

**PAIN ASSESSMENT IN A CULTURALLY DIVERSE
UNITED ARAB EMIRATES CONTEXT**

by

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DECLARATION

I declare that **PAIN ASSESSMENT IN A CULTURALLY DIVERSE UNITED ARAB EMIRATES CONTEXT** is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

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ABSTRACT

The need for nurses to become culturally competent is well documented in transcultural nursing literature. The subjective multidimensional nature of pain makes it imperative for nurses to use assessment methods that are culturally congruent. This study set out to explore the differences and similarities in conceptualization, experience, expression and management of pain between nurses and clients in the United Arab Emirates. The purpose of the study was to develop guidelines in the cultural pain assessment in the UAE context. The findings confirmed that nurses rely on biomedical approaches in assessment and relief of pain; clients were found to rely on the family for emotional support and on nurses for pharmacological interventions. Clients used sensory descriptors, and analogy when describing pain, nurses relied on the technical background and experience. Religious factors had a significant impact on clients' pain behavior. This study offers nurses new insights into cultural assessment of pain.

KEY CONCEPTS

Culture; experience; expression; pain; pain conceptualization; pain management.

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Dedication

*This study is dedicated to my children, Tshinyadzo, Mpho,
Ndanganeni and Rofhiwa*

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GLOSSARY

Bakhoor	Incense burned to cast away evil spirits
Bedaa	New practice not based on religion
Emic view	Data elicited from informants by what they say verbally
Esallam allekum	Peace be with you (Muslim Greeting)
Etic view	Identified by comparing clients' views against observed view
Halal	Describe things that are permitted
Hajj	Pilgrimage of Muslims to Mecca
Haram	Describe things that are prohibited
Hamdullah	Thank god
Holool	Mixture of herbs taken to 'cleanse the blood'
Mashallah	Protective' words used after a praise/congratulations from someone
Motawa	Muslim cleric
Ramadan	Muslims' month of fasting
Salaat	Ritual prayer for Muslims (five times a day)
Shahada	The profession of faith which requires bearing witness to one true God
Tawhid	Physical health is not separate from spiritual dimension
Whudu	State of cleanliness or ablution
Zakat	Alms giving (giving to the needy)
Zamzam	Holy water taken by some locals to protect against evil eye

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Pain is a lived experience, which has physical, emotional, social, spiritual and cultural dimensions to it. As primary care givers, professional nurses play a key role in pain assessment and management. Clinical studies on pain revealed cultural and ethnic differences in pain perception. Moreover, group norms for appropriate pain behaviours influence people's pain perception, interpretation and responses (Morris 2001:12). In culturally diverse health care settings, cultural differences, language problems, and diverse expectations contribute towards making pain assessment and management complex processes. Cultural factors influence professional nurses' abilities in providing meaningful, appropriate and satisfying health care to those in pain.

Professional nurses need knowledge and skills for pain assessment and management within the cultural context (Leininger & McFarland 2002:11). This ethnocentric study on pain assessment was conducted in an acute health care setting in the Abu Dhabi Emirate of the United Arab Emirates (UAE) in the Middle East. The focus of this study was to describe professional nurses' and clients' conceptualisation, experience and expression of pain in the UAE.

1.2 RESEARCH PROBLEM

A research problem is a situation in need of a solution, improvement, and/or alteration (Burns & Grove 2001:102).

1.2.1 Source of the research problem

The world today allows easy and free immigration and emigration. Populations are becoming more and more diverse. Ethnic and cultural diversity is a fact of life for many health care systems, including the health care system in the UAE. This present research study was conducted in Abu Dhabi which is the capital of UAE. The UAE is a multicultural and multi-racial society made up of several ethnic communities. The laws and practices are founded on Islam and the holy Q'uran. Muslims constitute approximately ninety-five percent of the UAE population. There are over 200 nationalities in the UAE, including Indians, Pakistanis, Iranians, Southeast Asians, British, Americans, Africans and Australians. This creates one of the most diverse workforces in the Middle East (UAE Ministry of Health 2002:44).

Abu Dhabi is situated on the South Western side of the Persian Gulf in the UAE (see figure 1.1 UAE map). The UAE is a former British protectorate; that became fully independent in 1971. UAE is a group of seven emirates countries in the South West Asia on the Persian Gulf. It consists mostly of flat desert, with mountains in the east; rich petroleum resources. The language spoken is mainly Arabic. The religion is predominately Muslim. The currency is dirham.



Figure 1.1 Map of the UAE (<http://www.uae-info.com>)

The varied UAE traditions and cultures add to the uniqueness of the region. Emiratis have their own distinct way of life and unique religious practices, and the practice of Islam varies widely across the cultures. The health care setting is therefore culturally diverse. Ninety seven percent of professional nurses in the UAE are expatriates; thirty two percent of the professional nurses are of Asian origin, three percent Emirati, the rest are from Africa, Australia, Europe and America (UAE Ministry of Health 2002:45). Professional nurses in the UAE need to adapt to the local cultures and the diverse cultures represented in the health care setting, and to provide culturally appropriate care to their clients. One challenge that professional nurses are faced with is to understand and care for clients who experience pain in a culturally diverse health care setting. The diversity of

the health workforce in the UAE led the researcher to explore how professional nurses and their clients perceive pain and the expression and conceptualisation of pain, and to identify similarities and differences in their perceptions.

The researcher's observations in the clinical setting stimulated this study. For example, in some units, *Prorenata* (when necessary) post-operative analgesia is often not provided if it is not requested, especially in the male wards. Comprehensive pain assessment is rarely done. The researcher observed that most clients expressed their pain loudly during labour and some expatriate professional nurses responded with a degree of irritability and abruptness to the loud verbal expressions of pain. Some of the clients were not vocal of their pain in the presence of expatriate professional nurses, but when local Emirati student nurses approached them, they vocalised their pain freely. Hence the researcher assumed that these clients did not feel free to vocalise their pain in the presence of the expatriate professional nurses. In paediatric units, some professional nurses stated that they believed that children's pain sensation is different; therefore, they did not give analgesics when performing painful procedures such as dressings. The interaction between professional nurses and clients raised the question of the differences in the professional nurses' and clients' perceptions of pain.

Moreover, professional nurses themselves reported that they were unprepared to manage pain in their clients. The training they received did not prepare them to fully understand culturally diverse clients' pain behaviour and expectations of pain management. The researcher, who has formal training in the field of transcultural nursing, realised that there might be cultural differences between professional nurses and clients on pain perception and pain management, and subsequently identified the need for research. The multicultural health care system found in the UAE poses challenges to the providers of health care who must overcome their ethnocentrism and cultural shock. Professional nurses are expected to be leaders in the provision of culturally competent and congruent care. Based on her observations, the researcher contemplated how professional nurses and their clients view, express and manage pain, and what the cultural similarities and

diversities pertaining to care are. A review of hospital protocols revealed neither policies nor guidelines on culturally congruent care.

In the nursing education setting, the researcher observed that when Arab students had dysmenorrhoea, they verbalised their distress freely, drew attention to their suffering and seemed to enjoy the attention given by others. It was not unusual for a student nurse to stay away from class during this period, and authorities accepted the excuse. The researcher discussed this behaviour with students and noted that it was well accepted in the local culture to turn private pain into public pain.

This study intended to explore pain conceptualisation, experience, expression and management among clients and professional nurses in the UAE. Furthermore, the researcher also determined their culturally unique expectations regarding pain expression and management. The findings of this study would contribute to culturally congruent care in pain management in the UAE.

1.2.2 Background to the problem

Pain is an inseparable part of everyday life, and probably the commonest symptom encountered in clinical practice (Helman 1994:178). Although the physical pain sensation is similar for most people, there are differences in the experience of pain. Both personal and cultural factors are important in the conceptualisation, experience, expression and management of pain. Culture is one variable that permeates human experience. It affects the way people label illness, identify symptoms, and decide whether someone is normal or abnormal. It sets expectations for therapists and clients, and it is the basis from which meanings are derived (Ridley Li & Hill 1998:829). Pain tolerance, experience of pain, outward expression of pain and communication about pain are very different across cultures. Some cultures emphasise the need to save face, for example Chinese and Filipino, whereas others are very expressive of pain. In some regions pain is regarded as a pathway to heaven. In others, it is viewed as a karmic return to past misdeeds. Different beliefs also influence attitudes to pain relief (Ridley et al 1998:830).

Luquis & Perez (2003:133) found that culture influences pain intensity, tolerance, and beliefs about treatment. Culture also determines a person's attitude toward pain, and the extent to which pain is considered abnormal. Each culture and social group, even each family, has its own unique language of pain, its own complex idiom by which ill and distressed individuals make other people aware of their suffering. There is a specific, often standardised ways of signalling, both verbally and non-verbally, that the people indicated that they are in pain or discomfort. The form that pain behaviour will take is largely culturally determined, as is the response to this behaviour (Helman 1994:188). The multiplicity of factors that influence the perception and expression of pain take on special importance in the health care setting, where pain becomes an interpersonal experience between the sufferer and the caregiver. How pain is signified by the client and understood by the nurse greatly determines how it is valued and, ultimately, how it is managed (Post, Bustein, Gordon & Dubler 1996:359).

According to Leininger (1988:155), care and culture are inextricably intertwined. Knowledge of meanings and practices of diverse cultures is essential to guide nursing decisions and actions in providing culturally congruent care. Therefore, health care professionals around the world are faced with the challenge of needing to learn about culturally appropriate health care. An appreciation of the influence of culture on health, illness and care is important if clients are to be managed effectively by professional nurses (Leininger 1996:33). According to Leininger (1996:34,35), professional nurses ought to appreciate the cultural conceptualisation of pain, personal experiences of pain, responses to pain, communication about pain and pain management. They also need to understand biological differences in individual pain experiences and responses. Both health professionals (including professional nurses) and clients bring their respective cultural backgrounds and expectations to the health care setting. These cultural differences can present barriers to appropriate care. Professional nurses are also cultural beings and bring their cultural orientation to the profession.

The profession socialises professional nurses to the biomedical perspective, but they may also hold traditional views towards pain. The biomedical and socio-cultural perspectives on health meet in the nurse-client encounters. Perhaps the expatriate professional nurses in the UAE bring their professionally learned health care patterns and perceptions of pain behaviour to the health care setting and find it difficult to adapt to a culturally diverse health care environment. Their socialisation may have led to ethnocentrism whereby cultural perspectives are viewed as inferior to the biomedical perspective.

Leininger (1988:156) points out that the biomedical perspective is “scientific, rational and technical. Disease, including pain is explained in terms of mechanical fault.” The professional health care system refers to scientifically based care or cure offered by diverse health personnel who have been prepared through formal programs of study in specialised educational institutions. The socio-cultural perspective considers the influence of socio-cultural factors on the definition of health, illness and care by different cultural groups. The folk health system refers to traditional or local indigenous health care or cure practices that have special meanings and application to heal or assist people. Clients’ world -views affect how they describe their health problems, the manner in which they present their symptoms, who they see for their health problems, how long they remain in care and how they evaluate the care provided (Leininger 1988:156).

Care, including pain management, always occurs in a cultural context. In each culture, there is a professional and a generic (folk) health care system. The nursing system is a major part of the professional system. Nursing care provides a bridge between the folk systems and professional systems (Leininger 1988:158). Leininger (1996:32-35) points out that professional nurses use scientific, rational, technical and evidence-based explanations, the roots of which are biomedicine and the Western, scientific world view. The lay care orientation arises from the life context of an individual’s values, beliefs, life experiences and health practices. Lay care systems are concerned with meeting people’s affective and anticipatory needs. Illness is viewed within an individual life context, which means that the words or the stories people tell about their life situation play an important role in care. Therefore, clients who experience care that fails to be reasonably congruent

with their beliefs, values and caring ways of life will show signs of cultural conflict, non-compliance, stress and ethical moral concerns.

With regard to pain, professional nurses can use their unique position in the professional health care system to enable them to learn about the meaning, expression, and management of pain from their encounters with the clients. This would enable them to render cultural congruent care. Leininger & McFarland (2002:128) define culturally congruent care as “respectful, meaningful and competent care to people of diverse cultures that leads to health and well-being or to face death or disability of individuals and groups”. Cultural care maintenance, cultural care accommodation and cultural care re-patterning are the three dominant modes that guide nursing actions in order to provide culturally congruent care (Leininger & McFarland 2002:129). Cultural care maintenance refers to facilitative and supportive professional actions professional nurses undertake to assist clients of a particular culture to maintain health care values for their health, restoration of health or dealing with death. Cultural care accommodation refers to professional actions that help clients to adapt or renegotiate health care practices. Cultural re-patterning means supporting clients to re-order, change or modify their lifestyle for new beneficial health care outcomes (Leininger & McFarland 2002:84). These actions could be implemented singularly or combined depending on the clients’ unique health needs. Professional nurses work with clients to identify culture-specific care in relation to the three nursing modes.

Culturally congruent care requires that professional nurses have knowledge of the biomedical as well as the socio-cultural perspectives with regard to pain conceptualisation, experience, expression and management. Culturally congruent care emphasises provision of care that incorporates the clients’ world-view, health care beliefs and patterns of health care. In the clinical setting, professional nurses are challenged to accurately diagnose clients’ discomforts, needs and problems, establish appropriate interventions and motivate them to comply with the recommended course of treatment.

Professional nurses working in situations completely different from those under which they received their initial training face considerable challenges (Gary, Marrone & Boyle 1998:223). With regard to pain, the challenges are for professional nurses to perform cultural assessment of pain adequately, formulate appropriate nursing diagnoses and negotiate culturally congruent nursing interventions with the clients. Assessment of pain from the cultural perspective is a prerequisite for culturally congruent care to alleviate pain. Professional nurses are responsible for assessing pain in clients and making appropriate decisions whether to or not to give relief, and how to manage pain. Professional nurses ought to use reliable cultural assessment procedures to enable them to negotiate culturally congruent pain management strategies for their clients.

The assessment data form the basis for negotiating with clients, a nursing diagnosis and planning intervention strategies. Professional nurses are responsible for providing an environment in which clients from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options. Confronting their own biases and differences should enable professional nurses to accommodate the cultural practices, beliefs and values of their clients. In the UAE, effective cultural assessment of pain is complex because of the cultural diversity among professional nurses. The UAE has a diverse society, with diverse languages, ethnicities, religions, classes and cultures. While knowledge of cultural diversity is vital at all levels of nursing practice, the level of professional nurses' preparedness in transcultural care is unknown.

Blank, Madder, Wolfe, Keyes, Kischer and Provo st (2001:329) evaluated assessment and management of pain in health care settings, and found that documentation of pre- and post-treatment pain assessment was virtually non-existent. More than sixty percent (60%) of clients discharged experienced more pain than they were willing to accept. Carr (1999:46) indicated that pain assessment is frequently inadequately conducted and poorly documented. Professional nurses often sanction some actions that indicate pain and not others; or may be unaware of their clients' forms of pain expression. It is needless to say that ineffective pain assessment invariably leads to ineffective pain management.

With regard to a knowledge deficit in factors associated with the cultural significance in pain management, Somer (2001:236) found that nursing education programmes do not provide sufficient time dedicated to transcultural pain management in their curriculum. This skill is largely learned in the clinical settings. This may lead to a haphazard approach towards pain management in culturally diverse health care settings, as pain management would be done without basing it on sound transcultural nursing knowledge. Furthermore, this could lead to stereotyping of clients, and thereby providing care that is not acceptable. Andrews & Boyle (1999:27) posited that every human being is basically ethnocentric, and people subconsciously tend to view other people by using their customs as standards for judgment. However, pain management should be appropriate, given the biological needs and cultural orientations of clients. This entails being ignorant about other cultural systems or with an unquestioning belief in the superiority of one's own. It has been shown that in an international environment such as the UAE, patriotic loyalties are magnified, for many, ethnic and cultural diversity results in uncertainty and stress that perpetuate clinging to the familiarity of one's own culture and nationality (Gary et al 1998:222).

1.3 PROBLEM STATEMENT

In the UAE, values, beliefs and practices associated with the biomedical and socio-cultural (especially religious) perspectives, influence pain conceptualisation, experience, expression and management. For Muslims, religion provides the framework that directs every aspect of human behaviour (own observation). It is therefore likely that they adopt a religious perspective on pain. On the other hand, cultural differences may exist between the clients and the expatriate professional nurses who render nursing care to clients in pain. These professional nurses also from different cultural orientations and their cultures may influence their pain perception. Furthermore they have been trained to view pain from a scientific perspective. In addition, each client probably reacts uniquely to pain. Any misunderstanding between professional nurses and clients about pain and pain management could compromise the goal of rendering effective and culture congruent

care. The possibility exists that professional nurses adopt an ethnocentric approach towards pain in an effort to deal with the cultural influences in the health care setting. They may resort to what they have been trained to do, namely, to manage pain scientifically and technically. This can lead to culturally inappropriate care, leading to dissatisfaction among clients and their families.

Professional nurses in the UAE, although well trained to deal with physical pain, may lack knowledge on their clients' pain perceptions. The researcher recognised the need for research in order to explicate the clients' and the nurses' perceptions, and to describe the cultural similarities and diversities. The researcher therefore intended to examine the cultural similarities and diversities with regard to pain conceptualisation, experience, expression and management between the professional nurses and their clients. This knowledge can be disseminated to professional nurses and used to guide professional nurses to render culturally congruent care.

The problem statement (stated in interrogative form) for this study was:

What are the culture care similarities and diversities between professional nurses and clients with regard to pain?

To address the research problem the researcher intended to answer the following questions:

- What are the differences and similarities between the professional nurses' and clients' views on
 - the nature and meaning of pain
 - the cause(s) of pain?
- What are the differences and similarities between the professional nurses' and clients' views on:
 - emotional reactions to pain
 - verbal and nonverbal expression of pain
 - care and care practices to alleviate pain?

- What are the differences and similarities between the professional nurses' and clients' expectations of pain management?

1.4 SIGNIFICANCE OF THE STUDY

The researcher envisaged that this study would contribute to professional nurses' cultural awareness and knowledge, which are essential prerequisites for cultural competence. It would enhance professional nurses' understanding of how cultural beliefs and practices influence their own and their clients' responses to pain, and their expectations of pain management. Professional nurses' increased awareness of the similarities and differences between their own and their clients' perceptions on pain will enable them to identify their biases and accept differences. Clients of health care will benefit through professional nurses' improved cultural competence in pain management, which forms the basis for rendering culturally congruent care. The provision of culturally congruent care has the potential to improve care outcomes and the efficiency of health care delivery. Health policy makers will be in a position to provide in-service training in culturally congruent interventions to alleviate pain.

A one-sided focus on a biomedical perspective on health, sickness and care is no longer adequate. Rigorous qualitative research on the ways in which culture shapes pain in the Western biomedical sense is limited. The author further states that qualitative research on the relationship between ethnic race and pain raises questions than answers (Lasch 2002:1). This study will provide an in-depth knowledge of pain assessment within the cultural context.

One of the greatest challenges for professional nurses is to discover how culturally based care factors can make a difference in providing meaningful, appropriate and satisfying health care to those in pain. To achieve this goal, professional nurses need knowledge and skills to conduct cultural pain assessments and to manage pain (Leininger & McFarland 2002:11). The nature of transcultural nursing requires a comparative focus to

know patterns, expressions, values and ways of life in and between cultures (Leininger & McFarland 2002:10). Discovering how and why cultures are alike and different with respect to care, health and illness provides new sights to advance transcultural nursing. Classic studies on pain and culture have described how group norms for appropriate pain behaviour influence pain perception, interpretation and response. Research has not produced consistent results on the relationship between ethnicity and pain. Clinical studies report ethnic differences in pain perception and response, and differences within cultural and ethnic groups as well as between them (Lasch 2002:1). The researcher found little or no data that compares different pain expression and responses in the Gulf region. In this present research study, the researcher intended to contribute towards ...

1.5 RESEARCH PURPOSE

The researcher intended to explore and describe similarities and differences between clients' and professional nurses' perceptions on pain, with specific reference to pain conceptualisation, experience, expression and management. The aim was to develop recommendations to equip professional nurses with the necessary competence to render culturally congruent care to clients who suffer from pain, in Abu Dhabi.

1.6 DEFINITIONS

For the purposes of this study, the following terms are used as defined below:

1.6.1 Client

A *client* is "a person, company, etc who seeks the advice of a professional man or woman; a customer" (Collins English Dictionary 1991:304). Mosby's Medical and Nursing Dictionary (1986:251) defines *client* as "a person who is the recipient of a professional service; a recipient of health care regardless of the state of health; a patient". This study defines clients as adults suffering from pain and receiving care in an acute health care setting in the UAE.

1.6.2 Cultural diversities

The Collins English Dictionary (1991:387) defines *culture* as “the total range of activities and ideas of a group of people with shared traditions, which are transmitted and reinforced by members of the group”. Leininger (1988:154) defines *culture* as “the specific pattern of behaviour which distinguishes any society from others”. The Collins English Dictionary (1991:457) defines *diverse* as “having variety; assorted; distinct in kind”. For the purposes of this study, *cultural diversities* refer to differences, among culturally diverse people, on pain conceptualisation, experience, expression and management based on culturally learned and transmitted beliefs, norms and practices.

1.6.3 Cultural similarities

The Collins Cobuild English Dictionary for advanced learners (2001:1450) defines *similarities* as “features that things have which make them similar to each other (alike)”. For the purposes of this study, *cultural similarities* refers to correspondence, among culturally diverse people, on pain conceptualisation, experience, expression and management based on culturally learned and transmitted beliefs, norms and practices.

1.6.4 Nurse

A *nurse* is “a person, usually a woman, who tends to the sick, injured, or infirm” (Collins Dictionary of Contemporary English (1991:1073). Mosby’s Medical and Nursing Dictionary (1986:783) defines a nurse as “a person educated and licensed in the practice of nursing; one who is concerned with ‘the diagnosis and treatment of human responses to actual or potential health problems’ (American Professional nurses’ Association)”. For purposes of this study, a nurse is an expatriate health professional trained to render health care to clients in acute care settings in the UAE.

1.6.5 Pain

The Collins English Dictionary (1991:1121) defines *pain* as “the sensation of acute physical hurt or discomfort caused by injury, illness, etc.; emotional suffering or mental distress”.

1.6.6 Pain assessment

Assessment refers to “a process of collecting data in order to make a judgment about a person or situation” (Potter & Perry 2000:63). *Pain assessment* is “an attempt to gain an objective understanding of a subjective experience” (Carr 1997:46). For the purposes of this study, *pain assessment* refers to making judgments about the intensity of the pain sensation, how it is conceptualised, experienced, expressed and managed.

1.6.7 Pain conceptualisation

The Collins English Dictionary (1991:333) defines *conceptualise* as “to form a concept, or concepts, out of observations, experiences, data, etc” *Conceptualisation* is the noun which refers to the word used to name a thing or person. Pain conceptualisation, then, means to form ideas about the meaning of pain sensation.

1.6.8 Pain experience

The Collins English Dictionary (1991:546) defines *experience* as “direct personal participation or observation; actual knowledge or contact; to participate in or undergo”. In this study *pain experience* refers to personal involvement with the pain event.

1.6.9 Pain expression

The Collins English Dictionary (1991:547) defines *express* as “to transform (ideas) into words; utter; verbalise; to show or reveal; indicate”. *Expression* is defined as “the act or instance of transforming ideas into words; a manifestation of an emotion, feeling, etc, without words”. *Behaviour* means “manner of behaving or conducting oneself; a specific response of a certain organism to a specific stimulus or group of stimuli” (Collins English Dictionary 1991:141). Waddie (1996:868) states that pain is influenced by “considerable variables, even individuals subject to similar stimuli react differently and reasons beyond the physical response must be considered”. Therefore, the meaning and expression of pain is unique to the individual.” This study defines *pain expression* as representing the pain experience through verbal and non-verbal means.

