

Cultural Diversity and Cancer Pain

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❖ One of the factors that can influence a person's perception of the pain experience is culture. Understanding cultural similarities and differences, nurses can better prevent problems related to stereotyping, miscommunication, and interpersonal stress that lead to inadequate control of pain. Despite inconclusive and sometimes conflicting studies on cultural influences and pain, understanding cultural diversity and ethnicity should be a primary concern for nurses caring for patients with pain. Healthcare professionals need to become sensitive not only to the patient's heritage but also to their own and to pay particular attention to what happens when different heritages come together.

K E Y W O R D S

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culture
diversity


Cultures influence the experience of cancer pain¹ and refer to the beliefs, values, and customs that are passed from one generation to another.² Differences in pain behavior have always struck the keen observer, and through the centuries, various observers have commented on cultural factors that appear to steer an individual toward pathos or stoicism in response to pain.³ The nurse in a culturally diverse society must increase cultural awareness and his/her sensitivity to pain responses in order to provide holistic care to patients who may have different beliefs, values, and customs.⁴ People universally perceive pain but react to it with their own individual emotions and behaviors. These unique patterns of pain behavior and expression are influenced by a person's total life experience as a member of a certain culture or society.

Culture provides the blueprint for a group's behavior. Cultural diversity refers to both overt and covert differences among groups, incorporating many variables.⁵ The terms *ethnicity* and *race* are often used interchangeably in the literature. Ethnicity pertains to having an ethnic quality or affiliation. An ethnic group is a large group of people classed according to common traits and customs, whereas race is more specific to physical traits

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that are transmissible by descent and sufficient to characterize it as distinct from all others. Studying other cultures helps to clarify one's own beliefs and values. When scrutinizing cultural diversity, it is easy to stereotype patients according to their ethnic or racial characteristics. What the culturally different patient perceives as important may seem irrational to the nurse. Lack of cultural competence can result in cultural conflicts, miscommunication, misdiagnosis, inappropriate care, and patient discontent.

Nursing care is not ethical if cultural factors are not considered.¹ Studying cultural competence is relevant in ultimately improving patient care and patient satisfaction. In today's climate of healthcare reform, increased marketplace competition is the engine driving many changes in healthcare. It is imperative that patients are cared for by nurses who can make accurate assessments, refrain from stereotyping, and provide holistic care to patients. Nurses must be able to recognize that their own values are not superior or dominant and that they should not impose their beliefs on others.

The purpose of this article is to increase health professionals' cultural competence when caring for individuals who have cancer pain. Following the presentation of a biocultural model, the first aim is to review studies on pain and culture and explore the relation between experimental and clinical studies regarding the influence of culture on cancer pain. The second aim is to discuss variables, such as the meaning of pain and language, that need to be taken into account when considering cultural influences on responses to pain. The third aim is to focus on culturally sensitive nursing interventions.

❖ **BIOCULTURAL MODEL**

Melzack's and Wall's refinement of the Gate Control Theory of Pain and the multidimensional conceptual framework of pain stress the role of psychological and cognitive variables in modulating the physiological reaction to pain.^{6,7} Cognitive processes involving attention, anxiety, sociocultural learning, and experiences exert a powerful influence on the pain process.⁶ When the sensation of pain occurs, the individual's past memories and cultural beliefs may influence whether pain impulses reach the level of awareness and may significantly influence the perception of pain and the response to it.⁸ Cultural patterning and interpersonal relationships teach people whether pain is to be avoided or accepted or whether certain reactions to pain will receive approval


or disapproval. Consequently, people learn and develop behavior and attitudes in response to the physiological stimulus of pain.

The biocultural model proposed by Bates⁹ appears ideally suited for studying variability in pain perception and response within a cultural context.¹⁰ The model integrates the Gate Control Theory with basic social learning theories and sociocultural dimensions. Individuals learn appropriate behavior and emotional responses by watching the actions of others who are socially similar to themselves. As the first source of social comparison and social learning, the family can transmit its values and attitude to its children.¹¹ The biocultural model hypothesizes that social learning from family and group membership can influence psychological and physiological processes, which turn can affect the perception and modulation of pain. Bates stressed that the biocultural model assumes that all physiologically normal individuals, regardless of ethnicity, have basically similar neurophysiological systems of pain perception. This assumption is consistent with studies on laboratory-induced pain and cultural differences that did not reveal racial or ethnic differences in ability to discriminate painful stimuli.¹²

❖ **CULTURAL INFLUENCES ON PAIN EXPERIENCE AND BEHAVIOR**

The question of whether there are differences between ethnocultural groups in the response to pain is difficult to answer. Widely divergent criteria to describe pain in various studies led a reviewer to comment that "one cannot assume that pain is pain."¹³ Many cross-cultural pain studies have been done both in the laboratory and in the clinical arena, but most have not been well controlled for many variables that affect pain behaviors. Even the personality, sex, or ethnicity of the investigator or interviewer may influence research results.^{3,14-16} It is particularly difficult to evaluate studies in which groupings are delineated only by race, with individuals categorized only as whites, blacks, or Asians. However, several studies^{4,17-21} have shown that members within a single race, Asian, for example, exhibit significantly different pain responses from those of a different ethnic group; thus, ethnic groupings maybe more appropriate for comparing pain in different cultures.³

Numerous studies of whites,²⁰⁻²³ Japanese,^{24,25} Italians,^{4,26} Jews,^{4,27} Irish,^{4,28} African Americans,²⁹⁻³¹ Chinese,^{25,32}



Hispanics,³³ Vietnamese,^{4,34} Indians,³⁵ Arab Americans,^{36,37} and Arab patients³⁸⁻⁴⁰ lend indirect support to the biocultural hypothesis of pain as related to various ethnic groups. The research findings support interethnic similarities and differences. When reviewing these studies, it is necessary for readers to avoid stereotyping patients and overgeneralizing their behaviors. The information merely helps nurses to become familiar with different responses to pain and with key areas of assessment. A number of the references cited are dated but are classic studies that represent pioneering research in culture and pain.

