

Socio-Cultural Influence on Patients' Reaction to Pain

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THE word 'pain' is not easily defined, and the varied meanings attached to the word give enough warning of the difficulty in explaining the involved complex phenomenon. The origin of the word itself indicates man's view of it. The word is derived from old French "peine" ; from Greek "poine" meaning penalty.

Mankind throughout the world and in all ages has been confronted with the phenomenon of pain. Pain is one of the man's major concerns in relation to suffering. Probably more than any other symptom, pain is responsible for causing the patient to ask for medical help. Thus the importance of the pain to the doctor, to the nurse, and especially to the patient cannot be over-emphasised. Nursing the patient in pain demands all the imagination, knowledge and skill, and all the compassion the nurse has at her command.

Basically, pain is a protective mechanism. It plays an important role in protecting the individual from harm. Because pain occurs whenever a tissue is damaged it causes the individual to react reflectively to remove the pain stimulus.

The study of the pain may be divided into three important parts : perception, subjective sensation and reflex action. Pain is perceived when a stimulus from the periphery (pain receptors are in the skin and in all other tissues as free nerve endings) is sufficiently intense to stimulate a sensory nerve ending which activates the nerve fibre. Studies have shown that the intensity of stimulus needed to cause pain varies with individuals. This extent is thought to be determined by the second pain component, the subjective sensation.

The subjective component of pain cannot be determined quantitatively because it involves both physiological and psychological factors. The perception pain is affected by the personality, attitude and mental state of the patient.

The third component of pain, the reflex action, is important because it may have harmful effects on the body systems. However, although the threshold for recognition of pain may remain approximately the same for all, the degree to which each one reacts to pain varies tremendously.

While pain also causes reflex motor reaction, the psychic reactions to pain are to be more subtle and include all the well-known aspects of pain such as anguish, anxiety, crying, depression, nausea, excess muscular activity, excitability throughout the body and many other emotional expressions. These reactions may vary markedly from one person to another following a comparable degree of pain stimuli and pain perception.

Cultural aspects of human behaviour play an important role in this field. A nurse who does not understand the patients' cultural differences may find certain behaviour of the patients very funny and may often call "neurotic".

When the cultural background of the nurse and patient differ, some common ground of understanding must be established to bring about better nursing care. It is often true that when a person is admitted in the hospital he seems to lose his identity as an individual member of the community and becomes a patient to the hospital staff. He starts to take the sick-role and he views himself as quite a different person from what the nurses and

doctors think of him. Both the patient and the nurse are the products of the culture to which they belong. Their cultural differences are of significant importance in establishing the successful nurse-patient relationship.

Nurses are confronted with a heterogeneous patient population coming from so many different cultural and ethnic backgrounds that it has become a potential source of daily problem in the hospital in terms of communication, understanding and optimum care. Besides the differences in language, religion, dietary practices and habit, various other cultural differences in attitudes, feelings and reaction to illness and pain are also not recognised and understood.

Edward Tyler says that "culture or civilisation is that complex whole which includes knowledge, belief, art, morals, law, customs and any other capabilities and habits acquired by man as a member of society." Linton equates culture with social heredity. Margaret Mead and her associates give the definition of culture as "an abstraction from the body of learned behaviour which a group of people share the same tradition, transmit entirely to their children and to adult immigrants who become members of the society." It appears culture is the learned ways of activity and thinking which are transmitted by group members, and new culture originates through necessity and need.

Family is the primary group that gives the individual not only biological heredity which may be a strong body and mind, or weak body and mind predisposed to certain diseases or forms of determination but also attitudes, beliefs, and certain superstitions that will affect his mode of thinking and

living. As the child grows he learns the ways of his community or the society in which he lives.

The role of cultural patterns in human physiological activity is so great that it may, in specific situations, act against the direct biological needs of the individual, even to the point of endangering his life. A knowledge of group attitudes toward pain is important for an understanding of the individual's reaction as it signifies specific social and cultural phenomenon.