1.6.10 Pain management

Manage means “to be in charge (of); administer; to succeed in being able (to do something) despite obstacles; to exercise control or domination over”. *Management* means “the technique, practice, or science of managing or controlling; the specific treatment of a disease, disorder, etc” (Collins English Dictionary 1991:947). In this study, *pain management* means a totality of interventions aimed at coping with and controlling pain.

1.6.11 Perception

Perception is defined as a way of regarding, understanding, interpreting, experiencing, conceptualising or viewing something. It is the conscious recognition and interpretation of sensory stimuli through unconscious associations, especially, memory that serves as a basis for understanding, learning, knowing or motivation of a particular action or reaction (Grice, Picton, Deakin 2003:821).

1.6.12 United Arab Emirates (UAE)

The Collins English Dictionary (1991:1678) defines the UAE as “a group of seven emirates in South-West Asia, on the Persian Gulf. It constitutes Abu Dhabi, Dubai, Sharjah, Ajman, Umm al Qaiwain, Ras el Khaimah, and Fujairah.

1.7 FOUNDATIONS OF THE STUDY

This study is founded on the following assumptions and theoretical framework:

1.7.1 Assumptions

Assumptions are “basic premises or principles that are presumed to be true, without proof or verification” (Burns & Grove 2001:46). The study was based on the following assumptions:

- Culture is an invisible and silent participant in nurse-client interactions and has an influence on the type and direction of this therapeutic relationship.
- Perception of painful stimuli, reaction to these stimuli, and health seeking behaviour are culturally determined.
- Professional nurses in foreign assignments or employment apply the biomedical approach to pain management as the main frame of reference, but their own cultural orientations also influence their pain perception.
- There is a fine or almost invisible divide between cultural and religious beliefs in the UAE.
- Knowledge of meanings and practices of clients is essential to guide nursing decisions and actions in providing culturally congruent care.
- Clients who experience nursing care that is not congruent with their belief system will show signs of cultural tension.

1.7.2 Theoretical framework

The study adopted Leininger's Theory of Culture Care Diversity and Universality. Leininger's theory provides a conceptual framework to systematically examine individuals, families, or groups and how their culture influences health care practices. In conceptualising the theory, the central tenet was that care diversities and universalities exist among and between the cultures in the world. The goal of this theory is to explain transcultural nursing constructs and practices. Therefore, professional nurses must take into account the cultural beliefs of individuals, groups and communities to provide effective, satisfying and culturally congruent care (Leininger 1988:152).

Leininger's theory was applied in this present research study to discover what was similar and different about conceptualisation, experience, expression and management of pain among professional nurses and clients suffering from pain. The culture care theory was essential to enable the researcher to elicit the cultural factors which influenced the pain perception of the research participants. The Sunrise Model served as a conceptual framework for achieving this. The Sunrise Model was used as a cognitive map to depict the different dimensions that needed to be covered in the literature review and in data analysis (see Figure 1.2). The Model shows different factors or components that need to be systematically studied or considered during the process of data interpretation (Leininger & McFarland 2002:80).

Leininger's Sunrise Enabler for the Theory of Culture Care Diversity and Universality

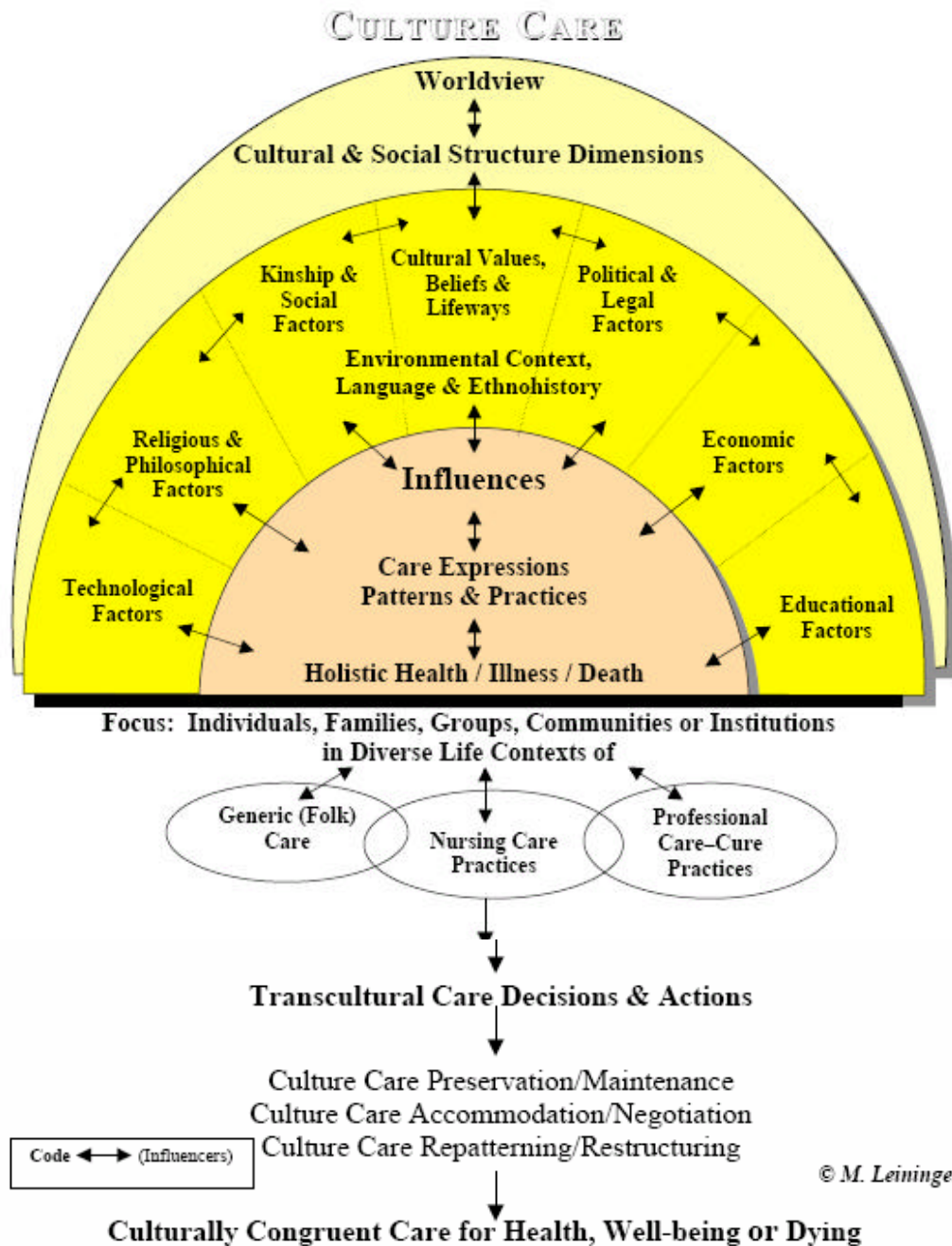


Figure 1.2 Leininger's Sunrise Model (Leininger and McFarland 2002: 80)

Andrews & Boyle (1999:323) define world-view as “a set of metaphorical explanations people give to explain life events, and offer solutions to life’s mysteries, for example such as falling ill or experiencing pain. It refers to the way people tend to look upon the world or universe to form a picture or value stance. A world-view creates security, and helps to attribute meaning to life and to determine which experiences and events are meaningful and which are not.” Thus all beliefs and values regarding pain are derived from a person’s basic world-view.

This theory depicts human beings as inseparable from their cultural background, social structure, world-view and environmental context. From the world-view, a cultural group derives its cultural and social structure dimensions that define their existence. The cultural and social structure dimensions, also referred to as cultural universals, are present in each and every culture. This theory holds that each cultural and social structure dimension is lived and experienced differently from one cultural group to another. The environment, history and language influence these experiences (Leininger & McFarland 2002:79). Leininger (1985:196) identifies the following cultural and social structure dimensions:

- technological factors
- religious and philosophical factors
- kinship and social factors
- cultural values, beliefs and lifeways
- political and legal factors

- economic factors
- educational factors

The world-view and social structure dimensions, together with the ethno-history and language influence cultural care meanings, expressions and patterns in different cultures. They also influence how people view health and illness (including pain) (Leininger & McFarland 2002:83). The social structure dimensions “are closely related to health and care values and practices, and they influence or account for health care differences and similarities” (Leininger 1985:197). This present research study focused on the influences of culture on pain perception, with specific reference to pain experience, conceptualisation, expression, expectations and management. The results revealed the influence of religion and family kinship in the conceptualization and management of pain.

Cultural values, beliefs and ways of life refer to “the learned, shared, and transmitted values, beliefs, and life practices of particular groups that guide thinking, decisions, and actions in patterned ways” (Leininger 1988:156). Religious and philosophical factors include the beliefs systems that reflect the spiritual and world-view.

In Leininger’s theory, clients who receive nursing care are conceptualised as individuals who belong to a particular culture that influence their world view. In this study families are “part of the client as the family is the extension of the self in Islam” (Athar 2004:3)

In every culture there is “evidence of a professional (scientific) and generic (traditional or folk) health care system. The professional health system refers to the professional care or cure services offered by diverse scientifically trained health personnel (including nurses) who have been prepared through formal professional programs of study in specialised educational institutions. Professional nurses learn to use scientific, rational, technical and evidence-based explanations, the roots of which are in biomedicine and the western, scientific world-view. The generic (folk or traditional) care system involves care practices that have special meanings which are grounded in culture. These practices influence illness behaviour, heal and assist people in the home or community” (Leininger

& McFarland 2002:145). Culture care “exhibits both diversity and universalism”, therefore, professional nurses must take into account the cultural beliefs of individuals, families, groups, and communities to provide effective satisfying and culturally congruent care (Leininger & McFarland 2002:10). The basis of the theory is to provide care practised within a cultural context and from a holistic way of knowing and helping people. Professional nurses are therefore in a unique position to synthesise aspects from the generic (tradition) and scientific professional care systems.

Leininger identifies three major care actions and decisions to arrive at culturally congruent care for the general health and well-being of clients or to help them face death or disability (Leininger & McFarland 2002:82). The three modalities guide nursing judgment, decision making and actions. They are an important means to provide culturally congruent care to clients in their own settings. Culture care preservation and maintenance “refers to those assistive, supportive or enabling professional actions and decisions that help clients of a particular culture to preserve and maintain a state of health or to recover from illness” (Leininger 1988:156). This can be accomplished by having knowledge about the social networks, cultural beliefs, family influence and health care practices of a particular cultural group related to pain management. Cultural accommodation or negotiation implies assisting and supporting clients of a specific culture to adapt or negotiate for a beneficial or satisfying health status or face death. Professional nurses can help their clients to adapt to the health care plan negotiated by both the nurse and the client/family or enable the client to negotiate an acceptable health plan (Leininger 1988:156). Leininger (1988:157) defines cultural care repatterning or restructuring as “the assistive, supportive or enabling actions and decisions that help clients change their lifeways for new or different patterns that are culturally satisfying”.

1.8 RESEARCH DESIGN AND METHOD

The researcher adopted a qualitative exploratory approach, applying the ethno-nursing method to describe and compare pain conceptualisation, experience, expression, expectations and management by clients and professional nurses. The population

consisted of expatriate nurses (general informants) and clients (key informants). The professional nurses who participated were expatriates from around the world, and the clients were adult Emiratis who received health care in acute health care institutions and who suffered pain. A non probability purposive sampling was used (See chapter 3 for detailed discussion). Data was collected through unstructured interviews and supplemented with participant observations. Leininger's (1985:52) observation-participation reflection model was as an essential guide to enable the researcher to enter and engage with informants in the health care setting, while collecting data. The researcher gradually moved from being an observer and listener to a participant and reflector (See chapter 3 for further discussion). The four phases of data analysis as described by Leininger's (1991:95) were used. Leininger's & McFarland's (2002:15) Sunrise Model served as an interpretive framework. (See chapter 3 for detailed discussion).

1.9 SCOPE

This study sought to describe and compare pain conceptualisation, experience, expression, expectations and management among clients and professional nurses in the UAE. The study was conducted in female surgical and male medical units of an acute care facility in the Emirate of Abu Dhabi. In qualitative research, the researcher is not interested in generalization of findings, but, to gain in-depth information about the phenomenon. Therefore, the results of this study cannot be generalized but will contribute to culture congruent nursing care in the UAE.

1.10 OUTLINE OF THE DISSERTATION

The structure of the dissertation is as follows:

CHAPTER	CHAPTER HEADING	CHAPTER CONTENT
1	Orientation to the study	The researcher discusses the research problem, the aims of the study, foundations of the study and the research method.
2	Literature review	The researcher discusses aspects related to pain, namely, the biomedical perspective, pain experience, expression and behaviour, cultural aspects, cultural assessment and the need for cultural competency in pain assessment and management.
3	Research design and method	Included are discussions on the research design and method.
4	Research results	The chapter presented the data analysis and data interpretation.
5	Discussion of the research findings, conclusions and recommendations	The chapter concludes the study and make further recommendations for practice and further research.

1.11 CONCLUSION

This chapter outlined the problem, aim and objectives of the study and defined key terms. Chapter 2 discusses the literature review conducted by the researcher.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The researcher conducted a literature review on the anthropological dimensions of pain to examine cultural influences on pain experience, the Islamic view on health, illness, care and pain and, finally, the need for culturally congruent care. It further intends to highlight the biomedical perspective, pain experience, perception, behaviour, cultural perspective, cultural assessment and the need for cultural competence in pain assessment and management.

2.2 PAIN: A BIOMEDICAL PERSPECTIVE

2.2.1 The biomedical perspective on pain

According to Andrews & Boyle (1999:95), professional nurses bring their personal cultural heritage as well as the cultural and philosophical views of their education into the professional setting. However, the dominant reference for professional nurses appears to be their biomedical preparation when implementing pain management interventions. The meaning of pain for both professional nurses and clients can be differentiated through the world-view the care is based on.

The biomedical perspective is based on the idea that health and disease are natural phenomena that exist within an individual's body. The principle of determinism dictates that nature (and disease) can be conquered through experimentation and applying the principles of science. There is a specific aetiology to disease. Once the cause is known the disease can be managed or cured through scientific interventions. Each illness is

believed to have a specific cause (Brown, Crawford & Hicks 2003:4, 109; (Morris 2001:1).

A mechanistic perspective is typically held by those western cultures that maintain a scientific approach to life. According to this perspective a machine is a metaphor for the human body and human functioning. The machine is a metaphor for the human body. The body is controlled by a person's physiology and is capable of being repaired. In this ideology, a person is isolated from his/her social space (Andrews & Boyle 1999:77; Peterson, Heesacker & Swartz 2001:214).

The biomedical perspective is the foundation for rendering health care from a scientific western perspective. This scientific perspective incorporates aspects such as diagnostic procedures, pharmacological preparations, surgical procedures and scientifically developed therapies in an effort to prevent or cure disease and trauma. These procedures, preparations and therapies are the result of carefully conducted research. The focus of care is a disease that is evident through the underlying pathology. The main interest is in a person's body system or an organ affected by microorganisms or any other causative agents (Helman 1994:1988). The person is expected to conform to the physician's regime and the role of the family is to support the patient in complying with medical advice (Peterson, Heesacker, & Swartz 2001:214). The cultural beliefs, values, perceptions and responses to pain and preferences for pain management have received little attention in the biomedical perspective.

The biomedical perspective defines pain in technical terms as, an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Therefore, pain is viewed as a physiological phenomenon that emanates from anatomical structures. The various dimensions of pain assessment have been inferred from verbal reports of pain and pain behaviour, and have frequently been reported in terms of pain intensity, pain location and pain effect (Closs & Briggs 2002:565). From a physiological perspective, pain can be thought of as a signal of tissue damage or physiological malfunction. This approach is related to the assumption that

pain is a universal biological reaction to specific stimuli. Therefore, from the biomedical perspective, it would appear that pain definitions are based on scientific knowledge about the functioning of the human bodily systems. Medical professionals, including professional nurses, occupy a powerful position of 'knowing' about the natural process of pain. They are also knowledgeable on the pain control measures that involve pharmacological and non-pharmacological interventions, which are aimed at restoring the body's physiological equilibrium. To be healthy, then, would mean being free of disease and pain. This view of pain is deterministic in that the cause of pain can be established, and interventions are applied to bring the body to balance (Llewellyn 2003:2).

2.2.2 Definitions of pain

There are various definitions of pain "partly because of the complex nature of pain and partly because of the many different existing perspectives on pain. The term *pain* is derived from the Greek word for penalty which helps explain the long association between pain and punishment in Judaeo-Christian thought" (Andrews & Boyle 1999:284). According to Smeltzer and Bare (2002:175) pain is "an unpleasant sensory and emotional experience resulting from actual or potential tissue damage". The Mosby's Medical and Nursing Dictionary (1986:826) defines pain as "an unpleasant sensation caused by noxious stimulation of the sensory nerve endings. It is a cardinal symptom of inflammation and is valuable in the diagnosis of many disorders and conditions. It is one of the human body's defence mechanisms that indicate that the body is experiencing a problem (Taylor Lillis & LeMone 2004:1195).

The above definitions reveal that pain involves some form of physical and emotional suffering, which is associated with an unpleasant sensation. This sensation is experienced in various degrees by individuals. Pain appears to be a private experience that needs to be expressed in some way for others to be responsive. Therefore the only one who can be a real authority on whether and how an individual is experiencing pain is the individual who suffers from pain.

2.2.3 The pathophysiology of pain

Pain may be classified according to its location, severity and intensity. Some of the terms used to describe it are mild, severe, chronic, acute, burning, stabbing, dull or sharp. In all types of pain, be it acute or chronic, the neurophysiological mechanisms to pain are similar. Pain receptors, the chemical mediators of pain such as the prostaglandins, endorphins, and enkephalins are the chemical receptors responsible for reducing or inhibiting the perception of pain. The dorsal horn of spinal cord has various functions, one of which is the sensory processing of pain receptors (Smeltzer & Bare 2002:179).

Pain management has profound physiological, psychological, ethical and financial implications. Mismanagement of pain contributes to prolonged recovery, delayed healing and patient suffering (Sherwood et al 2000:487). The physiological consequences of acute pain can lead to a systematic downward spiral starting with a general stress response that weakens the body and impairs the recovery process. Unrelieved pain could have adverse cardiovascular changes, such as increased vascular resistance that may lead to angina. The psychological effects of anxiety add to the problem by adversely affecting sleep and furthering the stress response. This may result in depression if allowed to continue. Sleep deprivation, anxiety and depression will exacerbate pain sensation and intensify suffering (Sherwood et al 2000:489).

2.2.4 Pain assessment and management

Only the patient can accurately describe and assess his or her pain. Nurses and physicians consistently underestimate patients' level of pain. Therefore, various pain assessment tools have been used to document the need for intervention or the need for alternatives. One of the tools used is the pain intensity scale, this scale is used to describe pain either as being mild moderate or severe. Visual analogue scales have been used on the level of ten, where the client will rate the intensity of pain between one to ten. The other rating scale for children is the scale where faces are displayed and the child will indicate according the degree of a smile displayed on the face to rate the degree of hurting (Smeltzer & Bare 2002:185).

The biomedical definitions of pain led to the development of several pain assessment tools, such as the McGill Pain Questionnaire, the Wisconsin Brief Pain Inventory, the Memorial Pain Assessment Card and verbal rating scales, which measure intensity, relief, psychosocial distress and functional impairment (Lasch 2002:3). The framework used to develop these tools was based on the bio-psychosocial model of pain. A comprehensive pain assessment needs to reflect the multidimensionality status of pain.

There are other factors, such as culture that influence individual response to pain, therefore, pain assessment requires specific knowledge, understanding, skill and willingness to accept that there are other ways of responding to pain. Nurses need to be knowledgeable about cultural variations and develop an understanding of cultural influences on pain tolerance, expressions, and alternative practices used to manage pain (Taylor, Lillis, & LeMone 2004: 1203).

Professional nurses have a role in pain management. Research by Salanterä & Sirkka (1999:289) has indicated that nurses' characteristics such as age, knowledge, experience, intuition, attitudes and beliefs as well as the nurses' personal experience with pain influence their implementation of the pharmacological and non-pharmacological strategies in pain management.

2.3 PAIN EXPERIENCE, PERCEPTION, EXPRESSION AND BEHAVIOUR

Pain is viewed as a multidimensional phenomenon. The multiple components of pain include:

- the physiologic (concerned primarily with the organic aetiology of pain)
- the sensory (how the person actually feels)
- the affective (feelings evoked due to pain, such as fear and anxiety)
- the cognitive (thought processes, such as meanings attached to pain)
- attitude (implies opinion or way of thinking about pain)
- the behavioural (behaviours related to pain, e.g. coping skills)

- the socio-cultural (values and beliefs)

(Morris 2001:2). A holistic definition of pain would therefore go beyond physiologic response to tissue damage to include emotional and behavioural responses based on the individual's past experiences and perceptions of pain (Andrews & Boyle 1999:285; Morris 2001:3).

Pain experience refers to personal involvement with the pain sensation. Closs & Briggs (2002:566) state that pain is an ageless, universal phenomenon; an unpleasant, multidimensional sensory experience that delivers wide variations in intensity, quality, duration and persistence. The experience of pain combines strong physical, cognitive and emotional components. Physically, different pains with different causes feel different. Moreover, the state of the body influences pain intensity. Many pain textbooks omit to mention the quality of pain experienced by sufferers, even though in some cases this information may aid in diagnosis. Emotions associated with the context in which pain is experienced can have a powerful effect on how pain is felt. (Bates, Edwards, & Anderson 1993:109). Emotionally, pain makes people feel they have lost control because it controls what a person can do. Pain also involves negative feelings associated with the pain sensation, such as fear, anxiety, anger and depression Each factor may affect the sense of well-being and define how pain is perceived and evaluated, which represents people's cognitive involvement with their pain (Bates, Edwards & Anderson 1993:103).

Perception refers to obtaining knowledge through senses (Combined Dictionary and Thesaurus1999:544). Perception is the people organise impulses that they inherit because they are human" (Andrews & Boyle 1999:291). Perception and experience are closely related. People attach meanings to their experiences, such as pain. How someone assigns meanings to the pain experience depends on what is felt, understood and experienced (Sherwood, Adams-McNeill, Starck, Nieto & Thompson 2000:487). Morris (2001:3) emphasises that pain perceptions cannot be defined simply in terms of particular kinds of stimuli because pain is a highly personal experience and unique to the individual. The pain perception of each individual therefore is also unique. When a person contracts an illness (or experience pain), the images, beliefs, perceptions and cognitive schemas define

illness for that patient. The patient uses these constructs to interpret a personal meaning for the diagnosis and to determine her/his ensuing behaviour. In light of its experiential nature, Morris (2001:3) views pain as whatever the experiencing person says it is, existing whenever he says it does. The sufferer is therefore considered to be the authority on his or her pain. Pain is a personal experience and, as such, is always contextually situated (Sherwood, Adams-McNeill, Starck, Nieto & Thompson 2000:487).

Pain experience, perception and toleration are closely related. Bates, Edwards & Anderson (1993:103) emphasise that some people seem to be more sensitive to pain than others. This may be due to individual differences in pain experience and perception. People's experiences and emotions play a major role in how they perceive pain. Their perceptions, in turn, affect the intensity and quality of the individual's experience of pain, and their pain toleration (Andrews & Boyle 1999:291). These constructs have tremendous influence over the patient's decisions about seeking help, namely their health seeking behaviour (Peterson, Heesackerm, & Swartz 2001:215).

Pain expression represents pain experience through verbal or non-verbal reports. According to Showalter [sa]:3 "people attribute meaning to their pain, and what it means to them and those close to them, through personal narratives. There is a sense in which the narratives not only reflect pain experience, but also create it. These narratives form a powerful means of defining, experiencing and expressing pain. Therefore, what pain means to a particular individual or group will be communicated through these narratives. Such narratives would carry shared meanings in homogenous situations, but can give rise to misunderstandings in culturally diverse healthcare settings. These narratives are influenced by the values and norms that guide behaviour and differ from one culture to another. The cultures that tell of their pain will use specific language that is understood by the significant others.