Experimental Studies

Experimental laboratory studies of pain have used pain threshold and pain tolerance as measures of induced pain. The meaning of pain as influenced by culture may affect pain threshold and tolerance. Pain threshold is the vocal report of pain by the subject when pain is first recognized, whereas pain tolerance is the level of stimulus at which the subject requests cessation or spontaneously withdraws from the painful stimulus.²⁹ Because of semantic difficulties, pain tolerance, which requires a simple stop or observed behaviors indicating withdrawal of the experimental subject, may be a more useful cross-cultural measure than pain threshold is.^{3,29} Pain tolerance seems to have more clinical utility because medical attention is sought more for intolerance of pain and discomfort than for pain perception or threshold.³

It is difficult to accurately assess and compare research findings of cultural pain responses in the laboratory because of the diversity of methods used to assess and measure the expression of pain. Some laboratory studies reported no significant cultural differences in pain response,^{3,28} whereas other studies^{28,30} showed significant influences of culture on pain responses. Keefe and colleagues⁴¹ reviewed several studies that demonstrated significant racial and ethnic variation in baseline pain threshold or tolerance or both; however, no two investigations studied the same combination of cultural groups. Given the complexity and confounding variables of studying pain in a laboratory, Keefe and colleagues⁴¹ concluded that there is no consistent experimental evidence to suggest cultural differences in pain response.

It is difficult to generalize these laboratory findings to the clinical setting because quite different types of pain were studied and multiple techniques of inducing pain were used. Furthermore, laboratory findings may



not be generalized to individuals in the clinical setting, particularly those with cancer pain, for whom meaning of and psychological reaction to pain are just as significant as the sensation of pain. Differences in pain perception are influenced by the meaning of the experience to an individual, and there is no simple, direct relation between comparable conditions and the pain experienced. Examining various types of pain ratings in a clinical setting, Williams et al⁴² found poor concordance in pain report between patients and inconsistent reporting by the same patient. They suggested that "The action of arriving at a [pain] rating is better conceptualized as an attempt to construct meaning, influenced by and with reference to a range of internal and external factors and private meanings, rather than as a task of matching a distance or a number to a discrete internal stimulus." This challenging comment raises the question of whether the pain report is, or can ever be, truly valid as a measure of pain. That led to the conclusion that generalizing findings from experimental studies to patients with pain remains an unresolved question.

Clinical Studies

The biocultural model proposes that culturally acquired patterns or ethnic meanings of pain may influence the neurophysiological processing of nociceptive information responsible for pain threshold and pain tolerance, as well as pain behavior and expression.¹¹ Although research has shown that there are no racial or ethnic differences in sensation threshold,¹⁴ there are anthropological and clinical studies^{3,43-46} indicating that pain tolerance reflects attitudinal and behavioral aspects of pain that may be culturally determined. Some of these areas are described as follows.

❖ PAIN EXPRESSION

The manner in which a person expresses reaction to the pain experience is strongly related to ethnic and cultural background.^{46,47} Zborowski²⁰ was the first to note ethnic differences in reports and treatment of pain, with patients of Italian and Jewish backgrounds expressing their pain more intensely than do "old American" clients, those who were third-generation American, and World War II veterans. The limitations of Zborowski's study was failure to control for the effects of other medical, psychological, and sociocultural variables on pain intensity. Some years later, Zola²¹ also observed



that patients of an Italian ethnic background reported pain more frequently than did patients of Irish or Anglo-Saxon ethnic background. The conclusion reached from these early studies was that the preferred values and traditions of culture affected an individual's handling of and communication about pain.

The sensation of pain is generally unpleasant, yet the unpleasantness of pain will be accepted when dictated by cultural tradition. Perhaps the most dramatic example of the influence of culture on pain expression is research on the Pokot in Kenya. They regard stoicism in the face of any pain as honorable and expression of pain as shameful and inappropriate. The first stage of female circumcision, the cutting into the clitoral area, is performed in public and is regarded as a test and trial of stamina. They learn to master their bodies by displaying no emotion in response to pain. Girls are subsequently infibulated privately, and endurance is not emphasized. Some women recall being told not to cry and to show stamina during the cutting.⁴⁸

Other studies were unable to show any significant differences in pain expression. To assess the effect of learned ethnic attitudes toward pain, Ramer and colleagues⁴⁹ conducted a study to describe the relationship between pain perception and ethnic identity and socioeconomic status, to evaluate the intercorrelations between pain measures in different ethnic groups, and to determine whether ethnicity or socioeconomic status influences a patient's pain control beliefs and satisfaction with the pain management provided. The sample consisted of 51 Anglo, African American, Asian, and Hispanic participants experiencing cancer pain who were 18 years and older and had a Karnofsky score of no less than 30. The Visual Analogue Scale (VAS), Memorial Pain Scale (MPS), and Faces Scale (FS) were used to measure pain perception. The investigators found that Asians reported the highest level of pain, followed by Hispanics, African Americans, and Anglos. Asians reported significantly more pain than Anglos did on the FS, VAS, MPS, and Memorial Pain Intensity Word Scale (MWS); they also reported significantly more pain than African Americans did on the MPS. However, in all pain analyses, Hispanics, African Americans, and Anglos did not differ significantly. These findings suggested that there are no significant differences in pain response among ethnic groups when the experimental stimulus is held constant, anxiety over medical procedures is minimized, and the patient's attention span is focused.⁴⁹


Another study by Calvillo and Flaskerud⁵⁰ examined the relationship between ethnicity and pain. The study

addressed three major research questions. The first question asked whether there was a significant difference in Mexican American women's and Anglo-American women's response to cholecystectomy pain. Second, the nurses' attribution of pain to each of the two ethnic groups was compared. Finally, the patient's evaluation of the pain being experienced was compared with the nurse's evaluation of the pain that the patient was experiencing. The sample consisted of 60 patient subjects and 60 nurse responses. Patient pain was measured using the McGill Pain Questionnaire, amount of analgesics, and three physiological measures. The nurse's assessment of patient pain was measured using the Present Pain Intensity scale. No significant differences were found between the two ethnic groups on any of the measures of pain. However, nurses judged the two ethnic groups' pain response differently, assigning more pain to Anglo-Americans. Also, nurses evaluated the patients' pain as being less than patients did. Moreover, in examining the relationship between pain and sample characteristics of both patients and nurses, for the nurses, pain was significantly related to the patient's education, place of birth, language, and religion.⁵⁰

Medication Use

Clinical studies have reported that some cultural groups receive, or require, fewer analgesics for pain relative to other groups. Streltzer and Wade²⁵ reported that white and Hawaiian patients received significantly more analgesics than did Filipino, Japanese, or Chinese patients. Although this study controlled for other variables, the findings were based only on differences in patients' request for analgesics, with no actual measurements of pain intensity. Streltzer and Wade concluded that cultural factors do contribute to variability in the treatment of postoperative pain; however, whether this finding was due to ethnic differences in analgesic requirements or cultural bias in treatment was not determined.

