

2008

Cultural Diversity: Pain Beliefs and Treatment among Mexican-Americans, African-Americans, Chinese-Americans and Japanese-Americans

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Cultural Diversity: Pain Beliefs and Treatment among Mexican-Americans, African-Americans, Chinese-Americans and Japanese-Americans

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Degree Type

Open Access Senior Honors Thesis

Department

Nursing

Keywords

Pain Treatment, Transcultural nursing

Subject Categories

Other Nursing

Running head: CULTURAL DIVERSITY

Cultural Diversity: Pain Beliefs and Treatment Among
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and Japanese-Americans

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Cultural Diversity and Pain Management

The world in which one lives in today, to some degree, is different than that of which our parents and grandparents lived. Minority populations in the United States are on the rise and will eventually emerge as the majority. The U.S. Census Bureau (2006) noted that the Hispanic and Asian populations would double between years 2000 and 2050, while the African-American population would only have a slight increase of inhabitants (<http://www.census.gov/Press-Release/www/releases/archives/population/001720.html>). The increase in minority populations can be taken into account by new immigrants coming to the United States or past immigrants expanding their lineage. As the United States population escalates in diversity, the need for healthcare workers to acknowledge different cultural beliefs, attitudes, and values toward one's health will be essential to providing care.

Culture is important because it "...represents behavior patterns or beliefs that define a group" (Sakaue, 2005, pg. 78). A great deal can be learned from understanding cultures that exist throughout the world. In order to provide culturally competent care, health care organizations, facilities and personnel must be cognizant of this matter. The experience of pain is personal and is influenced by one's cultural identity. The management of pain is multifaceted and when coupled with one's cultural attitudes, beliefs and values, can further add to its complexity. The purpose of this paper is to investigate how culture influences one's response to pain and belief in origin of pain, and the nursing implications. In this paper the author will examine cultures of Mexican-Americans, African-Americans, Chinese-Americans, and Japanese-Americans.

Methods

In this section the author will delineate the methods in which the above stated cultures were chosen. The author began researching through several books that provided information on various populations and cultures known throughout the world. Studies that were used in developing this paper had to include any one of the above stated populations dealing with their specific culture and pain. Other articles examined included health and illness beliefs/attitudes as

well as nursing knowledge about pain. The search engines included CINHALL, Medline and Eastern Michigan University's Bruce T. Halle Library catalog. In searching for the various cultures the terms used were as follows: African-American, African American, Japanese, Japanese-American, Chinese, Chinese-American, Mexican American, and Mexican-American. The author also used personal communications to further develop this paper. Although each culture is unique in nature, only a few were chosen to be examined. As mentioned above, the Mexican population will double in size in the years to come, hence the need to study and understand the culture's idiosyncrasies. Also, as previously mentioned, the Asian cultures will be in the forefront of growth as well. In regards to the Asian population, the author will examine the Japanese and Chinese cultures. The African population is also being studied due to the large population of this group residing in Detroit and the surrounding communities.

Pain: A Brief Explanation

In this section the author will discuss acute and chronic pain as it relates to both physical and emotional pain. Pain is first and foremost a subjective experience which involves the emotional, physical and cultural aspects of a person. The origin of the word "pain" is Latin and derived from the word *poena* which refers to suffering, punishment and penalty (Vance, 2004, pg. 29). Over the course of human existence, a variety of beliefs evolved about the causes of pain. One thought observed in some cultures is that pain derives from a supreme being as a form of punishment for one's sins or misbehavior. Another example includes the view that pain was "the soul's experience of evolution" (Matelliano, 2003, ¶ 1). Although this belief continues to prevail throughout a number of cultures, the sensation of pain may also be considered to serve as the body's "alarm system" that teaches one to avoid the same situation in the future. This alarm system is a prime example of the response to acute pain wherein it is brief and does not cause long lasting damage to the person. There are three types of pain that have been recognized by the healthcare profession: acute, chronic and cancer-related pain. Each of the three categories of pain will be briefly examined and discussed below.

Acute pain

As noted by Smeltzer and Bare (2008), acute pain occurs for a period of less than six months and tends to reduce over time, unlike chronic pain that extends beyond a six month period. Acute pain can occur when one undergoes surgery, experiences labor, or strains a muscle. It also can be associated with tissue inflammation or disease process. This particular type of pain is self limiting and does not tend to leave any severe permanent physical disability. Physical and emotional effects of this type of pain can often be remembered by the person. After one experiences a painful event, the body instinctively initiates the stress response. This response ramps up the metabolic rate which increases cortisol levels, which lead to the inability to use insulin effectively (Smeltzer et al., 2008). If the stress continues without any relief, the body systems begin to deteriorate and may lead to further complications. Therefore, it is imperative that the pain be treated in order to subdue the harmful effects of stress. Acute pain can be managed with nonsteroidal anti-inflammatory drugs (NSAIDs), warm and cool compresses, physical therapy, and narcotics if needed (<http://jama.ama-assn.org/cgi/content/full/299/1/128>).

Chronic pain

Chronic or persistent pain is unrelenting and often requires a substantial amount pain medications as well as behavior modification techniques. Chronic pain serves no meaningful purpose to the body. As with acute pain, those living with chronic pain can suffer undesirable physiological and emotional effects, which tend to be more severe. The stress response in those with chronic pain is continuous, and therefore increases the chance of uncontrolled blood glucose, interrupted sleep, tumor growth, depression, poor nutrition and disability (Smeltzer et al., 2008). If one's pain is not being properly managed it can hasten death. In addition, uncontrolled pain can also function as a appetite suppressant which can lead to further complications. The emotional state of the person can have an effect on the level of pain one experiences. Mavandadi, Sorkin, Rook and Newsom (2007) found pain can be exacerbated by having negative social encounters and a depressed mood when compared to positive encounters. Anxiety and fear is another issue that plagues those with pain. "Fear has been found to inhibit

pain, whereas anxiety has been found to enhance it” (Keefe, Lumley, Anderson, Lynch & Carson, 2001, pg. 593). It is imperative that health care providers understand that pain is not only physical but also emotional. Understanding this concept will allow nurses to establish appropriate interventions for the patient as well as to provide competent and compassionate care.

Cancer-related Pain

This category is unique in that this type of pain can be either acute or chronic. The pain that one suffers from can be caused by the presence of cancer itself. Smeltzer et al. (2008) noted that, “...most pain associated with cancer is a direct result of tumor involvement” (p. 262). In addition, pain stemming from outside sources, such as cancer treatments, may trigger both physical and emotional pain. This type of pain can be difficult to control because there are many variables in play. Sweirzewski (1999, Incidence and Prevalence, ¶ 1) stated “...90% of patients with advanced cancer experience severe pain and that pain occurs in 30% of all cancer patients, regardless of the stage of the disease. As many as 50% of patients may be undertreated for cancer pain...” (<http://www.oncologychannel.com/pain/index.shtml>). However, it should be noted that not everyone with cancer suffers from uncontrolled pain.

Why is Pain Important to Understand?

In this section the author will discuss the rationale for one to better understand pain and the barriers that may complicate treatment and patient comprehension. One may ask: people have been dealing with pain for decades, why is there such an interest in it now? What is the big deal? In recent years it has come to light that pain is not being managed effectively. According to Rick Blizzard (2005), only 53% of inpatients felt as if their pain had been well managed, a marginal increase since 2002. Sakauye (2005) noted that “Persistent pain syndromes occur commonly among...all cultures, and approx. 50% of persistent pain syndromes do not improve within 1 yr” (pg. 78). Pain is an enduring issue that must be addressed in order to provide appropriate health care. The issue of pain management has become a crucial component within the healthcare system and has been incorporated into nursing education as the “fifth vital sign.” As mentioned above, unrelieved pain can lead to serious and even deadly complications for the patient. For

those reasons, self-reporting has been used to guide nurses in recognizing and understanding when pain is occurring in the patient and to the degree of intensity.

