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Transcultural Differences in Pain Perception, Expression and Management: A Literature Review

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Abstract

The investigation of transcultural differences in pain expression, perception and management. A review was conducted in Medline/PubMed, Cochrane, Scopus, and Google Scholar from 1999 to 2014. Inclusion criteria were: English language, direct relation to the topic and methodology quality. Data independent extraction was performed by 2 authors from 14 finally selected original studies. The physical pain is more easily verbally expressed by Filipinos. The Afro-Americans have lower pain threshold. The use of opioids is not always acceptable (Africa,Saudi Arabia,Afrikaans). Herbals (Asians,Saudis), prayer (African Americans), and different kind of music are used for pain management. Racial related biases in pain assessment/management were reported. Healthcare professionals should be trained in order to perform a culturally effective pain assessment and management.

Keywords: pain, cultural, transcultural differences, pain treatment, pain expression, nursing.

1 Introduction

Pain is a symptom in many medical conditions and one of the most sited reasons for seeking medical assistance [1]. It is claimed that assessment of severe pain is necessary for the diagnosis and the effectiveness of treatment [2].

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According to McCaffrey and Beebe, 1989 “pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does". Physical examination is designed to evaluate the pain symptoms and the anatomical path of pain. The laboratory tests and diagnostic tools, such as questionnaires [3] (DN4, Pain Detect, McGill, etc.) and pain scales (Neuropathic pain scale, VAS, etc.) are usually applied in order to help in nursing interventions, which include the following: a) pain alleviation, b) stress reduction, (c) dealing with the consequences of pain and d) patient, family or friends’ education, when the patient has to follow the advices on quotidian life, after his discharge [4].

An effective communication with patient and family contributes to an appropriate assessment of the patient’s problems and develops an individually focused care plan for nursing intervention. The knowledge and the evaluation of racial cultural behavior are essential for the nursing care, which has to be appropriately adapted to an individual’s cultural background. Unfortunately, data have shown that there is a lack of evidence about the above issue.

2 Objectives

Specific objectives of this review were to investigate and evaluate factors affecting the perception and expression of pain in relation to patients’ cultural background and to detect the peculiarities and preferences of pain treatment in different ethnic groups. This review aimed to identify the appropriate ways for individuals’ transcultural approach and for culturally effective pain management.

3 Methods

A literature review was conducted in Medline/PubMed, Cochrane, Scopus and Google Scholar from 1999 until 2014. The key words used in the literature search were “pain", “cultural” "transcultural differences”, “pain treatment”, “pain expression” "nursing” and their combinations. The inclusion criteria were a) studies directly related to the topic (pain expression or treatment in different ethnic groups) b) studies in English language, published in journals with peer review system and c) clear methodology including significant outcomes. The search strategy revealed 50 studies. Thirty six were excluded and finally 14 original research studies were suitable for inclusion.

The identification and data extraction was performed by two reviewers. A data extraction sheet was developed with the following template: name of the first author, country of origin, year of publication, research design, aim, characteristics of participants, sample size, data collection method or instrument and, finally, the main results and outcomes. Studies’ selection process is summarized in the flow

diagram (Figure 1).

4 Main Results

The characteristics of selected studies for the review and their summary results are presented in Tables 1 and 2.

4.1 Transcultural differences concerning the perception, expression and pain threshold.

The study of Lovering et al., 2006 showed that there are similarities as well as differences in the expression of pain among cultures. Patients from the Philippines, Saudi Arabia, Irelands and Afrikaans (White colonizers in South Africa, originating from the Netherlands) were more likely to verbally express their body pain. Emotional pain seems to be expressed mainly in patients from Philippines and Ireland, and less in those from Africa and Saudi Arabia. In addition, the study showed that for Afrikaans, pain is a private matter and is not easily expressed to others, such as therapists [5].

In another study, with patients from Somalia, illness, suffering and pain were attributed to different causes such as spiritual, social isolation and grief [6]. In this study, a participant noted that: "The cause of the disease is the way of life here. There is more stress, depression and lack of sleep. We are isolated in our own world. All these are worsening our health". In addition, the participants have stated and sometimes emphasized, in spiritual explanations for the illness and pain. For example: "sometimes the disease is simply a part of the fate and destiny decided by Allah, so we need to deal with it uncomplainingly." Another participant in a different focus group said: "even if we are very sick we believe that it is coming from Allah, so we pray to Allah". Women in all groups have described the American health care system as "complex" and "difficult to understand". Western medicine generally considers illness and pain as something organic and temporary so as treatment to be addressed to each person individually. However, the majority of all participants in various groups of the above study were looking for holistic health approach and within the general framework of their everyday lives. Moreover Somalia women complained that health professionals do not give adequate time to listen to their problems, a fact that contributed negatively to their situation [6].