2.4 PAIN: A CULTURAL PERSPECTIVE

All human beings belong to a particular culture. Luquis and Perez (2003:132) refer to Spector's (1996:7) definition of culture as "the sum of beliefs, practices, habits, likes, dislikes, norms, customs, rituals, that people learn from their families". Leininger (1988:152) defines culture as "the specific pattern of behaviour which distinguishes any society from others. Culture shapes illness beliefs and behaviour, health care practices, health seeking behaviour and receptivity to medical care interventions (Taylor et al 2004:1204). Culture care values, beliefs and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion and environmental context of culture. Every human culture has lay folk care knowledge and practices, and some professional care knowledge which vary transculturally.

However, it should be noted that not everyone in every culture conforms to a set of expected behaviours or beliefs. (Andrews & Boyle 1999:285; Morris 2001:3). Therefore, it is important for nurses to be aware of cultural diversities in rendering nursing care

2.4.1 Pain experience, perception, expression and expectations

The **pain experience** for the client and family cannot be understood as an objective event separated from its cultural context. Cultural background appears to have a strong effect on pain, the measurement of pain and pain tolerance. Luquis & Perez (2003:133) found that culture influences both pain intensity and tolerance, it also determines a person's attitude toward pain, and the extent to which pain is considered abnormal. Emotions associated with the context in which pain is experienced can have a powerful effect on how pain is felt. Culture impacts on the pain threshold, which refers to the point which the individual reports that a stimulus is painful. Some cultures may report a sensation as painful, while others would describe it as minor discomfort. People raised in cultures that teach "bite the bullet" report decreased pain experience, while those who focus on their pain become more prone to complain (Bates, Edwards, & Anderson 1993:109). Pain tolerance is defined as the point at which the individual withdraws or asks to have the stimulus stopped. (Andrews & Boyle 1999:285). Zatzik & Dimsdale (1990:546) maintain

that the pain threshold rather than pain tolerance is a more relevant transcultural pain measure since cultural heterogeneity can exist within racial and ethnic groups. Several other factors have been found to decrease the threshold for and tolerance of pain: insomnia, anxiety, fear, anger and introversion. A study on the perceptions of the pain of childbirth in women who lived in North and Central America, Scandinavia, the Middle East, the People's Republic of China and Tonga, revealed a strong association between culture and women's beliefs about and behaviour in connection with childbirth pain. For example, Polish women were far more able to accept pain associated with childbirth than their American counterparts who had access to anaesthesia during labour (Callister, Khalaf, Semenic, Kartchef & Vehvilainen-Julkunen 2003:152).

Bates, Edwards, & Anderson (1993:101-112) assessed pain intensity to determine whether ethnic background was significantly related to inter- or intra-ethnic group differences in six ethnic groups in New England. They found major statistically significant intra-group differences in pain intensity and experiences to be related to difference in generation, degree of heritage consistency and locus of control style. Qualitative data suggested that the locus of control is not permanent; it may be changed by the chronic pain experience. Their study also shows that in many ethnic groups, an increased sense of control may contribute to an increased ability to cope successfully with the chronic pain experience. These findings have significant nursing implications especially in the Arab Muslim context, in the sense that response to pain is a collective issue that involves the family, and therefore, nurses need to include the family in pain management.

In their study of the relationship between pain perceptions and ethnic identity, Ramer, Richardson, Cohen, Bedney, Danley & Judge (1999:95) found no significant differences between Hispanics, African-Americans and Anglos. Moreover, Ramer et al (1999:95) refer to the following studies and their findings: Greenwald (1991:52) found no differences in measures of pain sensation among recently diagnosed cancer clients based on ethnic identity; Neil (1993) found no mean differences in pain ratings between Irish, Italian, Jewish and Black men with acute myocardial infarction; Pfefferbaum, Adams and

Aceves (1990) found similar behavioural responses and pain ratings between Anglo and Hispanic children with cancer.

Pain perception is influenced by culture. Culture is seen as a tool that defines reality for its members, within this reality or worldview, an individual forms categories of meanings including illness, health and pain (Morris 2001:3). This is supported by Luquis and Perez (2003:133) who found that culture influences a person's attitude towards pain, and the extent to which pain is considered abnormal."

Each individual has her or his own unique **pain expression**; which is specific and often standardised ways of signalling that she/he is in pain." Raab (2003:42). The language that people use to express pain is shaped by their culture (Morris 2001:3) Each culture has its own language of distress, which includes facial expression changes in an activity, sounds or words which describe the feeling. Cultural norms determine acceptable ways clients express pain to others. A study on the perceptions of the pain of childbirth in women who lived in North and Central America, Scandinavia, the Middle East, the People's Republic of China and Tonga, revealed cultural differences with regard to pain expression during labour. Chinese women indicated that it was shameful to scream, and Muslim women were verbally expressive. Callister, Khalaf, Semenic, Kartchefand Vehvilainen-Julkunen (2003:152)

Helman (1994:180) states that pain experience "evokes certain reactions in individuals and families. Voluntary reactions to pain include removing the source of pain, taking action to treat the symptom or asking other people for help in relieving the symptom. Therefore, the voluntary reactions involve other people and are influenced by social and cultural factors; this reaction is called **pain behaviour**." The hospital culture, clients' expectations and professional nurses' responses to pain, impact on pain behaviour (Bates, Edwards, & Anderson 1993:109). In the hospital setting, pain becomes an interpersonal experience between the patient and the caregiver. How pain is signified by the patient and understood by the provider determines in large how it is valued and treated (Post, Bustein, Gordon & Dubler 1996:349).

2.4.2 Pain management: cultural remedies and practices

Different cultures have their own distinct set of beliefs and values regarding pain behaviour and management. A study conducted by Moore (1990: 157) found that whilst Anglo-American patients preferred pills and injections, Chinese patients preferred agents such as oils, massage to help them cope with pain. There are various herbs that are used to treat illness including pain (own observation). Other methods of pain relief include cupping, holy water and prayers.

2.4.3 Pain: A religious perspective

- Islamic perspectives associated with pain

Islam, meaning “submission to the will of God”, is a monotheistic religion founded between 610 and 632 AD and based on the revealed word of God to the Prophet Mohammad. Muslims believe in one God, Allah. Muhammad is seen as succeeding and complementing Christ (Andrews & Boyle 1999:421). Muslims believe that the Islamic scripture, the Quran, is God’s revelation to Prophet Mohammad through the angel Gabriel (Ott, Al-Khadhuri & Al-Junaibi 2003:228). Gulam (2003:82) points out that Islam is a religion of peace, mercy and forgiveness, and a Muslim is a person who submits to the will of Allah.

Islam dictates how Muslims should live and forms the basis of community life (Ott et al 2003:228). Islam has five essential practices or Pillars of Faith (Andrews & Boyle 1999:421; Gulam 2003:82), namely:

1. The profession of faith (*shahada*): This requires bearing witness to one true god, and acknowledging Mohammad as his messenger. According to Muslim belief, Muhammad was merely a man and the messenger of God, but was in no sense divine. The confession of faith is uttered on a number of occasions such as birth and death.
2. Ritual prayer (*salaat/salaah*) five times daily: Prayers are fixed sets of standing, bowing, prostration and sitting in worship of Allah. Prayers consist of recitation in

Arabic of prescribed texts at dawn, noon, mid afternoon, sunset and nightfall. The direction of these prayers is the *Kaaba* in Mecca, Saudi Arabia, Islam's holiest city. It is necessary to be in a state of cleanliness or ablution (*Wudhu*) which means that the person and place of prayer must be free of all impurities before one can perform the *Salaat/salaah*.

3. Alms giving (*zakat*) to the needy: This reflects the Quran's admonitions to share what one has with those less fortunate.
4. Fasting from dawn till sunset throughout the month of Ramadan: Many Muslims extend this to oral medication, although according to Islamic law, the ill are exempt from the obligation of fasting, as are travellers or others whose health could be at risk from fasting.
5. Pilgrimage: Muslims are required to making a pilgrimage to Mecca at least once in one's life time (*hajj*).

Within Islam, the concepts of *halal* and *haram* are important to understand Muslim culture. *Halal* describes things that are permissible or lawful according to the tenets of Islam, and *haram* describes things that are forbidden (Leininger & McFarland 2002:304). Their faith requires Arab Muslims to try to stay healthy by practising moderation in everything (eating, exercising, working and praying) (Ott et al 2003:229).

Health is very important to Muslims. Allah is understood to be in charge of life, when He in His perfect wisdom decrees health to the people, they will be healthy. When He decrees illness, then people will suffer from illness (Mills 2004:8). Maintaining spiritual health and well-being is essential to Muslims since *tawhid* implies that physical health is not separate from the spiritual dimension. Health is an extraordinary blessing that God has bestowed on human beings. Therefore, all efforts should be united and directed towards health protection. Health promotion and protection refers to observance of the Five Pillars of Faith. Individuals need to behave properly and have a feeling heart. Communities need to maintain peace and unity. Prayer is essential to recovery and maintenance of health and well-being. The use of prayer beads is a reminder to Muslim

clients of the nearness of God, serves to reduce anxiety and provides a sense of peace and well-being (Leininger & McFarland 2002:306).

Illness (including pain) can be attributed to a natural occurrence, penance for sin, or a test of the Muslim's faith. Muslims approach illness and death with patience and prayers. They consider an illness as atonement for their sins, and death as a part of a journey to meet their Lord (Ott et al 2003:232). Ill health is viewed as a blessing. Illness is believed to wake people up from heedlessness, guide them to give up their sins, make them think about the hereafter, lead them to pious foundations; and make them to be thankful to Allah (Mills 2004:8). A sick person is encouraged to be grateful to Allah. He will receive rewards, and his suffering will be rewarded with spiritual honours and gifts of forgiveness. For Muslims, prayers and meditation bring psychological tranquillity (Athar 2004:5). Nikbatht, Ashayeni & Muhamad (2003:4) investigated the effectiveness of Holy Quran recitation song on the reduction of post-operative pain in Iranian clients and found significant pain relief in thirty clients. The amount of relief obtained with Quran song varied considerably: 30% obtained maximum relief and 30% obtained less than moderate pain relief.

However, they are strongly encouraged to seek medical treatment and care (Athar 2004:5). When illness strikes, a person seeks good medical treatment and prays to Allah for a cure (Ott et al 2003:244). An Arab patient consulting a medical doctor expects relief from pain and to receive medication during the visit. Clients expect that the doctors should explain the reasons for not getting medication. They also require explanations when laboratory testing is done (Athar 2004:5).

According to Athar (2004:6) one of the most important concepts in understanding what Islam means by family or community is the relationship between the self and the other, where the other is seen as an extension of the self and not as a separate entity. The Quran gives clear instructions less to individuals than to the individual in relation to others. The role of the family is very important in health matters among Muslims, When a person is sick, it is usual for the family to notify all relatives, and the sick person will be happy to

receive many visitors (Athar 2004:5). Self-care is not an important concept, and family interdependence is important. The presence of a family member during health assessment is acceptable and encouraged.

2.4.4 Pain: A holistic perspective

Pain is described as a complex experience encompassing sensory, emotional, cognitive and behavioural components. Interaction between these components is influenced by physiological, psychological and socio-cultural factors. These factors make pain unique for each individual, every time it is experienced. This means that although pain is a common experience it is difficult to understand what pain is like for another person (Alexander, Fawcett & Runciman 2003: 653).

2.5 CULTURAL ASSESSMENT OF PAIN

Luquis & Perez (2003:134) emphasise the need for health professionals to develop cultural skills and culturally appropriate interventions when dealing with people from diverse groups. This process requires health professionals to learn how to conduct a comprehensive cultural assessment to determine the explicit needs and appropriate interventions for the people targeted.

Nursing has its own unique culture which interacts with different cultures in the health care setting. It has its patterned beliefs, values norms, and practices that can have a significant influence on nursing actions and omissions. The ability of health care professionals to break through cultural barriers is the key to providing effective pain management in clients that are culturally diverse. Cultural assessment involves the interplay of both the nursing culture and clients' culture. Therefore, it is necessary to conduct cultural assessments prior to rendering nursing care. Cultural pain assessment would involve examination of cultural factors that influence pain perception. Andrews & Boyle (1999:24) define cultural assessment as "a systematic appraisal or examination of individuals as to their cultural beliefs, values and practices to determine explicit nursing

needs and interventions practices within the cultural context of people being evaluated” (Llewellyn 2003:3).

Ridley et al (1998:827-910) found that the role of culture becomes more obvious when clients and health care providers encounter one another. Expectations, meanings and unspoken assumptions have to be considered lest misunderstanding lead to disappointment, frustrations and failure in health care. If the role of culture is overlooked in health assessment including pain assessment, the flow of communication can become obstructed and development of good nursing practice stifled.

Pain is a multidimensional phenomenon therefore the accurate measurement or assessment of pain requires deeper understanding of factors related to pain, such as physical, emotional, cultural, past experiences and the meaning of the event being experienced. The private nature of pain experience demands an environment that enhances effective communication between professional nurses and clients in the health care setting. People’s responses to potential or actual tissue damage are parts of an experience that has different dimensions. The quality and intensity of stimuli results in behavioural responses influenced by emotional, cultural and cognitive processes. One of the main roles of professional nurses is to recognise signs associated with pain. Assessment of pain implies not just quantifying pain per se, but the nature of that experience, and what the individual assigns to that experience. Pain involves human suffering; therefore, it requires that the assessor appraise the whole experience of the object under assessment, and what that object (pain) means to the individual (Andrews & Boyle 1999:284).

Cultural assessment of clients has received some attention from professional nurses. Approaches to consider cultural background of clients have been addressed in a number of transcultural nursing publications. Leininger’s (2002) Sunrise Model (see chapter 1 page19) symbolises the rising of the sun (care) and provides a comprehensive assessment model. Giger & Davidhizar (1999) developed a cultural assessment model identifying six areas of focus, namely biological variations, environmental control, time, social

organisation, space, and communication. Gharaibeh & Abu-Saad (2002:16) found that despite the proliferation of pain assessment tools to obtain children's self report of pain intensity, none have been developed to measure pain in the Arab-Muslim culture. The lack of studies that tested the applicability of existing tools from Western cultures with Jordanian population is a major area of concern for Jordanian nurses. The researchers emphasize the need for accurate and culturally sensitive assessment tools that will provide objective information for health professionals to develop appropriate interventions for pain management.

The role of the professional nurse is important in the assessment and management of pain experience by clients during hospitalisation. According to Callister et al (2003:146), there is often incongruence between professional nurses' rating of pain and the perception of clients who are suffering that pain. The most commonly cited reason for this discrepancy is cultural and communication gaps. Gharaibeh & Abu-Saad (2002:17) found that despite the proliferation of pain assessment tools to obtain children's self report of pain intensity, none have been developed to measure pain in the Arab-Muslim culture. The lack of studies that tested the applicability of existing tools from Western cultures with Jordanian population is a major area of concern for Jordanian professional nurses. The researchers emphasise the need for accurate and culturally sensitive assessment tools that will provide objective information for health professionals to develop appropriate interventions for pain management.

2.6 THE NEED FOR CULTURAL COMPETENCE

Camphina-Bacote (2003:6) provided a cultural competence model depicted as volcano and including cultural awareness, skills, knowledge, cultural encounter, and desire to know about other cultures (ASKED).

Camphina-Bacote (2003:5) defines cultural competence as "the process in which the nurse continuously strives to achieve the ability and availability to effectively work

within the cultural context of a client individual, family or community". Cultural competence describes people and organisations that work effectively with their own culture and with cultural groups different to their own.

Camphina-Bacote (2003:6) provided a cultural competence model which explicate the abilities necessary to work effectively in culturally diverse healthcare settings, namely cultural awareness, skills, knowledge, cultural encounter, and desire to know about other cultures

Andrews & Boyle (1999:24) are of an opinion that nurses need cultural awareness to self-examine biases against people from different cultural backgrounds, and possess the skill to collect relevant cultural data regarding the patient's pain accurately performing a culturally-based, physical assessment, and cultural knowledge to seek and obtain information about pain behaviours of her/his clients.

Cultural knowledge refers to nurses' understanding of clients' health care and cultural practices. In order to provide culturally congruent care, professional nurses need to learn different perspectives about the culture at hand, Andrews & Boyle (1999:24).

Cultural encounter refers to interactions between people of different cultures Camphina-Bacote's (2003: 6).

According to Camphina-Bacote's (2003:7) model, cultural desire involves the commitment of the nurse to care for all clients, regardless of their cultural values, beliefs, customs, or practices. It entails being motivated to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful, and seeking cultural encounters (Camphina-Bacote's 2003:7)

According to Showalter ([sa]):2), when professional nurses treat clients from a different culture, the clients' concern for symptoms must be treated with as much concern as the actual physical symptoms present. Cultural competence is vital when practitioners treat

pain in a culturally diverse society. Generalisations about ethnic groups do not predict individual behaviour and are only to be used against a background of ongoing assessment that acknowledges and seeks to understand individual patient and family differences (Raab 2003:37). Professional nurses may encounter clients who do not have a strong ethnic identity; therefore, the uniqueness of an individual should be recognised. Perceptions, expected responses and acceptable pain management techniques may vary according to ethnic identity.

Llewellyn (2003:4) points out that nursing, medical and hospital cultures influence pain assessment, decision-making and care. A culturally competent nurse will help clients advocate for what feels appropriate for them within their cultural context. Understanding the patient may be difficult when clients are from different cultures and speak different languages.

In order to manage pain effectively, nurses need to have a cultural desire which, using Camphina-Bacote's (2003:5) ASKED model, involves the commitment of the nurse to care for all clients, regardless of their cultural values, beliefs, customs, or practices; the motivation of the nurse to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful, and seeking cultural encounters (Camphina-Bacote's 2003:7).

The physiological consequences of acute pain can lead to a systematic downward spiral starting with a general stress response that weakens the body and impairs the recovery process. Unrelieved pain could have adverse cardiovascular changes, such as increased vascular resistance that may lead to angina. The psychological effects of anxiety add to the problem by adversely affecting sleep and furthering the stress response. This may result in depression if allowed to continue; sleep deprivation, anxiety and depression will exacerbate pain sensation and intensify suffering (Sherwood et al 2000:489).

The understanding of unrelieved pain and its consequences should obligate the nurse to develop the desire to understand the behaviours involved in pain, and plan effective pain relief actions. The nurse needs cultural awareness to self-examine biases against people from different cultural backgrounds, and possess the skill to collect relevant cultural data

regarding the patient's pain accurately performing a culturally-based, physical assessment, and cultural knowledge to seek and obtain information about pain behaviours of her/his clients.

2.7 CONCLUSION

Although universally acknowledged, pain is a complex phenomenon for both nurse and patient. The multiple factors that influence the perception and expression of pain take on special importance in the health care setting, where pain becomes an interpersonal experience between the sufferer and the reliever. How pain is dignified by the patient and understood by the provider determines how it is valued and, ultimately, how it is treated. If the perceptions of pain are to be understood in a useful way, they must be examined in the context of culture, gender, imbalances of power, morality and myth (Post, Bustein, Gordon & Dubler 1996:350).

Cultural competence is vital when practitioners treat pain in a culturally diverse society. Generalizations about ethnic groups do not predict individual behaviour and are only to be used against a background of ongoing assessment that acknowledges and seeks to understand individual patient and family differences (Raab 2003:37). Nurses may encounter patients who do not have a strong ethnic identity; therefore, the uniqueness of an individual should be recognized. Perceptions, expected responses and acceptable pain management techniques may vary according to ethnic identity.

Chapter 3 deals with the research design and method of the study.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

In this present qualitative and exploratory research study, the researcher applied an ethno-nursing method to describe and compare the pain perception of clients who suffered from pain, and professional nurses who rendered care to these clients. The participants were selected by applying non-probability sampling. The researcher collected data through unstructured interviews and participant observations. Leininger's data collection enablers guided the data collection process. Qualitative data analysis was applied following Leininger's phases of ethno-nursing analysis of qualitative data. Leininger's Sunrise Model served as an interpretive framework. Ethical principles were observed to protect the integrity of the research study. The researcher applied measures to enhance the trustworthiness of the study.

3.2 RESEARCH DESIGN

The researcher adopted a qualitative exploratory design. According to Leininger (1985:23) nursing knowledge must be closely linked to cultural ways of life, values, and patterns of human groups. Therefore, qualitative methods are better suited to discover the subjective meaning of human care and health maintenance. Because pain is subjectively experienced, and illness is culturally bound, the researcher considered qualitative research to be appropriate.

Qualitative research regards reality as socially constructed and contextual. Qualitative research "rests on a paradigm that explains humans as conscious self-directing beings who are continuously constructing and re-constructing social reality" (De Villiers & Van der Walt 2004:239). One of the major distinguishing characteristics of qualitative research is that "the researcher attempts to understand people in terms of their definition

of their own world” (Gillis & Jackson 2002:182). It focuses on the subjective experiences of individuals and is sensitive to the contexts in which people interact with each other (Mouton 2001:194). Qualitative research involves exploring and describing the nature of a social phenomenon and the inter-relationships between its components. A holistic approach is maintained. The aim is to obtain an in-depth understanding of human beings, their experiences, values, beliefs and meanings that people attach to their daily lives (De Villiers & Van der Walt 2004:238).

Meanings of illness, including pain, are negotiated and defined continuously by cultural groups. People who suffer from pain conceptualise and experience it subjectively, within a particular cultural paradigm. This influences pain management and the expectations placed on caregivers. Likewise, the caregivers of clients who suffer from pain also function within a particular cultural paradigm. The focus of this present research study was to explore the cultural diversities and universalities, between professional nurses and clients, on various aspects related to pain. This required a holistic approach to capture the life world of the participants with regard to pain, as revealed by them while the researcher maintained an emic approach. The socio-cultural dimension of pain is comprised of a broad range of ethnocultural, spiritual, demographic, social, and other factors related to an individual’s perception of and response to pain. This warranted qualitative research, and specifically the application of the ethnonursing method. Qualitative research enabled the researcher to explore concepts related to pain sensation, experience, conceptualisation, expectations and management.

One of the characteristics of exploratory qualitative research is “to identify, document and confirm unknown aspects of human behaviour. The qualitative researcher seeks to discover, account for and explain unknown phenomena. Discovery of meanings is regarded as the basis of knowledge generation. With an open, inquiring manner, informants are encouraged to share their ideas about their experiences. Through the inductive discovery process, the researcher describes and documents diverse and common features about the phenomenon” (Streubert & Carpenter 1999:16). In this study, unstructured data collection was done in a naturalistic context. The researcher intended to

capture the participants' life worlds in relation to pain. Doing so enabled the researcher to explicate the phenomenon in the complex multi-cultural health care setting of the UAE.

Qualitative research involves an emergent design that emerges in the field as the study unfolds (De Villiers & Van der Walt 2004:243-244). It identifies "the characteristics and significance of human experiences as described by informants and interpreted by the researcher at various stages of abstraction" (Leininger 1985:36). According to De Vos (1998:280), an interpretive approach enables a better understanding of the social construction of reality or the process through which people make sense out of their lives and experiences. While conducting this present research study, the researcher's continuous interpretations served as a basis for deciding on subsequent courses of action or areas of focus. As the study unfolded, the researcher reflected continuously on what emerged and made ongoing decisions on the focus and process of data collection. The cultural meanings of pain that evolved as the researcher conducted dialogical discussions with participants formed the basis for further data collection, including selection of other participants to provide rich information.

3.3 RESEARCH METHOD

The method of choice was the ethno-nursing method, which Leininger & McFarland (2002:74) define as "the study and analysis of local or indigenous people's viewpoints, beliefs and practices about nursing care behaviour and processes of designated cultures". Ethno-nursing provides ways of assessing beliefs and practices in a natural context. Parts of the whole are discovered and interrelated, and the wholeness of culture evolves. It provides the framework for studying meanings, patterns, expressions and practices related to culture care that influence the health care and well-being of clients or assist them to face death or disability (Leininger & McFarland 2002:76). The ethnosing methods enabled the researcher to understand the research participants' daily experiences related to human care, health and well-being, with specific reference to pain.