It is not uncommon for one to have experienced some type of pain in their lifetime albeit from falling down, a broken bone, paper cut, etc. Imagine reliving the pain over and over again without any relief- many people go through life never having their pain adequately controlled and thus cease to remain active in society. One of the goals in nursing is to aid in alleviating discomfort that the patient is experiencing. The rationale for relieving or reducing pain is quite simple: it allows for healing to take place and to reduce the negative effects that pain can have on the body. Providing relief for one's pain allows them to move on with daily activities and become an active part of society. The healthcare system should demand that nursing and other health professionals understand the necessity of assessing and providing proper management for every patient. In doing so, it facilitates a respectable bond between the patient and the healthcare provider. However, healthcare providers must also educate the patient about the importance of pain relief and "listening" to their body for when pain medication are needed. It also is important that the patient learn to use alternative methods in reducing pain such as meditation, music therapy, animal-assisted therapy, distraction, and touch therapies. However, there are barriers that may exist with each patient and must be overcome in order for the healthcare professional to facilitate adequate management.

Barriers in Pain Management

In this section the author will talk about the knowledge deficit, language, and health illiteracy as potential and actual barriers to pain management. There are several barriers that may lead to complications when attempting to manage and educate the patient about his or her pain. One barrier is the lack of knowledge about pain medications. A lack of understanding how the medications work can be a problem for patients adhering to the regimen. A general concern with pain medications is the fear of addiction. In a study by Lebovits, Florence, Bathina, Hunko, Fox, and Bramble (1997), attitudes and knowledge of pain management, including addiction, in healthcare professionals was evaluated. They found that physicians were the most

knowledgeable about pain management followed by nurses and pharmacists. The most shocking finding in the study was that only 28% of those questioned “disagreed with ‘25% of patients receiving narcotics around the clock become addicted,’ when in fact the actual incidence is less than 1%” (pg. 242). Knowing that this is an area that is not well understood, it can lead to mismanagement of the patient’s pain by the healthcare provider and patients themselves. Monsivais and McNeill (2007), note that people do not like to be dependent on medication due to fears of addiction and dependency. Monsivais et al. also discovered that patients like to remain in control and may either stop taking the medication or decrease the amount taken.

This issue is important to note because it can lead to ineffective pain management. A corresponding issue with adhering to the pain medication is learning to deal with its side effects. These can include nausea, vomiting, constipation, and lethargy, just to name a few and can be so distressing or uncomfortable that the patient may stop taking the medication all together. However, there are patients that have had experience with excellent pain management and they are more likely to adhere to the prescribed management plan. Given the prevalence of fears and misconceptions about pain management, it is vital that the healthcare provider and the patient, separately and collectively, work through these concerns. Nurses also have a part in regulation of pain medication. The aforementioned hurdles when coupled with the inability to communicate with health providers, adds to the complexity of pain management.

Language barriers can occur between foreign languages and within one’s own native language. This especially can pose an issue when dealing with healthcare professionals. It can be a hindrance when one is seeking out help throughout the healthcare system. For instance, there is a large Arabic community living in and around Dearborn, Michigan and the nearest hospital systems in the area are the Henry Ford Hospital and the Oakwood Hospital. In working in either one of those facilities one must be cognizant of possible language barriers. Each hospital system has specific protocols in order to navigate through language barriers. At the Oakwood hospital

and Henry Ford Hospital, there are interpreter services that can be utilized in person or through the “blue phone” which will connect to an interpreter by telephone. Another issue that has plagued some minorities is the simple fact that English is not their first language. This issue may limit the persons ability to effectively communicate with healthcare professionals and leads to knowledge deficits.

In addition to language barriers, health illiteracy is rampant and must be addressed in order for health professionals to provide appropriate and competent care. Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (National Network of Libraries of Medicine, 2008, Definition, ¶ 1). This issue has an effect on individuals with little to no education, the elderly, those with language barriers and/or persons with low income. According to Pfizer (2006), about 45% of Americans have basic or less than basic reading skills, meaning one is capable of performing simple tasks such as adding, subtracting, or providing a signature. The National Network of Libraries of Medicine (2008, ¶ 9) states, “reading abilities are typically three to five grade levels below the last year of school completed.” This means that a patient who completed high school can comprehend between a seventh to ninth grade level or below. Acknowledgement of this dilemma is the responsibility of the healthcare system and those working within it that have patient contact. It will become vital that physicians and nurses tailor patient education accordingly to their level of health literacy.

Nurses themselves may have barriers that will not allow them to properly treat patients in pain. It is not uncommon for one suffering from substance abuse to come into the hospital for medical issues. Once the nurse is aware of the presence of substance abuse and dependence, it may deter him or her from adequately providing pain relief. The author, while working in area

hospitals, encountered various nurses that knew of their patient's substance abuse and would not provide immediate pain relief. Some comments that have been stated by some nurses consist of: "they are not having any pain; they just want to get high; they are going to have to wait because I have others things to deal with." These thoughts are dangerous are can lead to one not providing caring or adequate care. Greipp (1992) comments on this on-going issue, "There have been instances in which a client with a known drug abuse history had narcotics prescribed and they were not administered as frequently, because the nurse was fearful of respiratory depression or addiction. It is possible that nurses working with such clients form biases as a result of this dependency and the aggressive behavior that is sometimes demonstrated by this group of clients" (pg. 50). Although substance abuse can be a problem for some people, the nurse must remember that providing pain relief is an important intervention. The level of education and the nurse's culture can effect how he or she understands and manages pain. Nevertheless, healthcare professionals need to place thoughts about patients with substance abuse aside and attend to the patient's needs. Regardless if the patient has substance abuse issues, it should be the goal of all healthcare providers to effectively control one's pain.

Culture and Pain

The author will state the working definition of culture for the purposes of this paper as well as the effect it has on one's pain experience and management. There will also be a discussion of four cultures and their physical responses to pain, beliefs in the origins of pain, health and illness, and nursing interventions. Culture, in itself, can be a barrier to providing adequate pain management. This is an area which is currently being studied and evaluated in order to gain further knowledge and understanding. As a number of societies throughout the world become diverse, it is essential that healthcare providers begin to acknowledge and become

familiar with different cultures within their society. The meaning of culture can be interpreted in various ways; therefore, the author will use the following definition as noted by Kemp (2005): “...the learned and shared beliefs, values, and lifeways of a designated or particular group that are generally transmitted intergenerationally and influence one’s thinking and action modes” (pg. 44). As previously mentioned, culture has the ability to shape attitudes and beliefs about health and illness. More specifically, it affects one’s openness to receiving support through healthcare services in addition to one’s health seeking behaviors (Lovering, 2006, pg. 390).