The foreign language and communication difficulties are equally important. Patients often fail to communicate their pain because of foreign language. Nurses despite the fact that they want and try to offer their services, it is difficult to deal with the patients' pain and provide the proper care, without the assistance-use of an interpreter. The communication is an important factor in providing transcultural care [6].

Additionally in another study about sensitivity to pain, results showed that women are more vulnerable than men. Also in the same study it was found that south Asians have a higher sensitivity in the perception of pain [7].

In the study of Portenoy et al., 2004 relationships between chronic pain and race or ethnicity were explored. The sample included non-Hispanic white American, African American, and Hispanic participants. White Americans had pain longer but with lesser intensity than the other groups. Also there were racial and ethnic differences in treatment preferences. Significantly fewer Hispanic subjects than white participants or African American subjects had visited a physician for pain, and African American subjects were more likely than white subjects or Hispanic participants to have used prescription medications. Study's results have shown that even if race and ethnicity contribute to clinical diversity, the socioeconomic disadvantage (such as low income, less than a high school education and being unemployed) was more important predictor of disabling pain [8].

However, the research of Ruehleman et al., 2005 revealed that African American and Caucasian adults with chronic pain did not differ significantly in pain severity, interference, emotional burden, or current treatment status. The most frequently mentioned anatomical areas, where they had experienced pain, were the head, bones, joints, neck, back, hips and muscles. The results showed that between the two groups, pain did not differ, concerning the body areas. Nevertheless, differences were detected in different domains of psychosocial functioning. African Americans reported greater pain-related interference with daily life activities, deficiencies in coping, and counterproductive attitudes and beliefs, compared to Caucasians.[9].

In another study, African-Americans and Hispanics showed greater sensitivity to artificially induced pain compared to White Americans, especially in pain tolerance. These findings indicate that the race is an important predictive variable, for the sensitivity in artificially induced experimental pain [10].

On the other hand, black and white older adults did not differ on any pain variable (presence, intensity, locations, duration) explored in the study of Horgas et al., 2008. However, the pain had more consequences for the day-to-day life of the black race participants [11].

4.2 Transcultural factors affecting the evaluation and treatment of pain

According to the qualitative research of Im et al., 2009 which was investigated the cancer pain experiences of 4 major ethnic groups in the USA, appeared that there is a lack of communication between patients and health care providers, that makes very difficult the evaluation and treatment of pain; however the specific reasons for those difficulties differ by ethnic group (e.g. language barriers for the most of Hispanic and Asian participants). The results shown that while Whites tried to control their pain and treatment selection process, ethnic minorities tended to minimize and normalize their pain. White patients sought out diverse strategies of pain management and wanted to treat their cancer pain using

Western medicine. Ethnic minority patients tried to maintain normal lives and use natural modalities for pain management. Especially Asian participants thought that pain was a universal human experience that should not be emphasized at all and they wanted to reduce pain in natural ways instead of treating it aggressively through Western medicine. Finally, the pain experience of White patients was highly individualistic and independent, while that of ethnic minority patients was family-oriented. Although, differences among cultural origins, religions, etc, should not be obstacles for the management and treatment of pain it seemed that health care professionals have little knowledge of the prejudices associated with the underrepresented sex, race and age, and that patients have the misconception that only somebody of the same race would provide them the best health care [12].

Transcultural differences in pain management and treatment were also investigated in the study of Lovering, 2006. The use of herbal therapies and traditional healers were very similar among patients from Philippines, Asia, and Saudi Arabia, but were limited in the Afrikaans culture. Also, faith healers were used in the Filipino, Asian, and Irish cultures, whereas religious healing was prominent in the Saudi culture. The use of narcotics for pain relief was not acceptable in the Afrikaans due to the belief that narcotics are addictive. Additionally, individuals from Saudi culture were strongly against the use of narcotics due to the sedative effect. In the Filipino and Asian cultures also there was a fear of dependence and narcotics were acceptable for pain relief as a last resort. On the other hand, Irish believed that the narcotics' use is acceptable for pain relief, but only in controlled conditions [5].

Furthermore, the study of Good et al., 2000 has shown that music is used in many cultures for therapeutic and religious purposes because of inspiration and consolation which offers, but even if nurses use music therapeutically, they often suppose that all patients will equally prefer the same type of music. According to this study's results, there are cultural differences in music preferences for pain relief. Caucasians most frequently chose orchestra music, African Americans chose jazz, Taiwanese chose harp music, and Chinese prefer music strings similar to lute and zither [13].

