Cultural Influences on Pain Perceptions and Behaviors

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The perception of pain and behaviors associated with pain are influenced by the sociocultural contexts of the individuals experiencing pain. This article provides an overview of the literature on these cultural influences. With the increase in global migration, nurses need to develop increased sensitivity to the influence of culture on pain perceptions and behaviors. In the provision of home health care, it is essential that nurses are sensitive to such influences in the delivery of culturally competent care in the assessment and management of both acute and chronic pain.

Pain perception is "composed of highly interactive emotional, cognitive, as well as sensory components" (Gijsbers & Niven, 1993, p. 55). Pain is defined by the individuals who are experiencing it (Pasero & McCaffery, 2001). According to the Agency for Health Care Policy and Research (1994) guide for acute pain management, the single most reliable indicator of the existence and intensity of pain—and any resultant distress—are patient self-reports.

Although the pain experience is complex and influenced by multiple variables, the perception of pain and behaviors associated with pain are influenced by the sociocultural context of the individuals experiencing pain (Bates, 1987; Montes-Sadoval, 2000; Rollman, 1998; Streltzer, 1997). Pain is a culturally defined physiological and psychological experience. The classic work of Zborowski (1952) concluded that each culture has its own language of distress when experiencing pain. Gaston-Johannson (1990) noted more than a decade ago that there are similarities in word descriptors in a variety of cultural groups, with the word *pain* characterizing the most intense discomfort, the word *hurt* characterizing less severe discomfort, and *ache* describing minimal pain. In home health care services, the autonomy of the clients is greater than those seen in any other health care setting (Warner, 1997). Home care nurses provide assessment, support, and education, playing an important role in the assessment and management of both acute and chronic pain.

The population of the United States is becoming increasing diverse[11]. According to the 2000 U.S. Census, 75.1% of the population is White, 12.3% is Black or African American, 0.9% are American Indian and Alaska Native, 3.6% are Asia, and 0.1% are Native Hawaiian and other Pacific Islander. Hispanic or Latino or any race constitutes 12.5% of the population. According to Freedman (2000), "One of the implications of globalization is that virtually no culture is untouched by others" (p. 437).

With the increase in global migration, nurses need to develop increased sensitivity to the influence of culture on pain perceptions and behaviors. The literature on this topic will be reviewed, including pain tolerance and perception, acute pain such as that experienced by childbearing women, and chronic pain. Culturally related pain behaviors and knowledge and attitudes toward the management of pain among nurses will also be discussed.

PAIN TOLERANCE AND PERCEPTION OF ACUTE PAIN

Cross-cultural studies of pain, pain reaction, and coping published between 1985 and 1996 have been summarized (Moore & Brodsgaard, 1999). The most

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frequently reported cross-cultural differences were patterns of the meaning of pain. Coping styles also differed. African American and Caucasian college students were evaluated on thermal pain responses (C. L. Edwards, Fillingim, & Keefe, 1999). African Americans rated the stimuli as more unpleasant. Authors concluded that thermal pain unpleasantness ratings may account for greater self-reported pain symptoms among African Americans. Cutaneous pain perceptions have been compared in Caucasians and African Americans (Sheffield, Biles, From, Maixner, & Sheps, 2000), noting that African Americans rated the stimuli as more unpleasant and showed a tendency to rate the pain as more intense than did Whites. Johnson-Umezulike (1999) found a moderate correlation between self-reported pain intensity and ethnicity in a study of older African Americans and Caucasians, with African Americans reporting higher levels of pain intensity. In a recent comparative study exploring normative pain responses in college students in the United States and East India, it was noted that Indian participants had higher pain tolerance than did those living in the United States (Nayak, Shiflett, Eshun, & Levine, 2000). Galanti (2001) described Filipino attitudes toward pain medication, including stoicism and higher pain thresholds. In a comparative study of women experiencing cholecystectomy pain, no significant differences were found in Mexican American and Anglo-American women (Calvillo & Flaskerud, 1993). In an ethnographic study of Mexican Americans who had had recent experiences with acute pain or who had family members with recent pain experience, the following themes were identified: (a) Pain is an encompassing period of suffering, (b) pain is both expected and accepted as part of life, and (c) the primacy of caring in the face of pain and suffering is the essence of family (Villaurruel, 1995).