To answer the question of whether it is patient or clinician characteristics that determine the level of analgesic use, some researchers have found that, for example, with low-back pain, it is the physician's impression of a patient's pain rather than the patient's ethnicity or other characteristics that determined use.⁵¹ Another study by Harrison et al⁵² found that nurses who shared the same language as the patient assigned similar pain ratings to a population of Arabic patients when compared with those assigned by non-Arabic-speaking



nurses. These inconsistent results are not surprising given that research in this area is underdeveloped and, from a methodological standpoint, weak. Most of these studies rely on convenience samples, have relatively small sample sizes, and use retrospective review of chart data. These factors have the potential to bias results. Results of these studies leave questions of differences in pain behavior, discrimination, or, at the very least, inappropriate prescription behavior on the part of clinicians, as well as potential differences in pharmacokinetics and pharmacodynamics, unanswered. Simply put, are patients of various cultural groups asking for less medication, or are they, for a variety of reasons, being less well attended to than are patients from the mainstream population?

Coping With Pain

Culture may influence use of pain-coping strategies by members of ethnic groups. The use of specific coping strategies may differ across ethnic groups.⁵³ Moreover, Moore and Brodsgaard⁵⁴ noted that coping styles generally vary widely across cultures and that cultural differences in the use of pain-coping strategies may be at least as important as differences in the prevalence or reported severity of pain. Also, Moore⁵⁵ interviewed 54 patients and 31 dentists of Chinese, Anglo-American, and Scandinavian ethnic origin about ways of coping with pain. His study showed that patients' descriptions of remedies varied according to East-West ethnic differences. In contrast, dentists were influenced more by professional socialization than by ethnicity in describing pain remedies. Anglo-American patients and dentists preferred internally applied medicines (pills, injections, etc), whereas Chinese patients preferred external agents (salves, oils, massage, etc). Anglo-American and Danish patients preferred distractions methods, whereas Chinese patients used them least. Swedish and Chinese patients preferred not to use local anesthetics for dental treatment. Interestingly, the dentists shared similar perception about remedies, and these perceptions differed from those of their patients.

It has been noted that the coping strategies such as social support and religious coping are particularly salient for African Americans and it is possible that these coping styles may affect the pain experience.⁵⁶ For example, in a study of pain coping among patients with rheumatoid arthritis, although no ethnic differences in pain were noted, there were ethnic differences in the use of pain-coping strategies. African Americans


with rheumatoid arthritis reported significantly greater use of distraction and praying/hoping, while whites reported higher use of ignoring pain and coping statements and a greater perceived ability to control pain.⁵⁷

Cancer Pain

Few studies have addressed cultural factors and cancer-related pain. The way in which a culture treats and views cancer can influence the quality and tolerance of cancer-related pain.¹ Few researchers have begun to report ethnic variations in the cancer pain experience.^{58,59} In a national study, Cleeland and colleagues⁶⁰ reported that in settings with predominantly ethnic minority patients, including Hispanics and African Americans, 62% of those patients were undertreated according to the World Health Organization standards, and they were three times more likely to be undermedicated than patients seen in nonminority settings with predominantly white cancer patients. In a follow-up study,⁶¹ researchers reported that 74% of Hispanics and 59% of African American patients with pain did not receive the World Health Organization–recommended analgesics for their pain. In a subsequent study, Anderson and associates⁶² reported that 28% of Hispanic and 31% of African American patients received analgesics that were insufficient to manage their pain.

Ethnic differences in pain descriptions have been reported as well: ethnic variability is evident in ideas about cancer, pain expectations, pain tolerance, pain expression, and healthcare practices.⁶³⁻⁶⁷ Rabow and Dibble⁶⁸ reported that ethnic minority cancer patients reported more pain than white cancer patients did. Vallerand and colleagues⁶⁹ reported that African American cancer patients had significantly higher pain intensity and more pain-related distress and reported more pain-related interference with function than white cancer patients did. Chin⁷⁰ reported that Chinese patients might not complain of pain and might not want to “bother” the nurse to ask for pain medication. Guarnero⁷¹ indicated that Mexicans want pain relief as quickly as possible and preferred using words than numbers to describe pain easier.

Despite these findings, some recent studies indicated no such variation in pain experience by ethnicity. There were no ethnic differences found in the cancer pain experience, measures of pain sensation, pain ratings of ethnically diverse groups of persons with myocardial infarction, pain ratings during childbirth, and behavior responses and pain ratings of children with cancer.^{68,72,73}



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As these inconsistent findings indicate, it would be hasty to conclude that there are or there are no ethnic differences in the cancer pain experience, so further studies are needed to develop reliable knowledge that can be used to manage more effectively the pain of cancer patients from various culture. Furthermore, existing studies have tended to include only a limited number of ethnic minorities, and very few national studies having an adequate number of ethnic minorities for valid comparisons have been conducted.⁷⁴

❖ VARIABLES RELATED TO CULTURE AND PAIN

One explanation for the differences in the findings of cultural pain research is the failure of many studies to control for social background variables other than ethnicity that could affect perceptions or interpretation of pain. It is important for the clinician to be aware of the following factors that are related to culture and the pain experience.