In some cases, cultural/racial differences in treatment of pain are associated with socio-economic factors. According to the study of Lavernia et al, 2011 African-Americans, and Hispanics during perioperative period for total hip and knee arthoplast, presented with worse perceived well-being and function of two dependent measures (pain and joint stiffness) compared to whites. A possible cause of this difference could be due to the fact that African-Americans were willing to pay lower amounts for joint pain relief or disability than whites, because of their socio-economic situation and insurance status. Furthermore, African American and Hispanic patients were more prone to use of natural remedies, such as prayer, to help in the treatment of arthritis, compared to whites [14]. On the other hand, other data have shown that in the USA, white teens more frequently visit practitioners for pain relief compared to African-Americans, and Hispanics who prefer prescription treatments [8].

Additionally, a study carried out in Toronto-Canada showed that various prejudices on basis of numerous factors such as waiting list, national factors, and health providers' expertise affect patients in minority groups such as Chinese, who prefer care in traditional Chinese clinics rather than use Western health care services [7]. Minorities have systematically received less appropriate treatment for acute and chronic pain compared to whites, independently of the age, gender and intensity of pain. Such inequalities seem to reflect limited knowledge of cultural issues and stereotypes about the suffering and the use of narcotic analgesics [7].

Furthermore, another study which investigated nurses' pain assessment and treatment decisions showed that patients' demographic characteristics and facial expressions of pain were statistically significant predictors of many nurses' pain-related decisions, but practitioners had minimal awareness of biases and a lack of willingness to acknowledge that they may be prominent in decision-making about pain [15].

In accordance with the above mentioned results, another study revealed that African American and Hispanic cancer patients are at risk for under treatment of pain. Physicians underestimated baseline pain intensity and provided inadequate analgesics for more than 50% of the study's sample. Patients' pain education correlated with a significant decrease in pain worst ratings from baseline to first follow-up, suggesting that more intensive education for patients and interventions for physicians are needed [16].

The importance of patient education methods to treat cancer pain effectively and to develop culturally sensitive education material, were investigated in the study of Lasch et al., 2000 [17]. Results have shown that pain treatment preferences as well as responses to pain may depend on a variety of factors such as income, geographical area of origin, contact with mother country, educational level, and recentness of immigration. Cultural groups such as African-American, American Indian, or Asian are often inappropriately considered as one group. Nurses should be trained in working with patients from diverse cultural groups and should use patients' education materials culturally specific as well as linguistically appropriate. The same study revealed 14 culturally based issues that impact pain perception, communication with providers, or patient behavior.

Finally, nurses express a desire for training and education in order to improve their work and help as much as possible patients from different cultures. In particular, the study of Cang - Wong et al., 2009 showed that although most of the nurses seem to understand different cultures, nationalities and religions, there is a need to improve the communication and provision of information to patients. Also, additional training is required not only for nurses but for other health care professionals, as well [18].

