

Cultural attitudes / beliefs about pain: A collaborative inquiry journey

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Introduction

Action inquiry is an umbrella term used to describe any kind of plan, act, describe and review cycle for inquiry into action in a field of practice (Masters, 1996; Tripp, 1995). Collaborative inquiry is a form of action inquiry which focuses on repeated episodes of reflection by the inquirers within a group. Rigorous reflection within a process of social interaction is a method by which inquirers explore the inquiry question through their own experience and the experience of the others. Seeking to understand and make meaning of their own experience and the experience of others is one of the key differences between collaborative inquiry and action research (Heron, 1996). As explained by Bray, Lee, Smith and Yorks (2000), “collaborative inquiry is research based on personal experience” (p. 7).

This article presents the experiences of a collaborative inquiry group exploring cultural attitudes and beliefs about pain through repeated cycles of planning, action, and reflection. A summary of the knowledge shared by group members and reflections based on a journal by the facilitator assists in making sense of the collaborative inquiry experience and the transformation of data to knowledge.

The context for this inquiry project is a hospital in Saudi Arabia where a multicultural foreign and local health care team delivers care to Saudi nationals. An interest in the attitudes and beliefs about pain as held by the diverse cultural groups delivering care, and the Saudi patients led to the formation of a collaborative inquiry group drawn from this diverse cultural team.

Collaborative inquiry

Collaborative inquiry is derived from Heron's (1996) model of cooperative inquiry, where researchers use a series of cycles of action and intentional reflection to learn about a topic. Collaborative inquiry is defined as “repeated episodes of reflection and action which a group of peers strives to answer a question of importance to them” (Bray et al., 2000, p. 6). Collaborative inquiry treats research as a form of learning so everyone can gain greater

understanding of his or her world, and emphasizes participation and democracy in the research process (Bray et al., 2000). As in all forms of participative human inquiry, working collaboratively with participants in this process is essential. Closely related to collaborative inquiry are participative action research, co-operative inquiry, action science and appreciative inquiry (Heron, 1996).

The key features of collaborative inquiry are repeated episodes of reflection and action, the concept of participants as co-inquirers and co-subjects, and the principle that equality exists and is maintained between members of the inquiry group. Knowledge is constructed from making sense of, or understanding the experiences of the group, through the process of action and reflection. As noted by Bray et al. (2000), this 'making sense' may be internal to the group, or become public knowledge through sharing their findings with the public through writing or seminars.

Cultural attitudes and beliefs about pain

There are many definitions of culture in the literature. This collaborative inquiry group did not seek out a definition of culture to guide discussion, but reflected on their personal beliefs. The concept of culture that best reflects the group beliefs is found in definitions by Hahn (1995) and Ember, Ember and Peregrine (2002). A cultural system is defined as "a coherent set of values, concepts, beliefs, and rules that guide and rationalize people's behavior in society" (Hahn, 1995, p. 66), or "a set of learned behaviors, beliefs, attitudes and ideals that are characteristic of a particular society or population" (Ember, Ember and Peregrine (2002, p. 217). Lasch (2000) noted the impact of culture on health care behaviour: "culture has a vital influence on illness behaviors, health care practices, help-seeking activities, and receptivity to medical care interventions" (p.18).

Cultural background determines how pain is perceived and has meaning, how and whether a person communicates their pain or makes their pain public, and how the person acts or responds to the pain experience (Helman, 2001; Honeyman & Jacobs, 1996; Ramer, Richardson, Cohen, Bedney, Danley & Judge, 1999). Helman (2001) explains that pain is private, and in order to know whether a person is experiencing pain, it must become public through verbal or non verbal signals or behaviors. Social, cultural and psychological factors will determine whether private pain is conveyed as pain behavior, the form of this behavior, the social setting where it will occur, and the response of others to the person's pain experience.

Patients and health professionals bring their own cultural attitudes to the communication and interpretation of the patient's pain experience. In this interaction, it is the health professional's knowledge and attitudes that dominate the response to the patient's experience of pain (Clarke, French, Bilodeau, Capasso, Edwards & Empoliti, 1996; Watt-Watson, Stevens, Garfinkel, Streiner & Gallop, 2001). There is extensive literature about health professional's knowledge and attitudes towards pain and pain management, and the measurement and treatment of acute and chronic pain (Dalton, 1989; Harrison, Busabir, Al-Kaabi & Al-Awadi, 1996; Hiscock & Kadawatage, 1999; Lebovits, Bathina, Hunko, Fox & Bramble, 1997; McCaffery & Ferrell, 1995). There has been little attempt to examine the concept of pain from a cultural perspective, with the few studies reporting inconsistent results (Lasch, 2000).