To begin to understand another culture, it is beneficial for a healthcare professional to reflect upon one’s personal cultural beliefs and values in order to facilitate an unbiased relationship with the patient. This self-reflections is important, especially for healthcare professionals, because it will allow one to acknowledge and be aware of any prejudice or biases that one possess. Nurses must be capable of setting aside any prejudices or misconceptions when caring for patients. However, it would be naïve for one to think that healthcare providers are capable of completely removing all prejudices when caring for a patient. A prime example of a misconception that one may have is that pain is a “normal” part of aging. Despite the abundance of research, this idea still resounds within the elderly population, as well as some healthcare providers. However, the patient must be open and willing to share this concern with the healthcare provider. But this might be problematic because “...pain is private, and to know whether a person is experiencing pain, it must be public through verbal or nonverbal signals or behaviors” (Lovering, 2006, pg. 390). Arming one with this knowledge allows healthcare providers to be attentive in this matter and build upon cultural competence. One must be careful not to make assumptions based on what is learned from research because the risk of generalization. It should be noted that one may exhibit none or only partial behaviors, attitudes

and beliefs of a given culture.

Cultural Model

In this section the author will provide a description of The Process of Cultural Competence in the Delivery of Healthcare Services model. There have been several contributors to the field of transcultural nursing with one of the most famous being Leininger. However, other theorists have come to light such as Josephina Campinha-Bacote. Campinha-Bacote, a nurse, created a model of care that focuses on guiding one in developing an understanding of a patient's cultural needs. Her model is based off Leininger's model and that of Pedersen, a multicultural development model (Campinha-Bacote, 2000, p. 181). Campinha-Bacote views cultural competence as a "...ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)" (pg. 181). Using Campinha-Bacote's model allows health professionals to more fully understand their patients. The author used this model to help guide the development of this paper as well as to expand his present understanding of culture. The model consists of five areas of importance, or constructs: cultural awareness, cultural assumptions, cultural knowledge, cultural skill, and cultural desire. The five constructs of this model will be discussed below.

Cultural Awareness

This area has been defined as "...the self-examination and in-depth exploration of one's own cultural and professional background. This process involves the recognition of one's biases, prejudices, and assumptions..." (Campinha-Bacote, 2002, p. 182). As mentioned earlier, the idea of understanding one's own biases, misconceptions and prejudices becomes important to comprehend their own culture. This task may be difficult for some because it brings forth ideas and thoughts that may be perceived as vastly different from one's own ideas of their beliefs.

However, the ability to engage in reflection enables one to be aware of such judgments. If the healthcare professional is unable to reflect on his or her thoughts, it may lead to cultural imposition wherein the healthcare professional imposes one's beliefs and value system (Campinha-Bacote, 2002, pg. 182). This is crucial for the healthcare professional to avoid because they are in a position of power and can easily persuade others. It would be impossible to believe that all persons working within the healthcare system do not possess any previous biases, misconceptions, or prejudices. Therefore, it is essential that healthcare system employees address these matters and move forward.

Cultural Knowledge

Cultural knowledge is the "...seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups" (Campinha-Bacote, 2002, p. 182). Three focus areas incorporated within this construct include: health related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Essentially this construct enables one to gather an understanding of how various cultures view health and illness, which diseases and illnesses are found within that culture, and the effectiveness of treatment being provided. All of these subsets of the construct have to be investigated in order to obtain a thorough understanding of cultural knowledge. The author appreciates the hard work, time and dedication that nurses and physicians have given in pursuing their degrees. However, more work is needed in the area of cultural studies for prospective healthcare providers. In nursing and medical schools, there is an immense amount of material that is to be studied and learned. Hence, it would not be unlikely that the only cultural experience that encountered would be during training in the hospital and school environment. The author believes that in order to fulfill this component of the model, an individual must make the effort to study, and learn about various cultures, not just to

“experience” it.

Cultural Skill

This is “...the ability to collect relevant cultural data regarding the client’s presenting problem as well as accurately performing a culturally based physical assessment” (Campinha-Bacote, 2002, p. 182). Cultural skill is the idea that one will gather data on the culture that is being presented. The information that is collected should reflect the values, beliefs, and common practices of that specific culture that will enable one to provide culturally sensitive interventions. Physical assessment includes skin appearances, facial features, body structures etc., however it is outside the scope of this paper and will not be discussed. Regardless of the physical attributes collected during a physical examination, the personal significance is ultimately more important.

Cultural Encounters

Cultural encounter refers to “...the process that encourages the health care provider to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds” (Campinha-Bacote, 2002, p. 182). Interacting with different members of society allows a person to enhance one’s life experiences. Encounters with different cultures may occur in and out of the hospital setting. The idea behind this construct is for one to be culturally exposed and with luck, put aside any stereotypes that have been previously held. Campinha-Bacote (2002) noted that interacting with only a handful of members from a culture does not allow one to be deemed an expert (pg. 182). This is important to recognize because even within a particular culture itself, there are slight variations among individuals. When encountering someone from a different culture, there may be a language barrier that is encountered. Hence, it is essential that the language barrier be broken.

Cultural Desire

This final construct is defined as "...motivation of the health care provider to *want* to, rather than *have* to, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters (Campinha-Bacote, 2002, p. 182). Caring is an idea that has been discussed throughout the healthcare system and can take on many forms. One must remember that showing that one cares varies from person to person. For example, a patient may view that the doctor does not care about their situation because they "...perceive a battery of tests as inadequate attention from the doctor..." (Lasch, 2000, pg. 18). The desire to learn from other cultures allows one to gain different viewpoints as well as shared beliefs and values. The desire to learn will reflect on how one will provide care and demonstrate care when tending to the patient.

Cultural Backgrounds

As stated previously, culture simply "represents behavior patterns or beliefs that define a group" (Sakaue, 2005, pg. 78). In this section the author will discuss the Mexican-American, African-American, Chinese-American and Japanese-American cultures and their response to pain, beliefs of origin of pain, health and illness beliefs and nursing implications. These cultures were chosen because a few of them, namely the Mexican and Asian populations, are growing exponentially. Within the United States the term 'Asian' refers to those that are Japanese, Chinese, Taiwanese etc. For the sake of brevity, only the Japanese and Chinese cultures will be examined. The information provided below represents common themes that have been observed throughout the cultures but are not necessarily representative of each member of that culture. One must be cautious in not allowing one's self to generalize or pigeonhole someone from a specific culture based on the findings from research. Campinha-Bacote stated, "...it is crucial to

remember that no individual is a stereotype of one's culture of origin but rather a unique accumulation of life experiences, and the process of acculturation to other cultures" (pg. 182).

Mexican-Americans

The Mexican race and its culture, is growing at a rapid rate in the United States. Currently the Hispanic population "increased 1.4 million to reach 45.5 million on July 1, 2007, or 15.1 percent of the estimated total U.S. population of 301.6 million" (<http://www.census.gov/Press-Release/www/releases/archives/population/011910.html>). This growth establishes the Hispanic population as one of the largest minority groups. Therefore, it will become necessary for healthcare professionals to explore and become familiar with this culture. Religious beliefs have taken root in this culture and may direct one's understanding of health and illness. The vast majority of the Mexican population ascribes to Roman Catholic rituals and beliefs. Within the culture, the thought of health and illness are based on the beliefs such as it comes from God, imbalances of hot-cold and wet-dry and even as simple as having good luck or being rewarded from God for good behavior (Giger & Davidhizar, 2004, pg. 234). When communicating with a patient it is important to understand that the belief of God interfering with one's health may be prevalent. One should bear in mind that this belief, despite that held by the healthcare professional, is important to their cultural identity.