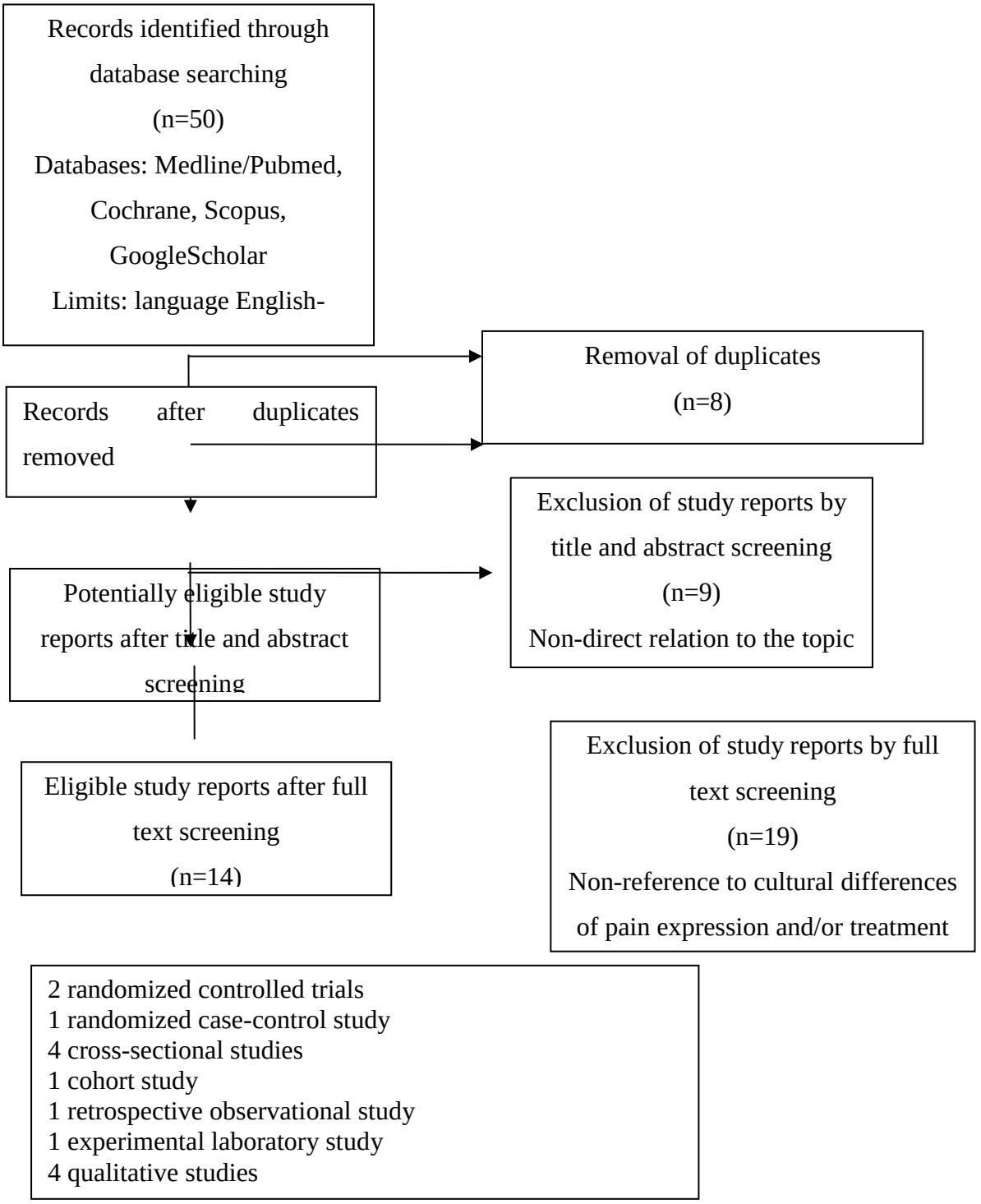

Figure 1:Flow diagram of study selection for the systematic review.

Table 1: Transcultural differences in perception, expression and sensitivity of pain

Study	Aim	Research Design/Sample size	Method/Tools	Results
Williams et al. 2007 **USA**	Assessment of experimental pain sensitivity and perception in 3 ethnic groups	Experimental laboratory study (n = 206 African-American, Hispanic-American and non-Hispanic white healthy adults)	Data collection during three experimental sessions over a 1–2 week period. Sensitivity and threshold range were computed for heat, cold and ischemic pain. Use of the MEIM Questionnaire	African-Americans and Hispanics showed greater sensitivity to artificially induced pain compared to White Americans, especially in pain tolerance.
Lovering et al. 2006 **Saudi Arabia**	Exploration of cultural attitudes toward pain	Qualitative survey (n=10 health care providers/hospital employees and groups consisted of 5 cultural pairs)	Multicultural inquiry group discussions. Use of a discussion guide consisted of 4 subject areas	Asian, Filipino, Saudi, and Irish are more likely to verbalize physical pain. Afrikaans and Tswana patients are stoic and usually deny having physical pain. Emotional pain is expressed in the Filipino, Tswana, and Irish cultures but less in the Asian, Afrikaans, or Saudi cultures.
Pavlish et al. 2010 **USA**	Exploration of immigrants' beliefs about health, pain and the American health care system	Qualitative study (n = 57 Somalia women)	Community based focus groups. Audio interviews	Illness, suffering and pain were attributed to different causes such as spiritual, social isolation and grief. The concept of stoicism aroused through the belief that the disease is part of the fate decided by the Allah. Communication difficulties and the need of an interpreter.
Mailis-Gagnon et al. 2007 Canada	To define gender and ethnocultural characteristics' impact on pain perception, expression and management	Cohort study (n = 1242 Comprehensive Pain Program participants)	Data collection through chart reviews, during a 3 year period.	Women are more vulnerable to pain compared to men. South Asians have a higher sensitivity in the perception of pain.
Portenoy et al. 2004 USA	To explore relationships between chronic pain and race/ethnicity	Cross-sectional study (n = 1335 participants with chronic pain)	Telephone survey. Use of a questionnaire developed by the authors.	Whites had pain longer but with lesser intensity. Significantly fewer Hispanics (68%) than whites (82%) or African Americans (85%) had visited a physician for pain. African Americans (81%) were more likely than whites (75%) or Hispanics (63%) to have used prescription medications. Socioeconomic disadvantage (such as low income, less than a high school education and being unemployed) was the more important predictor of disabling pain
Ruehlman et al. 2005 USA	To detect differences in chronic pain experience and pain	Randomized case-control trial (n =214	Telephone interviews using the PCP:S and PCP:EA instruments	The two groups did not differ significantly in pain severity. African Americans reported greater pain-related interference with daily life activities, deficiencies in coping, and counterproductive attitudes and

	adjustment between non-Hispanic African Americans and Caucasians	African-Americans and 214 Caucasians)		beliefs, compared to Caucasians.
Horgas et al. 2008 **USA**	To explore pain and disability differences between white and black elderly people	Cross-sectional study (n=115 community-dwelling older adults)	A pain questionnaire developed by the authors was used. SIP68 Form was applied to measure physical and social disability.	Black and white older adults did not differ on any pain variable (presence, intensity, locations, duration). However, the pain had more consequences for the day-to-day life of the black race participants.