Meaning of Pain

An individual's definition of pain may influence how much pain can be tolerated and endured. Pain, suffering, and human illness cannot be understood without taking personal meaning into account.⁴⁸ The word *cancer* may evoke images of pain and have cognitive and emotional meaning for the patient.⁷⁵ In a review of 28 international epidemiological surveys of more than 62,000 patients with cancer, 14 surveys were conducted in the United States. Most of the remaining studies were conducted in Europe (Finland, France, Germany, and United Kingdom/Ireland). These studies found that pain (persistent and breakthrough pain) was common and occurred in 50% or more of the patients in almost half of the surveys.⁷⁶ Lin et al⁷⁷ studied a total of 233 Taiwanese cancer patients with pain and demonstrated the effect of personal meaning on pain. Patients who perceived their pain as an indication of disease progression reported the greatest interference with activity and pleasure. O'Mahony and associates⁷⁸ also documented that patients with cancer pain experienced increased levels of depression and anxiety if they believed that their pain was related to a worsening of their condition. Consequently, culture influences on the pain experience should be determined within the context of cultural attitudes toward disease, health, and pain.⁷⁹

Sex and Age

Research has shown controversy and no clear trends in sex differences in pain tolerance and threshold.⁵⁹ Men may tolerate more pain and show more stoicism than women do.²⁴ It may be that most cultures permit the female child to more freely express pain.⁴⁰ Studies by Miaskowski et al^{59,80-82} have provided data on sex differences in pain severity in patients with chronic cancer pain. The findings from these studies indicated that men and women report similar levels of pain intensity when they experience chronic cancer pain. Additional research is warranted to determine whether this finding persists with different types of chronic cancer pain and with acute cancer-related pain.

Classical studies suggested that with increasing age, tolerance to cutaneous pain increases and tolerance to deep pain decreases.⁸³ Farrell and Gibson's⁸⁴ study of pain correlated greater pain sensitivity with younger ages. Assessment of pain may be more challenging in elderly patients because their reporting of pain may differ from that of younger patients and they may be more stoic about pain.¹⁵ Sex and age may be important mediators of ethnic differences because older and female patients carry on ethnic traditions more than younger and male patients do.⁸⁵

Living and Working Environments

Classical studies demonstrated that prolonged exposure to harsh living and working conditions may result in stoicism and increased pain tolerance. For example, Clark and Clark⁸⁶ reported that Nepalese porters, who were used to physical labor, had higher pain tolerance compared with East Indians and occidental visitors. Recently, a similar conclusion was found by Nayak and associates,³⁵ who compared pain responses of Americans and Indians and found that the Indians had a higher pain tolerance to cold pressor pain compared with Americans.

Social Class

Epidemiological studies have reported that apart from sex differences, there are other differences in the experience of pain. Several studies have found that socioeconomic factors such as low income,^{87,88} low education,^{87,89-91} unemployment and employment category,⁹⁰⁻⁹² and being on sick leave⁸⁹ are associated with pain; however, these

factors are not significant in all studies.⁹³ More research is needed to determine how socioeconomic factors influence the experience and reporting of pain.

Religion

Religious belief may provide greater meaning in people's lives and, in turn, help them better cope with their diseases.⁹⁴ Although many major religions have deemed illness and suffering the result of sin, many also believe that pain and suffering can be strengthening, enlightening, and purifying. According to various religious teachings, pain and suffering are inevitable and can be cleansing, test virtue, educate, readjust priorities, stimulate personal growth, and define human life.⁹⁵ Religions differ in how they confront suffering, and generalizations are difficult to draw because considerable variability exists within each religion. For example, many Buddhists believe in enduring pain matter-of-factly,⁹⁶ whereas many Hindus stress understanding and detachment from pain.⁹⁷

In the Arab-Islamic heritage, pain is not considered a divine punishment for sins but rather a test of faith. Therefore, Muslims are required to have patience and endure pain, as a sign of strong faith, in return for God's mercy and forgiveness. However, Muslims are required to seek treatment and pain relief when necessary because needless pain and suffering are frowned upon,⁹⁸ and many Christians stress seeking atonement and redemption.⁹⁹ Religion evidently provides more than just a distraction from suffering. The social network and support provided by religions may be associated with lower pain levels, and religious belief may improve self-esteem and sense of purpose.¹⁰⁰ Further research is needed on relations among pain, responses to management of pain, and individuals' religious beliefs.

Language

Because there are no reliable physiological tools to measure pain, it can be communicated or assessed only through words and behavior, which can vary by culture. Language may influence cognition or thought, which could affect the actual experience of pain.¹⁰¹ Pain in a cultural context may be shaped by language because language and culture may affect the neurophysiological response to pain. Just as the brain must have a way to receive, interpret, and express pain, the individual's language is the method of communication learned from his/her culture. Therefore, culture and

language cannot be separated from communication about pain and how the brain interprets pain.¹⁰²

Cultures differ regarding the types and number of words within their languages that are used to describe or classify pain. Some languages contain many words to describe pain, whereas in other languages, a single term with optional qualifiers is the norm.¹⁰³ For example, the Thai people commonly use more than a dozen basic words for pain,¹⁰⁴ whereas the Japanese have a single term for pain that can be qualified by other descriptors.²⁴ Some words for pain or its qualifiers have no equivalent terms in other languages. Thus, response to pain may be limited by the language available to describe or report the pain. The specific language available for pain reporting may not only be an effect of cultural differences on pain perception but also partly cause differences in pain perception. Even with tools such as the VAS, language is necessary to establish the anchor points.²⁸ Constructing or adapting tools to evaluate and compare pain that have cross-cultural validity is extremely complex.