Illness, as noted above, may be seen as a discord between elements or as a punishment. However, there are other beliefs that exist in the Mexican culture that cause illness which include: the evil eye (*mal ojo*), fright (*susto*), and intestinal blockage (*empacho*). *Mal ojo* refers to the belief that someone with evil powers or thoughts can cause one to get sick simply by giving the person the "evil eye." One way in which to remove the "evil eye" is to seek folk healers or have the person thought to have caused the illness touch the person. It is thought that

the person who creates *mal ojo* must touch the person to remove the illness. *Susto* is seen as being frightened into having an illness and, to some, may seem an unreasonable thought. Those with little or no education on the process of illness and disease would believe this to be true. Therefore, the healthcare provider must provide appropriate learning materials and education to the patient. *Empacho* is an “acute digestive distress caused by a complex interaction between social and psychological forces, such as eating against one’s will or disliking a food dish” (Saobralnske, 2006, pg. 349). Family is a vital part of the Mexican culture and often times plays a part in healthcare seeking behaviors. Thus, the family is actively involved with the patient’s health status and subsequent care. One family member in particular, the mother, holds a high ranking position within the family structure. The mother is deemed head of the household and thus becomes the decision maker of when one is to seek medical intervention (Geissler, 1998, pg. 184). It must become a priority to properly educate the mother when she utilizes the healthcare system. However, the family may first turn to a folk healer before using conventional medicine

The word *dolor* in Spanish translates to pain. Pain experience in the Mexican culture can vary from person to person. Geissler (1998) noted, that “emotional self-restraint and stoic inhibition of strong feelings and emotional expression are seen. Expression of pain may be a self-help relief mechanism” (pg. 184). This type of reaction to pain may be seen similarly in females and males, however *machismo* is a view that is often held by Mexican men. This idea of being *macho* has predominated and shaped Mexican society’s idea of what one considers to be a man. Being tough can lead to serious problems especially if the person is in need of medical intervention. It is important that this perception be able to be placed aside by the patient when health needs are high priority. An issue with being “big and tough,” is the need to modify this thinking in order to facilitate appropriate healthcare interventions. To assist in dealing with

machismo, one should let the patient know that despite their need for help, they are still considered to be strong and courageous. In addition, it should be noted that within this culture, the husband has a great deal of respect for the women in his life which can be used to help encourage men to seek assistance earlier. Knowing this, it could prove beneficial to reach out to the women in his life and explain about pain and the necessity for pain relief.

Although, *machismo* prevails throughout Mexican society, it can be placed aside in when facing severe, unrelenting pain. The author had an experience with a patient that was suffering from such pain. The patient had suffered trauma to both of his hips and was experiencing extreme pain. His pain medication was given every hour and a continuous dose of medication was given intravenously. The patient, when adjusted, would verbalize “aye, aye, aye” repeatedly because he said that it help control the pain. It was a challenge for the healthcare team to help keep the patient comfortable. Given that religion prevails throughout the culture, one must be aware that some patients may not want to have pain relief because it is an act of God and therefore something that should be endured (Lipson & Dibble, 2005, pg. 330). Suffering through the pain can be seen as one’s way of carrying out penance for leading an awful lifestyle or partaking in sinful behavior. The healthcare professional must acknowledge that this cultural belief may be real to the patient and should not be dismissed. It is imperative that the healthcare professional educate the patient on the need for controlling pain and possible consequences that can occur if not properly managed. In this culture pain medication is accepted, however the belief of addiction is ever present and thus requires extensive education and reinforcement to the patient.

African-Americans

African-Americans have a long history of immigration and oppression in the United

States. The roots of those currently living within the U.S. derive from Africa, the Caribbean, and South America. Slavery is a significant portion of these peoples' history, which helped to shape views of segregation and racism. Like other minorities, the African-American culture has developed with direct influences from British-Americans. In today's society it may be difficult to know how much of the British-American culture has impacted their culture. In terms of health and illness beliefs, the African-American culture is not that much different from those beliefs held by Mexican-Americans. Health is deemed to be in place when one is in harmony with nature (Lispon & Dibble, 2005, pg. 14). Having good health may also be seen as a gift from God and therefore is a blessing. These ideas of balance and a supreme being influencing one's health is also seen in the Mexican culture. Health is important within this culture and in a study conducted by Collins, Decker and Esquibel (2006), health maintenance activities, such as regular medical checkups, eating proper diet, exercising and adequate amount of sleep, was mentioned by 90% of the African-Americans participants. On the other hand, illness is seen as disharmony, a result of punishment from improper behavior, not living to His will or the work of the devil (Lipson & Dibble, 2005, pg 14).

Family is an important part of the African-American culture especially when one becomes ill. The need for family during illness is not uncommon from other cultures. However, when a one is sick the family may view this illness as a family illness unlike with other cultures where it is seen as a personal burden (Leininger & McFarland, 2002, pg. 313). This is a great attribute, especially for the one that is ill, to have a culture that embraces this concept. Dr. Alford-Trewn, an African-American nurse, emphasized that family is an important part of the African-American culture especially when one becomes ill. She stated that families come together for support and to be there for the one who is sick. If however someone fails to show up

during that time, you are considered to be not caring or uninterested in the well-being of the person. When pain is added into the picture one may react with stoicism. The theory that was offered for this stoicism was due to the fact “hard experience has convinced them that trouble and pain are God’s will” (Giger & Davidhizar, 2004, pg. 188).

Dr. Alford-Trewn commented that due to the history of mistreatment that African-Americans have had in the United States these feelings have carried throughout the generations. These feelings may contribute to subconscious thoughts such as: “why should I tell you? You won’t do anything about it anyway. Historically you didn’t care so why do you care to know now?” (P. Alford-Trewn, personal communication, October 22, 2008). It was also stated that the stoicism stems from the time during slavery, when one’s grandparents endured immense pain and therefore would not be sensible to complain or “show” pain when experiencing significantly less pain. In some way it was disrespectful of their intense pain. She also believed that there was an expectation in the culture that both women and men are supposed to be strong. A personal experience that the author had with one patient from the African-American culture gave another perspective about how pain is perceived. The patient was very cautious about portraying that he was suffering from severe pain to this author. After the pain was under control the author discussed with the patient about the need to make certain that the pain was relieved. The patient stated that he did not want to seem like he was weak. This example shows that it is important to monitor and ask patients about their pain frequently and to understand its meaning to them. One must heed warning that not all members of this culture will exhibit stoicism.

Pain expression may be open and publically voiced by the African-American culture (Lipson & Dibble, 2005, pg. 14). In order to relieve a painful experience, medication may be used and is often accepted. Medication may not be taken if one fears addiction. It is therefore

important that healthcare providers educate the patient about the pain medication and addiction facts to subside one's fear. Dr. Alford-Trewn stated that some patients she interacts with do not bother filling the pain prescription because they believe that God will take care of it. She also commented on how there are some patients that have bottles upon bottles of medication in the cabinet that have never been touched, again due to the belief that a supreme being will deal with the pain. In the author's conversation with Dr. Alford-Trewn, it was mentioned that this belief was held more with the older generations and seemed to have little effect on younger generations. African-American may also use the technique of "laying on of hands" or one may pray in a language, also known as "speaking in tongues," that is only understood by the one in prayer (Purnell & Paulanka, 2005, pg. 20). Like the Mexican culture, African-Americans may also seek folk healers and use various herbs to help in relieving one's pain.

