This curriculum was produced pursuant to grant agreement number 11-161-001. This project was supported by Carl D. Perkins Career and Technical Education Improvement Act of 2006, Title 1, Part B. Funds awarded to Butte Community College by the Chancellor's Office, California Community College.

Cultural Competence Module 11
Cultural Knowledge – Pain Expression and Management

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Ms. Balistreri has served as President of the California Healthcare Interpreting Association (CHIA) for 2010 and 2011, and currently serves in several Advisory Boards as Cross-Cultural Communication & Language Access Expert. In 2007 she founded REACH - reaching diversity to provide Cultural & Linguistic Consulting Services and Solutions to the Health Care and Hospital sectors to enhance quality of care, increase patient safety and maximize customer satisfaction.

Module 11: Cultural Knowledge – Pain Expression and Management

Module Estimated Time: 40-45 minutes

Statement of Purpose:

The purpose of this module is to address the human behavior changes that exist across ethnic groups in relation to pain perception and pain response. Furthermore, it addresses cultural issues that may give variances to Pain Quality, Pain Intensity, Prevalence of Pain, as well as Patient/Provider Estimates of Pain and Use of Analgesics.

Objectives:

Upon the completion of this module, the learner will:

1. Be able to define Pain and distinguish the various types of pain
2. Be able to identify two or three cultural issues that affect pain
3. Be more aware of the relationship between Race, Ethnicity and the Treatment of Pain

Terminology

Race
Ethnicity
Pain Expression
Pain Definition
Misunderstanding
Aspects of Pain
Pain Quality
Prevalence of Pain
Treatment of Pain
Human Behavior
Pain Management
Poena
Algos
Akos
Psychic Pain
Verbal Cues
Non-Verbal Cues
Analgesic
Perceptions
Expressive
Stoic

1. **Dimensions of Pain (Introductory Lecture)**
   Introduce Pain and the Effect of Culture

Time: 2 minutes

Materials: None

Although Pain is universal to all human beings, how people perceive, express and deal with pain is controlled by learned behaviors. Cross-cultural communication is pivotal to understanding the relationship between culture and pain and the expression of many learned behaviors around the concept of pain.

The universality of pain has been studied by multiple anthropologists, social scientists, and biologists. Because pain is the most common complaint that patients present at doctor's offices in North America, the medical literature has given much attention to it, focusing on the response to pain across many cultures, including Chinese, Islamic and Indian cultures.

2. What about Pain? (Lecture)

Time: 10 minutes

Materials: Laptop/Computer
LCD Projector/Screen
PowerPoint of Module 11

Preparation: Before class, prepare laptop, screen and LCD projector. Have remote control at hand to advance PowerPoint Slides.

Slide 1

Pain comes from the Latin word *Poena* and from Greek "ποινή" (*poine*), generally "price paid," "penalty," "punishment." Also in Greek, the word used most often for physical pain is *algos,* which derives from roots indicating "neglect of love." Another Greek word is *Akos* meaning "psychic pain" from which we derive the English "ache."

The International Association for the Study of Pain defines it as, "An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."

In the past, Pain has been theorized as having three dimensions: "sensory-discriminative" (sense of the intensity, location, quality and duration of the pain), "affective-motivational" (unpleasantness and urge to escape the unpleasantness), and "cognitive-evaluative" (cognitions such as appraisal, cultural values, distraction and hypnotic suggestion).

Whatever the new theories and pain assessment tools may be today, pain is a multidimensional phenomenon and very difficult to define with precision, hence careful observation around the expression (or lack of) to pain is a very important tool. The response to pain can be culture-specific or influenced by barriers such as age, intake of medications that can alter the perception of pain, or even lack of verbal communication.

Slide 2

Pain is the primary reason for people to seek health care and it has been related with length of hospital stay, recovery time and poorer health outcomes. Barriers both from the provider and client's end may hinder the healing process of pain.

Race, ethnicity and even socio-economic status are great factors in the experience and treatment of pain. Racial groups have indicated differences in the expression of pain, the physical reactivity to pain as well as tolerance to pain.