The ethno-nursing method is a naturalistic (largely emic focused) and open inquiry mode to discover the informants' views of knowing and experiencing life. This method facilitates the discovery of care and health knowledge related to areas such as world-views, social structure factors, ethno-history, environmental factors and other additional areas of the informant's cultural life world (Leininger & McFarland 2002:85). With the ethno-nursing research method and Leininger's theory, the researcher was challenged to discover the similarities and diversities, about various aspects related to pain, among professional nurses and their clients who suffer from pain. The ethnonursing method enabled the researcher to maintain an emic perspective.

3.3.1 Sampling

Sampling involves selecting a group of people, events, behaviours, or other elements with which to conduct a study (Burns & Grove 2001: 365).

3.3.1.1 Population

A research population is "the entire set of individuals who have some common characteristics and meet certain criteria of interest to the researcher" (Burns & Grove 2001:366). Two populations were involved in this study, namely professional nurses and clients. The professional nurses were general informants. The clients, who personally experienced pain, served as key informants. Key informants are people who "have been thoughtfully and purposefully chosen for the knowledge they have about the culture under study, while general informants may not be fully knowledgeable, yet they have a general idea about the domain of inquiry" (Leininger 1985:47). In the context of this study, the key informants (clients) were considered to have first hand knowledge of their pain experience. The general informants (professional nurses) rendered nursing care aimed at relieving pain which they do not experience personally. By including these two categories, the researcher ensured that the professional and generic (lay or traditional) health care systems were represented in the study (refer to section 1.7.2).

The general informants, namely the professional nurses, were expatriate professional nurses who rendered direct client care to clients in pain, in a health institution at the time of data collection. The expatriate professional nurses were from the Philippines, Pakistan, Canada, England, and Germany. The professional nurses were selected to participate in this research based on their personal experiences in caring for those clients who suffered from pain.

The key informants, namely the clients, were comprised of adult Emiratis and other Muslims who suffered from pain and received health care in a specified acute health care setting. The clients were selected to participate in this research based on their first hand knowledge of pain, by being exposed to a pain sensation. The researcher involved various clients whose main complaint was pain from diseases that evoked painful sensations, and from surgery and other painful procedures. The researcher assumed that they had relevant knowledge of pain and of their own cultures.

3.3.1.2 Sampling

Qualitative research is not aimed at generalising results but rather “at achieving an in-depth, holistic understanding of the phenomenon of interest” (Polit & Hungler 1996:238). Qualitative research requires that the data to be collected be rich in description with regard to people and places (De Vos 1998:253). Therefore, a non-probability sampling approach, involving a small sample, is appropriate. In non-probability sampling, not every element of the population has an equal chance of being selected in the sample (De Villiers & Van der Walt 2004:242; Polit & Hungler 1996:238).

In this study, the researcher conducted purposive sampling method. Purposive sampling involves “the conscious selection of informants by the researcher” (Burns & Grove 2001:376). This ensures that informants who are knowledgeable about the topic are included in the study (Burns & Grove 2001:376). Clients who suffered from pain selected to participate. The researcher ensured that the sample included both sexes and various age groups. Those professional nurses, who rendered nursing care to the selected clients,

were included in the general informant sample. The researcher ensured that newly qualified and experienced professional nurses were included in the study.

3.3.1.3 The research participants

The researcher collected data from key informants and general informants. The clients who suffered from pain were the key informants, and the professional nurses served as general informants.

- ***Key informants***

Three key informants (clients) from the female surgical ward participated in the study. The clients were Arab Muslims who resided in the UAE. Their diagnoses included gall bladder stones, for investigation, and sickle cell anemia (with threatened abortion).

There were five participants from the male medical ward. The clients were Arab Muslims who resided in the UAE. The diagnoses included chest pain, pleurisy, nephritis, pneumonia, and gastritis.

Key informants who participated in in-depth interviews were all Muslims. Their age ranged from 20 to 45 years, with a mean age of 29 years.

- ***General informants***

Five general informants (professional nurses) participated in the study. Three were from the female ward and two from the male ward. All professional nurses held Bachelor of Nursing degrees. The mean length of service in the UAE was 2 years, while the mean professional experience was 7 years. Their ages ranged from 24 years to 38 years, with a mean age of 29 years. All the professional nurses were expatriates from England,

Pakistan, Philippines, Germany and Canada. All the professional nurses were non-Muslims.

3.3.2 Data collection

Leininger's ethno-nursing data collection enablers were applied to guide data collection. These enablers allow emic and etic data to be studied together. An “emic view is elicited from informants by what they say verbally, how they explain events and interpret their meaning and action modalities” (Leininger 1985:39). The “etic view is identified by comparing the clients’ views against the observed societal view”. Etic data often includes the group’s social structure, history, ecology and religious beliefs” (Leininger 1985:39). The researcher obtained the emic view before reflecting on the etic view of professional knowledge.

3.3.2.1 Data-collection methods and instruments

The researcher selected an unstructured data-collection method. Unstructured data collection involves “a minimum of structure and researcher-imposed constraints” (Polit & Hungler 1996:280). Unstructured approaches “provide for greater latitude in the answers given” (Streubert & Carpenter 1999:23).

Data was collected from key informants by means of participant observations and unstructured interviews. A participant observer “participates in the functioning of the group and strives to observe and record information within the contexts, experiences, and symbols that are relevant to the participants” (Polit & Hungler 1996:280). The researcher participated in care activities to observe and accurately capture the words and expressions clients used when they experienced pain. This method was applied to the observe actions, reactions and interactions that occurred during nurse-client encounters. The researcher also kept field notes to capture the context of the study. The observations were supplemented with unstructured interviews, through which the researcher obtained a

deeper insight into the research topic. An “open-ended interview allows information and ideas to be revealed” and is ideal to elicit emic data. (Leininger 1985:54). During the unstructured interviews, the participants responded freely to open-ended questions in narrative form, using their own words, thus sharing their perspectives with the researcher. The researcher asked probing questions to guide informants to further elaborate upon their responses where additional information was required (De Villiers & Van der Walt 2004:243). This approach enabled in-depth discovery of the clients’ experiences, and expressions of pain and both clients’ and nurses’ conceptualization, expectations and management of pain.

The researcher developed two interview guides, namely one for the key (clients) informant interviews (Annexure A), and one for the general (professional nurses) informant interviews (Annexure B). The interview guides comprised open-ended questions for the unstructured interviews. An observation guide (Annexure C) assisted the researcher in conducting the unstructured observations.

3.3.2.2 Research setting

The inquiry was conducted in natural setting settings, namely health care settings where clients in pain received nursing care. This allowed the researcher to get close to the participants and try to understand their social world from an emic view. Data was collected at two acute units in Abu Dhabi; these units had a maximum of two occupants, therefore, privacy was ensured. Observations were conducted on clients in the general and side (private) wards. Interviews were conducted on clients in the side (private) wards. Nurses were interviewed during on duty time. Available unoccupied rooms were used to conduct the interviews.

The researcher became personally involved in the social world of the participants to obtain inside views of their values and beliefs regarding pain and pain management practices.

3.3.2.3 *Data-collection process*

In qualitative research, “successful fieldwork is usually determined by the accessibility of the setting and the researcher’s ability to build up and maintain relationships with gatekeepers” (De Vos 1998:258). The researcher “should strive to establish a cordial atmosphere and to lay the foundation for a relationship of trust. The researcher needs to create a sense of equality between her and the informants; when people feel comfortable, they are more willing to share their emic views” (Leininger 1985:53).

It was important for the researcher to develop a relationship of trust with the informants. In order to create a sense of trust, the researcher applied Leininger’s (1985:53) observation-participation-reflection model as an essential guide to enable the researcher to enter and engage with informants in the health care settings, while collecting data. The researcher gradually moved from being an observer and listener to a participant and reflector.

- ***Phase 1: Primary observations with no active participation***

This phase include mainly observation of the events and listening with no active participation. During this phase, the researchers observed actions, reactions and interactions that occurred during nurse-clients encounters.

In this current research study, the researcher made informal visits to the professional nurses and clients in the health care settings, in order to introduce herself, explain the nature of the study and obtain informed consent for their participation. The clients’ main complaints, diagnoses and care plans were studied prior to the first visit. The researcher also informally observed professional nurses’ and clients’ interactions and communication patterns in the health care setting. During this phase, the researcher closely observed and attentively listened to both groups of informants to obtain a broad view of their life worlds, including their perceptions and experiences of pain. The researcher gained the informants’ trust by obtaining informed consent from them to participate in the study and explained the importance of their participation to ensure the

credibility of the data. The informants were assured of confidentiality and anonymity. They were advised on the setting of the interviews, the duration and number of anticipated participants. They were also made aware that they had the right to withdraw from the study at any stage, and would not be exposed to any harm during data collection.

- ***Phase 2: Primary observation with limited participation***

This phase involves observation and accurate capture of the words and experiences of informants. This phase mainly involved observing the patterns of pain expression, expression of expectations and pain management in the ward. Some participation occurred by asking broad questions related to what was observed. This phase comprised identifying and describing the professional nurses' and clients' behaviour and expectations related to pain expression and management. The researcher documented specific and unusual events and observed behaviour regarding pain expression, expectations and management. Incidents and verbal and non-verbal interactions between professional nurses and clients were documented. The researcher remained alert to the culture care theory tenets, especially commonalities and diversities.

Specific attention was given to clients' :

- pain complaints
- ways of expressing their pain sensation or their discomfort
- requests for pain management
- communication of expectations on pain management and desired responses by professional nurses.

With regard to the professional nurses, the following were observed:

- verbal and non-verbal reactions to clients' pain complaints and ways of expression
- pain management activities
- communication of expectations on patient compliance or behaviour.

The interview data were captured on audiotape and verbatim transcriptions were made. The observational data were organised into personal and analytic logs (refer to section 3.3.2.3).

- ***Phase 3: Primary participation***

This phase is characterised by active participation in the research context (Leininger 1985:55). The researcher participated in doctors' round, medicine round, and dressings to obtain an in-depth understanding of clients' interactions with professional nurses in terms of pain assessment and relief. The observations of the previous phase were followed up with unstructured interviews. The aim was to elicit data about pain conceptualisation and experience, and expectations regarding pain and pain management. The interview setting was negotiated in advance with the clients, and the researcher selected appropriate times to conduct the interviews with the informants. The interviews were conducted face to face in the side units which are regarded as 'private' in this particular health care setting. Audio-recording equipment was used to capture data. Key informants were encouraged to talk freely about their ideas on the meaning of pain, their pain experiences and their pain management expectations. General informants were also encouraged to talk freely about the meaning of pain, clients' responses to pain, and their expectations of client behaviour and pain management.

During the interviews with clients and professional nurses, the following topics were covered:

- conceptualisation of pain and its causes
- pain experiences (emotions) – this applied only to the clients
- pain management practices and expectations
- client satisfaction in terms of pain alleviation
- whether culturally congruent care was rendered.

- **Phase 4: Primary reflection and reconfirmation of findings**

Leininger (1985:60) describes this stage as a stage of reflection, preliminary analysis and interpretation. During the reflection phase, the researcher considered and interpreted the data collected. Reflection occurred during and after all phases of data collection. Reflections during data collection enabled the researcher to conduct a preliminary data analysis to determine whether to probe further or terminate data collection. The reflective-observation phase allowed the researcher to recapture the data-collection setting, events and processes. Understanding what transpired between the researcher and the participants is essential to obtain an accurate and full account of the situation (Leininger 1985:53). The period of reflection was followed by reconfirmation of findings with informants to ensure that the researcher had captured the data accurately and truthfully.

3.3.3 Data analysis

In this present research study, the researcher conducted qualitative data-analysis. Qualitative data analysis requires that “the researcher become immersed in data. This requires full understanding of data and a significant degree of dedicated reading, intuition, analysing, synthesising and reporting of the discoveries” (Gillis & Jackson 2002:185). In this study, the researcher applied Leininger’s (1991:95) phases of ethno-nursing analysis of qualitative data.

- **Phase 1: Collecting, describing and documenting raw data**

This phase entails data collection, management and interpretation (Leininger 1985:58). In this study, data was collected as described in 3.3.2.3. The data collected during the interviews was captured on audiotape and verbatim transcriptions made. The observational data were organised into personal and analytic logs, which were also transcribed. The personal logs included descriptive accounts of what was observed with regard to the informants and the settings and incorporated the researcher’s reflective notes on the participatory experience. The analytic logs included a detailed review of the

research questions and emerging ideas as the study progressed. All data were computer processed and preserved electronically. The researcher transcribed the recorded interviews and the field notes. The transcriptions were imported into QSR NUD*IST 4.0. The researcher carefully read the transcriptions to obtain a general feel for the data and plan a preliminary coding system. The data management process is described in section 4.2.

- ***Phase 2: Identification and categorisation of descriptors and components***

This phase entails “reduction of data by means of coding and categorising raw data” (Leininger 1985:58). The emic and etic descriptors are studied within the context of similarities and differences, and recurrent components studied for their meanings (Leininger & McFarland 2002:95). During this stage, the researcher coded the raw data and classified the coded data into categories (refer to section 4.2). She created nodes and node definitions, and coded each data unit under an appropriate node. Coding and categorising was done repeatedly as new insights developed into emerging meanings and how the coded data related to the emerging meanings. The researcher printed out and read the node reports in preparation for phase 3.

- ***Phase 3: Pattern and contextual analysis***

This phase entails a thorough examination of the data for saturation of ideas and recurrent patterns of different meanings, expressions, structural forms, interpretation or explanation of data related to the domain of enquiry (Leininger & McFarland 2002:95). In this present research study, the researcher studied the node reports to elicit the emerging meanings. The researcher identified interrelationships between the emerging ideas, with specific reference to cultural diversities and similarities on various emerging concepts related to pain. The researcher shared the results with the participants to give them the opportunity to confirm whether the researcher’s interpretations were consistent with the life worlds they revealed during their participation. This activity enhances the credibility of the research findings (Leininger 1985:61).

- ***Phase 4: Data synthesis***

The last phase entails data synthesis and interpretation (Leininger & McFarland 2002:95). In this phase, the researcher engaged in creative reflection and abstract thinking to synthesise the meanings that emerged during the previous phase into themes that transcended the created categories and sub-categories. A comparison was made across the themes to present research conclusions and recommendations.

“Discovered meanings and practices about care are usually embedded in the social structure factors, cultural beliefs, language and environment” (Leininger & McFarland 2002:82). Leininger’s Sunrise Model therefore served as an interpretative framework during data analysis. Using Leininger’s Sunrise Model as a theoretical foundation served as a means “to tease out cultural care from a holistic perspective of multiple factors that can potentially influence people’s care and well-being” (Leininger & McFarland 2002:80).

3.4 TRUSTWORTHINESS

Trustworthiness refers to “the process of establishing the validity and reliability of qualitative research” (Polit & Hungler 1996:312). The researcher used Lincoln and Guba’s (1985) model and strategies as documented in (Leininger & McFarland 2002:88) to enhance trustworthiness of this study.

3.4.1 Credibility

“Credibility refers to direct sources of evidence or information from the people within their environmental contexts of their ‘truths’ held firmly as believable to them” (Leininger & McFarland 2002:88). During data collection, the researcher spent considerable time with participants collecting data and repeatedly observing and

interacting with them. Using different sources, namely clients and professional nurses, enabled the researcher to cross-validate responses.

To enhance the credibility of the research findings, the researcher performed bracketing. Bracketing refers to suspending or laying aside what is known about an experience being studied (Burns & Grove 2001:790). Researchers usually explicate their beliefs about the research topic through the process of bracketing. This process is important in qualitative research because the researcher develops a close relationship with participants (Burns & Grove 2001:595). The researcher's personal interests and biases were made explicit at the beginning of data collection, by keeping a personal log. In this log she described her existing knowledge of pain and the health care patterns in the UAE. She also explicated her own perceptions on pain. The researcher deliberately put aside her own preconceived ideas and biases. She continually explored her position as researcher and registered nurse, and how it may have influenced the participants' responses and her interpretations.

The researcher refrained from demonstrating ethnocentrism during data collection. She avoided any signs of surprise or disapproval. By revealing what she researcher believed, she was in a better position to approach the topic in an unbiased manner. Explication of personal beliefs "makes the investigator more aware of the potential judgments that may occur during data collection and analysis based on the researcher's belief system rather than on the actual data revealed by participants" (Streubert & Carpenter 1999:20).

It is important for a researcher to be knowledgeable in research and the field of study. The present researcher is a nurse educator with postgraduate preparation in medical sociology, transcultural nursing and research. She has extensive experience in teaching behavioural sciences and has a personal interest in studying social behaviour. This empowered her to undertake the study. An extensive literature review was done on pain, Islam and the Arab culture to obtain the linkage between culture and illness with specific reference to pain. The application of the participation-observation-reflection enabler, the data analysis enabler and Leininger's Sunrise Model also contributed to the credibility of the study (refer to section 3.3.2.3).

3.4.2 Dependability

Dependability of qualitative data refers to “data stability over time and over condition” (Polit & Hungler 1996:313). An audit trail is established to enable other researchers to scrutinise the research method and the researcher’s interpretations. To enhance the dependability of this study, the researcher documented the research method. The research was conducted under supervision of the supervisors who were advanced practitioners in nursing, with knowledge and experience in transcultural nursing and qualitative research. The researcher submitted raw data, the node reports comprising the coded data and her interpretations to the research supervisors, who performed an audit to confirm the findings. All raw data and the node reports were filed.

3.4.3 Confirmability

Confirmability refers to “the objectivity or neutrality of the data, such that two or more independent people would reach an agreement about the data’s meaning” (Polit & Hungler 1996:315). According to Leininger & McFarland (2002:88), confirmability refers to “documented verbatim statements and direct observational evidence from informants, situations and other people who firmly and knowingly confirm or substantiate the data or findings”. Confirmability is enhanced through a process of leaving an audit trail that entails a full and accurate description of the data collection, analysis methods and procedures and by ensuring that there is coherence between these aspects (Polit & Hungler 1996:315). In this study, the researcher established an audit trail as described above. She also sought confirmation from the informants that her interpretations were true reflections of their perceptions on pain, as revealed during data collection. This was done through sharing the reflections with the informants and asking them to validate the findings.

3.4.4 Transferability

Transferability refers to “the extent to which findings from data can be transferred to other settings or groups and is thus similar to the concept of generalisability of findings” (Polit & Hungler 1996:316). According to Leininger & McFarland (2002:88), transferability refers to “whether the findings from a completed study have similar (not necessarily identical) meanings and relevance to be transferred to another similar situation, context, or culture”. In this present research study, the researcher provided thick descriptions of the research setting, and what she had heard and seen in relation to pain during data collection. This should enable others to determine the transferability of the findings to similar settings.

3.4.5 Data saturation

Saturation of data refers to in-depth information of “all that is or can be known about the phenomenon under study” (Leininger & McFarland 2002:88). Data saturation is achieved when no new data emerges but previously collected data is repeatedly re-introduced into the study (Streubert & Carpenter 1999:22-23). In this study, the researcher collected data about pain from key and general informants, and made observations until no new data emerged (refer to section 3.3.2.3).

3.4.6 Recurrent patterning

Recurrent patterning refers to “documented evidence of repeated patterns, themes and acts over time reflecting consistency in the patterned behaviours” (Leininger & McFarland 2002:88). In this study, descriptive numbers (non-statistical) were used to document patterns, directional foci and patterned frequencies.

3.5 ETHICAL CONSIDERATIONS

Ethics is about “what is wrong and what is right in the conduct of research. Since scientific research is a form of human conduct, it follows that such conduct has to conform to generally accepted norms and values (Mouton 2001:238). The researcher needs to search for the truth, but not at the expense of participants or scientific integrity.

3.5.1 Human rights of the respondents

A country’s constitution contains descriptions of basic human rights, of which the aim is to provide protection to the citizens. Nurse researchers have an ethical responsibility not only to the participants in the study but also to society at large and to the nursing discipline (Gillis & Jackson 2002:347). In this study, the researcher followed Ray’s (1994) ethical framework or model (cited in De Villiers & Van der Walt 2004:256).

In applying the right to self-determination, the researcher informed all participants that participation was voluntary and that they had the right to withdraw at any time during the study if they so wished (refer to section 3.3.2.3). They were reassured that the information gathered would not be used against them at any point. In the case of informed consent, the researcher observed the cultural values of the clients. In the case of female clients, a male member of the family was involved. Professional nurses signed the consent form. The researcher explained the topic and purposes for the study to the professional nurses, the clients and the clients’ families. Permission to publish the findings of the study was also obtained. The researcher also obtained permission to quote the informants verbatim, so that important data was not lost.

During data collection, the researcher demonstrated respect for Islam by observing the dress code. Interviews were interrupted at specific times to observe prayer times and clients were allowed to take breaks for prayer. From the transcultural caring dynamics, the researcher used enabling and empowering communication strategies that allowed the clients and nurses to express themselves freely and tell their stories. Nurses were

interviewed during their free time; this was collaborated with the director of nursing who made sure that the ward routine was not disrupted.

The participants' right to privacy and confidentiality was ensured. Interviews in the health care settings were conducted in side 'private' units. The researcher sought permission from participants to record the interviews on audiotape. With regard to the female clients the researcher obtained permission from a male member of the family. The reasons for capturing the interviews on audiotape were explained to the participants. As data was transcribed, identity codes were allocated to each informant's interview data. Only the researcher was able to relate a particular interview to an individual informant.

The researcher maintained a professional relationship with the participants by not imposing her status on participants. The researcher recognised that she was the co-creator of meanings of pain, and accorded participants the power and freedom to share their pain experiences. The researcher refrained from being paternalistic and ethnocentric. Pain relief interventions were promptly made, where appropriate and informants were not exposed to suffering for the purpose of the study. The researched also did not interfere with the duties of the professional nurses.

3.5.2 Rights of the institution

Institutions, hospitals government agencies and universities in which research involving human subjects is carried out require specific information to make informed and responsible decisions regarding the ethical acceptability of a proposal (Gillis & Jackson 2002:336). The proposal was submitted to the Department of Health and Medical Services (DOHMS) and the Ministry of Health to seek approval. The study did not commence until permission had been granted (refer to annexure C). The report did not reveal the names of institutions. The research results were disseminated to the relevant authorities.

3.5.3 Scientific integrity

Scientific honesty refers to the “publication of true findings, and avoidance of plagiarism” (Mouton 2001:240). In qualitative research this involves honesty in data collection, analysis and interpretation, giving the emic view of the phenomenon. In this study care was taken to portray the participants’ and not the researcher’s views. Findings were represented fully and not misrepresented. The researcher adhered to high technical standards, and all sources consulted were acknowledged.

3.6 CONCLUSION

This chapter explained the research design and method. The ethno-nursing method was applied to discover data on pain perception of nurses and clients’ pain experience, expression and management. The focus was on emic and etic knowledge and behaviours related to pain.

Chapter 4 presents the data analysis and interpretation.

CHAPTER 4

RESEARCH FINDINGS

4.1 INTRODUCTION

Qualitative ethno-nursing research was conducted to investigate the cultural similarities and diversities with regard to pain conceptualisation, experience, expression, expectations and management, between professional nurses and their clients. The research method was applied as outlined in the previous chapter (refer to section 3.2). Unstructured data collection was performed to answer the following research questions:

- What are the differences and similarities between the professional nurses' and clients' views on
 - the nature and meaning of pain
 - the cause(s) of pain?
- What are the differences and similarities between the professional nurses' and clients' views on:
 - emotional reactions to pain
 - verbal and nonverbal expression of pain
 - care and care practices to alleviate pain ?
- What are the differences and similarities between the professional nurses' and clients' expectations of pain management?

The aim was to explicate the similarities and differences on pain perception, between expatriate nurses and Muslim clients. The sources of data were clients suffering from pain and professional nurses caring for these clients. Leininger's data analysis enabler was applied (refer to section 3.3.3).