Chinese-Americans

The Chinese-Americans have a history of immigrating to the United States in the late 1800s during the gold rush in California and eventually ceasing after a federal law was enacted (<http://lcweb2.loc.gov/learn/features/timeline/riseind/chinimms/chinimms.html>). They too, along with other immigrants, were used as cheap labor, thus adding to their history of hardships. In this culture the reaction to pain may be presented stoically (Giger & Davidhizar, 2004, pg. 411). In addition, Leininger & McFarland (2002) noted that showing emotions such as pain and anger are seen as signs of weakness in one's character. This thinking may be linked to the idea, within this culture, that one's reputation is of the utmost importance. Often times they may present themselves as the "perfect patient" because of limited requests and ability to suppress their emotions to pain, stress and anxiety. This is important for the healthcare provider to acknowledge because these patients may suffer quietly. It then becomes important for healthcare

providers to look for non-verbal cues to assist in determining if the patient is suffering from pain. The Chinese population has long used characters or symbols as a way to communicate. Pain is represented as 痛苦 which is pronounced *tong ku* (<http://www.chinese-word.com/chinese/pp08.html>). During the author's examination of this culture, it was found that it is custom not to accept anything after the first offer, even pain medication (Geissler, 1998, p.52). Therefore it is important that each patient be assessed and treated on an individual basis. However, those that have been living in the United States for a longer period have adopted this type of thinking fully, partially or not at all.

Education is highly valued within this culture and therefore it is important that the patient be provided with valid and reliable information. In this culture, the one that is receiving the information is expected to understand what is being presented. Those in respected power positions such as the doctor and the nurse are rarely ever challenged even if the patient does not agree with the medical regimen being followed (Chen, 2002, pg. 172). This is due to the belief that it is culturally inappropriate to challenge those in authoritative positions. Health and illness in the Chinese culture is seen as a part of a continuum that is a part of life (Geissler, 1998, pg. 52). This continuum resembles the one that is taught in nursing theory wherein the goal of the healthcare provider is to move the person closer to the health. The idea of balance or harmony exists within the belief of: yin and yang, Confucianism, Taoism, and Buddhism (Chen, 2002, pg. 271). This concept appears to transcend through those cultures mentioned in this paper and creates a connectedness between them. The yin and yang are essentially the opposites of each other that keep one another in balance. "This production of yin from yang and yang from yin occurs cyclically and constantly, so that no one principle continually dominates the other or determines the other. All opposites that one experiences—health and sickness, wealth and

poverty, power and submission—can be explained in reference to the temporary dominance of one principle over the other. Since no one principle dominates eternally, that means that all conditions are subject to change into their opposites” (<http://www.wsu.edu/~dee/CHPHIL/YINYANG.HTM>).

Illness is also seen as a personal burden when a member of the family becomes ill (Giger & Davidhizar, 2004, pg. 411). This indicates that the person taking care of the ailing family member must “carry” and deal with this added stress. A study conducted by Holroyd, Yue-kuen, Sau-wai, Fung-shan and Wai-wan (2002) found that Chinese patients valued the professional knowledge and skills more than the skills of comforting because it is the family’s responsibility to care for the patient (pg. 1294). This is especially important for nurses to note because caring is often seen as the foundation of nursing care. Although this study found that these patients valued the nurses’ technical skills rather than affective skills it does not imply that all Chinese patients value the same competencies. It is not uncommon for those who are ill to seek more “traditional” methods of healing. These may include: moxibustion or cupping, acupuncture, and herbal supplements (Geissler, 1998, pg 52). Other remedies that may be tried before seeking help from western medicine could entail use of oils, message therapy, sleeping on the area of pain, and relaxation techniques (Purnell & Paulanka, 2005, pg. 100). As seen in other cultures, the fear of addiction to pain medication is prevalent. The notion that pain is inevitable and the medication will not provide adequate relief is also a common belief (Sham, 2003, pg. 69). The healthcare provider should work to educate the patient about addiction and the usefulness of pain medication. If a language barrier exists it is important that the healthcare provider assess pain through non-verbal cues. The use of description that are most familiar to them maybe the best indication of pain.

Japanese-Americans

Like the Chinese culture, the Japanese also have a long history of immigrating to the United States between the years of 1886 and 1911. It was noted that “more than 400,000 men and women left Japan for the U.S. and U.S.-controlled lands, and significant emigration continued for at least a decade beyond that. The two most popular destinations were the archipelago of Hawaii and America's Pacific coast” (<http://lcweb2.loc.gov/learn/features/immig/japanese.html>). Those that immigrated to the United States and surrounding territories also endured hardships. In the Japanese language pain is referred to as *itami*, *kurushimi*, *kushin*, *itazuki*, or *kutsuu* which loosely translates into the meaning of pain. However, the meaning of pain in the English language versus the Japanese language is different in that there are several definitions within the Japanese language hence the multiple labels for pain. To bear through pain, by some, is considered to be an honor and a virtue (Purnell & Paulanka, 2005, 294). This is an important belief to note because pain, if not adequately managed, can lead to longer healing time and can eventually cause physiological harm. Pain is not a foreign concept to the Japanese culture and it is interesting to note that there are similarities between other cultures. For example, the belief that health and illness are determined from harmony and balance between oneself, society and the universe are foundations found within Shinto and Buddhism religions (Giger & Davidhizar, 2004, pg. 339). The ideas of balance and harmony have been noted within the Mexican, African and Chinese American cultures as well. This idea of balance has been noted through the various cultures examined within this paper. An explanation of this the similarities may stem from the inherent conviction of good and evil. One should be cautious with this generalization because some may not consider this idea to exist.

Another similarity that exists is the portrayal of oneself as stoic. It is believed that the

expression of pain or anger must be restrained because in doing so it allows one to be in control of one's self (Carol Tavris, 1989, pg.67). It would then be helpful for one to look at other modalities in order to determine if one is in pain. These other modalities may include looking at blood pressure, facial expressions during activity, or body movement. It is important for the healthcare professional to be astute to these minor details. Pain medication may be used in this culture, however with older generations caution must be used in administering the medication due to fears of addiction. This seems to be a common theme that runs throughout almost every culture. Again, the goal for the healthcare professional is to be certain that the patient is educated on the use of medication and the likelihood of addiction. It was found that addiction is a significant taboo which adds to the complexity of one's uncertainties in using pain medication. Nonetheless, Purnell & Paulanka (2005) stated that it would be ideal to have the pain medication on a scheduled format rather than on-demand to aid in managing pain. Health and illness beliefs derive from the religions that are found throughout the country which include: Zen Buddhism, Confucianism, and Shintoism. As noted previously, the idea that disease is caused from an imbalance prevails throughout these religious beliefs. It was noted by Lipson & Dibble (2005) that imbalance can also arise from lack of sleep, poor diet, or from loss of spiritual, family or environmental harmony (pg. 304). Older generations within the culture embrace this idea while those in younger generations tend to relate with more westernized thinking.

Family is an extremely important aspect within the Japanese culture and therefore family participation in one's illness is tremendously important. If one has the misfortune of getting ill, one may seek out "old" medicine before turning to more conventional methods. When an illness occurs it is important that the healthcare professional understand that the patient may link the causative factors of the illness to the spiritual world. Older Japanese patients may believe that

illness can be warded off by seeking a priest. Much like other cultures, there are several alternative therapies to pain management that are used in alleviating pain. Suzuki (2004) commented on complementary therapies to pain management and noted that “dietary supplements are [is] the most important, followed by aromatherapy, traditional Chinese medicine (Kampo), Ayurveda and electromagnetic fields. In addition to these domains, hot spring bathing, lifestyle drugs, anti-aging medicine and environmental medicine are thought to be important” (pg. 117). Although alternative therapies can be used it may be essential for one to still receive pain medication. Pain medication in this culture is accepted and as noted above, may be more effective in scheduling pain medications than on an “as needed” basis. In caring for a patient from this culture it would be valuable to assess the patient’s understanding of pain medications and rationales for using conventional and/or alternative therapies.