Slide 3

Inadequate or inaccurate knowledge of pain management or assessment techniques, or concerns with overuse of or addiction to controlled substances, as well as adverse effects or developing tolerance to analgesics can all be specific barriers to pain relief created by healthcare professionals.

Slide 4

Other specific barriers to pain relief are systemic in nature: inadequate reimbursement for costly pain management therapies; stringent regulation around controlled substances; and low priority given to pain treatment as compared to other clients needs.

Slide 5

Lastly, the most difficult barriers are those related with clients and may involve: patient's reluctance to report pain; unwillingness to take medication for several reasons; fears that patient may associate with pain or pain medication.

Slide 6

Because cost is very significant in healthcare, and good analgesia can carry a very high cost, it is important that healthcare providers have a good understanding of their patient's level of pain and its cause in order to proceed with the best treatment to relieve it.

For this very reason, it is extremely important that the healthcare professional is responsive to the cultural variances in the interpretation of pain based on individual experiences, which may give varied shapes to pain perception, as well as to the psychosocial factors in addition to physical stimuli.

Slide 7

Assessing pain can be a tricky process especially since the assessment is contingent on pain tolerance, which is the amount of pain that a person is willing to endure. This tolerance can vary drastically from person to person. Some people can tolerate very high pain without distress; others are very sensitive even to the lowest level of pain.

Because pain has psychological, social, spiritual and physical dimensions, it is greatly influenced by cultural factors. Thus, people of different cultures respond differently to pain. People from cultures that value stoicism tend to avoid vocalizing with moans or screams when they are in pain. They may strive to keep their faces "masked," trying not to show their pain even by grimacing. They may feel that they'll be perceived as weak if they admit to or show pain, and they may deny having pain when asked.

Other cultural groups tend to be more expressive about pain. They learned from childhood that when one is in pain, the appropriate response is to moan or cry. Indeed, some cultural groups believe that one of the best ways to cope with and relieve pain is to groan or scream. Some groups encourage members in pain to seek attention and support and encourage caregivers to attend to them. Members of these groups may prefer not to be alone when they're in pain.

Although nurses may have deeply held beliefs about how best to respond to pain, they must be mindful that no response is inherently right or wrong. The responses may simply differ and may well be the products of cultural patterns and expectations.

The healthcare team alone cannot determine how tolerant a person is to pain, however, they

can engage with the patient in an effort to understand what factors maybe affecting the patient's pain experience based on:

- Ethnic and Cultural Values
- Developmental Stage
- Environment & Support
- Past Pain Experience
- Meaning of Pain
- Anxiety and Stress

Slide 8

Ethnic and Cultural Values have a strong influence on behavior related to pain. Individuals of one particular culture may have learned to be very expressive of pain, while others may have learned to keep feelings of pain to themselves.

Because pain can be an integral part of ritualistic or religious practices, tolerance to pain may translate into strength or endurance. In some African cultures, self-inflicted pain is a sign of mourning and grief.

Slide 9

When it comes to considering Developmental Stage, children may be less able to articulate their needs caused by under-treatment of pain.

Although age does not seem to change pain thresholds, the effect of analgesics may vary in older people due to metabolic changes or acute and chronic diseases.

Slide 10

Environment and Support are extremely important as different cultures set specific values to where care is given and who is present at the time of care. Hospitals can be seen as a strange place for some people and can affect the pain experience. For some patients, being surrounded by family and friends can cause them to have a less severe perception of pain than if they were alone.

Slide 11

People who have experienced suffering in the past may feel more threatened by the idea of pain. Our past experience has a great impact on our meaning of pain. People who have been tortured may find it difficult to express in words their perception of pain.

When language is a barrier, it may even be difficult to express certain nuances around the meaning of pain that a patient may want to express. Words like "stabbing" and "acute" may have little or no meaning to the patient.

Slide 12

Anxiety often accompanies pain. The threat of the unknown, such as being in a foreign environment or surrounded by a healthcare team that does not speak the patient's language,

or that is not sensitive to the cultural variations that the patient may present, may increase stress and create anxiety which often augment the feeling of pain.

People in pain who believe that their provider is listening with attention to their needs experience a decrease in their pain perception.