Level of Assimilation and Acculturation

The extent of acculturation into American norms for health and illness may greatly affect interethnic variations in pain responses. Commonly, individuals who belong to a homogeneous, socially tight ethnic group will be less acculturated and assimilated into American culture, whereas the further an individual is from the immigrant generation, the more "American" is his/her behavior.¹⁰⁵ As groups become more acculturated, cultural or ethnic influences on pain behavior may not be readily apparent.¹⁰⁶

❖ NURSING IMPLICATIONS

Awareness of theoretical advances in pain and increased recognition of mind-body interrelations should facilitate the inclusion of cultural variables in the management of pain. The studies discussed so far have increased understanding of the complex relation between culture and pain. Adequate interpretations and assessments of verbal and nonverbal communications require an understanding of patients' statements and behavior within a cultural framework. If nurses and other healthcare professionals do not pay attention to the influences of culture on patients' reports of pain, important cues necessary for appropriate assessment, diagnosis, and treatment may be overlooked or misinterpreted.¹



Cultural considerations are important throughout the nursing process. If nurses from one culture stereotype, or believe broad generalizations about, patients from another culture, their beliefs or misconceptions might affect patient care outcomes. There are intra-ethnic, as well as interethnic, differences in pain responses. Researchers have clearly shown that nurses respond much differently to patients from another culture even when patient descriptions and information are identical.^{52,56,61} Another barrier to providing culturally sensitive nursing care is ethnocentrism, or the belief that one's own beliefs and values are superior.⁴ Ethnocentrism prevents an understanding of the viewpoints of another culture. Nursing's goal should be to foster ethnorelativity, or the ability to honor another culture's beliefs even though they may conflict with one's own beliefs. The nurse must practice the concept of tolerance, meaning to accept a cultural belief or behavior that is not harmful to anyone but may be culturally unapproved by the nurse when working with culturally diverse patients.¹⁰⁷ Rather than learning the specific details of a particular ethnic group that could ultimately classify people into rigid categories, health-care providers need to be sensitive to a patient's heritage, to their own heritage, and to potential discrepancies. Cultural data can be used productively if they do not exclude other pertinent variables and are incorporated within a framework of total patient assessment.¹⁰⁸

It is important to develop rapport before implementing interventions. The nurse should use simple words if the patient speaks little English and should point to and name items as they are being used. Then the nurse needs to retain an open and respectful attitude to minimize cultural conflicts. There is a general consensus among behavioral scholars that the culturally congruent patient-caregiver relationship (ie, one in which patient and caregiver share the same racial or ethnic background) is ideal.¹⁰⁹ In such relationships, the quality of the rapport and the communication process (eg, openness, empathy, disclosure, and trust) are improved, and the feeling that caregiver and patient can relate "on common ground" is maximized.¹¹⁰ Lastly, when language remains a true barrier, it is important and appropriate to involve an interpreter. However, interpreters need to convey the meaning of the patient's words and not just the words. Often, because of intergenerational differences and other cultural factors, a family member is often not the appropriate interpreter. Social roles may be a major factor in determining who would be an appropriate translator.¹¹¹

The following guidelines may facilitate adequate relief of pain when caring for patients from various cultural backgrounds.^{1,108} These include using appropriate assessment tools, appreciating variations in affective response to pain across cultures, being sensitive to variations in communication styles across cultures, recognizing that communication of pain may not be acceptable within a culture, appreciating that the meaning of pain varies between cultures, using knowledge of biological variations, and developing personal awareness of values and beliefs that may affect responses to pain.

❖ CONCLUSION

Understanding cultural similarities and differences, nurses can better prevent problems related to stereotyping, miscommunication, and interpersonal stress that lead to inadequate control of pain. Despite inconclusive and sometimes conflicting studies on cultural influences and pain, understanding cultural diversity and ethnicity should be a primary concern for nurses caring for patients with pain. Healthcare professionals need to become sensitive not only to the patient's heritage but also to their own and to pay particular attention to what happens when different heritages come together. An individual's communication pattern has been developed through years of experience and feedback from others.¹⁰⁷ Physiologically, pain warns of harm; however, cultural learning or patterning determines whether pain is good or bad, whether pain is to be avoided or accepted, or whether certain reactions to pain will receive approval or disapproval.²⁰ Differences in interpretation and expression of pain will continue as new groups become assimilated into the American culture. Proper awareness of cultural influences, particularly when caring for recent immigrants, first-generation descendants of immigrants, and patients who maintain strong ethnic ties, will remain important in preventing discrepancies in pain assessment and interventions. Nurses need to bridge, but not change, and to build, but not destroy, the uniqueness of interacting cultural groups.

In summary, pain is a critical component of patient care. It is even more critical for the patient from another culture who has special considerations relative to the culture. This article has addressed cultural perspectives that should be considered when a patient is in pain and specifically has presented biocultural model for studying variability in pain perception and response within a cultural context, reviewed studies on pain and culture,



explored the relation between experimental and clinical studies about the influence of culture on cancer pain, and focused on culturally competent nursing interventions.