Table 2: Transcultural factors affecting the evaluation and treatment of pain

Study	Aim	Research Design/Sample size	Method/Tools	Results
Im et al. 2004 USA	To explore transcultural similarities and differences in cancer pain experience	Qualitative **study (n=75 cancer patients)**	Four ethnic-specific online forums. Use of a discussion guide consisted of 9 topics related to cancer pain experience.	The pain experience of White patients was highly individualistic and independent, while that of ethnic minority patients was family-oriented. Whites prefer to treat their cancer pain using Western medicine. Asian participants wanted to reduce pain in natural ways instead of treating it aggressively through Western medicine. Health care professionals have little knowledge of prejudices related to gender, race and age. Patients believe that only somebody of the same race would provide them the best care
Lovering et al. 2006 **Saudi Arabia**	Exploration of cultural attitudes toward pain	Qualitative survey (n=10 health care providers/hospital employees and groups consisted of 5 cultural pairs)	Multicultural inquiry group discussions. Use of a discussion guide consisted of 4 subject areas	The use of herbal therapies and traditional healers were very similar among patients from Philippines, Asia, and Saudi Arabia, but were limited in the Afrikaans culture. The use of narcotics for pain relief was not acceptable in the Afrikaans and Saudi-Arabians due to the addictive and sedative effects. In the Filipino and Asian cultures narcotics were acceptable for pain relief as a last resort. The Irish believed that the narcotics' use is acceptable for pain relief, but only in controlled conditions
Good et al. 1999 [26] USA	To determine the effect of music on postoperative pain and patients' preferences according to their cultural origin	Randomized controlled trial (n=500 culturally diverse patients after major abdominal surgery. 250 of 500 received music)	Pain was measured with the visual analogue sensation and distress of pain scales	Caucasians most frequently chose orchestra music, African Americans chose jazz, Taiwanese chose harp music, and Chinese prefer music strings similar to the lute and the zither
Lavernia et al. 2011 **USA**	To evaluate the effect of gender, race and ethnicity on perceived pain and function after total joint arthroplasty	Quantitative retrospective study (n = 1749 patients with hip or knee total joint arthroplasty)	Data collection from patients' records	African-Americans, and Hispanics during the perioperative period presented with worse perceived well-being and function of two measures (pain and joint stiffness) compared to whites. African Americans were willing to pay lower amounts for joint pain relief or disability than whites, because of their socio-economic situation and their insurance status. African American and Hispanic patients were more prone to the use of natural remedies, such as prayer, to help in the treatment of arthritis, compared to whites.
Portenoy et al.	To explore	Cross-sectional study	Telephone survey.	White teens more frequently visit practitioners for pain relief

2004 USA	relationships between chronic pain and race/ethnicity	(n = 1335 participants with chronic pain)	Use of a questionnaire developed by the authors.	compared to African Americans, and Hispanics who prefer prescription treatments.
Mailis-Gagnon et al. 2007 Canada	To define gender and ethnocultural characteristics' impact on pain perception, expression and management	Cohort study (n = 1242 Comprehensive Pain Program participants)	Data collection through chart reviews, during a 3 year period.	South Asians prefer Chinese clinics instead of western hospitals. Minorities have systematically received less appropriate treatment for acute and chronic pain compared to whites, independently of the age, gender and intensity of pain. There is limited knowledge of cultural issues and stereotypes about the suffering and the use of narcotic analgesics.
Hirsh et al. 2010 **USA**	Evaluation of factors affecting nurse s' pain assessment and treatment decisions	Cross-sectional study via the internet or by the use of a laboratory computer (n= 54 Registered nurses)	Nurses' pain assessment on visual analogue scale after viewing video of virtual human profiles with varied sex, race, age, and pain facial expression Treatment decisions were provided in an open-text format. A demographic questionnaire was used	Demographic characteristics and facial expressions of pain were statistically significant predictors of many nurses' pain-related decisions. Nurses had minimal awareness of biases and a lack of willingness to acknowledge that they may be prominent in decision-making about pain
Anderson et al., 2004 **USA**	Evaluation of the efficacy of a pain education intervention	**Randomized controlled trial** (n= 97 underserved African American and Hispanic outpatients with cancer-related pain)	Culture-specific video and booklet on pain management. Data were collected via: • BPI scale for pain and pain-related interference • Physical and Mental Health Summary Scales of the Short Form (SF) for quality of life • Pain Control Scale of the Survey of Pain Attitudes • Physician Pain Assessment Survey	Patients' pain education correlated with a significant decrease in pain worst ratings from baseline to first follow-up. Physicians underestimated baseline pain intensity and provided inadequate analgesics for more than 50% of the study's sample. More intensive education for patients and interventions for physicians are needed
Lasch et al. 2000 **USA**	Treatment of Cancer pain and communication with patients	Qualitative study (n=70)	11 Focus Group composed of 2-11 patients and 1 or more nurses Taped interviews	The study revealed 14 culturally based issues that impact pain perception, communication with providers, or patient behavior The income, geographical area of origin, contact with the mother country, educational level, and recentness of immigration influence pain treatment preferences as well as responses to pain. Cultural groups such as African-American, American Indian, or Asian are often inappropriately considered as one group. Nurses should be trained in working with patients from diverse cultural groups and should use patients' education materials