3. **Case Study (in group of three)**
   Students will engage in a case study analysis

Time: 15 minutes

Materials: Case Study Handout for Module 11

Mr. Nguyen, a 68-year-old Vietnamese man who immigrated to the United States in 1990, is brought to the ED by his daughter, who discovered that he'd been treating upper abdominal pain for several months with herbal tea. He's admitted after testing reveals stomach cancer. The nurse caring for Mr. Nguyen can see that he's a reserved man who tends to deny pain, and she's concerned that he may have a need for pain medication.

With the help of an interpreter, the nurse performs a comprehensive pain assessment. She discovers that Mr. Nguyen has a history of being quite stoic, having refused pain medication when he was recovering from wounds incurred during the Vietnam War. She also discovers that he doesn't like to take pills; he believes that teas made from medicinal herbs are more helpful and that opioids have the "wrong energy." He feels he should accept "what is"—what life hands him, including pain—without complaining. Mr. Nguyen reports that he is a Buddhist and that he frequently copes with pain by using a breathing meditation practice.

What steps as a nurse would you take in assessing and providing pain management treatment to Mr. Nguyen?

4. **Case Study Debriefing (in group of three)**

Time: 5 minutes

Materials: None

Allow two groups of students to volunteer and share with class what steps they discussed to approach Mr. Nguyen to assess his level of pain and offer pain management options.

5. **Problems complicating Pain Management (Closing Points)**

Time: 10 minutes

Materials: Laptop/Computer
LCD Projector/Screen
PowerPoint of Module 11

Close this lesson with these points:

Slide 13

A great level of research indicates that individuals of racial and ethnic minority groups are less likely to receive adequate pain management. As discussed, culture, race and ethnicity greatly impact pain management, particularly in these areas.

- Language & Interpretation Problems: comprehensive pain assessment and education relies on effective communication. When language barriers are present, the whole process of assessment and education is compromised. When interviewing an LEP patient, it is very important to use trained medical interpreters who can competently help the provider assess patients and teach pain management techniques.

- Non-verbal communication: Health care providers may use other cues beside direct communication to assess the pain levels. These cues may be facial expression, body posture, and activity level. However, because body language and facial expression are just as varied as vocabulary is to language across cultures, these can easily be subject of misinterpretations.

- Culturally & Linguistically inappropriate pain assessment tools: Numeric visual analog and verbal rating scales are all types of pain assessment tools. When asked to rate pain in a numeric scale, some cultural groups can tend to choose a favorite or sacred number, rather than the number that best indicated the level of pain. Likewise, for many Asian cultures, they may never select the number 4 as this is associated with death.

- Underreporting: Some patients may believe that a "good" patient should not complain and may be less reluctant to admitting experiencing pain and may underreport their pain to their providers.

- Reluctance to Take Pain Medications: Because of cultural taboos or fears, some patients may be reluctant to take opioid pain medications and they may feel more comfortable with culture-based remedies, such as herbal teas. Encouraging alternative therapies, rather than replacing them with medical therapy, can build trust and reduce reluctance to Pain Medications.

- Access to Pain Medication: Minority patients may not have health insurance, and therefore, no access to medical care and medications.

- Prejudice and discrimination and provider's fear of drug abuse: Many healthcare providers tend to associate minority groups with drug-seeking and abusing behaviors. Prejudicial stereotypes and negative judgment is unfortunately still prevalent in healthcare. Providers should always assess if indeed some patients may be receiving less than optimal pain management based on personal bias.

Individual beliefs about the meaning of pain can influence decisions about the treatment of pain. Pain from the same source may be perceived by one person as an expected part of life; by another as an omen of a serious health problem; and yet by another as deserved punishment, a character- or karma-building opportunity, or something else entirely.

The U.S. healthcare culture instills in people the concept of patient autonomy, seeing the patient as the one in control of how to respond and manage health related issues, including pain. Others, instead, tend to be fatalistic and believe they can exert little influence over the future, including matters of health, illness, and pain.

In the end, no matter how puzzled we may be about the different responses we may receive from patients, it's important to recognize that these beliefs and behaviors may arise from the social and cultural contexts in which the person lives rather than from a lack of willingness to confront pain.

Module 11
Case Study

Work with two other students to analyze the patient described below to determine the best course of action.

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