean and 19 white patients with advanced cancer.</p>	<p>-Qualitative interviews.</p> <p>Informal structured interviews.</p> <p>Exploratory study.</p>	<p>Patients reported pain experiences based on cultural factors, which range from moderate to persistent pain, pain as a test for their religious beliefs. Some describe it as a major challenge</p>
<p>Q4: Conceptions of pain among Somali women.</p> <p>Finnström, &amp; Södermann. (2006).</p>	<p>Cultural view of pain behavior, causes and treatment among Somalia women</p>	<p>-Focused conversational interview.</p> <p>-Qualitative content analysis.</p>	<p>Differentiations of pain experiences/behaviors among Somalis'. Men were meant to be stoic while women develop strategies for pain communication/relief.</p>
<p>Q5: Postoperative pain experiences of central Australian aboriginal women. What do we understand?</p> <p>Fenwick, C &amp; Stevens, J.</p>	<p>Exploratory study on postoperative pain experiences by aboriginal women in Australia.</p> <p>Interpretation of pain</p>	<p>Qualitative study (grounded theory).</p> <p>Interview</p> <p>Comparative analysis process.</p>	<p>Expression of pain through culturally appropriate approach by aboriginal women.</p> <p>Existence of culture deficit by non-aboriginal nurses during care delivery.</p>



(2004)	by non-aboriginal female nurses.		
Q6: Perspectives of Swedish patients on postoperative pain management.  Idvall, Bergqvist, Silverhjelm, & Unosson, 2008.	Descriptive study on patient's perspectives of pain management during hospitalization.	Qualitative descriptive approach.  Individual interviews.  Qualitative content analysis.	Highlights important factors of nursing care lacking during postoperative pain management.
Q7: Postoperative pain management experiences among school-aged children: a qualitative study.  Sng, Q; Taylor, B; Liam, J; Klainin-Yobas, Wang &	Exploratory study on school-aged children postoperative pain experience	Qualitative study  Face-to-face (in-depth) interview  Thematic analysis	Findings involved using different strategies such as cognitive-behavioral approach to relieve pain among these children.

He, H-G. (2012)			
<p>Q8: Postoperative pain and self-management: women's experiences after cardiac surgery.</p> <p>Leegaard, M; Nåden, D &amp; Fagermoen, S. (2008)</p>	<p>Descriptive study on self-management of postoperative pain among women living in Oslo.</p>	<p>Semi-structured interviews for 10 women.</p> <p>Qualitative content analysis.</p>	<p>Individualized and gender-specific information remains imperative to self-management of pain among patients.</p>
<p>Q9: Identification of perceived barriers of pain management in Iranian children: A qualitative study.</p> <p>Namnabati, M; Abazari, P&amp; Talakoub, S. (2012)</p>	<p>Phenomenological study about meaning and nature of pain experiences among Iranian children.</p>	<p>In-depth interview.</p> <p>Colaizzi method of data analysis.</p>	<p>Numerous factors were highlighted as barriers towards achieving an optimal pain management among these children. Barriers such as organizational factors and specific behaviors affect pain management/assessment.</p>

<p>Q10: A meta-ethnography of patients' experiences of chronic pelvic pain: struggling to construct chronic pelvic pain as 'real'</p> <p>Toye, F; Seers, K &amp; Barker, K. (2014).</p>	<p>Qualitative study to increase chronic pelvic pain understanding among patients' experiencing such pain.</p>	<p>Qualitative (meta-ethnography) study.</p> <p>5 electronic bibliographic databases sourced.</p>	<p>Findings point out if pain remains a cultural secrecy among patients.</p> <p>Differentiation construct was evaluated between pathological and chronic pelvic pain experiences.</p>
<p>Q11. One-dimensional scales for pain evaluation adopted in Italian nursing practice: Giving preference to deaf patients.</p> <p>Palese, A; Salvador, L &amp; Cozzi, D. (2011)</p>	<p>Exploratory study on preferred pain evaluation and administration for deaf patients.</p>	<p>Descriptive qualitative study.</p> <p>Focus group interviews and purposeful sampling method.</p> <p>Content analysis</p>	<p>Findings suggest that communication is effective by making use of simple sign language during pain evaluation among deaf people.</p>

<p>Q12: Perspectives and experiences of elective surgery patients regarding pain management.</p> <p>Rejeh, N; &amp; Vaismoradi, M. (2010).</p>	<p>Exploratory study on surgical patients' perceptions and experiences during pain management.</p>	<p>Qualitative study.</p> <p>Semi structured interviews.</p> <p>Content analysis.</p>	<p>Highlights how patients' view nursing roles during pain management.</p> <p>Suggest further promotion of optimal quality care for nurses.</p> <p>Experiences and perceptions were highlighted also.</p>
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Appendix 2