4.2. Coding system

After data-collection, researcher transcribed the data from the field notes and tape recordings, and specified text units. She imported the transcribed data into QSR NUD*IST 4.0. The researcher created nodes and node definitions, and coded each text unit under an appropriate node. The node definitions enabled the researcher to determine the appropriate location of each text unit. Coding and categorising was done repeatedly as new insights developed with regard to emerging meanings. The coding system and data categories are presented in table 4.1.

Table 4.1 Coding system

Category	Node	Category / node definition
Nurse-client interactions		Encounters between professional nurses and clients focused on pain assessment and management
Pain experience	Nature of pain	Feeling a particular physical sensation or emotion related to pain The physical characteristics of the pain sensation.
	Immediate reactions	Responses to pain that occur at once when the pain sensation is experienced
	Emotions experienced	Strong feelings experienced as a result of pain
Pain conceptualisation		To form ideas about the meaning of the pain sensation
	Biomedical explanations	Those descriptions used to indicate an association between pain and illness or other abnormal conditions of the body

	<p>Religious explanations</p> <p>Magical forces</p> <p>Holistic explanations</p>	<p>Those explanations that are based on a particular belief and faith in supernatural controlling power entitled to obedience.</p> <p>Explanations related to magical forces represent supernatural explanations other than God</p> <p>Holistic explanations refers to the total and all-inclusive management of pain by professional nurses.</p>
Pain expression		The words or gestures clients used to communicate pain
Pain management	<p>Personal strategies</p> <p>Cultural interventions</p> <p>Scientific interventions</p> <p>Interventions indicative of holistic care</p> <p>Barriers to effective nursing care</p> <p>Clients' expectations</p>	<p>Immediate and long term strategies clients and professional nurses use to alleviate pain.</p> <p>Practices that people normally adopt to deal with their own unpleasant pain sensation.</p> <p>Shared culture care patterns and practices that are valuable means to help sustain or maintain health and deal with pain.</p> <p>Professional nursing pain relief interventions, which are based on empirical evidence.</p> <p>Natural therapies, relaxation techniques, massage, and energy conservation measures.</p> <p>Barriers are obstacles which prohibit nurses to render effective nursing care</p> <p>The beliefs clients had that they would receive the care which they anticipated to receive.</p>

	Professional nurses' expectations	Anticipation of nurses regarding pain behaviour
Therapeutic relationship		The interactions between professional nurses and clients that influence healing or enhance the clients comfort levels.
Client satisfaction		A feeling of pleasure that clients experience if they receive the care they expected

4.3 RESEARCH SETTING

Data collection occurred in a health care institution. The researcher involved clients and professional nurses in a female surgical and a male medical ward. The female ward was a 24 bed unit, with a bed occupancy ranging between eighty five (85%) to hundred percent (100%). Most clients presented with acute health problems, and the length of stay ranged between four (4) to ten (10) days. A day shift consisted of three professional nurses, and the night shift consisted of two professional nurses. Besides professional nurses and clients, the ward had visitors who were constantly around, and helpers, contracted by the family, who stayed with clients throughout their entire stay in the hospital.

The male medical ward was a 24 bed unit, with a bed occupancy rate of seventy (70%) to ninety (90%) percent. Most clients were acutely ill, and the average length of stay ranged between six (6) to ten (10) days. A day shift consisted of three professional nurses, and night shift two professional nurses. The observations were conducted in side care units which had two clients. The visitors in this ward were less than in the female ward, and there were no sleepovers.

Observations were conducted on clients in the general and side (private) wards. Interviews were conducted on clients in the side (private) wards. Nurses were interviewed during on duty time. Available unoccupied rooms were used to conduct the interviews.

4.4 RESEARCH FINDINGS

4.4.1 Nurse-client interactions

Nurse-client interactions refer to encounters between professional nurses and clients focused on pain assessment and management. The researcher observed that the nurse-client relationships appeared to be more relaxed in the male medical ward than in the female surgical ward. Communication appeared to be good. The professional nurses' Arabic proficiency in the male ward was fair as compared to nurses in the female ward. The professional nurses seemed to be responding reasonably well and promptly to clients' requests for pain relief, and showed understanding for such requests. Pain assessment was performed occasionally.

The timing of responses to pain requests ranged from prompt to some delay. Professional nurses demonstrated caring acts, and communicated with clients casually. One nurse remarked that clients in that ward were not demanding and 'interfering'. According to her, clients who respect and trust the professional nurses' decisions to relieve pain were 'model' clients. A nurse mentioned that she expected clients to be cooperative, conform to the regimen, and to verbalise their needs. Professional nurses appeared to expect that clients demonstrate understanding of the ward regime. This could be interpreted as indicative of unequal power relationships existing between the professional nurses and their male clients.

A measure of paternalism, on the part of the professional nurses, may have been at play. This is quite surprising given the dominant position of males in the UAE. However, these clients were acutely ill and this could explain their apparent submissiveness. The professional nurses' attitudes may be perceived as domineering, that is, professional nurses feeling that they know what is wrong with the client, therefore, they will 'fix' it in the best way they know. It appears as if they expected clients to be 'obedient', and cooperative to ensure smooth running of the ward.

In the female surgical ward, the professional nurses' communication with clients was limited to verbal exchanges during ward procedures. The researcher observed language barriers, and apparent cultural strain on the part of both professional nurses and clients. Both clients and professional nurses demonstrated limited understanding of the worldviews and health care practices of each other. The professional nurses' Arabic levels ranged from poor to fair. Interpreters were called in case of perceived misunderstanding. It was often noted that the hospital interpreters did not have the basic knowledge of medical terminology. The researcher did not observe any occurrences of cultural assessments as part of the pain assessment procedure. The researcher observed inconsistencies between the clients' pain expression and the nurses' responses. In some instances clients would scream out and professional nurses either ignored or became irritated with the loud pain expression. This was followed up during active participation phase. In the male ward, the professional nurses performed caring acts and provided pain relief when requested; in the female ward, professional nurses followed routine rigidly. In situations where the prescription was *prorenata* (prn), professional nurses provided relief based on their own clinical judgment.

4.4.2 Pain experience

The Collins English Dictionary (1991:546) defines *experience* as "a particular incident, feeling, etc, that a person has undergone". For the purposes of this research study, pain experience refers to feeling a particular physical sensation or emotion related to pain. The experience of pain combines strong physical, cognitive and emotional components. Each factor may affect the sense of well-being and define how pain is perceived and evaluated (Closs & Brigs 2002:566).

4.4.2.1 Nature of pain

Nature is defined as 'the particular kind of thing' (Longman Dictionary of Contemporary English 1995:946). *Sensation* is defined as a feeling that is hard to describe, caused by a

particular event (e.g. pain), experience or memory (Longman Dictionary of Contemporary English 1995:1296). *Nature of pain* refers to the physical characteristics of the pain sensation. Sherwood, McNeill, Starck, Nieto & Thomson (2000:487) states that “how someone assigns meanings to the pain experience depends upon what is felt, understood and experienced”. The clients described their pain sensation in terms of the physical feeling involved, its intensity, location, radiation and frequency.

Some clients described the nature of their pain in general, vague terms. Their explanations included statement like “*you feel pain in your bones and body*”; “*my heart is heavy*”; “*my bones feel like they are on fire*”. Other clients were very specific about how they physically felt their pain. Their explanations included:

- “*It is tight and cramping*”; “*sometimes this pain takes my breath away*”.
- “*It suffocates me, you know what I mean? Like choking, that’s how terrible it can be*”.
- “*It feels like I would stop breathing*”.
- “*It is hot, pulling and overwhelming*”
- “*... my whole body is on fire*”.

Pain intensity refers to the force or the power of pain as experienced by clients. Clients qualified their pain intensity through words such as:

- “*... very sore*”
- “*... very strong*”
- “*... very painful*”
- “*... hard to tolerate, vicious, and excruciating*”
- “*... as if my body is tearing apart*”
- “*... sometimes it is excruciating, and takes my breath away*”.

Pain location refers to a specific area or locality that clients described as sore. Some clients were specific about the location of pain. This was explained in statements like:

- “*I feel it deep inside my body*”
- “*I feel it deep inside my abdomen*”.

- “... it hits in the heart”.

Radiation refers to the spread of the painful sensation namely, the direction or path of the painful sensation. A client stated:

- “It radiates to the back”.

Clients described the pain frequency in terms of duration and number of times the pain sensation was experienced. Various frequencies were given, which appeared to reflect the underlying pathology. For instance a client with gastritis described his pain as “coming and going”. A client suffering from pneumonia explained that “the pain is not always there, but when it comes then I know I am going to suffer”. According to Closs and Briggs (2002:4) different pains with different causes feel different.

Factors that aggravated pain were outlined. The clients seemed to have a clear understanding of their pain, and the factors that made the pain experience worse. Their explanations included:

- “It is exaggerated by exertion”.
- “It hurts a lot early morning when my stomach is empty. It comes and goes. It is not always present”.

The findings indicate that the clients’ descriptions of the nature of their pain sensation were clear. The terms used would enable professional nurses to derive a nursing diagnosis if they conduct pain assessments.

4.4.2.2 Immediate reactions to the pain sensation

Reaction means “a response to some foregoing action or stimulus” (Collins English Dictionary 1991:1290). Immediate reactions to pain are those that occur at once when the pain sensation is experienced. Reaction to pain is usually informed by the experiences the person has of pain and the meanings attached to that pain (Sherwood, McNeill, Starck, Nieto & Thomson 2000:487).

Informants reacted to the pain sensation by describing a sense of wondering what was happening, and uncertainty about the significance of their experience. Clients indicated that their immediate reaction was to ask questions about what was happening, why this happened and whether they would survive this experience. One client said: *“I wish I knew what is happening in my body”*.

Client’s immediate reactions appeared to be tied to their belief in the powers of the spirit. A client specifically turned to God for answers, and said: *“I ask Allah, what I have done to deserve this”*. Another one indicated a willingness to surrender to the will of God namely: *“Sometimes I ask Allah ‘why’, but, at the same time I think it is His will and I pray”*.

The above findings indicate that clients had a need to obtain information about their pain and specifically its causes. Professional nurses are equipped to provide biomedical explanations about their clients’ pain. However, the clients also needed to understand the spiritual significance of their pain. Professional nurses could involve the clients’ religious leaders in addressing the spiritual questions.

4.4.2.3 Emotions experienced as a result of pain

Emotion refers to a strong human feeling such as love, anger or fear (Longman Dictionary of Contemporary English 1995:449). Applied to this study, emotion refers to strong feelings experienced as a result of pain. Human emotions play a major role in the perception of pain. Pain can make people feel they have lost control because it often restricts their functioning and activities. Therefore, besides a physical experience, pain also becomes an emotional one (Bates, Edwards & Anderson 1993: 103).

In recounting their pain experience, informants expressed a variety of emotions. The data revealed that the clients experienced fear. Fear refers to a panic caused by impending danger (Oxford Dictionary 1999:231). The clients verbalised fear of what was happening

to them, fear associated with a sense of loss of control, and fear of the professional nurses who cared for them. Clients' responses are captured below:

- *“This pain scares me a lot”.*
- *“I am afraid to ask nurses to use the warm cloth, I told the doctor about it”.*
- *“The hospital injection is very good too, but it makes me sleep all the time. This scares me because I want to be fully awake and understand the process taking place in my body”.*

Pain provoked a sense of anxiety and distress. *Anxiety* refers to a troubled state of mind worry or eagerness, while *distress* refers to suffering caused by pain, grief or anxiety (Oxford Dictionary 1999:185). The clients were alarmed by their pain sensation. The clients appeared to experience anxiety because they were concerned about their health, and because of a sense of helplessness. One client stated: *“I am anxious about my health”*. Another confirmed by stating: *“It is very distressing and alarming”*. Fear, combined with anxiety, resulted in a sense of paralysis. One client said: *“I cannot do anything when it comes”*. The researchers' observations revealed that the clients' anxiety manifested in frequent requests for pain relief, facial expressions of anxiety, and over-reactions by the family members.

Loneliness is a state of feeling isolated or being without a companion (Oxford Dictionary 1999:375). One client expressed loneliness while in the hospital. This could be attributed to the fact that the hospital was a strange place full of strangers. Some clients dealt with their pain privately and it was a frightening experience. One client remarked: *“One gets frightened sometimes and lonely here”*.

One client explained that she experienced sadness. *Sadness* refers to sense of unhappiness caused by a situation (Oxford Dictionary 1999:570). She stated that by stating: *“I feel sad sometimes that my faith is low, but I am just a human being”*. However, this sadness appeared to be associated with doubts about her level of faith rather than the pain sensation itself. This is a further indication of the fact that pain is also a spiritual matter.

A basic religious orientation and hermeneutic of hope appears to accompany the clients' emotional involvement in their pain experience. This appears to be accompanied by acceptance of their pain, and hope that they would be healed. Ott, Khadhuri, and Al-Junaibi (2003:234) described Islam as a religion that is based on the belief in the supremacy of God, and a Muslim is a person who submits and surrenders to the will of God. This view was confirmed by the informants. The clients' responses revealed their trust in God and their willingness to surrender to His will. They said:

- *“Everything is in the hands of God. If He wants me to go through this pain, it is acceptable”.*
- *“We trust completely in Allah”, “... everything is in the hands of God”.*
- *“But we accept that all things depend on the will of God, the air we breathe, the food we eat and all the things we do”.*
- *“When I get healed my whole being will be healed. When I die it would be my time to go, yet I still have hope that I will get healed”.*

The clients believed God to be central to everything in their lives, yet, this did not mean that they just sat back and did nothing about their health. This implies that God has given people wisdom to seek help when they are sick. An informant said: *“We trust completely in Allah, but that does not mean we just give up, otherwise we would not be here (the hospital)”.*

The clients experienced negative emotions, but, their faith in God and willingness to surrender gave them a sense of hope which is positive.

4.4.3 Pain conceptualisation

Conceptualisation means “to form ideas about a situation or an event” (Longman Dictionary of Contemporary English 1995:497). In this study *pain conceptualisation* is defined as, to form ideas about the meaning of the pain sensation. In this present research study, a combination of worldviews and their religious orientation strongly influenced the

clients' conceptualisation of pain. The professional nurses viewed pain primarily from a biomedical perspective.

4.4.3.1 Biomedical explanations

Biomedical explanation refers to the application of the principles of the natural sciences especially biology and physiology to clinical medicine (Andrews & Boyle 1999:42). In the context of this study biomedical explanations are those descriptions used by informants to indicate an association between pain and illness or other abnormal conditions of the body (refer to section 2.2.1).

- *Clients' perspective*

Some clients appeared to link abnormal physical bodily processes to their pain. There seemed to be an understanding that pathological processes associated with disease may cause pain. These views are captured by the following statements:

- *“Pain means there is something wrong in your body”.*
- *“Illness and pain are similar, because, you can only get pain when you are ill”.*
- *“I have a disease hence I have pain”; “When you have disease, you get pain, like I have now”.*

Pain has also been associated with external conditions which influence the human body. An informant explained: *“My pain is caused by too much work and stress”.*

One informant related pain to irresponsible human behaviour such as failure to drink enough fluids. Given that the temperatures in the UAE reach 50 degrees Celsius in summer, there was merit to her explanation. The same client provided a solution for the problem, namely that people need to drink lots of water.

Professional nurses' perspective

Professional nurses viewed pain mainly according to a biomedical perspective. According to them, pain has a pathological basis which can be explained in terms of science. They attributed pain to bodily malfunctioning, and pathological processes associated with disease. Professional nurses' explanations for pain include:

- malfunctioning of one or more organs in the body
- some underlying pathology, like a swelling and pressure on the nerves
- diseases (angina, sickle cell anemia).

The professional nurses however, did not rule out alternative perspectives on pain causation, other than the biomedical perspective. In their words:

- *“Disease, health and pain have scientific basis. There is some pathology underlying the disease process, but, there are times when you are tempted to think that there's something beyond scientific explanations, especially when science fails to give us explanations”.*
- *“We are professional nurses. We are taught to believe in the power of science over disease, but we know for sure that science does not provide answers to all ailments. There must be some explanations for the disease other than science”.*

These findings revealed some similarities between clients and professional nurses regarding pain conceptualisation. The clients acknowledged the possibility of the presence of pathological processes, while the professional nurses attributed pain to specific conditions and pathology. It is evident that the professional nurses were willing to adopt a cultural relativist stance, by acknowledging that supernatural forces might be at play.

4.4.3.2 Religious explanations

Religion is “belief in, worship of, or obedience to a supernatural power or powers considered to be divine or to have control of human destiny; any formal or

institutionalised expression of such belief; the attitude and feeling of one who believes in a transcendent controlling power or powers” (Collins English Dictionary 1991:1309). Religion refers to peoples’ beliefs in the life of the spirit and usually in one God or a number of Gods (Longman Dictionary of Contemporary English 1995:1195). Applied to this research study, religious explanations are those explanations that are based on a particular faith. Informants made statements that denoted peace and acceptance of the way God works in the lives of people and issues like pain.

- *Clients’ perspectives*

The clients provided explanations about their pain, based on their religious orientations. The dominant understanding abstracted from the clients’ responses was that people need to trust and surrender to God, a position that is consistent with Islam. The concepts of health, illness, healing and religion were inextricably linked. It is therefore clear that health preservation cannot be seen in isolation from religion and God’s will (see chapter 2).

Informants’ responses reflected a belief in the power of God (Allah). They indicated that He created every living creature and that He makes it possible for humans to survive. The clients also appeared to consider God to be the source of their pain. In this sense pain can be regarded to be due to the will of God. Mills (2004:4) explains that sickness is believed to wake people up from heedlessness, guides them to give up their sins, makes them to think of the hereafter, leads them to pious foundations and makes them to be thankful to God. The findings of this present research are in accordance with this view. Informants made statements such as:

- *“God created everything, ‘hamdullah’ (praise his name), even this pain I have”.*
- *“Illness and pain reflect that something has gone wrong and God allowed that to happen”.*
- *“Inshallah” (meaning “God willing”).*
- *“We accept that all things depend on the will of God, the air we breathe, the food we eat, and all the things we do”.*

- *“I have to be brave because that's what God wants”.*

The clients indicated that God communicates with people in many ways, including through illness, pain and suffering. Pain may or may not be associated with illness. There may be a lesson from God inherent to pain and suffering. A client specifically indicated that God is not a punishing God, but, he merely reminds people to pray and be good. People need to engage in self-reflection to identify what they did wrong, or how they removed themselves from His presence. God can use His powers to draw people to him through pain. The informants explained:

- *“When God is talking to you for one reason or another you experience some pain mashallah (praise God)”.*
- *“It (pain) comes from many things that happen to us in this world, like not doing the right things. God becomes sad with you and allow disease and pain to inflict your body”.*
- *“It is time for me to look into my life and identify bad things that are against Allah's teachings and the Holy Quran. If I do well in Allah's eyes, I will be healthy”.*
- *“This pain is a reminder to His people to pray and be good to other people”.*

Pain and illness are regarded as God's gift, a blessing that God has bestowed on humans. This was reflected by the clients' expression of gratitude and acceptance of pain in the hope of receiving rewards in the afterlife. Some informants believed that God tests peoples' faith through trials, and that He will reward those who go through the suffering. The clients mentioned that rewards will follow their acceptance and endurance of their pain. This view provides hope to people during trying periods. Therefore, people may be willing to endure any suffering inflicted by God with hope of achieving good things from Him. The clients explained:

- *“Everything is in the hands of God. If he wants me to go through this pain, it is acceptable. I know if I do good things, there will be good life for me”.*
- *“God has given us many gifts; being healthy is a gift from God as well as being ill”.*

- *“Pain is from God. In this world we pass through many trials such as illness and pain. If we pass these trials, we will be rewarded by good health and the kingdom of Allah”.*
- *“Prophet Mohammed (peace upon him) said Allah created suffering and pain so that the hidden good in things should appear”.*
- *He uses His powers to cleanse me from my sins”*
- *“When we are in pain we thank God; when we are healthy we thank God too”.*

It was evident from the informants’ responses that some regarded God to be a punishing master. They explained that God punishes evil behaviour, and He shows His anger by inflicting pain on those who deviate from Islam’s teachings. This was highlighted by one informant: *“Allah must be angry with me. Why this pain”?*

- *Professional nurses’ perspective*

Most professional nurses viewed pain from a biomedical perspective, and only acknowledged, in general terms, that something beyond science may be involved. One nurse specifically mentioned the limitations of the biomedical perspective. She said: *“... yet, in all the knowledge we have about the causation of disease, there is another power we never get to hear about in the nursing literature and that is the hand of God on humanity”.*

The clients’ explanations revealed that the clients’ attributed pain to God’s will and a way in which he communicated a lesson. Pain is a gift from God because it awards opportunities for repentance and earning future rewards. The professional nurses’ responses revealed that they acknowledge the hand of God in health matters.

4.4.3.3 Explanations related to magical forces

Magic is “the art that, by use of spells, supposedly invokes supernatural powers to influence events; sorcery; any mysterious or extraordinary quality or power” (Collins

English Dictionary 1991:938). Magico-religious explanations represent supernatural explanations other than God provided by clients.

- Clients' perspective

Limited evidence of magico-religious explanations emerged from the data. A few clients attributed their pain to supernatural forces such as an evil eye. The evil eye has been reported in literature as a pervasive folk illness known throughout the Mediterranean and Spanish speaking cultures (Leininger 1988:188). It is believed to have powers to cast ill luck and even disease. Belief in the evil eye features in Islam mythology, and it is not part of the Islamic doctrine but features as folk religion ([http://www.e.wikipedia.org; 2005](http://www.e.wikipedia.org;2005)).

The clients indicated that the evil eye is an intentional result of envy. People with negative intents were thought to be particularly capable in casting the eye on their victims. A client stated: *“There are bad people out there who are not true Muslims; they have the bad eye. Thank God, I am still alive”*.

- Professional nurses' perspective

Professional nurses are trained to provide scientific explanations for any ailment. However, professional nurses are from various cultures, and their belief systems may also give rise to cultural meanings for situations and circumstances. Some of the professional nurses vaguely indicated that they were aware of the evil eye. They indicated that supernatural powers such as an evil eye cannot be ruled out simply because science cannot provide a basis for its existence. One nurse indicated that the evil eye is incorporated in the belief systems of some tribes in her country of origin. This demonstrates shared cultural beliefs across geographic boundaries. One nurse specifically attributed pain to an evil eye. She said: *“I am aware of cultural explanations of illness and pain. Much as I am a nurse, I cannot rule out the evil eye and engage in certain*

rituals to avoid been afflicted". It appears as if this nurse also engaged in cultural rituals to counteract the influence of the evil eye. Another nurse indicated that she was aware of the evil eye as it was part of the belief systems of some tribes in her country.

These findings revealed that, although clients believed in the absolute power of God over human kind, there was still a belief in magical forces causing harm in the form of disease and subsequent pain. It is also evident that some professional nurses maintain their cultural views on health and illness (including pain), despite their scientific training. They could therefore draw upon their own cultural understandings to enhance their abilities to render cultural congruent care.

4.4.3.4 Explanations related to the holistic perspective

Holistic perspective refers to the total and all-inclusive management of pain by professional nurses. It involves the appropriate care, actions and decisions, which often lead to accepting care offered (Leininger & Mc Farland 2002: 82).

- **Clients' perspective**

Some clients provided alternative explanations on pain and illness which were indicative of the holistic perspective. Some clients mentioned bad blood as an influencing factor. A client said: "*Some of these diseases are caused by bad blood*". Further probing revealed that bad blood meant that in times of sickness and pain, the whole body or all body systems are affected by bad things which needed cleansing.

The findings revealed that in addition to the biomedical and religious-magico explanations, pain was also conceptualised according to the holistic perspective.

4.4.4 Pain expression

Expression is defined as, *to tell people what you are feeling or thinking by using words, art, music or gestures* (Longman Dictionary of Contemporary English 1995:482). Pain expression refers to words or gestures clients used to communicate pain. The researcher supplemented the in-depth interviews with observations to capture clients' pain expression.