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References

1. Lasch K. Culture, pain, and culturally sensitive pain care. *J Pain Manag Nurs*. 2000;1(3):16-22.
2. McGoldrick M, Giordano J, Garcia-Preto N. *Ethnicity and Family Therapy*. 3rd ed. New York, NY: Guilford Press; 2005:1-38.
3. Edwards RR, Doleys DM, Fillingim RB, Lowery D. Ethnic differences in pain tolerance: clinical implications in a chronic pain population. *Psychosom Med*. 2001;63:316-323.
4. Davidhizar R, Giger JN. A review of the literature on care of clients in pain who are culturally diverse. *Int Nurs Rev*. 2004; 51(1):47-55.
5. Betancourt JR, Green AR, Carrillo JE, Park ER. Cultural competence and health care disparities: key perspectives and trends. *Health Aff*. 2005;24(2):499-505.
6. Melzack R, Wall PD. *The Challenge of Pain*. Harmondsworth, England: Penguin Books; 1982:173.
7. Turk DC, Melzack R. *Handbook of Pain Assessment*. 2nd ed. New York, NY: Guilford Press; 2001:50.
8. Walco GA, Harkins SW. Life-span developmental approaches to pain. In: Gatchel RJ, Turk DC, eds. *Psychological Factors in Pain: Critical Perspectives*. New York, NY: Guilford Publications; 1999:107-170.
9. Bates MS. Ethnicity and pain: a biocultural model. *Soc Sci Med*. 1987;24(1):47-50.
10. Spires A. Managing cultural diversity in caring. In: Kenworthy N, Snowley G, Gilling C, eds. *Common Foundation Studies in Nursing*. London: Elsevier; 2001:129-145.
11. Bates MS. Chronic pain: theories and research and treatment approaches. In: Bates MS, ed. *Biocultural Dimensions of Chronic Pain: Implications for Treatment of Multi-Ethnic Populations*. Albany, NY: Suny Press; 1996:7-22.
12. Weisse CS, Foster KK, Fisher EA. The influence of experimenter gender and race on pain reporting: does racial or gender concordance matter? *Pain Med*. 2005;6:80-87.
13. Devine EC. Meta-analysis of the effect of psychoeducational interventions on pain in adults with cancer. *Oncol Nurs Forum*. 2003;30(1):75-89.
14. Campbell CM, Edwards RR, Fillingim RB. Ethnic differences in response to multiple experimental pain stimuli. *Pain*. 2005;113: 20-26.
15. Gibson SJ, Helme RD. Age-related differences in pain perception and report. *Clin Geriatr Med*. 2001;17:433-456.
16. Sheffield D, Biles PL, Orom H, Maixner W, Sheps DS. Race and sex differences in cutaneous pain perception. *Psychosom Med*. 2000; 6:517-523.
17. Jakobsson U, Klefsj rd R, Westergren A, Hallberg IR. Old people in pain: a comparative study. *J Pain Symptom Manage*. 2003;26:625-636.
18. Koopman C, Eisenthal S, Stoeckle JD. Ethnicity in the reported pain, emotional distress and requests of medical outpatients. *Soc Sci Med*. 1984;18:487-490.
19. Lai YH, Keefe FJ, Sun WZ, et al. Relationship between pain-specific beliefs and adherence to analgesic regimens in Taiwanese cancer patients: a preliminary study. *J Pain Symptom Manage*. 2002;24:415-423.
20. Zborowski M. *People in Pain*. San Francisco, CA: Jossey-Bass; 1969.
21. Zola IK. Culture and symptoms: an analysis of patients presenting complaints. *Am Sociol Rev*. 1966;31:615-630.
22. Melzack R, Torgerson W. On the language of pain. *Anesthesiology*. 1971;34:50-59.
23. Portenoy RK, Ugar te C, Fuller I, Haas G. Population based survey of pain in the United States: differences among white, African American, and Hispanic subjects. *Pain*. 2004;5:317-328.
24. Hobara M. Beliefs about appropriate pain behavior: cross-cultural and sex differences between Japanese and Euro-Americans. *Eur J Pain*. 2005;9:389-393.
25. Streltzer J, Wade T. The influence of cultural group on the undertreatment of postoperative pain. *Psychosom Med*. 1981;43: 397-403.
26. Pieroni A, Quave C, Nebel S, Heinrich M. Ethnopharmacy of ethnic Albanians (Arb resh ) in northern Basilicata (southern Italy). *Fitoterapia*. 2002;73:217-241.
27. Elbaz-Luwisch F. Personal story as passport: storytelling in border pedagogy. *Teach Educ*. 2001;12(1):81-101.
28. Zatzick DF, Dimsdale JE. Cultural variations in response to painful stimuli. *Psychosom Med*. 1990;52:544-557.
29. Edwards C, Fillingim R, Keefe F. Race, ethnicity and pain. *Pain*. 2001;94(2):133-137.
30. Green CR, Baker TA, Smith EM, Sato Y. The effect of race in older adults presenting for chronic pain management: a comparative study of black and white Americans. *Pain*. 2003;4:82-90.
31. Green CR, Ndao-Brumblay SK, Nagrant AM, Baker TA, Rothman E. Race, age, and gender influences among clusters of African American and white patients with chronic pain. *Pain*. 2004;5:171-182.
32. Chung JWY, Wong TKS, Yang JCS. The lens model: assessment of cancer pain in a Chinese context. *Cancer Nurs*. 2000;23:454-461.
33. Duggleby W. Helping Hispanic/Latino home health patients manage their pain. *Home Healthc Nurse*. 2003;21(3):174-179.
34. Cleeland CS, Ladinsky J, Serlin R, et al. Multidimensional measurement of cancer pain: comparisons of U.S. and Vietnamese patients. *Pain Symptom Manage*. 1988;3:32-37.
35. Nayak S, Shiflett S, Eshun S, Levine F. Culture and gender effects in pain beliefs and the prediction of pain tolerance. *Cross Cult Res*. 2000;34:135-151.
36. Reizian A, Meleis AI. Arab-Americans' perceptions of and responses to pain. *Crit Care Nurs*. 1986;6:30-37.
37. Rollman GB. Cultural clinical psychology: theory, research, and practice. In: Kazarian SS, ed. *Culture and Pain*. New York, NY: Oxford University Press; 1998:267-286.
38. Boyle D, McClary J, Sheridan A, White J. A multifocal education strategy to enhance hospital-based cultural competency in professional staff. *Oncol Nurs Forum*. 2002;29:764-768.
39. Forgeron PA, Finley GA, Arnaout M. Pediatric pain prevalence and parents' attitudes at a cancer hospital in Jordan. *J Pain Symptom Manage*. 2006;31:440-448.
40. Gharaibeh M, Abu-Saad H. Cultural validation of pediatric pain assessment tools: Jordanian perspective. *J Transcult Nurs*. 2002;13: 12-18.