Attitudes towards pain may vary in different cultural groups. Two of the important attitudes are pain expectancy and pain acceptance. Pain expectancy is the anticipation of pain which is unavoidable in a given situation, as in childbirth, in war, etc. Pain acceptance is the willingness to experience pain. This attitude is mostly manifested as an inevitable component of culturally accepted experience. Labour pain is expected and accepted in some cultures, such as in India and some European countries, while in the United States it is expected but not accepted and requires various methods and techniques to alleviate it.

Studies of the cultural influences of pain among Jewish and Italian groups show that individuals of both groups were very emotional in their responses to pain. Both Italians and Jews allow free expression of feelings and emotions by words, sounds and gestures. They are not ashamed of expressions and they admit willingly that when they are in pain they do complain a great deal, call for help, expect sympathy and assistance from others. This behaviour is accepted by both Jewish and Italian cultures. The studies also suggest that medical personnel tend to minimise the acute pain experience of these patients whether or not they have the objective criteria of pain experience.

Studies of the aged Americans indicate that there is little emphasis on emotional complaining about pain. Their reaction to pain was in different patterns; one manifested, in the presence of family members, friends etc., in attempts to minimize pain to avoid complaining and invoking pity. When pain becomes too severe, there is tendency to withdraw and not to freely express reactions such as groaning, moaning crying etc. They manifested, however, true reactions to pain in the presence of professional people be-

cause they felt it was necessary to make appropriate diagnosis.

In my experience of working with patients, I have observed a reaction similar to that of the Italians in Indians. Because most of the people in India view the hospital with fear and as a place of last resort, their reaction to pain is freely shown by groaning and crying. Some try self-control by prayers and performing religious rituals. There is a deep dependency role played by the sick on the family concurrent with the family's willingness to accept a great deal of the responsibility for care and support. Thus the apprehension of pain experience seems to be lessened in the presence of the family members. Faith and passive dependence on God seem to ease the tension associated with pain, and pain is expressed by invoking God's name.

Although studies showed similarities in the different groups in their reactions and attitudes to pain, individual variations are often found depending on the nature of the disease and the personality of the patient. However, there are also other factors which are instrumental in provoking these differences and can still be traced back to the cultural backgrounds of the individual patients. Such variables as degree of modernisation, socio-economic status, educational background, etc. act in co-operation with an occupational factor when a pain affects a specific area of the body. It is also seen that the perception of pain is less in patients who are kept busy with occupational and recreational activities.

The pain perception threshold may be raised or lowered by various methods or as a result of changes at the site of noxious stimulation. Among measures which are capable of raising the pain perception threshold are hypnosis, auto-suggestion, placebos, distraction and analgesics. Pain perception threshold can only be uniformly measured if full consideration is not given to such factors as attitudes, mood, attention, lethargy and suggestibility.

The attitudes towards pain and the expected reactive patterns are acquired by the individual members of the society from early childhood along with other cultural attitudes and values which are learned from the parents, siblings, peer groups, etc. In each culture, parents teach

the child how to react to pain and, by approval and disapproval, they promote specific forms of behaviour. For example, the Jewish and Italian parents, by their over-protective and worried attitudes, foster complaining and tears. The child learns to pay attention to each painful experience and to look for help and sympathy which are readily given to them. But in some other culture the attitude is different. For example, in American family the parental attitude is quite opposite. The child is told not to run to mother for every little thing or hurt, he is told to accept the pain as an adult.

In the relationship between the nurse and the patient, the respective attitudes toward pain play a cultural role, especially when the nurse feels that the patient exaggerates his pain, while the patient feels the nurse is minimising his suffering. The same may be true, for example, in a hospital where the members of the medical and nursing staff may have attitudes toward pain different from those held by the patients or when they expect a certain pattern of behaviour according to their cultural background while the patient may manifest a behaviour of his own culture. These differences may play an important part in the evaluation of individual pain experiences and in dealing with patients.

Therefore a knowledge of the socio-cultural influence on a patient is essential for administering comprehensive nursing care. A nurse must understand that the social influences affect perception of pain in a very marked way. Perception and reaction to pain are clearly dependent upon previous experience, interests, and concern. These in turn are related to the perceiver's occupation, class, education, and so on—in short, to his own social background.

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