				culturally specific as well as linguistically appropriate.
Cang-Wong et al. 2009 USA	To explore nurses' experiences of culturally different patients care.	Cross-sectional study (n= 111 Registered nurses)	Use of a questionnaire developed by the authors with multiple choice and open-ended questions	The majorities of nurses understand the different cultures, nationalities and religions. They expressed a desire for more training and continuing education, exposure to more diverse cultures, and availability of more interpreters.

5 Discussion

This review explored the transcultural differences related to pain expression and treatment and revealed very interesting findings. Most of the articles retrieved through data bases search, originated from the USA. This can be attributing to the fact that the United States is the most culturally diverse country in the world and includes approximately 100 racial, ethnic, and cultural groups [19]. The sample size of the articles reviewed wasn't large; however the sample size of the participants in the studies reviewed was adequate and in some studies was very large. In addition, most of the studies included were published during the last 5-8 years, thus can be considered up to date. Based on the inclusion criteria applied, such as the clear methodology and the significant outcomes, the validity of the review was strengthened.

Existence of cultural differences in the expression, treatment of pain and need for intercultural education in the area of health have been revealed through this review. However, some obstacles have been emerged from the review of literature, which are divided into three categories.

The first category concerns the structural obstacles namely the way that is structured the health system. One of these is the lack of linguistic communication due to the lack of an interpreter. For example many Somalia women do not trust healthcare providers, while others expressed disappointment because there was no interpreter [6].

The second category focuses on the lack of intercultural training of health personnel. The majority of nurses understands the different cultures, nationalities and religions, but also expressed a need for more training and education [20].

Lastly, the third category, beliefs and prejudices of both patients and health care professionals, can be obstacles to the proper management of pain. Some studies have aimed to raise awareness of diversity in relation to gender, race and age for the evaluation and treatment of pain [20].

As regards, interpretation of disparities in the treatment of disease and pain, some researchers have tried to attribute them on tribal characteristics of each population. This approach, however, has to overcome the racist interpretations, which might be occurred, instead of the cultural characteristics that are more reliable. We have found large differences in the behavior of various groups, who although, they live in the same area and not differ racially value cultural, social and other peculiarities [21].

Anderson et al., 2004 in a randomized clinical trial of ninety-seven underserved African American and Hispanic outpatients with cancer-related pain showed that physicians underestimated the baseline pain intensity and provided inadequate analgesics for more than 50% of the sample, even though patient of the control group have received pain management education [16].

In another study, Lofvander M., 1999, twenty-six first generation immigrants - Turks and Southern Europeans -with long-standing musculoskeletal

or imprecise pain were studied. A difference was found concerning the meaning of pain, where interviewees focused on a disorder for pain and sensation itself [22].

In some cultural groups, such as Chinese, asking for assistance is considered to be lack of respect. If a patient asks nurse for pain medication may be viewed as taking the nurse away from more important duties. A patient may consider nurse as a professional who will know the needs without being told and thus wait passively for pain medication expecting that if it is needed it will be provided [23].

Therefore, the reaction for the disease and the pain connected with global value systems, beliefs and the ways cultural expression, prompting people to behave in a very different way when exposed to different situations. In other words, is reflected a significant lack indulging to the fact that in different cultures and social areas the concepts of health and disease can be differentiated, indicating simultaneously substantial changes and transformation in content than those which define and describe. Simultaneously, there is research indifference in sociological observation that the concepts of health and disease associated with expression and result in social and cultural mediation. So, very often, on a backbreaking daily medical or nursing practice, the theoretical concern for reestablishment intercultural information and sociological reflection seems to be bypassed in favor of logic method. This one-dimensional perception has not met of great importance to the value of the interdisciplinary investigation and the combination of scientific examples and methodological tools that can lead to proper management and treatment of pain [20]. There are similarities and differences in the expression of pain. The bodily pain is expressed with words more easily from people belonging to certain ethnic groups (such as Philippines and Saudi Arabians, while others show greater reluctance considering a sick condition as private matter which is not concern third parties). The above situation must not distract the health personnel from the severe pain the patient may fell.