### McGill - Melzack Pain Questionnaire

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ am/pm

Analgesic(s) \_\_\_\_\_ Dosage \_\_\_\_\_ Time Given \_\_\_\_\_ am/pm

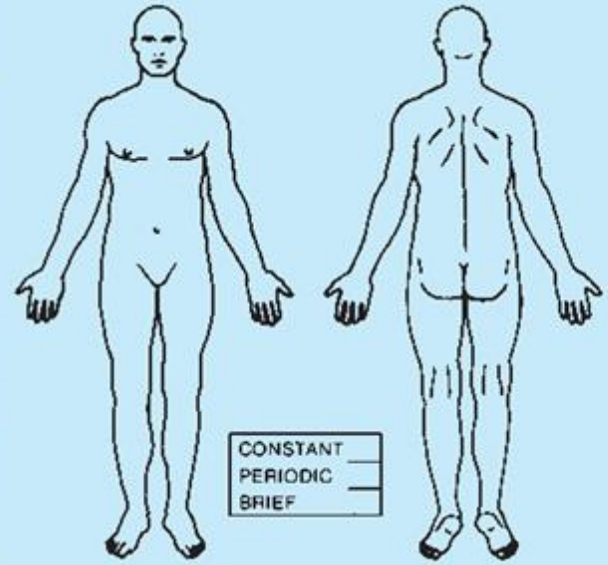
\_\_\_\_\_ Dosage \_\_\_\_\_ Time Given \_\_\_\_\_ am/pm

Analgesic Time Difference (hours): +4 +1 +2 +3

PRI: S \_\_\_\_\_ A \_\_\_\_\_ E \_\_\_\_\_ M(S) \_\_\_\_\_ M(AE) \_\_\_\_\_ M(T) \_\_\_\_\_ PRT(T) \_\_\_\_\_  
 (1-10) (11-15) (16) (17-19) (20) (17-20) (1-20)

1 FLICKERING	11 TIRING
QUIVERING	EXHAUSTING
PULSING	12 SICKENING
THROBBING	SUFFOCATING
BEATING	13 FEARFUL
POUNDED	FRIGHTFUL
2 JUMPING	TERRIFYING
FLASHING	14 PUNISHING
SHOOTING	GRUELING
3 PRICKING	CRUEL
BORING	VICIOUS
DRILLING	KILLING
STABBING	15 WRETCHED
LANCINATING	BLINDING
4 SHARP	16 ANNOYING
CUTTING	TROUBLESOME
LACERATING	MISERABLE
5 PINCHING	INTENSE
PRESSING	UNBEARABLE
GNAWING	17 SPREADING
CRAMPING	RADIATING
CRUSHING	PENETRATING
6 TUGGING	PIERCING
PULLING	18 TIGHT
WRENCHING	NUMB
7 HOT	DRAWING
BURNING	SQUEEZING
SCALDING	TEARING
SEARING	19 COOL
8 TINGLING	COLD
ITCHY	FREEZING
SMARTING	20 NAGGING
STINGING	NAUSEATING
9 DULL	AGONIZING
SORE	DREADFUL
HURTING	TORTURING
ACHING	PPI
HEAVY	0 No pain
10 TENDER	1 MILD
TAUT	2 DISCOMFORTING
RASPING	3 DISTRESSING
SPLITTING	4 HORRIBLE
	5 EXCRUCIATING

PPI \_\_\_\_\_ COMMENTS: \_\_\_\_\_



ACCOMPANYING SYMPTOMS:

NAUSEA \_\_\_\_\_

HEADACHE \_\_\_\_\_

DIZZINESS \_\_\_\_\_

DROWSINESS \_\_\_\_\_

CONSTIPATION \_\_\_\_\_

DIARRHEA \_\_\_\_\_

COMMENTS: \_\_\_\_\_

SLEEP: GOOD \_\_\_\_\_

FITFUL \_\_\_\_\_

CAN'T SLEEP \_\_\_\_\_

COMMENTS: \_\_\_\_\_

ACTIVITY: GOOD \_\_\_\_\_

SOME \_\_\_\_\_

LITTLE \_\_\_\_\_

NONE \_\_\_\_\_

FOOD INTAKE: GOOD \_\_\_\_\_

SOME \_\_\_\_\_

LITTLE \_\_\_\_\_

NONE \_\_\_\_\_

COMMENTS: \_\_\_\_\_

Key:  
 PPI = present pain intensity  
 PRI = pain rating index  
 S = sensory components of pain  
 A = affective, or emotional, components of pain  
 E = evaluative terms  
 M = miscellaneous terms

Combinations of words can be identified: M(S) and M(AE) and the entire number totaled: PRI(T). (Copyright 1970. Ronald Melzack)