Overview of the Selected Cultures

Four cultures were analyzed (Mexican-American, African-American, Chinese-American and Japanese-American) as they related to pain, belief of pain, and responses to pain that may be encountered. In order to better understand cultural influences regarding pain, a table was created to highlight each culture’s salient points regarding pain. This table, illustrated in table 5, provides a brief overview of the four cultures examined and includes the following items: health/ illness beliefs, translation of pain in each culture, belief in origins of pain, physical responses to pain, and nursing implications. One should be cautioned that the materials represented in the chart are subject to change and are not set in stone. As globalization continues to thrive, cultures will inevitably have an impact on each other and will ultimately change the dynamics of the world.

Table 1. Cultural Table: Beliefs, Responses and Nursing Implications to Pain

Culture	Response to Pain	Health & Illness Beliefs	Nursing Implications
Mexican-American	<p>May exhibit emotional restraint, stoicism, or vocalize pain</p> <p><i>Spanish Translation:</i> Pain = Dolor</p>	<p><i>Health:</i> Reward from God for good behavior or having good luck</p> <p><i>Illness:</i> Punishment from God; imbalances of hot-cold or wet-dry; the evil eye (<i>mal ojo</i>), being frightened (<i>susto</i>), or having an intestinal blockage (<i>empacho</i>).</p>	<p>May turn to a folk healer before conventional methods are used. Address the treatment that was used prior to seeking “western” medicine.</p> <p><i>Machismo</i> can be seen often times in men. Need to acknowledge that they are still strong and courageous for seeking help.</p> <p>Family is very important within this culture. Often times the mother is the one whom decides when to seek medical treatment. Involve the appropriate family members when providing care to the patient.</p> <p>Suffering can be seen as penance for sinful behavior or awful life style. Educate the patient about the need to control pain and the negative effects that can occur when not properly controlled while respecting their cultural beliefs.</p> <p>Language may be a barrier and it is the responsibility of the healthcare professional to utilize proper communication communications methods. The patient must also be assessed for existing knowledge deficits due to possible communication barriers.</p>
	<p>Belief related to Origins of Pain</p>		
	<p>See <i>Health & Illness Beliefs</i> Section</p>		

Table 1. Cultural Table: Beliefs, Responses and Nursing Implications to Pain

Culture	Response to Pain	Health & Illness Beliefs	Nursing Implications
<p>African-American</p>	<p>May exhibit stoicism; vocalize pain</p>	<p><i>Health:</i> Being in harmony with nature; gift from God; a blessing</p> <p><i>Illness:</i> Disharmony; punishment for inappropriate behavior; not living to His will; the Devil’s work</p>	<p>Family is important and should be incorporated into the care of the patient.</p> <p>Past history of slavery and abuse from other cultures may result in the reluctance to communicate their level of pain. One should talk with the patient about their meaning of pain and provide education on pain.</p> <p>The idea of stoicism is prevalent because of the idea that men and women are to be strong. It is not ideal to complain of or show pain because when compared to past generations whom endured slavery, it is not comparable. Educate the patient about the necessity to treat pain in order to avoid negative repercussions.</p> <p>The idea of weakness when one is ill or suffering from pain is look down upon. It is important that the healthcare professional acknowledge this belief.</p> <p>Pain medications may not be taken due the fear of addiction. The patient should be educated on the facts about addiction and reinforcement teaching should be initiated as warranted.</p> <p>May use folk healers, herbs, prayer, “laying of hands,” and “speaking in tongues” as a way of dealing with pain before turning to “western” medicine. The healthcare professional should review the treatments done prior to seeking assistance from modern medicine.</p>
	<p>Belief related to Origins of Pain</p>		
	<p>Hard experience that was endured in previous generations; Gods will</p> <p>See <i>Health & Illness Beliefs</i> section</p>		

Table 1. Cultural Table: Beliefs, Responses and Nursing Implications to Pain

Culture	Response to Pain	Health & Illness Beliefs	Nursing Implications
Chinese-American	<p>May exhibit stoicism, restraint of anger and pain</p> <p><i>Chinese Translation:</i></p> <p>Pain= <i>tong ku</i></p> <p>痛苦</p>	<p><i>Health:</i> Balance or harmony</p> <p><i>Illness:</i> Disharmony; unbalance</p> <p>* The idea of balance and harmony exist in the following belief systems found within this culture: yin and yang, Confucianism, Taoism, and Buddhism</p>	<p>If pain is shown it is perceived as a sign of weakness in one's character. The healthcare professional should acknowledge that the patient is not weak for expressing pain.</p> <p>May not accept pain medications on the first offer. It may be useful to have the patient put on a scheduled dose of pain medication instead of on "as needed" basis.</p> <p>Education is highly valued in this culture and authority positions such as a doctor or nurse or never challenged. The healthcare professional should emphasize the importance in asking questions about one's health care.</p> <p>During a time of illness it is the family's role and responsibility is to comfort the patient. This does not imply that the healthcare professional should cease demonstrating care for the patient.</p> <p>Alternative therapies used may include: moxibustion, acupuncture, herbs, message therapy, use of oils, relaxation techniques and sleeping on the area of pain. Health professionals should incorporate these therapies into the patient's plan of care.</p> <p>Some may show stoicism which will make it difficult for one to use physical assessment only. Healthcare professionals could use pain measurements such as physiological factors, <i>FACES</i> scale, and VAS.</p>
	<p>Belief related to Origins of Pain</p>		
	<p>Hardships from generations that endured hardships as immigrants.</p> <p>See <i>Health & Illness Beliefs</i> section</p>		

Table 1. Cultural Table: Beliefs, Responses and Nursing Implications to Pain

Culture	Response to Pain	Health & Illness Beliefs	Nursing Implications
<p>Japanese-American</p>	<p>May exhibit stoicism, emotional restraint of anger and pain</p> <p><i>Japanese Translation:</i></p> <p>Pain= <i>itami, kurushimi, kushin, itazuki</i> or <i>kutsuu</i></p>	<p><i>Health:</i> Balance and harmony between oneself, society and the universe</p> <p><i>Illness:</i> Unbalance and disharmony between oneself, society and the universe; lack of sleep, poor diet, and loss of family, spiritual or environmental harmony; spiritual world inference</p>	<p>It is thought that if one suffers silently through the pain it is a virtue and honor. The patient must be educated on the necessity of treating pain. It may be appropriate to have pain medications scheduled for those that hold this belief.</p> <p>Emotional restraint of pain and anger may be seen in this culture. The healthcare professional should create an environment that is conducive for the patient to feel comfortable in expressing said feelings.</p>
	<p>Belief related to Origins of Pain</p>	<p>* The idea of harmony and balance can be found in the following belief systems: Shinto, Confucianism and Buddhism</p>	<p>The patient may seek alternative therapies to aide in pain relief which may include: dietary supplements, aromatherapy, traditional Chinese medicine (Kampo), Ayurveda, electromagnetic fields, hot spring bathing, lifestyle drugs, anti-aging medicine and environmental medicine. Again, the healthcare professional should acknowledge these therapies and incorporate them into one’s plan of care.</p>
	<p>See <i>Health & Illness Beliefs</i> section</p>		

Nursing Implications

The cultures examined in this paper have provided the opportunity for one to be exposed to different beliefs and attitudes about pain. Several common themes emerged from each of the cultures mentioned and include: fear of addiction to pain medication, machismo or importance of portraying a strong image, past history and the use of complementary and alternative therapies. Pain in general has an impact on one's emotional and physiological status and therefore it is essential that healthcare professionals utilize appropriate pain assessment tools. The aforementioned themes and pain assessment tools will be discussed later on in this paper.