Patients from different origins have different ideas, even on the causes of the pain. The socio-economic differences and their impact should not be ignored as the personal perceptions of health different beliefs, way of life in general, the different perception of time which should be devoted to understand the health condition in which has made the patient, the different languages, which makes it difficult to communicate, the prejudices from both sides of patient and healthcare professional, the social situation of the patient, gender, and religion that may be different. More specifically, individuals, who belong to ethnic minorities with different socio-economic status than white people, having fewer economic opportunities and non-quantified to withstand the economic costs of accuracy for their own medical service, is less willing to take it into account, even if it is necessary and recommended. So using natural "remedies" such as the prayer for the treatment of the eye is discovered or suspected, as serious as this illness. Also a significant role plays the place of origin and provenance as to the greater confidence and trust in therapists and religious treatment, showing patients from Asia and Ireland origin and Saudi Arabia in contrast to Afrikaans.

Furthermore, the music is important in many cultures for the treatment and relief of pain. While, the facial pain of patients is an important alternative factor for the evaluation and therefore the administration of pharmaceutical treatment. The gender, age and race is to a lesser extent. In contrast, the facial pain does not appear to affect significantly the nurses in making decision, regarding the administration of non narcotics.

Many time the beliefs of both patients and health professionals' prejudices; can be an obstacle to the proper management of pain. General prejudices in relation to gender, age and race for evaluation and treatment of pain make difficult the work of nurses and health care providers.

The communication is an important factor in providing care to painful patients, and the use of an interpreter is necessary. The health staff must be given appropriate intercultural education that can approach painful patients in a more efficient.

5.1 Study Limitations

Although there are numerous studies addressing the issue of pain perception and management, there are several limitations inherent in these studies and wide variations between studies in a number of areas. Those include study design, length of observation and the sample size of the articles reviewed wasn't large.

6 Conclusions

In conclusion, the findings of this systematic review highlighted the fact that the culture can be an important variable for the national-racial differences related to pain.

The intercultural differences regarding the perception, expression and resistance to pain, as well as the transcultural factors affecting the evaluation and treatment of pain, must be taken seriously as a reality which all healthcare professionals will be confront with (if they have not already) sometime during the course of their professional career. This clear fact originated from various studies and investigations which is a challenge that the 'western' health system will take account of and respond to the performance of increasingly requires obligatory informed and effective provision of health services.

7 Clinical Implications

In clinical practice it is important to make changes in intercultural education, which will improve the assessment and treatment of suffering patients from another race or from a different culture. More specifically, the presence of an

interpreter both in areas of primary and secondary health care systems is essential for ensuring communication between health providers and patients.

In order to evaluate the pain with culturally sensitive manner, the health care professionals in the decision making process, should take into account the national origin and the cultural beliefs of each patient. So they can manage and treat patients using specific standards-models from the existing types of intercultural nursing care (e.g. the model of intercultural evaluation of care [24,25].

Furthermore, the use of Intercultural mediator in all levels of health care will contribute to better understanding of suffering patients (e.g. in black race using analgesics is undesirable).

Conclusively, in health care institutions should be created programs of activities related to different communities, offering courses and seminars on different cultures and having active cultural education program targeted at all. These activities will be provided experiences and programs which will help clinicians to become more sensitive to differences between cultures in clinical practice.

8 Research Directions

The bibliographic data indicate that nurses derive their knowledge from a large extent on previous experience, including the experience of family, friends and colleagues from different cultures. We, also, note that during nursing education is necessary to prepare trainees for working with different populations. The well-trained nurses in combination with their experiences in the care of suffering patients from other cultures can approach, manage and deal with them using a standard model intercultural nursing care.

Therefore, future investigations must be carried out by health care institutions and examine the impact of training on Intercultural care not only for nurses, but also for other health professionals: Moreover institutions must provide new activities relating to Community programs offering courses or seminars on different cultures and having active cultural education program targeted at all.

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References

[1] Leininger, M. Quality of Life from a Transcultural Nursing Perspective. *Nurs Science* 1994,Q7,7-22.