The collaborative inquiry project

The goal of the project was to learn about the process of action inquiry with diverse cultures through initiation of a collaborative inquiry process. The objectives were to:

- ◆ Plan and initiate a collaborative inquiry project on the topic of cultural attitudes and beliefs about pain using a diverse cultural group
- ◆ Explore the cultural issues that impact on the collaborative inquiry process within a diverse cultural group

The question guiding the group was “what do the different cultures represented within this inquiry group believe about pain?”

The first phase of collaborative inquiry, forming the group, is crucial to the future effectiveness of the collaborative inquiry process. Bray et al. (2000) explain that group members must be passionate about the focus of the inquiry, willing to share their experiences and work with others. Group diversity is important, to ensure breadth of experience which will be the source of knowledge for the inquiry. Membership should range from five to twelve members for diversity and effective group functioning.

Collaborative inquiry requires effective group relationships and communication. This group was drawn from the main cultural groups in the hospital, to include Saudi, Irish, Filipino and the South African cultures of Asian, Afrikaans and Tswana. In forming the group, careful consideration was given to group dynamics. A female only group was formed, as a mixed gender group may have impacted on the communication flow due to cultural attitudes, particularly for the Saudi females. Members were invited to attend, after an explanation had been given as to the objectives of the project, and their interest in the subject confirmed.

Ting -Toomey (1994) presents evidence that cultural variability critically influences cross cultural conflict negotiation. The dimension of individualism - collectivism provides a broad perspective to understanding the impact of culture on collaborative inquiry relationships and communication styles. Individualism is described as “tendencies of a culture to emphasize the importance of individual identity over group identity, individual rights over group rights, and individual needs over group needs” (Ting -Toomey, 1994, p. 361). Collectivism emphasizes “the importance of the “we” identity over the “I” identity, group obligations over individual rights, and in-group-oriented needs over individual wants and desires” (Ibid). In this collaborative inquiry group, there was a dominance of collectivist cultures.

A decision was made to form cultural pairs, with each pair having a nurse or medical person paired with a non medical person. The rationale for this decision was to help the group focus on their own cultural experience, rather than the medical experience of pain for patients. Pairing was intended to support a collectivist culture and facilitate reflection and sharing of cultural experiences. The group had five pairs: Saudi, Filipino, South African Asian, South African Tswana and Western (Irish and Afrikaans). The resulting group experience showed that the deliberate selection and rationale was correct. However, the assumption that the western cultural pair (Irish and Afrikaans) was similar was a mistake. The individuals quickly identified that they did not share similar cultural values about pain, however, they did share a similar individualistic approach to communication.

According to Bray et al., (2000), leadership is a significant issue for collaborative inquiry groups. This group was led by a group facilitator and recorder, who did not fully participate as an analogous co-subject (Heron, 1996). The short time frame for the project did not allow for the group to incorporate different roles for members, such as facilitator and recorder. In addition, the facilitator was in a more senior organizational position to the participants, in a cultural context where some group members would defer to the authority of the position, rather than relate as equal co-subjects.

The collaborative inquiry group experience

This collaborative inquiry was a time limited project conducted over a two month period. The group met on six occasions, and each meeting lasted one and a half hours. The continuous

cycle of planning, action, and reflection guided the experience. The first meeting focused on getting to know each other and the different cultural groups represented. A brief basic introduction to the collaborative inquiry process, and the purpose of the project (to learn about cultural attitudes towards pain, and about collaborative inquiry) was given. A brief formal exercise using a collaborative inquiry reflection tool was attempted, but was a flop if measured by academic standards. This led the facilitator to reflect on how to do reflection with the group. The homework (action) the group agreed to do was to write down the questions they wanted to ask about cultural attitudes towards pain.