Sakauye (2005) noted, "Culture is known to influence the psychological appraisal and expression of pain and illness and folk beliefs about acceptable treatments" (pg. 78). It is this author's belief that obtaining education on different cultures will allow one to better understand and care for one's patients. Putting the aspect of culture aside, pain is real and must be attended to with rigorous effort. Quite often healthcare organizations provide educational opportunities for nursing staff to stay current with management interventions. Education in nursing is life-long and is often shaped by governing bodies such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In previous years, JCAHO determined that pain was an issue that needed to be addressed within the healthcare system. It was apparent that the need for appropriate pain assessment and management was essential to all patients and therefore created guidelines to assist with this issue. Dr. Chapman (2000) from the American Pain Society provided a brief description of the JCAHO Standards for pain management:

- Recognize the right of patients to appropriate assessment and management of pain.
- Screen for the existence and assess the nature and intensity of pain in all patients.

- Record the results of the assessment in a way that facilitates regular reassessment and follow-up.
- Determine and ensure staff competency in pain assessment and management, and address pain assessment and management in the orientation of all new staff.
- Establish policies and procedures that support the appropriate prescription or ordering of effective pain medications.
- Educate patients and their families about effective pain management.
- Address patient needs for symptom management in the discharge planning process.
- Maintain a pain control performance improvement plan.

With these new standards of care in place, pain has been placed in the forefront of patient care as well as in nursing education. As mentioned previously, pain is now considered to be the “fifth” vital sign and should be addressed with each patient. Pain management is now considered an important issue within the healthcare world that pain assessment and reassessment documentation is mandatory. As the population within the United States becomes increasingly diverse so to does the need to develop and improve culturally competent care. JCAHO has initiated a taskforce that will evaluate and address findings from research, various hospital studies and projects to assist in developing cultural standards of care. This “18-month project will increase national attention to cultural competence, highlight its intersection with patient-centered care, and improve the safety and quality of care for all patients” (http://www.jointcommission.org/PatientSafety/HLC/HLC_Develop_Culturally_Compentent_Pt_Centered_Std.htm). This task taken on by the Joint Commission appears to be promising and should improve the quality of care that patients receive in the healthcare system.

For nurses, it is important that patients as well as family members are educated on the processes of pain and methods used to reduce one’s pain experience. For the nurse, it is

important to bear-in-mind that each patient encountered experiences pain differently and may have preconceived beliefs about the types of management that will work. One's culture will also guide how the nurse approaches the patient's pain management. It is within the nurse's scope of practice to educate patients about various topics such as one's illness, medications, activity level, and diet. As one may ascertain, it also the responsibility for the nurse to provide education to the patient about the effects of non-relieved pain and the management options that are available to assist in relieving one's pain. There are various types of pain relief methods that can be used to aid in relieving ones pain. Medications as well as alternative and complementary methods can be used. Pain medications can prove to be very useful in providing comfort to a patient in pain but the side effects must be taken into account. Most common side effects of pain mediation are nausea, vomiting, constipation, and drowsiness. For some, these side effects can be unbearable and thus lead to noncompliance with the pain medications.

Fear of Addiction

The fear of addiction also exists among patients that are taking pain medication. The fear of addition permeates through the Mexican, African, Chinese and especially the Japanese cultures. It was stated earlier in the paper that the elderly are the ones that have the greatest fear of becoming addicted to pain medication. It is therefore vital that the nurse educate the patient on the difference between addiction and tolerance. To open the conversation about pain medication addiction one may ask: "In your culture it was found that it was a virtue to suffer through pain. What do you think of that? How will we work together to adequately manage your pain? How does your fear of addiction impact you? Are you afraid of becoming addicted to the medicine?" In the Japanese culture it was noted that addiction to pain medication is taboo and therefore may lead to one refusing the medication. As mentioned earlier it would wise to have pain medication

on a schedule in order to properly manage the pain. It would be wise for the nurse to consult with the physician to recommend changing pain medications from an “as needed” basis to a regular schedule medication. Evidence that can be used to make this determination is longer recovery time, failure to progress or decline in daily activities and refusal of pain medications. It was mentioned previously that authority figures are well respected and should help one in administering pain medications.

Machismo/ Strong Image Portrayal

In the Mexican, Chinese and African American culture the image of being strong is evident. The idea that men are an invincible force is an image that has been cultivated by society and thus has influence upon men living throughout the world. The healthcare professional should maintain that male patients are strong and courageous despite their current ailment. Education about the need for controlling pain is necessary in order to prevent the negative repercussions that can occur. The nurse must maintain that despite the need to use pain medication, one is not deemed weak. As for the Japanese culture the same information applies. Although it is a virtue for one to endure pain, in the Japanese culture it is not within the best interest of the patient to suffer in pain. Overall, the nurse must be aware of these beliefs and provide care that does not negate one’s personal or cultural beliefs.

Past History of Hardships

At one point or another one has experienced hardships and had to learn to cope with the issue. The African, Chinese, Mexican and Japanese cultures, as well as many others, had to endure hardships in the United States. The African-American culture had to suffer through slavery, which left a considerable mark within the culture. As mentioned previously, one may not be as willing to share their pain status with a healthcare professional from the British-

American culture due to past history. It is vital that the healthcare professional work with the patient to elicit a response about their pain in order to provide adequate relief. Questions that inquire about the patient's experience with pain, what they know about pain and how they relieve their pain could provide a frame of reference. In order to understand the patient's beliefs and attitudes about pain it is ideal to engage them in conversation. The nurse could ask that patient about what they believe causes pain, illness and health. Example dialogue could be: "Tell me about what pain means to you. How do you think we should manage it? What concerns do you have about being in pain? How do you manage your pain?" If the patient is not keen about working with someone from a different culture it might be wise to talk about the issue in order for patient care to be initiated. One may start off with: "I know that in the past our cultures have conflicted however I am here for you and to take care of your needs. What can I do to help you on the road to recovery?" This example conversation is just that, an example and should not be taken as the only way to engage a patient. This will allow the nurse to find out what they believe and what is going to be the best method of assessing and managing their pain.

Complementary and Alternative Therapies

Although pain medication has its place in pain management, there are also alternatives that should be considered and whenever reasonable, the nurse should provide other methods of pain reduction. It was noted by the National Center for Complementary and Alternative Medicine (2004) that one-third of Americans use complementary and alternative therapies. This statistic is important to note because it indicates that people are seeking other methods for treating their health concerns. Complementary and alternative therapies are not foreign concepts in nursing and have been used throughout history. In fact, it has been acknowledged that Florence Nightingale understood the therapeutic effect of animals (Hooker et al., 2002). Each

culture has their distinct methods and beliefs about how to facilitate healing when one is ill. It should be noted that different generations of the same culture may vary in beliefs of what methods may work. The older generations and those that have not been influenced by “westernized” thinking may hold onto antiquated methods. Nonetheless, the nurse should be willing and able to incorporate adjuvant therapies to their daily nursing care. Whichever method(s) chosen it is essential that the patient understand the treatments they will be receiving.