- 
- 
41. Keefe FJ, Lumley MA, Buffington ALH, et al. Changing face of pain: evolution of pain research in psychosomatic medicine. *J Psychosom Med.* 2002;64:921-938.
 42. Williams AC, Davies HTO, Chadury Y. Simple pain rating scales hide complex idiosyncratic meanings. *Pain.* 2000;85:457-463.
 43. Ruehlman LS, Karoly P, Newton C. Comparing the experiential and psychosocial dimensions of chronic pain in African Americans and Caucasians: findings from a national community sample. *Pain Med.* 2005;6:49-60.
 44. Wolff B. Ethnocultural factors influencing pain and illness behavior. *Pain.* 1985;1:23-30.
 45. Wolff B, Langley S. Cultural factors and the response to pain: a review. *Am Anthropol.* 1968;70:494-501.
 46. Zborowski M. Cultural components in response to pain. *J Soc Issues.* 1952;8:16-30.
 47. Mazanac P, Kitzes J. Cultural competences in hospice and palliative care. In: Forman WB, Kitzes JA, Anderson RP, Sheehan DK, eds. *Hospice and Palliative Care: Concepts and Practice.* 2nd ed. Boston, MA: Jones & Bartlett Publishers; 2003:170-188.
 48. Johansen E. Pain as a counterpoint to culture: toward an analysis of pain associated with infibulation among Somali immigrants in Norway. *Med Anthropol Q.* 2002;16:312-340.
 49. Ramer L, Richardson JL, Cohen MZ, et al. Multimeasure pain assessment in an ethnically diverse group of patients with cancer. *J Transcult Nurs.* 1999;10(2):94-101.
 50. Calvillo E, Flaskerud J. The evaluation of pain response by Mexican Americans and Anglo American women and their nurses. *J Adv Nurs.* 1993;18:451-459.
 51. Bartfield JM, Alluzzo RF, Raccio-Robak N, et al. Physician and patient factors influencing the treatment of low back pain. *Pain.* 1997;73:209-211.
 52. Harrison A, Busabir AA, al-Kaabi AO, al-Awadi HK. Does sharing a mother-tongue affect how closely patients and nurses agree when rating patient's pain, worry, and knowledge? *J Adv Nurs.* 1996;24:229-235.
 53. Tan G, Jensen MP, Thornby J, Anderson KO. Ethnicity, control appraisal, coping, and adjustment to chronic pain among black and white Americans. *Pain Med.* 2005;6:18-28.
 54. Moore R, Brodsgaard I. Cross-cultural investigations of pain. In: Crombie IK, ed. *Epidemiology of Pain.* Seattle, WA: IASP Press; 1999:53-80.
 55. Moore R. Ethnographic assessment of pain coping perceptions. *Psychosom Med.* 1990;52:171-181.
 56. Edwards RR, Moric M, Husfeldt B, Buvanendran A, Ivankovich O. Ethnic similarities and differences in the chronic pain experience: a comparison of African American, Hispanic, and white patients. *Pain Med.* 2005;6:88-98.
 57. Jordan M, Lumley M, Leisen J. The relationships of cognitive coping and pain control beliefs to pain and adjustment among African-American and Caucasian women with rheumatoid arthritis. *Arthritis Care Res.* 1998;11:80-88.
 58. Laliberte R. *Doctors' Guide to Chronic Pain: The Newest, Quickest, and Most Effective Ways to Find Relief.* New York, NY: Reader's Digest Association; 2003.
 59. Miaskowski C. Gender differences in pain, fatigue, and depression in patients with cancer. *J Natl Cancer Inst Monogr.* 2004; 32:139-143.
 60. Cleeland CS, Gonin R, Hatfield AK, et al. Pain and its treatment in outpatients with metastatic cancer. *New Engl J Med.* 1994; 330(9):592-596.
 61. Cleeland CS, Gonin R, Baez L, et al. Pain and treatment of pain in minority patients with cancer. The Eastern Cooperative Oncology Group minority outpatient pain study. *Ann Intern Med.* 1997;127(9):813-816.
 62. Anderson KO, Mendoza TR, Valero V, et al. Minority cancer patients and their providers. *Cancer.* 2000;88(8):1929-1938.
 63. Beck SL. An ethnographic study of factors influencing cancer pain management in South Africa. *Cancer Nurs.* 2000;23(2):99-100.
 64. Chung JWY, Yang JCS, Wang TKS. The significance of pain among Chinese patients with cancer in Hong Kong. *Acta Anaesthesiol Sin.* 1999;37:9-14.
 65. Lubeck DP, Kim H, Grossfeld G, et al. Health related quality of life differences between black and white men with prostate cancer: data from the cancer of the prostate strategic urologic research endeavor. *J Urol.* 2001;166(6):2291-2292.
 66. Thompson TE, McCune JS, Bernard SA, et al. Cancer pain survey: patient-centered issues in control. *J Pain Symptom Manage.* 1998;15(5):275-284.
 67. Uki J, Mendoza T, Cleeland CS, Nakamura Y, Takeda F. A brief cancer pain assessment tool in Japanese: the utility of the Japanese Brief Pain Inventory VBPI-J. *J Pain Symptom Manage.* 1998;16(6):364-373.
 68. Rabow MW, Dibble SL. Ethnic differences in pain among outpatients with terminal and end stage chronic illness. *Pain Med.* 2005;6(3):235-241.
 69. Vallerand AH, Hasenau S, Templin T, Collins-Bohler D. Disparities between black and white patients with cancer pain: the effect of perception of control over pain. *Pain Med.* 2005;6(3): 245-250.
 70. Chin P. Chinese. In: Lipson JG, Dibble SL, eds. *Culture & Clinical Care.* San Francisco, CA: UCSF Nursing Press; 2005:98-108.
 71. Guarnero PA. Mexicans. In: Lipson JG, Dibble SL, eds. *Culture & Clinical Care.* San Francisco, CA: UCSF Nursing Press; 2005: 330-342.
 72. Edrington JM, Paul S, Dodd M, et al. No evidence for sex differences in the severity and treatment of cancer pain. *J Pain Symptom Manage.* 2004;28(3):225-232.
 73. Rustoen T, Fosså SD, Skarstein J, Moum T. The impact of demographic and disease-specific variables on pain in cancer patients. *J Pain Symptom Manage.* 2003;26(2):696-704.
 74. Im EO, Chee W, Guevara E, et al. Gender and ethnic differences in cancer pain experience: a multiethnic survey in the United States. *Nurs Res.* 2007;56(5):296-306.
 75. Skaggs BG, Barron CR. Searching for meaning in negative events: concept analysis. *J Adv Nurs.* 2006;53(5):559-570.
 76. Goudas LC, Bloch R, Gialeli-Goudas M, Lau J, Carr DB. The epidemiology of cancer pain. *Cancer Invest.* 2005;23:182-190.
 77. Lin C, Lai Y, Ward SE. Effect of cancer pain on performance status, mood states, and level of hope among Taiwanese cancer patients. *J Pain Symptom Manage.* 2003;25(1):29-37.
 78. O'Mahony S, Goulet J, Kornblith A, et al. Desire for hastened death, cancer pain and depression: report of a longitudinal observational study. *J Pain Symptom Manage.* 2005;29: 446-457.
 79. Beach MC, Price E, Gary TL, et al. Cultural competence: a systematic review of health care provider educational interventions. *Med Care.* 2005;43:356-373.
 80. Miaskowski C, Dodd MJ, West C, et al. Lack of adherence with the analgesic regimen: a significant barrier to effective cancer pain management. *Clin Oncol.* 2001;19:4275-4279.