The second meeting started with a reflection on the last meeting. Great feedback and insight into the group functioning and interest in different cultural attitudes led into a discussion (action) on 'what is culture', and a brainstorming on 'what do we want to learn about cultural attitudes towards pain'. We finished with 22 questions on our flipchart (action). These questions were later reorganized, grouped under subject headings as summarized in Table 1. The group clarified that they were interested in emotional, physical and mental pain from the personal or cultural view, and not as experienced within the hospital setting. Members of our group designed a tool for recording their answers to the questions by group members (planning).

Table 1: Questions on cultural attitudes towards pain

Experience of Pain	Causes of Pain
How do we express pain?	What causes physical pain?
Is it OK to show pain?	Does the Evil Eye cause pain?
Is there a difference in how people in my culture show pain (gender, age, married, poverty / rich)	Is pain a form of punishment? An opportunity for reward in the afterlife? Or atonement?
Treatment of Pain	Values about Pain
Does every pain justify relief?	Is there 'good' pain and 'bad' pain?
What traditional and other healing methods are used?	What types of pain have a stigma? Are people avoided or marginalized?
What is the impact of religion on treatment of pain?	Do people use pain to seek attention?
Do you seek medical attention or self medicate?	
What are the beliefs about using narcotics to treat pain?	

The next four meetings used a similar approach. Each meeting started with a reflection on the last meeting. These reflections covered similarities and differences in cultural attitudes, group dynamics and feelings about the collaborative inquiry process. In general, there was an infectious enthusiasm for the discovery of knowledge about other cultures, and amazement at the similarities found across many of the groups. The group then discussed each question under the subject area (e.g. the experience of pain). Each pair took a turn in sharing their cultural beliefs, and responding to questions from the group (action). Copious notes were taken by the recorder, to be later transcribed on to a comparative chart for sharing with the group. This comparative chart became the data or record of knowledge for the group. An example of a comparative chart is seen in Table 2, which presents the group knowledge about the "Experience of Pain: How do we express pain?"

Table 2: The experience of pain: How do we express pain?

Filipino	Irish	Saudi
<p>Uses words “aroooy”, meaning feeling discomfort</p> <p>Body language: restlessness, sleeplessness, protect the area</p> <p>Facial: grimace, sadness, close eyes, cry, irritable</p>	<p>Will express pain, don't feel need to `put up with pain', it is okay to use medication</p> <p>Will note pain in the tone of voice</p> <p>Noted generation difference: older generation put up with headaches, various pains</p>	<p>`Similar to Afrikaans'</p> <p>Noted older people are healthier and people from south because of environment</p> <p>Noted differences between single and married women: if c/o period pain, married will express less `we've had babies'</p> <p>New generation allowed to express pain, Older generation won't express pain, as they need to fulfill their duties and work</p>
South African Asian	South African Tswana	South African Afrikaans
<p>Will express pain readily, will say `I'm having pain, especially with physical pain'</p> <p>Much verbal expression, groans and sounds, cry, may use abusive language, some will faint with pain, may crouch down, hold area in pain, tie scarf around head</p> <p>Will take pain medication</p> <p>Generation dependent: older generation more stoic; people in country more stoic; younger generation `will tell if have pain'</p>	<p>Don't verbalize, more facial & body language; withdraw, `not interact' “don't talk about pain'</p> <p>Females will c/o more than males</p> <p>If you verbalize being sick, you are `very sick', but will only say `I'm not feeling well'</p> <p>Noted `new generation' are different, will express more readily</p>	<p>Don't verbalize pain “75% won't tell you, they are silent”</p> <p>Depend on body language to tell if there is pain, or an expression of `not being comfortable'</p> <p>`Do not c/o headache, backache, dysmenorrheal pain'</p> <p>Not allowed to take medication</p> <p>Ladies are stronger, can handle pain e.g. birth</p>

There were similarities and differences in the experience of pain across the cultures. The Asian, Filipino, Saudi and Irish were more likely to verbalize physical pain, whereas Afrikaans and Tswana are stoic and will usually deny having physical pain. Emotional pain will be expressed in the Filipino, Tswana, and Irish cultures, but less in the Asian, Afrikaans or Saudi cultures. All cultures noted the differences between the way pain is experienced and expressed between the rich and poor, as well as changes noted across the generations.