[2] Helman, C.G. Cultural aspects of time and ageing. Time is not the same in every culture and every circumstance; our views of aging also differ. *EMBO Rep. 6* Spec 2005,No,S54-58.
[3] McCaffery, M., Beebe, A. Pain : clinical manual for nursing practice. *C.V. Mosby, St. Louis.*1989
[4] Herr, K.. Neuropathic pain: a guide to comprehensive assessment. *Pain Manag Nurs*, 2004,5 (4 Suppl 1), 9-18.
[5] Lovering, S. Cultural attitudes and beliefs about pain. *J Transcult Nurs.* 2006,17(4),389-95.
[6] Pavlish, C.L., Noor, S., Brandt, J. Somali immigrant women and the American health care system: discordant beliefs, divergent expectations, and silent worries. *Soc Sci Med.* 2010,71(2),353-61
[7] Mailis-Gagnon, A., Yegneswaran, B., Nicholson, K., Lakha, S.F., Papagapiou, M., Steiman, A.J., et al. Ethnocultural and sex characteristics of patients attending a tertiary care pain clinic in Toronto, Ontario. *Pain Res Manag.* 2007,12(2),100-6.
[8] Portenoy, R.K., Ugarte, C., Fuller, I., Haas. G. Population-based survey of pain in the United States: differences among white, African American, and Hispanic subjects. *J Pain.* 2004,5(6),317-28.
[9] Ruehlman, L.S., 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(1), 49–60.
[10] Williams, F.B., Riley III, J.L., Herrera, D., Campbell, C., Barbara, A., Fillingim, H. Ethnic Identity Predicts Experimental Pain Sensitivity In African Americans and Hispanics Pain. *R B*, 2007,129(1-2),177–184.
[11] Horgas, A.L., Yoon, S.L., Nichols, A.L., and Marsiske, M. The Relationship Between Pain and Functional Disability in Black and White Older Adults. *Res Nursing Health*, 2008,31(4),341–354.
[12] Im Eun-Ok Lee, S.H, Liu Y, Lim, H-J , Guevara, E , and Chee, W. A National Online Forum on Ethnic Differences in Cancer Pain Experience *Nurs Res.* 2009,58(2),86-94.
[13] Good, M., Picot B.L., Salem, S.G., Chin, C.C., Picot, S.F., & Lane, D. Cultural differences in music chosen for pain relief. *J Holist Nurs*, 2000,18(3), 245-260.
[14] Lavernia, C.J., Alcerro, J.C., Contreras, J.S., Rossi. M.,D. Ethnic and Racial Factors Influencing Well-being, Perceived Pain, and Physical Function After Primary Total Joint Arthroplasty. *Clin Orthop Relat Res*, 2011,4691838–1845.
[15] Hirsh, A. T., Jensen, M.P., and Robinson. M.E. Evaluation of Nurses' Self-Insight into their Pain Assessment and Treatment Decisions *Journal Pain*, 2010,11(5),454–461.
[16] Anderson, K.O., Mendoza, T.R., Payne R., Valero, V., Palos, G.R., Nazario,

A., et al, Pain education for underserved minority cancer patients: a randomized controlled trial. *J Clin Oncol*. 2004,15,22(24),4918-25.

[17] Lasch, K., Wilkes, G., Montuori, L.M., Chew, P., Leonard, C.S. Hilton, S. Using focusgroupmethods to develop multicultural cancer pain education materials. *Pain Manag Nurs.* 2000,1(4),129-38.

[18] Cang-Wong, C, Murphy, S.O., Adelman, T. Nursing responses to transcultural encounters: what nurses draw on when faced with a patient from another culture. *Perm J.*, 2009,13(3),31-7.

[19] Kavanaugh, K.H., & Kennedy, P.H. Promoting cultural diversity: Strategies for health care professionals. *Newbury Park*, 1992,CA, Sage

[20] Boruchovitch, E., Mednick, B.R. Departamento de Psicologia Campinas, SPCross-cultural differences in children's concepts of health and illness. Department of Educational Psychology, School of education, University of Southern California. Los Angeles - USA (B.R.M) Rev. *Saúde Pública*, 1997,31 (5),448-56.

[21] Harle, M.T., Dela, R.F., Veloso, G., Rock, J., Faulkner, J., Cohen, M.Z. The experiences of Filipino American patients with cancer. Oncol *Nurs Forum*, 2007,34(6),1170–5.

[22] Löfvander, M. Attitudes towards pain and return to work in young immigrants on long- term sick leave. *Scand J Prim Health Care*, 1999,17(3),164-169.

[23] Davidhizar, R., Giger, J.N. A review of the literature on care of clients in pain who are culturally diverse. *Int Nurs Rev.* 2004,51(1),47-55.

[24] Giger, J.N., Davidhizar, R. Promoting culturally appropriate interventions among vulnerable populations. *Annu Rev Nurs Res.*2007,25,293-316.

[25] Leininger, M. Culture Care Theory: A Major Contribution to Advance Transcultural Nursing Knowledge and Practices. *Transcultural Nursing Journal*, 2002,13(3),189-92.

[26] Good, M., Stanton-Hicks, M., Grass, J. M., Anderson, G.C., Choi, C.C., Schoolmeesters, L., & Salman, A. Relief of postoperative pain with jaw relaxation, music, and their combination. *Pain*, 1999,81(1-2), 163-172.