- Observational data

The researcher frequently encountered apparent differences between professional nurses' expectations on how clients should express their pain, and the clients' actual modes of expression. Some professional nurses appeared uncomfortable when the clients expressed their pain loudly. Some clients frequently requested pain relief, while the professional nurses ignored these requests or tried to convince them that pain relief measures were unnecessary. They possibly underestimated the clients' pain levels or were not convinced by the clients' means of communicating that they had pain.

A possible explanation for the above observations is that professional nurses may tend to base their judgments on physical, observable manifestations of pain and not necessarily the clients' subjective expressions. This explanation is supported by the following responses:

- *"When a person is in pain you will see observable changes in behaviour".*
- *"One can easily identify clients who are in pain".*

The clients verbalised their pain freely, verbally and non-verbally. Professional nurses often responded to what they perceived as the 'reasonable' pain relief requests, by asking the clients to wait for the next dose when it was due. In this instance the professional nurses' responses to the clients' pain requests were guided by the prescribed frequency of administration.

In some instances the professional nurses appeared to be uncertain or indifferent towards the clients' pain expression. One nurse commented: *'It is difficult for me to tell regarding some clients'*. Apparently this might be due to difficulties in interpreting the clients' ways of expressing their pain. One possible explanation is a lack of communication. The researcher specifically observed minimal communication in the female ward. In this ward, the professional nurses would respond by either providing pain relief promptly, or by simply ignoring clients who groaned continuously and loudly. This occurred without first conducting pain assessment in order to gather specifically subjective data.

- *Clients' perspective*

Especially the female clients freely verbalised their pain. Religious expressions were dominant. They would call out *'yarrop'*, *'yarrop'* (my God, my God) or *'inshallah'* (thank God).

Some clients indicated that they expected professional nurses to offer pain relief, even if they do not specifically request it. It seemed that they expected that the professional nurses would sense their need for pain relief and respond favourably. They therefore expected that professional nurses should anticipate their suffering and respond accordingly. This is captured by the following explanation: *'If I don't ask for pain I still expect them to give medication because they know I need it. It shows when I am in pain, it is intolerable'*.

Tolerance is defined as the point at which the individual withdraws or asks to have the stimulus stopped (Andrews & Boyle 1999:285). Some clients tolerated their pain for a while before asking for pain relief as indicated by one informant: *'In the hospital I don't show much when I have pain. It is embarrassing, but, when it is too much I tell the professional nurses and doctors'*. The researcher observed that male clients demonstrated a higher degree of pain tolerance than the female clients. Cultural factors might have contributed to this, as it is usually not expected of men to make 'unacceptable' verbal expressions.

Clients generally appeared to be satisfied with the professional nurses' responses to their specific verbal pain relief requests. A client said:

- *“If professional nurses don't give me pills, I ask for them, and then they always give me”.*
- *“They give me medication when I ask. It is good with me; furthermore, I don't expect anything from them”.*
- *Professional nurses' perspective*

The professional nurses reported that the pain expression by their clients was different from what they expected and that made them uncomfortable. They indicated that the clients' frequent requests for pain relief were signs of an inability to tolerate pain, which may be culturally determined. Some professional nurses seemed to have inculcated the culture of stoicism, and felt unsettled by the clients' loud cries and verbal expressions. They acknowledged that it is acceptable to show and verbalise pain; however, the professional nurses had difficulties in accepting uncontrollable screaming. The professional nurses expected clients to be stoic and show restraint. The informants explained:

- *“It appears in their culture they have to show when they are in pain”.*
- *“I find the screaming uncomfortable. It overwhelms me”.*
- *“When they exaggerate the pain, I get upset”.*
- *“You don't have to show the world that you are in pain”.*
- *“Most of the time it is the 'cold cases' who scream a lot”.*

The professional nurses indicated that they encounter difficulties in interpreting the clients' ways of pain expression. They were often uncertain about the intensity of the clients' pain and whether pain relief measures were required. This is further complicated by some clients' low pain tolerance, as perceived by the professional nurses. They explained:

- *“The problem is they are not able to describe their pain exactly”.*

- *“Maybe there’s something we do not understand in their behaviour, they cry for every little thing, especially the female clients”.*
- *“They are taught not to tolerate pain, so, it is difficult to know if they are in real pain or not”.*
- *“Sometimes it (pain expression) is proportional to their pain sensation”.*

True to their training, the professional nurses interpreted the clients’ pain expression according to the biomedical perspective. The professional nurses’ exercised scientific reasoning. This resulted in judgments, on the part of the professional nurses, that the clients’ demonstrated pain behaviour might be incongruent with their clinical diagnosis, and the level of pain normally associated with the diagnosis. They stated:

- *“Clients with serious illness will experience some form of pain”.*
- *“I think they exaggerate a bit”.*

Professional nurses based their reactions to pain on scientific understanding of the language of pain. They expected their clients to adhere to a specific regime of pain alleviation. It was evident that professional nurses lacked the skill in managing pain within the cultural perspective.

The data revealed apparent inconsistencies between the clients’ need for pain relief and the nurses’ responses to the clients’ ways of communicating their pain. This is due to failure to consistently conduct pain assessments on the part of the professional nurses, while the clients expected pain relief without even specifically asking for it. It is apparent that, although the clients freely expressed their pain, they did not necessarily specifically ask for pain relief. The nurses’ expectations of restraint may have further contributed towards a failure to promptly meet the clients’ pain relief needs. They seemed to use their own expectations of pain tolerance. There is also evidence of the professional nurses being judgmental and non-accommodating.

4.4.5 Pain management

Management refers to the act or skill of dealing with a situation that needs to be controlled in some way (Longman Dictionary of Contemporary English 1995:870). Within the context of this study, pain management is the immediate and long term strategies clients and professional nurses apply to alleviate pain.

4.4.5.1 *Personal strategies for immediate relief*

Personal is defined as something that involves you and yours and no one else (Longman Dictionary of Contemporary English 1995:1030). Strategy refers to a well planned series of actions for achieving an aim (Longman Dictionary of Contemporary English 1995:1426). In this study the concept *personal strategies* refers to the practices that people normally adopt to deal with their own unpleasant pain sensation.

The clients mentioned many immediate measures that they adopt to alleviate their pain. They indicated that they sit or lie still until the pain goes away, and take shallow breaths. The researcher's observations confirmed that clients mainly engaged in physical rest in an attempt to deal with their pain. The clients also indicated that they applied of heat to the affected parts. The researcher observed that some clients verbalised a wish for a warm bed. One client complained that the air conditioning in the ward exacerbated his pain. Interestingly, one client explained: "*I have to sit and listen to it until it goes away*". This may be an indication that he allows himself to experience and become aware of his pain. This may indicate a strategy to exercise internal control to alleviate his pain.

Some clients' responses were indicative of a view which stretches beyond their immediate circumstances. They adopted a long-term view on improving their well-being. They mentioned stress reduction, adopting good eating habits and slowing down in terms of working habits.

The findings indicate that when clients experienced a painful sensation, they applied various physical and spiritual measures to deal with it.

4.4.5.2 Cultural interventions

Culture refers to a patterned behaviour response that develops over time as a result of socialisation. Culture is shaped by the values, norms, beliefs and practices that are shared by members of the same cultural group (Giger and Davidhizar 1999:3). Intervention refers to the act of doing something to deal with a situation (Longman Dictionary of Contemporary English 1995:746). In the context of this study cultural intervention refers to the shared culture care patterns and practices that are valuable means to help maintain health and deal with pain.

- *Herbal remedies*

Herbs are plants that are valued for their medicinal properties. Herbal means made of herbs (Longman Dictionary of Contemporary English 1995:669). A remedy refers to medicine to cure illness or pain that is not serious (Longman Dictionary of Contemporary English 1995:1197). For the purposes of this study, herbal remedies are medicinal preparations, made of herbs, which are administered to alleviate pain. The herbal part of a remedy may come from the leaf, seed, root, fruit, or bark of the plant.

Clients' perspective

Clients indicated that they used various herbal remedies believed to have medicinal properties. Most of these were home remedies which were administered in the family context.

Some clients ingested helba seeds to relax the body. The common name for helba seed is “*fenugreek*”. These small stony seeds are from the pod of a bean plant. It is used in herbal medicine especially in the Middle East, North Africa and India. It is believed that the

seeds have nourishing effects when given to convalescents, and they have anti-inflammatory and anti-diabetic properties (Suttie [sa]:1)

Pain due to bad blood was treated by ingesting *holool*. The researcher struggled to obtain information on *holool* in the literature. The researcher was informed that this term is specific to the region in which the research was conducted. There is no data that suggest the spelling could be correct, in view of the wide differences in the language characters and symbols. The researcher was shown this herb by students who prepared presentations on herbal medicine. Holool is an herbal mixture, which boiled. It is ingested on an empty stomach, and is believed to purge bad blood, due to its laxative properties. According to one client, *“bad blood is cleansed by drinking holool. It makes you have a runny stomach”*.

The clients indicated that they applied Indian ointments to relieve joint pain. Apparently these ointments contain camphor. They often applied the ointment and wrapped the affected part in warm a cloth, or lie in a warm bed. Camphor is used in medicine for its calming and anti-inflammatory effects. (Grieve [sa]:1). The Indian herbs are popular in the Middle East. This may be due to the large presence of Indians in this country, and also due to intermarriage. In the previous years before the influx of Western health professionals, clients who needed tertiary health care were referred to India. Therefore, it appeared that the Indian culture might have some influence on the healing practices in the UAE.

Some clients believed that mixing garlic with lemon and rubbing the mixture on the forehead relieves headache, and another client believed that garlic boosted the immune system, and that it could be administered to treat various ailments. Garlic is reported to beneficially affect platelet function, blood pressure, and fibrinolysis. It was found to retard lipoprotein oxidation. It causes vasodilatation and has anti-platelet effects (Phelps & Harris 1993:476).

Professional nurses' perspective

Professional nurses demonstrated awareness of the importance of their clients' care practices. However, it was evident that most professional nurses had insufficient knowledge of the clients' cultural care practices. The professional nurses appeared to be uncertain about the herbal remedies which the clients administered for their pain. There was, however, evidence that they might be willing to practice culture care accommodation. This was captured by one nurse's explanation: "*We could do that to some extent, accommodate other options of care, but it is difficult when you have no knowledge of their traditions and customs*". This is an indication of the importance to improve the nurses' transcultural nursing knowledge.

Some professional nurses, however, appeared to be critical of the herbal remedies and did not view these as compatible with scientific treatment. A nurse mentioned: "*I do not expect them to use any of the home remedies in the hospital. What's the point of coming here then*"? Others were also critical, but acknowledged that cultural remedies could be beneficial to the clients. One nurse referred to the herbal remedies as concoctions. However, she also clearly indicated that she would be willing to adopt a cultural relativist stance, if the clients' safety is not compromised. She said: "*The family brings all kinds of concoctions. If it is not harmful; it is fine. If it helps relieve pain and heal the disease, it's ok by me. After all, that's what they use at home*".

The findings indicate that the clients often administered herbal remedies in addition to the prescribed medication. The professional nurses appeared to fluctuate between stances of cultural accommodation and ethnocentrism. Some seemed to accept the local cultural practices while, while others appeared to be critical of the use of herbal remedies in the hospital especially if clients' safety was at stake.

- Cupping

The clients indicated that they applied cupping to alleviate their pain. Some clients explained that that pain and disease are brought about by bad blood (refer to section 4.4.3.4). Therefore, the blood needs to be removed from the system by using the cupping method. Apparently the cup sucks dirt from one's blood. Cupping is one of the oldest methods of traditional Chinese medicine in which a cup is applied to the skin and the pressure in the cup is reduced (by using change in heat or by suctioning out air), so that the skin and superficial muscle layer are drawn into and held in the cup. Some people apply small amounts of medicated or herbal oils to the skin before the cupping procedure. Acupuncturists apply cupping to certain acupuncture points, as well as to regions of the body that are affected by pain (where the pain is 'deeper' than the tissues to be pulled). The most commonly method used consists of using both hands on the affected part with the person lying on the floor, and 'sucking' the bad blood to relief pain (Dharmananda [sa]:1)

- Incense

Incense is a preparation of aromatic plant matter, often with the addition of oils, intended to release fragrant smoke for religious or therapeutic purposes. Incense exists in many forms: raw woods, chopped herbs, pastes, powders, and even liquids or oils. Incense and herbs go hand-in-hand, and probably originated among the Indian Vedas (Oller [sa]:1). In this present research study, some clients mentioned that these practices were '*Bedaa*'. '*Bedaa*' describes any new practice that is not based on religion.

Clients' perspective

The data revealed that an evil eye was regarded as one of the causes of pain (refer to section 4.4.3.3), and treatment is therefore aimed at removing these supernatural influences. A client said: "*We burn incense 'Bakhor' to cast the evil spirits away*".

Nurse's perspective

The professional nurses communicated a different perspective regarding the incense because it involves some burning and smoke which affected everybody within the vicinity. They indicated the burning of incense is inappropriate behaviour in the hospital. They regarded a hospital ward to be a public venue, and people from various cultures often share the same physical space. Incense was regarded to be a private ritual that must be performed at home. The professional nurses appeared to find it difficult to accommodate the various rituals that have an effect on the physical surroundings that a number of people share. Professional nurses also wished that clients did not expect them to offer assistance during such rituals. One response captured the professional nurses' views on incense: *"I do not mind the prayers, but the incense is no good for us and other clients. Some clients seem not to mind. I asked one about it. She said it would not affect her, because it is between that person and God. I hope they do not expect us to be party to that"*.

The findings revealed instances of discrepancy between the professional nurses' views, and the clients' beliefs and practices regarding incense. There is a need for nurses to negotiate how to incorporate this care practice into the care plan and to ensure that it does not cause any discomfort on others.

- Religious interventions

In this study, the clients conceptualised pain in religious terms. Therefore, for clients, the dominant form of management of pain appeared to be of a religious nature. Religious interventions are those interventions that are based on particular beliefs or faith in supernatural controlling power entitled to obedience (Oxford Dictionary 1999:545).

Clients' perspective

The clients indicated that they rely on God for their healing, as explained by informants:

- “... *healing is from Allah...*”;
- “*I pray, it is God who knows my fate, not professional nurses*”.

As a result, their management practices are derived from their religious orientation. The clients explained that they, and their families, usually pray and read the Quran. The researcher observed that family members brought religious music and recited what was assumed to be Quranic verses in the ears of clients. A religious practitioner also participated when requested to do so. A client explained: “*My family recites the holy Quran verses for me, when I am in the hospital when that does not give relief, we call motawa (cleric), to pray for us*”.

The clients and their families engaged in prayers. Prayer awarded the clients an opportunity to seek forgiveness and to enhance their relationship with God. Prayer appeared to have had a therapeutic value, as one informant specifically mentioned that he found comfort in performing *Salaah*. *Salaah* refers to one of the five pillars of Islam. It involves ritual prayers that follow a certain sequence and statements that Muslims perform five times a day (Leininger & McFarland 2002:306). These prayers are performed irrespective of health or illness. When someone is ill, the prayers would be specific for healing. Those who pray also, acknowledge acceptance of God's will and the health outcome which would ensue. Prayer is essential to recovery and maintenance of health and well-being. The use of prayer beads reminds Muslims clients of the nearness of God and thereby serves to reduce anxiety and provides a sense of peace and well-being (Leininger & McFarland 2002:306). The clients explained this health seeking behaviour as follows:

- “*The first thing is to get your acts right with God through prayers. Praying gives a sense of calm and that is necessary to allow your body to fight disease*”.
- “*When I am sick, I pray and ask God to forgive me my wrong doings so that I can enjoy life after death*”.

One client indicated that doctors' and professional nurses' interventions are guided by God. Therefore, professional nurses should pray all the time and ask God to give them the wisdom to treat them well. However, this client did not wish to impose his wishes on the professional nurses. He understood that praying is a personal issue and accepted the principle of religious freedom. This is what he said: "...if they don't believe in God, it is ok, it is their choice".

The clients appeared to seek forgiveness for their sins through their actions. The clients explained that they make offerings by donating to the poor. Giving alms (offerings) is one of the five pillars of Islam (*zakat*). It refers to giving to the needy and to share what one has with those less fortunate. In Islam, it is obligatory to give to the poor especially during Ramadan (Andrews & Boyle 1999:421). In this way they ask God to have mercy on them and to forgive their sins. The clients also indicated that they invite people over for a meal. An informant explained: "*Once my family slaughtered a goat and invited a neighbour to dinner*".

Professional nurses' perspective

Prayers were acceptable to professional nurses. They acknowledged the importance of prayer in people's lives, healing and suffering. The professional nurses also appreciated the importance of the involvement of the family and the *Motawa* during prayer. The professional nurses indicated that practices that did not harm anyone, were acceptable. This was supported by the researcher's observations. Prayer did not interfere with the professional nurses' caring acts, and the professional nurses did not show any discomfort. One nurse explained: "*It is good to pray. I am from Pakistan. Most people are Muslims, and prayer is important in our lives and in healing suffering*".

One nurse specifically indicated that she was reluctant to help the clients to perform *Salaah*, and specifically to position themselves to face Mecca. She nurse remarked: "*They can pray. It does not bother me. The only thing is when they need someone to help them face Mecca, which I do not relate to, it becomes a problem*".

The findings revealed that the clients engaged in religious practices as part of their pain management strategies. The nurses respected this but some were reluctant to participate.

- Family involvement

The role of the family is very important in health matters among Muslims. The family is believed to have a moral responsibility to ensure the health of all the members. Self care is not an important concept. Family interdependence overrides individuality. The family ministers spiritual care during times of crises such as illness and pain. The presence of a family member during health assessment is acceptable and encouraged, therefore. Illness becomes a social matter (Athar 2004:3). This is supported by the data which emerged from this research study.

Clients' perspective

Data collected from clients revealed that the authority for decision making on health care resided with the family. Decision making on behalf of the clients was made collectively. The family members had to have a say. The researcher observed that family members participated in discussions and that consensus was sought, especially among the male relatives.

The importance of the family was evident in the wards. Family members spent considerable time with the female clients. The presence of the family members was of therapeutic value. The family members showed concern for the clients. The families also provided contracted helpers who slept in the wards and assisted long term clients with basic care. The female clients' husbands assumed a protective role. The male members of the family at times demanded 'extra' care for the clients.

The researcher's observations revealed a variety of physical care practices among the clients and their families. The family members assisted with basic care such as positioning of the clients and massaging. They brought home remedies, such as soothing ointments which they apply. They applied heat to the affected area and kept the client in a warm bed.

The family also assisted in meeting the spiritual needs of the clients. The family members participated in praying, performing *salaah*, reading the Quran, and burning incense. They also ensured that the clients were in a state of cleanliness of ablution (*whudu*). This means that the person and place of prayer should be free of all impurities before one can perform *salaah*. The following statements capture the family involvement:

- *“My family prays with me and we read the Holy Quran together”.*
- *“My family recites verses from the Holy Quran for me when I am in the hospital”.*

The family provided emotional support and security to the clients. Mutual understanding existed between the clients and their family. The family appeared to understand the clients' conditions, and their coping mechanisms. The clients remarked:

- *“My family helps me to tolerate this pain better”.*
- *“My family understands my illness better. They know what to do when I go into a crisis. I get this terrible pain and turn blue all over my body”.*

Professional nurses' perspective

The professional nurses encouraged family involvement in health care. However, they verbalised concern about the home remedies which the family provided (refer to the above section on herbal remedies).

The researcher observed that the hospital had a policy on visiting hours, but, the level of compliance was low. Despite this, the professional nurses appeared to appreciate the value of family involvement, especially in distracting the clients from their pain, and

providing basic care. One nurse remarked: *“Yes relatives are helpful especially when they sit with the clients and engage them in some sort of activity to keep them company.”*

The family members engaged in prolonged visits. In the female ward, family members were allowed to stay overnight. These prolonged presence of the family often created tension between the professional nurses and the clients’ families. The researcher observed a few instances when professional nurses needed to perform their professional duties but they did not respect the space that the professional nurses required. Their interference and demands made it difficult for the nurse to relax, exercise professional judgment, and perform their duties. Some professional nurses tended to perceive the family’s behaviour as a lack of trust in the professional nurses’ competence. The professional nurses said:

- *“The family members are here the whole day. That hardly gives us the chance to interact with the clients the way we would like to. I recognise the family importance in health care, but in the hospital it's kind of difficult”.*
- *“They brought the patient to the hospital to receive medical care. Therefore, they should allow us to do what we have been trained to do. Some families want to dictate to us what to do”.*
- *“We feel bad, especially when the relatives pretend to be the one's feeling the pain, and constantly ask for pain relief on behalf of the patient”.*

Some nurses believed that the continuous presence of family members denied the clients the opportunity to learn to cope with their pain and illness. The prolonged family involvement was therefore perceived to be detrimental to the clients themselves. One said: *“I think that family members reinforce clients' non-coping behaviour”.*

The professional nurses expected that family members should be courteous when they communicate with them. Some professional nurses complained that some relatives were unfriendly, and showed neither respect nor appreciation for their nursing care efforts. Some professional nurses complained that especially the male relatives treated them like maids, and disregarded the hospital schedule. A few professional nurses acknowledged that some clients and relatives were courteous and appreciative. They however stressed

that there should be limits to what the family can do. The professional nurses wanted to provide care in the best possible manner according to the training they received, yet they felt helpless when the family seemed to ‘take over’.

There were differences among the professional nurses on the value of family involvement in the health care setting. Some appreciated their presence in assisting clients with basic needs, but on the other hand, they were seen as ‘interfering’. Professional nurses could have handled the situation better if they had some basic knowledge of the cultural practices of their clients. The role of the family appeared at times to be in conflict with the nursing culture.

4.4.5.3 Scientific interventions

Science refers to knowledge about the world, especially based on examination and testing and on facts that can be proved (Longman Dictionary of Contemporary English 1995:1274). In this study scientific intervention means professional nursing pain relief interventions, which are based on empirical evidence.

- *Pain assessment*

The professional nurses indicated that they sometimes conducted pain assessments and they relied mainly on objective data. They appeared to interpret their clients’ pain from a biomedical perspective. The researcher’s observations confirmed this. However, the professional nurses did not gather any cultural data during pain assessments.

- **Objective data**

Professional nurses reported that it is easy to make conclusions about their clients’ pain on the grounds of observable, physical signs. Professional nurses indicated that they derive their understanding of clients’ pain from physical signs such as:

- changes in their vital signs,

- excessive sweating
- observable behavioral changes, such as crying or groaning
- restlessness

- **Subjective data**

Professional nurses indicated that their clients' pain means of pain expression confused them and it was therefore difficult to interpret the subjective data that they gather (refer to section 4.4.3). Cultural differences appeared to contribute to this. The professional nurses explained:

- *"In my country clients know how to describe their pain sensation. They use familiar language. Here it is difficult. You barely understand the location of pain, what more of the intensity. So we just give medication and do our best".*
- *"Most (clients) fear the worst at any given moment - all pain is serious or fatal. They are taught not to tolerate pain so it is difficult to know if they are in pain or not, because they constantly ask for analgesics".*

- Biomedical interventions

Biomedical interventions are the curing medical regimes that professional nurses follow in a health care setting. Professional nurses are trained to provide care using scientific, rational explanations to guide their decisions about care (refer to section 2.2.1). The focus of care is on managing the disease and the underlying pathology. The biomedical model of care appeared to provide the basis for professional nurses' decisions and actions in providing care for their clients. The professional nurses also brought their worldview and professional values to the pain relief care setting. The researcher observed that the professional nurses followed the hospital routine and the prescribed intervals for administering analgesics. Their decisions and actions were based on the hospital protocols and the scientific framework that informs their profession.