CHILDBIRTH PAIN

There is a body of literature on the childbirth pain experience and culture (Callister, 2001; Callister et al., 2002; Callister, Lauri, & Vehvilainen-Julkunen, 2000; Callister, Semenic, & Foster, 1999; Callister & Vega, 1998; Callister, Vehvilainen-Julkunen, & Lauri, 1996, 2001; Kartchner & Callister, 2003; Khalaf & Callister, 1997). Study participants included childbearing women living in North and Central America, Scandinavia, the Middle East, the People's Republic of China, and Tonga. Participants described their attitudes toward, perceptions of, and meaning of childbirth pain. Mastering pain was viewed as a self-actualizing experience. Women who were active in their religious faith seemed to accept pain as an inevitable and important part of life. These women relied on a higher power to give them strength. Culturally related pain behavior was also articulated by these participants and varied greatly from stoicism to strong verbal and nonverbal expressions. It should be noted that childbirth pain is unique and complex, differing from the pain of disease, trauma, or medical and/or surgical procedures (Niven & Murphy-Black, 2000) and is usually characterized by the generally positive event of giving birth. Maternal self-efficacy or confidence in women's ability to cope makes a difference in the ability to manage the pain of childbirth.

PAIN TOLERANCE AND PERCEPTION OF CHRONIC PAIN

Based on a study of 372 chronic pain patients from six ethnic/cultural groups, Bates, Edwards, and Anderson (1993) generated a model of pain perception and response. The impact of ethnicity and level of acculturation on pain perception in Hispanic, Caucasian, and African American persons with fibromyalgia has been evaluated (Caldwell, 2001). There were no statistically significant differences across the three ethnic groups on total pain perception. However, it was noted that fibromyalgia is likely misdiagnosed or undiagnosed among Hispanics and African Americans in primary care clinics, indicating there are some implications for the delivery of culturally competent care. In a comparative study of 337 individuals suffering chronic pain, African Americans reported higher levels of clinical pain and pain-related disability (R. R. Edwards, Daniel, Fillingim, & Lowery, 2001).

The influence of culture on cancer pain management in Hispanics has been described in a qualitative work by Juarez, Ferrell, & Borneman (1998). Cancer pain was the focus of the work done with study participants who were immigrants from Europe and Eastern Europe (Greenwald, 1991). There were statistically significant differences in cultural identity and measures of pain sensation. In a study of four different ethnic/cultural groups, descriptors used to describe pain were both similar and different among cultural groups (Gaston-Johannson, 1990).

An advanced practice nurse practicing in an ambulatory care setting extensively compared those living with chronic pain in the United States with those living in East India. Kodiath (1998) concluded that clients "in both cultures who find meaning in their pain show markedly less suffering than those who find pain to be meaningless" (p. 46). She purports there are considerable cultural differences in the meaning of pain, which then influence human suffering. Differences in coping mechanisms and beliefs about pain control in African American and White women diagnosed with rheumatoid arthritis have been identified (Jordan, Lumley, & Leisen, 1998). Pain-coping strategies differ in cultural groups, and this may be as significant as differences in perceptions of pain (Moore & Brodsgaard, 1999). In Mexican American families dealing with chronic childhood illness, religious faith represented a powerful coping strategy engendering hope and a sense of well-being (Rehm, 1999).

PAIN BEHAVIORS

Pain behaviors vary widely and may be culturally bound. Some clients cope by turning inward, describing pain as a private and personal experience. Other clients are verbally expressive, sometimes crying and screaming. It has been suggested that "people in Eastern cultures have higher pain tolerance than those in the West" (Nayak et al., 2000, p. 146; Khalaf & Callister, 1997). In dominant cultures living in the United States, it is postulated that the willingness to verbalize pain may "be due to the belief that pain is bad, need not be endured, and should be quickly eliminated" (Nayak et al., 2000, p. 146). This may not be true in other cultural groups.

EVALUATION OF PAIN BY NURSES

In a study of nurses caring for women experiencing surgical pain, nurses' evaluation of patients' pain was less than the patients' evaluation (Calvillo & Flaskerud, 1993). This is widely supported in the literature. Laborde and Texidor (1996) assessed the knowledge and attitudes toward chronic pain management in 100 home health care nurses. Of these nurses, 80% had had a recent personal experience with pain and at least 50% had dealt recently with a client experiencing chronic pain. The researchers concluded that there was a need for additional education of home health care nurses in analgesic pharmacology and pain management.