Pain Scales

In assessing pain in the patient the nurse has a variety of methods to use which include: the FLACC scale, visual analog scale (VAS), FACES scale, numeric pain intensity scale (0-10), simple descriptive pain intensity scale (no pain – worst possible pain) or physiological indicators. When one is choosing a scale to use it is important to make sure that it appropriately applies to the patient and the patient’s unique situation.

FLACC

The FLACC scale is primarily used for very young children however it has become useful in assessing pain within adult patients whom are unable to verbally communicate. FLACC stands for face, legs, activity, cry, and consolability. The nurse assesses the patient in each of these categories and is given a rating from 0-2 points in each of the five categories. The maximum points that one can receive is 10 which would indicate a high pain rating. The FLACC scale is shown in Figure 1 (http://www.anes.ucla.edu/pain/assessment_tool-flacc.htm).

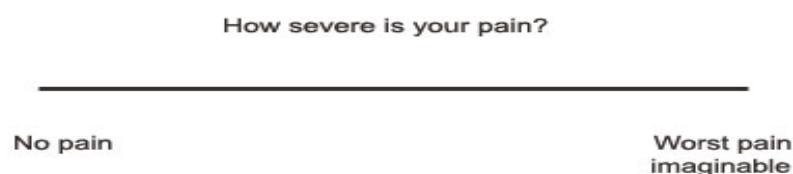
Figure 1. FLACC Pain Scale

CATEGORIES	SCORING		
	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested.	Frequent to constant quivering chin, clenched jaw.
LEGS	Normal position or relaxed.	Uneasy, restless, tense.	Kicking, or legs drawn up.
ACTIVITY	Lying quietly, normal position moves easily.	Squirming, shifting back and forth, tense.	Arched, rigid or jerking.
CRY	No cry, (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints.
CONSOLABILITY	Content, relaxed.	Reassured by occasional touching hugging or being talked to, distractable.	Difficulty to console or comfort

Visual Analog Scale

The visual analog scale (VAS) is a 100 millimeter horizontal line that the patient is asked to place an X on the line in terms of how much pain they are experiencing. At the far left of the horizontal line is labeled 'no pain' and the far right is labeled 'pain as bad as it could possibly be' or 'worst pain imaginable.' The patient is asked to mark an X on the line to indicate the intensity of his or her pain. Once the patient has marked their pain rating on the scale the nurse must measure, from left to right to assess if the patient's pain is being managed. See the illustration in Figure 2 (<http://scienceblogs.com/clock/upload/2007/02/vas1.jpg>)

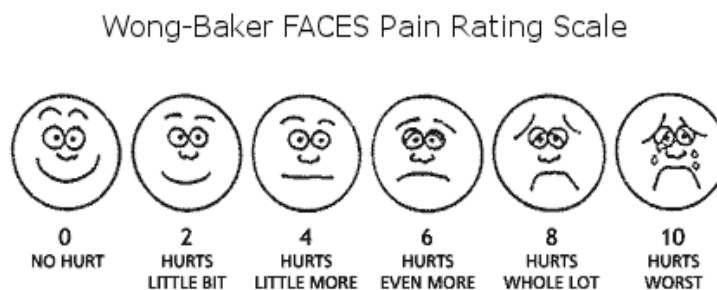
Figure 2. Visual Analog Scale



FACES

The FACES scale illustrates six cartoon faces in various states of emotion. On the left of the scale the face is smiling indicating that no pain is present. As one moves from left to right the faces progressively become more uncomfortable in appearance with the last face being in tears. M. Williams, as nursing instructor, commented that the *FACES* pain scale was modified to better suite Asian patients. He noted that the scale was modified because patients, mainly children, stated that the facial features on the existing *FACES* scale did not reflect their facial features found within the Asian population. This scale has been used for children but is able to be applied for adult patients as well. The scale is illustrated in Figure 3(http://www.dukeraleighhospital.org/patient_information/pain_management/index/wong_baker_faces.gif).

Figure 3. FACES Pain Rating Scale



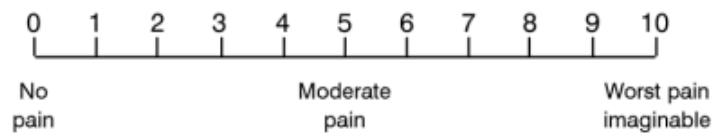
From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Numeric Pain Intensity Scale

This is probably the most familiar pain scale for some is the numeric pain intensity scale. This scale is numbered 0 – 10 from left to right with 0 meaning ‘no pain’ and 10 the ‘worst possible pain.’ To use this scale the nurse must ask the patient their current level of pain. However it is important that the patient understand what the numbers represent. Zero takes on

the meaning of no pain, five is moderate amount of pain and ten is extreme pain. Each patient experiences pain differently and thus the nurse must understand what the patient deems to be a tolerable and intolerable level of pain. These levels must be correlated with each number in order for the scale to be fully effective. This scale is illustrated in Figure 4. (http://www.amputee-coalition.org/fact_sheets/painmgmt_03.gif)

Figure 4. Numeric Pain Intensity Scale



From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032; February 1992; Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

Physiological Factors

The nurse may also use physiological indicators to aid in assessing the patient for pain. This type of assessment can also enhance pain assessment tools to grasp a better understanding of the patient's pain level. Physiological indicators may include increased blood pressure, increased pulse, decreased or increased respirations, diaphoresis, shaking, or agitation. For those patients that are unable to communicate or culturally do not voice their pain status it would be reasonable to use the FLACC scale, physiological indicators, FACES scale or even the VAS. Regardless of the patient's culture it is at the discretion of the nurse to use a method that is suitable for the patient.

Conclusion

It is imperative that those seeking help for pain be managed in a timely and appropriate manner. Every patient has the right to be treated for their pain and there is no valid reason that

one should have to suffer. Ultimately pain is a subjective matter and must be believed by the healthcare professional when the patient states it is occurring or shows signs of physical discomfort. Today, there are several interventions ranging from medication to alternative therapies that can be provided to the patient. It is important to work with the patient and ancillary staff in establishing a plan of care. Nurses must remain open-minded and creative when providing pain management to the patient. Regardless of the methods used to reduce one's pain it is essential to evaluate the effectiveness and make modifications as needed. It is not enough for the healthcare professional to set pain management goals without the patient's vested interest. One should use creativity in modifying existing pain assessment tools to better suite their patient's cultural needs. When communication between then patient and the healthcare provider has been achieved then both are able to being the journey towards pain relief.

Being capable of providing proper pain relief will not only aide the patient in healing but will also allow one to gain a positive hospital experience. This positive experience can be enhanced by the healthcare professional's willingness to provide culturally sensitive care. Throughout this paper, different cultures were examined to provide readers with information to better understand the beliefs and attitudes about pain, health and illness and types of management used during said experiences. Culture can influence and be influenced by other cultures which may make it difficult to generalize findings. Collins et al. assert, "...nurses need to recognize individuals often embrace more than one culture. Therefore, nurses need to acknowledge each person as an individual who experiences different input and life experience. This recognition requires nurses to be culturally competent" (pg. 15). It can be challenging for a nurse to understand culture variations however it is the essential that the nurse respect the patient's beliefs and values. Healthcare providers need to place aside any pre-conceptions and

beliefs about different cultures in order to be capable of providing excellent care. One should take the opportunity to learn from their patients and be diligent in providing pain relief.

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