CULTURALLY COMPETENT CARE
Transcultural Differences in Responses to Pain

Expressions of pain vary from culture to culture and may vary from person to person within a culture.

AFRICAN AMERICANS
■ Some believe pain and suffering is a part of life and is to be endured.
■ Some may deny or avoid dealing with the pain till it becomes unbearable.
■ Some believe that prayer and laying on of hands will free a person from suffering and pain.

MEXICAN AMERICANS
■ May tend to view pain as a part of life and as an indicator of the seriousness of an illness.
■ Some believe that enduring pain is a sign of strength.

PUERTO RICANS
■ Many tend to be loud and outspoken in their expressions of pain. This is a socially learned way to cope and it is important for the nurse to not judge or disapprove.

ASIAN AMERICANS
■ Chinese culture values silence. As a result, some clients may be quiet when in pain because they do not want to cause dishonor to themselves and their family.
■ Japanese may have a stoic (minimal verbal and nonverbal expressions) response to pain. They may even refuse pain medication.
■ Filipino clients may believe that pain is “God’s will”. Some elderly Filipino clients may refuse pain medication.

NATIVE AMERICANS
■ In general, Native Americans are quiet, less expressive verbally and nonverbally and may tolerate a high level of pain. They tend to not request pain medication and may tolerate pain until they are physically disabled.

ARAB AMERICANS
■ Pain responses are considered private and reserved for immediate family, not with health professionals. As a result, this may lead to conflicting perceptions between the family members and the nurse regarding the effectiveness of the client’s pain relief.


individuals of northern European descent tend to be more stoic and less expressive of their pain than individuals from southern European backgrounds.

Nurses must realize they have their own attitudes and expectations about pain. Andrews and Boyle (2003) pointed out that health care has been dominated by white Anglo-Saxon Protestants and most nurses have been influenced by these values and beliefs. For example, nurses may place a higher value on silent suffering or self-control in response to pain. Nurses expect people to be objective about pain and to be able to provide a detailed description of the pain. Nurses who deny, refute, or downplay the pain they observe in others may be culturally incompetent (unaware and emotionally apathetic toward others’ viewpoints). To become culturally competent, nurses must become knowledgeable about differences in the meaning of and appropriate responses to pain. They must be sympathetic to concerns and develop the skills needed to address pain in a culturally sensitive way.

Developmental Stage
The age and developmental stage of a client is an important variable that will influence both the reaction to and the expression of pain. Age variations and related nursing interventions are presented in Table 46–3.

The field of pain management for infants and children has grown significantly. It is now accepted that anatomic, physiologic, and biochemical elements necessary for pain transmission are present in newborns, regardless of their gestational age. The American Academy of Pediatrics and the Canadian Paediatric Society (2000) recommend that environmental, nonpharmacologic, and pharmacologic interventions be used to prevent, reduce, or eliminate pain in neonates. Physiologic indicators may vary in infants, so behavioral observation is recommended for pain assessment (Ball & Bindler, 2003). Children may be less able than an adult to articulate their experience or needs related to pain, which may result in their pain being undertreated. However, children as young as 3 years can accurately report the location and intensity of their pain if it is evaluated properly.

With puberty comes the emergence of some pain syndromes, particularly for women. Unfortunately, women are overrepresented in a large number of painful disorders, including headaches, fibromyalgia, lupus, and menstrual-related disorders. Men are more vulnerable to pain related to their occupational or risk-taking patterns, including burn pain, posttrauma pain, and pain related to HIV/AIDS. A needless disparity is that the very young, the very old, women, and ethnic minorities are undertreated for their pain more frequently than their adult male counterparts.

Studies have shown that chronic pain affects 25% to 50% of older clients living in the community and 45% to 80% of those in nursing homes (American Geriatrics Society [AGS], 1998). With the number of older persons in our society increasing dramatically, by 2030, nurses will be caring for elders in all settings of care in greater numbers.

Elders constitute the largest group of individuals seeking health care services. The prevalence of pain in the older population is generally higher due to both acute and chronic disease conditions. Pain threshold does not appear to change with aging, although the effect of analgesics may increase due to physiologic changes related to drug metabolism and excretion (Stanley, Blair, & Beare, 2005).

Environment and Support People
A strange environment such as a hospital, with its noises, lights, and activity, can compound pain. In addition, the lonely person who is without a support network may perceive pain as severe, whereas the person who has supportive people around may per-