Clients' perspective

The fact that the clients were admitted to the hospital indicated that they sought medical care from health professionals. The clients mentioned that they accepted the pharmacological medicine offered to them orally or intramuscularly. The responses also indicated that the clients underwent laboratory tests. They appeared to be satisfied with their treatment:

- *“In the hospital I take pills and injections. They are good”.*
- *“Medication is ok for me, and the professional nurses do the tests and tell me the results, they are good”.*
- *“You have to get medication for it (the pain) to get well. ... inshallah (God willing)”.*

The clients appeared to believe that medication will bring prompt relief. Some demanded medication frequently and seemed not to understand the professional nurses' explanations on the importance of administering medications at the prescribed intervals. One client's response bore evidence of some insight into the mechanism of action of the medicine. The client said: *“I do not expect the pain to go away immediately. It takes time for medicines to work in your body”.*

A client indicated that the medication resulted in a sense of disempowerment. The client explained: *“The hospital injection is very good too, but it makes me sleep all the time. This scares me because I want to be fully awake and understand the process taking place in my body”.*

The clients mentioned various pain relief techniques, which they learnt through their previous experience, and through the professional nurses' health education. A client explained: *“For my pain, I drink plenty water and fluids. That's what professional nurses told me previously.”*

There was evidence that the clients complimented biomedical interventions with cultural interventions to obtain relief. One mentioned: *‘If need be, I will mix home remedies and hospital medicine’*.

The clients were generally content with the professional nurses and the care provided. Only a few indicated some dissatisfaction. One client expressed dissatisfaction with the environmental conditions in the ward, which seemed to aggravate the pain. The informant explained: *‘Sometimes I wish I could have a warm bed like at home. They open the air conditioner 24 hours a day. It can get very cold for me, and my pain gets worse’*.

Professional nurses’ perspective

The professional nurses showed concern for the clients. They reported that the nursing care could be improved if better communication could be established between them and their clients. The interviews with professional nurses brought to light that they employed the following pain relief measures:

- proper positioning and joint protection for clients with joint related pain
- ensuring that the clients are comfortable
- applying hot and cold compresses
- administering oxygen for post operative clients and for those with chest pain
- administering sublingual medication to provide fast relief for chest pain
- administering analgesics as prescribed by the medical doctor.

The professional nurses indicated that all the measures were followed up with effective follow up and evaluation.

The professional nurses indicated that their interventions also included health education on health promoting topics related to the clients’ lifestyle, diet, rest and posture. They also gave the clients information about the disease process and the dangers of self-medication. The effects and consequences of medication, specifically analgesics have also been explained to the clients. In addition the professional nurses mentioned that

clients needed to be taught about the hospital routine. The purpose appears to be to empower clients with self management skills.

The findings indicate that the professional nurses managed pain from a biomedical perspective. They based their judgments on observable manifestation pain which the clients presented with. Their interventions included various pharmacological and non-pharmacological measures, as well as health education. The clients also relied on biomedical pain relief measures, but they supplemented this with cultural remedies. The clients appeared to have had unrealistic expectations with regard to the frequency to which they could have analgesics.

4.4.5.4 Interventions indicative of holistic care

In relation to pain management, holistic care refers to the total and all-inclusive management of pain by professional nurses. It involves the appropriate care actions and decisions, which often lead to accepting care offered (Leininger & McFarland 2002:82). Holistic care includes natural therapies, relaxation techniques, massage, and energy conservation measures. These were found to reduce stress and promote a sense of well-being. They produce a decrease in sympathetic nervous system activity (Andrews & Boyle 1999:298). The professional nurses appeared to understand their clients' need for holistic care. One informant stated: *"They (clients) would benefit from caring more than pills and injections. They seem to thrive on that. I cannot blame them. The hospital is a lousy place"*.

In addition to the biomedical interventions the professional nurses also applied alternative pain relief measures which were indicative of holistic care, such as distraction. Distraction from pain is a kind of sensory shielding in which one is protected from the pain sensation by focusing on sensations unrelated to pain (Andrews & Boyle 1999: 298). One nurse had this to say: *"We distract them from the pain sensation. We talk them out of their pain, use the 'nurse magic' "*.

The professional nurses also revealed that they adopted a caring approach. This became evident through their explanations. They explained that they optimised the therapeutic value of being present and giving the clients the necessary attention. One nurse remarked: *“We do provide the attention they (clients) need and they become very pleasant”*. They also indicated that they administered massage.

The interviews with the professional nurses revealed their concern and their intention to act in the best interests of their clients. Professional nurses also expressed doubts as to the real needs of their clients and whether their pain relief measures were effective. They explained:

- *“They (clients) feel it never gets better, despite treatment or analgesia given”*.
- *“We provide relief as needed, but I always feel there's something missing. I try to give relief as much as possible”*.
- *“I cannot think of other measures. In my country I would know what my clients need and would respond appropriately”*.

The data revealed that the professional nurses provided holistic care by supplementing biomedical interventions with alternative measures. This included distraction techniques and massage. This is consistent with those interventions which the family offered to the clients.

4.4.5.5 Barriers to effective nursing care

Barriers refer to obstacles (Oxford Dictionary 1999:46). In the context of this study, it will refer to obstacles which prohibit nurses rendering appropriate nursing care.

The professional nurses indicated that a high workload, time constraints, and a rigid hospital routine hamper their efforts to render effective nursing care. These factors also hampered the professional nurses' efforts to engage in practice which is indicative of a caring attitude. In the words of informants:

- *“It is this whole thing of routine in the hospital, which I think is rigid, or we make it rigid. We tend to work like machines sometimes, and miss out on the vital aspects of caring such as getting to know our clients better”.*
- *“It would be good if we had plenty time to assess every bit of needs they have, but , as you can see for yourself the ward is always busy and the demands very high. We just do not have time to do the right things sometimes”.*

The findings indicated that various realities related to the bureaucratic hospital system restricted the professional nurses in their efforts to meet all the clients’ needs based on thorough assessments.

4.4.6 Clients’ expectations

The term *expectation* refers to a belief that something will happen according to plan (Longman Dictionary of Contemporary English 1995:179). Client refers to someone who pays for services or advice from a person or an organisation (Longman Dictionary of Contemporary English 1995:237). Within the context of this study, the concept client expectation refers to the beliefs clients had that they would receive the care which they anticipated to receive.

- ***Pain relief***

Clients’ perspectives

The actions and responses of clients indicated that they expected immediate and prompt pain relief. The researcher observed that the clients frequently requested pain relief and openly verbalised their pain. Especially in the female ward, clients were always asking for pain relief. In some instances the relatives demanded relief from professional nurses and did not appear to understand the explanations provided by the professional nurses about having to adhere to the prescribed frequency of administration. The urgency of the clients’ pain relief needs is captured in the following statement: *‘I expect professional*

nurses and doctors to use any medical treatment to cure my disease and relieve my pain". It would appear that some clients did not expect much more than pain relief, as one client stated: *"They give me medication when I ask. It is good with me. Furthermore, I don't expect anything from them."*

Some clients explained that professional nurses are trained, and therefore they ought to be able to conduct pain assessments and initiate pain management measures proactively. Clients expected professional nurses to initiate treatment by identifying behaviours associated with pain and provide relief. The client explained:

- *"If I don't ask, I still expect them to give medication because they know I need it"*.
- *"In the hospital I expect the professional nurses to give patient care and understand our signals for pain relief"*.

Professional nurses' perspectives

The professional nurses, on the other hand appeared to experience uncertainty regarding their clients' expectations. This prevented them from promptly acting on the clients' requests. One nurse commented: *"Sometimes I feel as if I am floating. I cannot put my fingers on what my clients expect of us or me in particular"*. Another nurse answered by saying: *"I wouldn't know. I have never tried to find out"*.

The professional nurses reported that they found it difficult to determine their clients' needs. Especially in the female ward the researcher observed that communication was poor. Perhaps that contributed to the state of uncertainty. One said: *"I am not sure really, maybe they expect us to provide a much more holistic care that includes emotional, cultural and religious aspects"*.

The professional nurses' interpretations of their clients' expectations were consistent with the expectations which the clients verbalised. However, the professional nurses recognised the importance of pain relief, irrespective of the means. They said:

- *“One thing I know is they prefer health professionals including professional nurses to remove their pain, or fix any pain”.*
- *“As far as pain is concerned, I bet they think our job is to give analgesics whenever they cannot tolerate their pain, so we do. If we don't, big mushkila (problem)”*
- *“We do it all the time. Sometimes we use other means to relieve the pain”.*
- *“At the moment, what they want from us is analgesics”.*

The researcher observed that, at times, there was incongruence between clients' and professional nurses' expectations regarding the frequency of pain relief. Clients expected prompt interventions to reported pain, and expectations appeared to be consistent with the perceived peak of pain. On the other hand, professional nurses adhered to the prescribed frequency. Athar (2004:2) explains that an Arab patient consulting a doctor expects pain relief and to receive medication during the consultation. The clients expect that the doctors to give reasons for not administering medications. Clients expect to be actively involved in their care.

Some professional nurses showed empathy for their clients. They acknowledged that it might be difficult for clients to be cared for by foreign health professionals, especially when language barriers exist. One nurse stated: *All of us, professional nurses, doctors and technicians, are foreigners. It could be a bit overwhelming for clients. I think they do not have any place where they speak their language freely and express their needs, without feeling uncomfortable”.*

- ***Mutual respect***

Some clients explained that being respectful evokes reciprocal respect from the professional nurses. The clients therefore acknowledged the importance of mutual respect. The clients furthermore indicated that a caring approach would enhance the healing process. They added:

- *“I also expect professional nurses to have a smile on their faces”.*

- “...maybe to ask us often how we are...”.
- ***Communication and gender***

Communication between the professional nurses and their clients appeared to be difficult at times, due to an apparent language barrier. The clients indicated that they expect effective communication. This appeared to be lacking. The clients mentioned that many professional nurses do not speak Arabic. They expressed a need to communicate in Arabic, either directly or with the help of an interpreter. They indicated that the professional nurses should explain, in Arabic, the underlying disease process and their progress. The clients said:

- “*It would be good to have professional nurses who speak Arabic well, and who understand our language*”.
- “*Some of them are not willing to say even one word in Arabic*”. To say ‘*esallam allekum*’ (peace be with you) is not difficult”.
- ‘*If they don't feel comfortable with it (language), no problems. I do not mind. But then they must bring a Muslim person to help me*”.

One male client related his communication expectations to the gender issue. The gender divide became apparent in his remark: “*I wish we could have more male professional nurses because it is easier to communicate with them*”. The researcher observed that there is a clear division between men and women in the UAE. All government institutions provide separate amenities for men and women. However, in a therapeutic relationship, the interaction between males and females is allowed with some limitations. Yet, some clients still found it difficult to accept that fact.

Although the professional nurses indicated that they applied measures to distract the clients from their pain (refer to section 4.4.5.3), the clients indicated that professional nurses should do this more often. One client stated: “*I would like professional nurses to talk to me more often to distract the pain*”.

The findings indicate that the professional nurses and the clients agreed that the clients' most important expectation is prompt and effective pain relief. Another important expectation is effective communication, preferably in Arabic. The nurses were uncertain about what the clients expected beyond pain relief. Another important expectation was effective communication, especially being able to communicate in Arabic.

4.4.7 Professional nurses' expectations

Professional nurses' expectations are anticipation of behaviours likely to happen with regard to clients' pain (Oxford Dictionary 1999:222). The professional nurses revealed their own expectations on the clients' pain behaviour and the nurse-client encounters. trust their clinical judgements, and be active ly involved in their care.

- **Conformation**

The professional nurses expected the clients to follow doctors' orders and cooperate with the professional nurses. The professional nurses indicated that they expected that the clients should conform to the ward routine and comply with the rules. Professional nurses expected clients to understand the process of the disease that caused their pain, and the medical management of pain. They, however, acknowledged that the hospital culture does not support a caring approach. The professional nurses remarked:

- *“When a person comes to the hospital, it means she has placed her trust in the medical team, therefore, the team should be allowed to prescribe the best possible treatment plan and clients need to conform”.*
- *“I expect clients to know everything about their pain, so that they become more understanding”.*
- *“Sometimes we expect clients to behave in a certain way. It is how we are trained. We tend to forget the uniqueness of each individual. The hospital culture makes us have specific expectations regarding pain, disease etc”.*

- ***Active involvement***

Professional nurses expected clients to be active members of the health team and taking responsibility for the healing process. They believed that when clients are active partners, they will have realistic expectations about the progression of the disease and what the professional nurses can do to alleviate their pain. They said:

- *“I want clients to be active partners”.*
- *“...to participate in care by letting me know when she is pain. In this ward, they do it all the time, so it is not a problem. We provide relief as needed, but I always feel there's something missing. I try to give relief as much as possible”.*
- *“...to do everything they think would help them cope better”.*
- *“...to help us plan their treatment and not just expect us to perform magic and take away their pain”.*

- ***Respect and trust***

The professional nurses viewed the involvement of the family and the frequent requests for pain relief as indications that the clients had a lack of trust in the professional nurses' ability to provide effective care. Miscommunication led to poor outcomes for both the professional nurses and clients. Professional nurses felt that some family members and clients did not show respect for their professional experience and knowledge. Their views indicated that they expected clients to possess some degree of pain tolerance, and not to request relief all the time. They should trust the professional nurses' clinical judgment. They claimed that the clients did not treat them like professionals who were trained to make informed decisions. They expected clients to have adequate coping strategies for pain. One stated: *“I expect them to trust, and treat us like professionals who have knowledge”.*

The findings indicate that the professional nurses assumed a paternalistic and an ethnocentric stance with regard to pain relief. They expected conformance and compliance from the clients, and some understanding of the constraints that the

professional nurses face in relieving the clients' pain. The professional nurses expected that the clients and their families should trust and respect their clinical judgements. They expected active involvement on the part of the clients.

4.4.8 The therapeutic relationship: Professional nurses' perspective

Therapeutic refers to, '*intended to help treat or cure illness, making someone feel calm and relaxed*' (Longman Dictionary of Contemporary English 1995:1496). Relationship refers to the way two or more people are connected to each other (Longman Dictionary of Contemporary English 1995:1193). Therapeutic relationship refers to the interactions between professional nurses and clients that influence healing or enhance the clients' comfort levels.

The professional nurses reported that it was difficult to establish a good therapeutic relationship with their clients because of the perceived lack of trust on the part of the clients, cultural and religious differences, and language barriers (refer to section 4.4.5.5). Cultural and religious differences appeared to be the most important barrier to establishing a good therapeutic relationship. One nurse indicated: "*I think the most important barrier is religious differences. Some clients are quite sticky about their religions and kind of expect us to understand it. Somehow I think it gets into the way of good relations.*" A lack of knowledge on the local traditions, and the misunderstandings this ensues, further complicate the nurse-client relationship.

The nurse-client relationship was further complicated by language barriers. One nurse believed that the clients would prefer to be cared for by Emirati professional nurses who speak their language and understand their local traditions. The use of hospital interpreters was viewed as problematic by professional nurses. They indicated that the interpreters' proficiency in English was almost the same as that of the clients. The researcher also observed that they did not have adequate insight into medical terminology.

The clients' confusing ways of expressing their pain, were thought to contribute to failure to match nursing interventions with the clients' expectations.

The findings indicate that a lack of trust and mutual understanding were detrimental to the therapeutic relationship between the professional nurses and their clients. Ineffective communication and cultural and religious differences aggravated the situation.

4.4.9 Client satisfaction

Satisfaction refers to a feeling of pleasure and happiness because a person has achieved something he/she wanted (Longman Dictionary of Contemporary English 1995:1265). In the context of this study client satisfaction refers to a feeling of pleasure that clients experience if they receive the care they expected.

Despite reported misunderstandings and differences in expectations between the professional nurses and their clients, evidence of client satisfaction emerged from the data. The clients reported that the professional nurses' clinical decisions and subsequent actions on pain management were generally good, and resulted in satisfactory outcomes. The clients expressed satisfaction with the medication provided and the professional care rendered. They appeared to trust the caregivers. They explained:

- *“The professional nurses are good here. They always give me pain tablets when I ask”.*
- *“The injection is very good”.*
- *“The medication is ok for me”.*
- *“I trust the professional nurses and doctors. They are doing their best for mankind, hamduallah (praise God)”.*

The clients also indicated that they are satisfied with the professional nurses' professional knowledge and their understanding of the clients' medical conditions. The clients appreciated the professional nurses' efforts to explain test results to them. They generally voiced their trust in doctors and professional nurses despite the communication problems

that occurred. They showed understanding that professional nurses have a high workload while having to care for many clients.

However, the apparent lack of effective communication with the professional nurses had a detrimental effect on client satisfaction. Some clients expressed fear to communicate their needs to the professional nurses. As a result the professional nurses did not understand their clients' needs properly and could not consistently respond appropriately to the clients' pain relief requests. They believed that effective communication would enhance mutual understanding and improve the care outcomes.

The findings reveal that the clients were generally satisfied with the care received. This is indicative that the professional nurses were able to overcome the language, religious and cultural barriers to render care to the satisfaction of their clients. Some basis for rendering culturally congruent care may therefore have been established.

4.5 CONCLUSION

This chapter discussed the findings in relations to pain assessment. Data from professional nurses reflected the need to understand clients' world view rather than rely on biomedical assessment only. The findings revealed that for clients the dominant form of pain management appeared to be of religious nature. Prayer appeared to have a therapeutic value for key and general informants. Magico-religious beliefs were also observed.

Following is chapter 5 which elaborates on the similarities and differences found, briefly discuss the conclusions reached, and make recommendations for practice and further research.

CHAPTER 5

DISCUSSION OF THE RESEARCH RESULTS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This qualitative ethno-nursing study was conducted to answer the following question:

What are the culture care similarities and diversities between professional nurses and clients with regard to their pain perception?

This chapter provides discussions on the research results. Leininger's (1988:52) theory of culture care diversity and universality served as an interpretative framework. The central purpose of Leininger's culture care diversity and universality theory is to discover, document, interpret, explain and even predict some of the multiple factors influencing care from an emic and etic view as related to culturally based care (Leininger & McFarland 2002:76).

5.2 DISCUSSION OF THE RESEARCH FINDINGS

5.2.1 Pain experience, emotions and immediate reactions to the pain sensation

The clients subjectively described the nature, intensity, location, frequency and radiation of their pain sensation, using terms which are compatible with the biomedical perspective (Refer to section 4.4.2). They were also clear on what aggravated their pain. Their descriptions generated important data which would enable the professional nurses to generate a nursing diagnosis when conducting pain assessments.

The clients' immediate reactions indicated that they needed information regarding the biological and spiritual significance of their pain. The professional nurses, on the other hand considered the biological significance of the clients' pain and were less inclined to consider its spiritual significance.

The clients' emotions that accompanied their pain were rooted in the physical, social and spiritual dimensions of human life. The clients' pain sensation was accompanied by negative emotions such as fear and anxiety. The clients feared the pain, the effect of the analgesics and the professional nurses. They were anxious about the physical health implications of their pain. Fear, combined with anxiety led to a sense of paralysis in at least one client. The hospital setting appeared to be facilitative of a sense of loneliness, namely feeling socially marginalised, for some clients despite the evidence of family involvement in the wards. In spiritual terms, the clients' pain reminded them of their vulnerability and their limitations as faithful beings. This resulted in feelings of sadness. The clients' faith, however, also gave them a sense of hope and motivated them to accept their pain and to seek treatment. They demonstrated their willingness to trust God and to surrender to His will.

5.2.2 Pain expression

There were cultural differences on the interpretative framework according to which the professional nurses approached the clients' pain expression. The nurses viewed the clients' pain in scientific terms, while the clients were subjectively involved in their pain. The clients' ways of expressing their pain were derived from their personal pain experiences. When interpreting the clients' pain expression, the professional nurses tended to consider the clients' physical, observable signs rather than their subjective pain experience. The professional nurses' point of departure was therefore their clinical judgments on the observable physical signs that pain might be present in a certain level of intensity. Consequently the professional nurses appeared to underestimate the clients' levels of pain, and the urgency of their pain relief requests. In some instances they

therefore tended to adhere to the prescribed frequency of administering pain medication, while the clients needed immediate pain relief.

Western cultures encourage stoicism while people from some non-western cultures tend to turn private pain into public pain (Helman.1994:192). This view was supported by the research findings. There were differences between the professional nurses' views on appropriate ways of pain expression the clients' actual ways of pain expression. The clients tended to freely express their pain. The professional nurses, who viewed pain from a biomedical perspective, were of the opinion that more restraint would have been more appropriate. The professional nurses attributed the clients' behaviour as indicative of a low pain tolerance and an inclination to exaggerate, especially when family members were present. However, some clients (especially the males) indicated that they did try to restrain themselves until the pain became unbearable.

There were differences between the professional nurses and the clients when making judgements on the clients' pain intensity. When interpreting the pain, the clients' point of departure was their pain experiences, while the professional nurses adopted a scientific point of view. This could have resulted in cultural misunderstandings. The professional nurses exercised scientific reasoning. They encountered difficulties in establishing the clients' pain intensity and the urgency of their pain relief requests. Their frame of reference was science and pathology, and the clients' clinical diagnosis. They considered physical and other behavioural changes to determine whether pain was present and whether pain relief interventions were required.

Some professional nurses thought that there was a mismatch between the clients' pain expression and their clinical diagnoses. Some clients, on the other hand, expected proactive interventions from the professional nurses. They expected pain relief interventions without having to ask. It appeared that the nurses sometimes responded promptly to pain relief requests, and sometimes requested the clients to wait for the next scheduled time for administering analgesics. This apparently depended on the nurses' interpretations on whether the pain relief requests were reasonable.

5.2.3 Pain conceptualisation and management

There were similarities between the professional nurses and the clients with regard to their explanatory models for pain causation, although they differed with regard to their dominant explanatory model.

Both the clients and the professional nurses provided biomedical explanations about the occurrence of pain, and acted accordingly. The biomedical perspective appeared to be the dominant perspective among the nurses.

The professional nurses specifically linked the clients' pain to pathological bodily processes and disease. They therefore provided biomedical explanations for the occurrence of pain. These explanations are rooted in the western worldview, science and biomedicine. They linked the clients' pain to bodily malfunctioning, pathological processes and disease. Professional nurses applied scientific methods to assess and alleviate pain. However formal pain assessments were only done occasionally. They mainly relied on objective assessment data to conduct pain assessments. The clients' verbal and behavioural modes of pain expression confused the professional nurses and this resulted in difficulties to accurately interpret the assessment data. There was no indication that they conducted cultural assessments.

With regard to pain management, the professional nurses applied pharmacological measures by administering analgesics as prescribed. They followed the ward routine. They supplemented this with health education on the disease process, the effects and consequences of the medication, and on the dangers of self-medication. They also administered oxygen where appropriate. Their non-pharmacological interventions included positioning the client, ensuring comfort, and applying hot and cold compresses. They also provided health education on

lifestyle, diet, rest and posture. The measures generally satisfied the clients although one client complained that the air conditioning resulted in a cold environment which aggravated his pain. Although the professional nurses were mainly oriented towards biomedical explanations for pain, they demonstrated some cultural relativism which would enable them to be open to the clients' views and explanations.

The clients provided some explanations which were indicative of a biomedical perspective on pain. They indicated that their pain might be indicative of stress, dehydration or illness. The clients employed measures such as rest and warmth for immediate pain relief. The clients and their families exercised pain management through adopting a comfortable position, massaging the affected area and applying heat to the affected area. These measures were similar to the non-pharmacological nursing interventions, which were mentioned above. One client mentioned water intake as a pain relief measure. The clients insisted on receiving analgesics whenever they needed pain relief, irrespective of the prescribed frequency of administration. They expected immediate relief and were generally satisfied with the effect of the medication.

The professional nurses on the other hand, were uncertain about the appropriateness and effectiveness of their pain relief measures. The clients indicated that they supplemented the professional nurses' biomedical pain relief interventions with home remedies. This is indicative of the co-existence of the scientific and generic (lay) health care systems. The clients also indicated that they employ health promoting measures such as stress reduction, lowering the pace of life, and following a healthy diet. These measures are indicative of a long term health promotion view.

The clients utilised herbal remedies to relieve their pain. Herbal remedies included helba seeds, holool, garlic mixtures, and camphor containing ointments. Apparently these herbal remedies are utilised for their relaxation, anti-

inflammatory, and laxative effects. The professional nurses were critical of the herbal preparations. They were however willing to practice culture care accommodation if these preparations are compatible with scientific treatment, and if the clients' safety was not compromised.