81. Miaskowski C, Gear RW, Levine JD. Sex-related differences in analgesic responses. In: Fillingim RB, ed. *Sex, Gender and Pain: Progress in Pain Research and Management*. Seattle, WA: IASP Press; 2000:209-230.
82. Miaskowski C, Levine JD. Does opioid analgesia show a gender preference for females? *Pain Forum*. 1999;8:34-44.
83. Chapman W, Jones C. Variations in cutaneous and visceral pain sensitivity in normal subjects. *Clin Invest*. 1944;23:81-91.
84. Farrell M, Gibson S. Age interacts with stimulus frequency in the temporal summation of pain. *Pain Med*. 2007;8(6):514-520.
85. Gibson SJ, Farrell MJ. A review of age differences in the neurophysiology of nociception and the perceptual experience of pain. *Clin J Pain*. 2004;20:227-239.
86. Clark WC, Clark S. Pain responses in Nepalese porters. *Science*. 1980;209:410-412.
87. Latza U, Kohlmann T, Deck R, Raspe H. Influence of occupational factors on the relation between socioeconomic status and self reported back pain in a population based sample of German adults with back pain. *Spine*. 2000;25:1390-1397.
88. Lipton R, Stewart W, Diamond S, Diamond M, Reed M. Prevalence and burden of migraine in the United States: data from the American Migraine Study II. *Headache*. 2001;41:464-657.
89. Hagen K, Bjorndal A, Uhlig T, Kvien T. A population study on factors associated with general practitioner consultation for non inflammatory musculoskeletal pain. *Ann Rheum Dis*. 2000;59:788-793.
90. Blyth F, March L, Brnabic A, et al. Chronic pain in Australia: a prevalence study. *Pain*. 2001;89:127-134 .
91. Smith B, Elliott A, Chambers W, et al. The impact of chronic pain in the community. *Fam Pract*. 2001;18:292-299.
92. Bergman S, Herrstrom P, Hogstrom K, et al. Chronic musculoskeletal pain, prevalence rates, and sociodemographic associations in a Swedish population study. *Rheumatology*. 2001;6:1369-1377.
93. Picavet H, Schouten J. Musculoskeletal pain in The Netherlands: prevalence, consequences and risk groups, the DMC3-Study. *Pain*. 2003;102:167-178.
94. Patel SS, Shah VS, Peterson RA, Kimmel PL. Psychosocial variables, quality of life, and religious beliefs in ESRD patients treated with hemodialysis. *Am J Kidney Dis*. 2002;40:1013-1022.
95. Williams DR, Sternthal MJ. Spirituality, religion and health: evidence and research directions. *Med J Aust*. 2007;186(10 suppl):S47-S50.
96. Berger AS. Choosing to suffer: reflections on an enigma. *J Relig Health*. 2003;42(3):251-255.
97. Steefel L. Treat pain in any culture. Nursing Spectrum-Career Fitness Online. December 19, 2001. <http://community.nursingspectrum.com>. Accessed December 30, 2007.
98. Abushaikh L. Methods of coping with labor pain used by Jordanian women. *J Transcult Nurs*. 2007;18:35-40.
99. Glucklich A. *Sacred Pain: Hurting the Body for the Sake of the Soul*. Oxford, NY: Oxford University Press; 2001:150-180.
100. Lee BY, Newberg AB. Religion and health: a review and critical analysis. *Zygon*. 2005;40:443-468.
101. Dirven R, Verspoor M. *Cognitive Exploration of Language and Linguistics*. Amsterdam, The Netherlands: John Benjamins; 2004.
102. Kugelmann R. Pain as symptom, pain as sign. *Health*. 2003;7(1):29-50.
103. Vlaar AP, Klooster PM, Taal E, et al. A cross-cultural study of pain intensity in Egyptian and Dutch women with rheumatoid arthritis. *Pain*. 2007;8(9):730-736.
104. Chaudakshetrin P, Prateepavanich P, Chira-Adisai W, et al. Cross-cultural adaptation to the Thai language of the Neuropathic Pain Diagnostic Questionnaire (DN4). *J Med Assoc Thai*. 2007;90(9):1860-1865.
105. Henry HL, Stiles WB, Biran MW, et al. Loss and mourning in immigration: using the assimilation model to assess continuing bonds with native culture. *Counsel Psychol Q*. 2005;18(2):109-119.
106. Caldwell NL. The assessment of the influence of ethnicity, acculturation, and explanatory models on pain perception and the resulting impact of primary care patients with fibromyalgia. *Dissertation Abstr*. 2001;6:553-570.
107. Leininger MM. *Culture Care Diversity and Universality: A Theory of Nursing Care*. 2nd ed. Boston, MA: Jones & Bartlett and National League for Nursing Press; 2001.
108. Beach MC, Saha S, Cooper LA. The role and relationship of cultural competence and patient-centeredness in health care quality. *Commonw Fund*. 2006;36:3-21.
109. Charnuff R, Pierce R. Differential effects of therapists' race and social class upon patient depth of self-exploration in the initial clinical interview. *J Consult Psychol*. 1967;31:632-634.
110. Houston L. *Psychological Principles and the Black Experience*. Lanham, MD: University Press of America; 1990.
111. Fadiman A. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York, NY: Farrar Straus & Giroux; 1997.

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