CONCLUSION AND IMPLICATIONS FOR CLINICAL PRACTICE

Pain perceptions and behavior are heavily influenced by culture and by the sociocultural context of clients (Rollman, 1998). Level of acculturation and family support are other considerations (Flaskerud & Uman, 1996). More research is needed to build on the current body of knowledge regarding cultural influences on both acute and chronic pain.

Incongruities have been identified in nurses' assessments of clients' pain and clients' perceptions of that pain (McDermott, 2000). Nurses should be aware of how personal beliefs and perceptions make objective assessment and treatment of patients' pain difficult. Undertreatment or overtreatment of pain may result if nurses are not familiar with the cultural backgrounds of patients or make stereotypical assumptions. According to national standards of health care, pain should be assessed as the fifth vital sign (Mayer, Torma, Byock, & Norris, 2001). Pain is difficult to assess because it is so subjective. Guidelines indicate that patients' reports of pain should be accepted as valid (American Pain Society, 1999).

Pain assessment may become particularly problematic when clients and nurses have differing cultural backgrounds. This may be common, because only 9% of registered nurses in the United States come from culturally diverse backgrounds (U.S. Department of Health and Human Services, Bureau of Health Professions, 1998). It has been noted that how and whether people communicate their pain to health care professionals is influenced by social and cultural factors. Disparities may exist from both perspectives: the expression of pain by clients and the interpretation of reports of pain and pain behaviors by the home health care nurse (Nayak et al., 2000).

Nurses should seek to establish a common vocabulary for exploring issues of pain and comfort (Jimenez, 1996). The McGill Pain Questionnaire is widely used and includes a vertical visual analogue scale (Stephenson & Herman, 2000). Continuing work is being done to develop other scales (McCrea, Wright, & Stringer, 2000). The Joint Commission on Accreditation of Healthcare Organizations (2000) requires the use of the 0 to 10 pain rating scale to assess clients' pain. Clients' scores on the pain intensity scale is less important than a sense of satisfaction about how the pain is being managed because in many cultures, pain is an expected and accepted part of life.

Culturally sensitive pain assessment should be part of the plan of care (Streltzer, 1997). Discussing with clients a plan of care to manage pain enhances their sense of control and positively influences the quality of nurse-client relationships. In our society, the availability and use of analgesics and the assumption that health care providers are responsible for pain relief may be associated with greater expressions of pain and relinquishment of control for pain management to nurses (Johnson, 1989). Clients "from different cultural . . . groups differ in their beliefs about the appropriateness of expressing pain and that these beliefs are associated with actual pain expression" (Nayak et al., p. 150). The meaning of pain should be explored because making meaning of the pain experience is culturally bound and may be a powerful coping mechanism in dealing with pain (Aldrich & Eccleston, 2000).

The plan for pain management should also include sensitivity to clients' cultural beliefs and approaches using traditional healing practices (Lasch, 2000). In many cultures, it may be more appropriate to use nonpharmacological measures to reduce pain (Rhiner, Dean, & Durcharmes, 1996). Reliance on a higher power may represent an effective coping mechanism that should be acknowledged and respected. A holistic approach to pain management is indicated (Cole & Brunk, 1999; Locsin, 2000). Avoiding making stereotypical assumptions about cultural groups is an important consideration. Individual differences exist within cultural groups; thus, the pain experience should be understood within the context of patients' beliefs, values, coping strategies, and life experiences.

In the provision of home health care, it is essential that nurses are sensitive to the influence of culture on perceptions of and expressions of pain (Kodiath, 1998). The establishment of trust, sensitivity to nonverbal cues that may indicate pain and/or suffering is present, and encouragement to honestly express the need for pain management is so important (Luckmann, 1999). For example, in cancer patients, suffering often overshadows the pain experience (Streltzer, 1997). Thus the level of suffering as well as pain should be assessed. It is critical that home health nurses be prepared to deliver culturally competent care through increasing knowledge, attitude, and skills (Villaurreul, 1995). The expanding culturally diverse population in the United States provides new challenges and opportunities in the provision of home health care as well as many rewards as cultural understanding is increased and culturally appropriate care is provided.

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