The discussion about causes of pain took us into the world of the evil eye, witchcraft, the power of ancestors and the concept of pain to be tolerated for greater reward in the afterlife. The use of witchcraft and a belief in the evil eye featured in the Filipino, Saudi and Asian cultures, where dispelling the evil eye always involves invoking religion. The Tswana, Afrikaans and Irish cultures did not believe in the evil eye however the Tswana culture noted the power of the ancestors to cause physical pain. It is of interest that medical explanations for causes of pain did not feature in our discussions.

Traditional and other healing methods featured prominently in the majority of cultures for the treatment of pain. The use of herbal treatments, traditional healers found similarities between

Filipino, Asian, Tswana and Saudi cultures. Faith healers were used in the Filipino, Asian, and Irish cultures. Religious healing was prominent in the Saudi culture, while the role of the ancestors was important in the Tswana culture. There was limited use of traditional and herbal treatments in the Afrikaans culture, which is consistent with their beliefs that pain is a private matter, not to be expressed to others, or treatment sought.

The question of 'good' and 'bad' pain brought little response. The stigma of mental pain was a consistent belief across all cultures.

Reflection on the collaborative inquiry experience

The cycles of reflection and action are integral to collaborative inquiry. In our experience, reflection flowed naturally within the discussions, rather than as a deliberate act. On the occasions that the facilitator attempted to inject theory into discussions, or formalize the reflective process by saying 'lets reflect on ...', the reflective process faltered. The use of a naturalistic approach in encouraging the participants to talk about their experience enabled rich data to emerge. The use of 'ordinary talk' rather than formal academic sense making processes is noted as an effective method for action inquiry (Bradbury & Reason, 2001).

Bray et al. (2000) describe three forms of reflection: descriptive, evaluative and practical. Descriptive reflection relates to events and responses to the event experienced by the group. In this group, descriptive reflection occurred at the beginning of each meeting, when reflecting on the experience of the previous meeting. Evaluative reflection critiques actions, thoughts and feelings, as related to the inquiry process. The group engaged in evaluative reflection when discussing how they thought the collaborative inquiry process was working, and how they felt about being a part of the group. Practical reflection is used to guide the future steps of the inquiry. Practical reflection always occurred at the end of each meeting, when the plan for the next meeting was made, as well as at the last meeting when a plan was made for continuation of the project into a second phase.

Storytelling was frequently used to explain a cultural belief to the group. For example, the belief in the evil eye was exemplified by the story of the death of a participant's younger sister. Bray et al. (2000) note that storytelling is particularly valuable when working with diverse groups. From our experience, storytelling was very effective in presenting cultural data, and was a natural form of expression within many of the cultural groups represented. Of importance, storytelling is effective as the starting point for the making of meaning in the experiences of the participants (Ibid).

The aim of collaborative inquiry is to construct meaningful, practical knowledge from the experiences of the participants. As noted by Bray et al. (2000), 'it is a discovery oriented form of inquiry, not a confirming or validating one' (p. 89). The group process enables enriched insights into the experiences of others, from which the group engages in making meaning of these experiences. This inquiry group recorded data which was transformed into knowledge through using comparative charts and repeated reflections on the similarities and differences between cultures. This knowledge will be transformed into public and practical knowledge when the group completes the proposed second phase of the project.

In this project, a collaborative inquiry process was used to gain knowledge about cultural attitudes about pain, using a culturally diverse group. The cycles of reflection and action occurred naturally as part of the discussion and discovery process. In using a naturalistic, rather than academic approach, rich data flowed from the discussions, with the use of storytelling and sharing of beliefs and experiences. The data was transformed into knowledge, through reflection on the similarities and differences between culture and recording the data on a comparative chart for use by group members.

Cultural concepts played a key role in forming and maintaining the group. The concepts of individualism and collectivism assist to understand the dynamics of a culturally diverse group. In our experience, the dominance of collectivist cultures may have contributed maintaining effective group functioning and a cohesive group identity. This in-group focus did not adversely impact on the degree of sharing between members, as the goal of the group was to explore the different cultural attitudes towards pain.

The success of this project is demonstrated in the considerable knowledge generated over the six meetings, and the desire of the group to engage in a second phase to apply the knowledge within the hospital setting, as well as share, or make public their new knowledge. From our perspective, it was a very rich and inspiring process of discovery.

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