The clients provided religious explanations about the occurrence of pain, and acted accordingly. The nurses acknowledged the religious perspective. The religious perspective appeared to be the dominant perspective among the clients.

Some professional nurses acknowledged that supernatural forces might be at play when the clients experienced pain. They did not offer any specific explanations and did not indicate that they employed any spiritual pain management interventions. On the other hand, the clients mainly viewed pain from a religious perspective. They clearly indicated that physical and spiritual health are interrelated. The clients attributed pain to God, not in a direct causal sense, but, in a more general sense of God being responsible for some of the human afflictions. The clients viewed pain in positive and negative terms. Positively pain was perceived to be God's will and God's gift. Illness and pain were believed to be indicative of God's revelation to His people. It allows God to test peoples' faith and gives people the opportunity to earn rewards for enduring their suffering. It also motivates people to engage in self-reflection to identify what they did wrong and to accept the lesson from God inherent to their pain and suffering. Negatively viewed, pain signifies God's punishment for evil behaviour. However, pain allows people an opportunity to change their ways and seek repentance and purification. These results signify that professional nurses ought to consider the religious significance of pain during pain assessment and management.

In the hospital, the clients prayed for pain relief and for forgiveness for their transgressions which resulted in their pain. Prayer also served to stabilise their relationship with God. In addition, the clients, or their families, also read the Quran, recite Quranic verses. The clients also performed the Salaah, which entails

praying five times a day each day, irrespective of the presence or absence of illness and pain. The professional nurses were supportive of the religious rituals and the participation of family members or religious practitioners, especially since they considered these practices to be harmless. Only one nurse revealed that it is problematic if the clients ask her to help them with performing the Salaah, because she does not relate to it. Outside the hospital the clients and their families seek forgiveness through offerings.

Both the clients and the professional nurses provided magical explanations about the occurrence of pain, and acted accordingly.

The data revealed that some clients and professional nurses considered magical forces to be at play and pain management was aimed at counteracting magical influences. The informants also attributed their pain to an evil eye which envious people use to cast evil on other people. Both the clients and professional nurses mentioned this. One nurse also admitted to participation in rituals to counteract the influence of an evil eye. The clients indicated that they burnt incense to cast the evil spirits away. The professional nurses were critical of this practice, especially since the smoke might bother the professional nurses and other clients. A nurse specifically mentioned that she would not participate or help with burning the incense. These findings indicate that the clients and the professional nurses acknowledged the influence of an evil eye. Participating in rituals to cast away the evil eye appeared to be controversial from a nurse point of view.

The clients provided explanations about the occurrence of pain which were indicative of the holistic perspective. They acted accordingly.

There is also limited evidence that the clients conceptualised pain according to the holistic perspective, while the professional nurses did not offer any such explanations. Specifically from a client perspective, pain could result from bad

blood, namely the presence of impurities in the blood. This is opposed to “good blood” or blood that is free of impurities. The clients applied cupping to treat bad blood, namely to remove impure blood from the blood system. The professional nurses neither mentioned nor commented on the practice of cupping. Both the clients and the professional employed alternative health care practices such as massage and distraction techniques.

5.2.4 Family involvement

Family involvement was evident in the research setting, especially in the female ward. The family was involved by rendering basic physical care, administering home remedies and providing spiritual care. Especially the male family members acted as client advocates on behalf of the female clients. They communicated the clients’ needs to the professional nurses and demanded pain relief. The family was also involved in collective decision-making on behalf of the clients. The therapeutic value of the family resided in their presence, understanding and compassion, and in protecting the interests of the clients.

There were similarities between the professional nurses and the clients on the value of family involvement in client care. The professional nurses appreciated the value of family involvement in the care of their clients within certain limits, while the clients described its therapeutic value. Some professional nurses experienced the family as courteous and appreciative. They valued the basic care that the family rendered, and the fact that they offered distraction from pain. However, some of the professional nurses believed that limits must be placed on family involvement. The family often disregarded the hospital schedules. Their prolonged and intense involvement sometimes made it difficult for the professional nurses to make clinical judgments and to perform their normal duties. The family members’ over-involvement might have disempowered the clients because it resulted in diminished opportunities to develop personal coping mechanisms. The family’s presence often caused tension in the wards because the professional nurses felt unappreciated and disrespected at times. Some professional nurses perceived the family

interference to be indicative of a lack of trust in the professional nurses' competence. They took exception to being dictated on what to do. The professional nurses were uncomfortable with the family asking for pain relief on behalf of the clients.

5.2.5 Expectations and client satisfaction regarding pain management

There were differences between the clients' pain relief expectations and the professional nurses' views on when pain relief interventions would be appropriate. The clients indicated that their main expectation was to receive prompt and effective physical pain relief irrespective of the frequencies of their requests and the measures that needed to be taken to ensure pain relief. They expected that the professional nurses should understand the covert and overt signals indicative of pain, and that they should respond proactively and immediately. The professional nurses understood the importance of this expectation. They however indicated that they experienced much uncertainty about the intensity of the clients' pain and what they expected from the professional nurses.

The professional nurses indicated that they were often unable to always administer medications upon request, because clients often requested pain relief more frequently than the frequencies of analgesic administration which the doctors prescribed. The professional nurses expected that the clients should conform to the ward routine and comply with hospital rules. They should respect the fact that the professional nurses had to adhere to a prescribed treatment regime, and rather try to cooperate. The professional nurses expected that the clients should attempt to understand the underlying disease and the principles on which the medical treatment were based. They expected that the clients should trust the health professionals' clinical judgment about pain relief interventions. The professional nurses' expectations allowed for little margin for acting in accordance with each clients' unique needs and expectations.

Despite the differences in expectations the clients generally were satisfied with the care that they received. They indicated satisfaction in the professional nurses' efforts to

relieve their pain and the effect of the analgesics. The clients also appreciated the professional nurses' professional knowledge and understanding of their condition.

There were similarities between the professional nurses' expectations and the clients' behaviour with regard to client active involvement. The professional nurses indicated that the clients ought to be active partners in pain management by verbalising their needs and adopting coping strategies beyond pain medication. The research findings revealed that the clients gave expression to their pain. The clients and their families communicated pain relief requests and applied pain relief measures such as massage, heat application and distraction. However that fact that some clients were fearful of professional nurses and therefore did not verbalise their need for pain relief, demands consideration..

There were similarities and differences between the professional nurses and the clients on the clients' health care needs. The professional nurses' responses revealed that they thought that the clients required physical, emotional, cultural and spiritual care. The clients' however revealed their physical, emotional and intellectual needs. The clients expected a caring approach as manifested by friendliness and personal interest in the clients' welfare. They needed comfort and reassurance. Both the professional nurses and the clients expected the presence of mutual respect. The clients expected effective communication. They expected to receive health education in Arabic. Reality however indicated serious language barriers and ineffective translation services. The clients recognised that effective communication is a prerequisite for establishing a therapeutic relationship based on mutual understanding. The clients indicated that they were most dissatisfied with the ineffective communication which prevailed in the wards. Despite the language barriers, the clients were appreciative of the professional nurses' efforts to give them information about their condition.

5.2.6 The therapeutic relationship

There were similarities between the professional nurses and the family members' therapeutic involvement with the clients. Both the clients' families and the professional nurses were therapeutically involved with the clients through being present, giving attention to the clients, and applying the technique of distraction. The clients however indicated that the professional nurses should apply distraction more often. The professional nurses and the clients' families indicated that they massaged the affected area. Massage could contribute towards pain relief, and can also be considered to be a caring act which strengthens the therapeutic relationship.

The therapeutic relationship was hampered by cultural, religious and language differences. Especially critical were the language and religious differences. The professional nurses' limited knowledge on the local traditions and the misunderstandings ensued this. The professional nurses regarded a lack of trust on part of clients as detrimental to the therapeutic relationship. A high workload, time constraints and a rigid hospital routine hampered the professional nurses' efforts in rendering holistic and effective care, and to establish a caring environment. The clients indicated that they understood the constraints that a high workload place on professional nurses. However, some clients specifically indicated that they trust the professional nurses' intentions to do the best they can.

5.3 CONCLUSIONS

In this chapter, pain experience, expression, conceptualization, management, expectations, and family involvement is discussed.

The researcher derived various conclusions from the research findings, which are discussed below.

The clients' pain experiences had physical, emotional, spiritual, social and cultural dimensions:

The clients experienced their pain as a physical sensation which they described in terms that were consistent with the biomedical means of describing the characteristics of pain. The occurrence of pain has emotional consequences and the clients indicated the emotions which accompanied their pain sensation. Apart from worrying what went wrong in their bodies, the clients sought the spiritual meanings which were inherent in their pain experiences. It was perceived to be a consequence of their limitations as faithful beings. The clients' faith mainly provided the opportunities to seek answers and solutions. It served as an important source of strength and hope. In some instances the clients sought explanations and solutions in terms of magical forces. The social dimension of pain became evident in the involvement of the clients' families, in their health care. The family members acted as client advocates to secure pain relief, decision making resources and sources of protection and social support. The cultural dimension of pain became evident in the cultural interventions which the clients applied while they received medical treatment.

There were cultural diversities with regard to pain expression between the professional nurses and the clients

There were differences in the way professional nurses expected their clients to express pain and the clients' actual behaviour. Clients freely expressed their pain, while the professional nurses valued stoicism. While the professional nurses interpreted the clients' pain expression from a scientific point of view, the clients' ways of expressing pain were derived from their subjective pain experiences. The professional nurses were uncertain on how to interpret the clients' ways of pain expression. Consequently the professional nurses may have underestimated the clients' pain intensity and the urgency of their pain relief requests. The professional nurses' responses and the researcher's observations of their interactions with their clients revealed evidence of ethnocentrism and a judgmental attitude.

There were cultural universalities and diversities between the clients and the professional nurses with regard to pain conceptualisation, pain management and expectations.

There was evidence of both the biomedical and the generic (lay) perspectives in the research setting. The research revealed the involvement of the social and cultural structure dimensions of religion, kinship, and cultural values, beliefs and lifeways.

The professional nurses conceptualised pain mainly from a biomedical perspective. The clients, on the other hand, mainly adopted a religious perspective. However, the clients also offered some explanations according to the biomedical, magical and holistic perspectives. The professional nurses did not offer any explanations according to the holistic perspectives, but acknowledged that religious and magical explanations could be appropriate.

With regard to pain management, the clients revealed that they combined practices inherent in the professional and the generic (traditional) health care systems. They applied pain management strategies that are associated with the biomedical, magico-religious and holistic health care paradigms. The professional nurses, on the other hand, assessed (occasionally) and managed pain according to the biomedical paradigm and appeared to be compliant to the bureaucratic prescriptions of the health care institution. The professional nurses demonstrated cultural relativism. They applied some interventions which were indicative of holistic care. They accepted most of the clients' religious practices, but were uncomfortable in assisting the clients with some rituals. They adopted a critical stance towards some of the cultural practices, especially the burning of incense and the herbal remedies.

The professional nurses' relativistic stance could serve as a foundation for negotiating culturally congruent nursing diagnoses and care plans. The principle

of culture care preservation should be applied to the holistic and religious pain relief interventions. Culture care accommodation ought to be applied to the administration of herbal remedies, cupping and the burning of incense.

Sources of cultural conflict in the research setting hamper the professional nurses' ability to render culture congruent care:

Several potential sources of cultural conflict existed. The clients expected effective communication in Arabic, while the professional nurses spoke little Arabic. This resulted in poor communication, especially since the interpreters possessed insufficient language skills and knowledge of medical terminology.

There were conflicting views on the intensity of the clients' pain and the urgency of pain relief requests. While the clients expected immediate pain relief the nurses often delayed the administration of analgesics. Possible reasons are failure, on the part of the registered nurses, to consistently conduct comprehensive pain assessments, which included cultural assessments. This resulted in uncertainty, among nurses, with regard to how to interpret the clients' ways of expressing their pain and what they expected from them. Furthermore, the professional nurses relied on objective data and the clients' clinical diagnoses to make care decisions, while the clients' expressed needs were derived from their subjective experiences. The professional nurses expected that the clients should conform to the bureaucratic realities and the prescribed medical regime; the clients may have considered the professional nurses as paternalistic and ethnocentric.

Although the professional nurses valued the involvement of the clients' families, their prolonged and intense involvement, their perceived interference was a potential source of conflict. The family members sometimes made it difficult for professional nurses to make clinical decisions and to perform their normal duties. Furthermore the professional nurses perceived their over involvement to be indicative of a lack of trust in their clinical judgements. Professional nurses took

exceptions at being dictated to, especially by the male members of the family. They perceived the family members' behaviour as indicative of disrespect and a lack of mutual understanding. On the other hand, the professional nurses acknowledged that their lack of knowledge on the clients' religious and cultural practices may have aggravated the lack of mutual understanding.

The professional nurses were able to overcome the potential sources of cultural conflict because the clients indicated that they were generally satisfied with the nursing care which they received. A foundation for rendering culturally congruent care was therefore already established.

Professional nurses, clients and the clients' families are role players in establishing a therapeutic relationship which revolved around pain management.

This study showed that the clients dependent on family and professional nurses for recovery and pain relief. The family provided for the physical, emotional and spiritual health care needs of the clients. They furthermore assisted in decision making and acted as client advocates to secure the necessary care from the professional nurses. The professional nurses provided physical care and health education. They partly succeeded in meeting the clients' emotional needs.

5.4 RECOMMENDATIONS

5.4.1 Recommendations with regard to education of professional nurses

It is recommended that foreign professional nurses undergo a cultural orientation programme.

The proposed cultural orientation programme should cover basic aspects of local care practices and Islam, and the principles of transcultural nursing. This would prepare the professional nurses to provide cultural congruent care.

Culturally competent professional nurses recognise similarities and differences in values, norms and health care practices regarding pain and pain management. Professional nurses would be in a position to recognise the value of diversity.

The professional nurses should be given opportunities to develop self awareness to deal with their own biases and examine how they deal with difference.

It should be recognised that these professional nurses may have to deal with their own cultural shock, before they could be expected to render culturally congruent care.

Professional nurses experience culture shock on arrival and it is through well planned orientation and induction programs that the professional nurses would be able to assimilate the difference among themselves and between professional nurses and clients.

It is recommended that a short course in pain assessment, with specific reference to cultural assessment be offered to professional nurses

Leininger (1996:34) posited that a client who experience nursing care that fails to be reasonably congruent with his/her beliefs and patterns of care will show signs of cultural conflict. The implication of this study for professional nurses is improved competence in pain assessment in a cultural context and development of a culturally congruent pain intervention plan.

The core of the proposed short course should be pain assessment. This course should develop the professional nurses' skills in gathering biomedical and cultural data pertaining to pain. The cultural data should include:

- Cultural explanatory models for pain and illness
- Cultural pain expression practices
- Religious and cultural pain management practices

The professional nurses should be motivated to accept and consider the clients' subjective means of pain expression. They should learn to confidently and accurately interpret the clients' subjective expression of pain....

The short course should also enable the professional nurses to develop culture congruent care plans for pain. The care plans should incorporate relevant care practices from the biomedical, magic-religious and holistic paradigms. The care plans should bare evidence of the preservation of beneficial and harmless cultural care practices. Professional nurses would be in a position to acknowledge the existence of other culturally relevant viewpoints and offer client centred care. Provision should be made for health education aimed at helping the clients to restructure harmful care practices.

It is recommended that an Arabic language course be offered to foreign professional nurses.

The language course should enable professional nurses to develop communication skills in relating to people who speak Arabic.

The language people use to express pain is embedded in culture, people act toward objects and others on the basis of meanings that have been created. These meanings have been found to be different for cultural groups. This is the language that professional nurses are expected to learn.

The language course should also include other aspects of communication such as non verbal messages embedded in culture; this will enable professional nurses to appreciate the cultural phenomenon of pain communication.

5.4.2 Recommendations with regard to clinical practice

It is recommended that the clients receive information about the physical and spiritual significance of their pain.

Effective communication in the health care setting need to start with professional nurses providing explanations to clients on the pathological processes which give

rise to their pain, explanation on the health and health care implications of their pain in simplified language.

It is recommended that provision is made for culture congruent physical, emotional, social and spiritual care for clients who suffer from pain

Most important is cultural assessment of pain and immediate, effective physical pain relief using biomedical and cultural measures.

Clients need to be supported emotionally by allowing the family to attend to the client in ways that are meaningful for them and provide presence as a caring act.

Professional nurses should accept that in the local cultures, decision making is a collective action that includes extended family members, especially in the case of female clients.

Nurse could also show appreciation and understanding of religious aspects of care, and integrate those in the health care plan.

It is recommended that professional nurses establish a therapeutic environment in which human caring prevails despite cultural differences

Professional nurses should accept that every individual is culturally unique, and use caution to avoid imposing on the clients their own cultural values. Professional nurses need to separate their own beliefs from the clients' beliefs and values. Professional nurses must avoid being ethnocentric, judging clients from their worldview. The professional nurses must be guided by acquired knowledge in the assessment of clients; basic needs.

It is further recommended that professional nurses assess beliefs of clients about meanings of pain and assess clients' expectations of the health team, especially professional nurses. Understand clients' perceptions of pain behaviour within their cultural framework, the use of the care concepts of trust and being provided for are essential to help clients in pain.

Professional nurses must recognise that there is variations within cultures and therefore, avoid generalisations. This will lead to mutual trust and understanding between professional nurses, clients and families.

Matriarchal family patterns need to be recognised and respected, professional nurses to adopt a non judgmental approach to clients' belief systems.

Professional nurses should increase their efforts in provision of non pharmacological therapy, and include, comfort, touch, massage, reassurance and distraction.

Understanding communicative patterns would enhance mutual understanding and trust.

Professional nurses must also be aware that professional nurses are viewed in a subordinate role to doctors by local people. Initially professional nurses were recruited from Asia, house maids are mainly from Asia, for other clients, it is difficult to differentiate professional nursing and care provided by house maids.

It is recommended that the hospital managers establish a therapeutic working environment for professional nurses

Management should have policies on cultural diversity and translate those into procedures that aim to create a supportive environment to professional nurses.

The hospital management to recognise that cultural pain assessment is a key of both cultural competence and the delivery of cultural congruent care.

Workload of professional nurses is distributed equitably to allow professional nurses to foster nurse-clients relationship.

Experienced professional nurses should be allowed to take therapeutic decisions; management should provide an enabling environment with opportunities for growth. Giving these professional nurses the opportunity to grow would greatly enhance their sense of accomplishment; and subsequent high quality nursing practice. Most of these professional nurses are skilled to take therapeutic decisions, they are responsible practitioners and do not need a rigid ward routine to guide their practice.

5.4.3 Recommendations with regard to further research

It is recommended that a model for cultural assessment of pain in the UAE be developed through theory generating research. This approach is useful in discovering issues around cultural pain assessment and the processes nurses use to make effective decisions regarding pain relief. The discovery mode within grounded theory will lead to the identification of patterns in pain management.

It is recommended that an in-depth investigation is done on the pain experience of people and the emotions associated with it. The findings will enable health professionals to render holistic care that is client centred.

5.5 LIMITATIONS OF THE STUDY

Critics may indicate that the greatest limitation of this study is lack of generalisability of the research findings. Qualitative research is not aimed at generalising results but rather “at achieving an in-depth, holistic understanding of the phenomenon of interest” (Polit & Hungler 1996:238). Therefore, non-probability sampling was conducted and data was collected in two wards of one hospital. The researcher enhanced the transferability of the research findings by providing thick descriptions of the research setting and what she had heard and seen in relation to pain during data collection and data analysis. The depth of emic knowledge gained from this study regarding the influence of the social structures such as religion and culture on pain might help professional nurses in other parts of the county who may encounter clients who hold to a parallel worldviews.

Cultural and language differences between the researcher and participants were also noted, the researcher and the nurses were predominantly English speaking. Clients were predominantly Arabic speaking with very limited ability to speak English. The researcher relied on interpreters for clarity of difficult concepts, but was able to conduct a simple conversation in Arabic. Some of the valuable information might have been missed during

the discussions. Throughout the encounter with key informants, the researcher demonstrated utmost respect for Islamic beliefs and teachings.

5.6 CONTRIBUTIONS OF THE STUDY

This research study generated in-depth contextualised knowledge on pain behaviour in the United Arab Emirates. This study provided a framework for cultural congruent care, and revealed the need for hospital management to make culturally congruent care an integral part of a professional nurses' orientation in order to provide client centred care.

5.7 CONCLUSION

This study focused on pain assessment within a culturally diverse UAE. The study set out to explore the differences and similarities in conceptualization, experience, expression, and management of pain between nurses and clients in the UAE. The findings confirmed that nurses rely on biomedical approaches in assessment and relief of pain. Clients were found to use religion as their main point of reference for any inflictions on their body, with some providing magico-religious explanations. Clients also relied on the family for emotional support and used biomedical, spiritual and cultural remedies in the relief of pain. Religious factors had significant impact on clients' general behaviour.

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United Arab Emirates



دولة الامارات العربية المتحدة

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منطقة العين الطبية

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9 August 2004

Ms. MM Ramukumba
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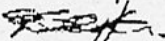
Re: Permission to conduct research project

Dear Ms. Ramukumba,

I am pleased to inform you that your study: 'Pain assessment in the culturally diverse UAE context' has been approved.

You are requested to respect the confidentiality of the study participants and the hospital.

We thank you for your interest in our nursing services.

LIZ SOJKA 

Acting director: Nursing & Quality



23 March 2004.

Ms. A. Yazbek
Director: Continuing Education
Al Ain Medical District
Ministry of Health
Abu Dhabi

Re: Permission to Conduct a Research Study - "Pain Assessment in a culturally diverse United Arab Emirates context"

Dear Ms. Yazbek,

I am a registered Masters Degree student at the University of South Africa (UNISA). I am writing to request permission to conduct a research study in Abu Dhabi hospitals. The focus of my research is on the anthropological aspects of Pain.

I have attached a summary of my research proposal, letter of registration from UNISA, and would be happy to discuss this with you at your convenience.

Thank you for your kind consideration of this request.

Margaret Ramukumba
RN, RM, RNE, RCHN. BA Hons. M Ed.

Fujairah Nursing Institute
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ANNEXURE C

Permission letter to participants

Dear Potential Participant,

I am Margaret Ramukumba a student in the department of Health Studies at the University of South Africa undertaking Masters in Nursing course. As part of my studies, I am conducting a research project titled 'Pain assessment in the Culturally Diverse UAE context.'

You are invited to take part in this research project, which examines the meaning, experience, expression and management of pain by clients and nurses. The purpose of this study is to develop guidelines for nurses to render a culturally appropriate care to clients in pain.

You are invited to participate in this research. If you consent to participate, this will involve:

- Observation of normal ward routine
- Interview which will take about 20 minutes

To protect your privacy and confidentiality, you will not be asked to disclose your name.

Participation is **entirely voluntary**. You can withdraw at any time and there will be no disadvantage if you decide not to complete the survey. All information collected will be confidential. All information gathered from the survey will be **stored securely** and once the information has been analysed the interview guides and responses will be destroyed, no individual will be identified in any reports resulting from this study.

Please indicate whether you agree or disagree to participate in the study.

Agree:

Disagree:

Thank you for you interest,

MM Ramukumba

ANNEXURE D

INTERVIEW GUIDE: CLIENTS

BIOGRAPHIC DATA

- 1 What is your highest level of education? _____
- 2 How old are you? _____
- 3 What is your nationality? _____
- 4 What is your religious orientation? _____
- 5 What is your medical diagnosis? _____

INTERVIEW QUESTIONS:

- 1 How would you describe your pain sensation?
 Probing:
 Tell me more about how you react to your pain sensation.
- 2 What emotions do you experience when you suffer from pain?
- 3 What meanings do you attach to the pain that you experience?
 Probing:
 What, in your mind, are the underlying reasons for the pain that you experience?

4 How do you communicate your needs to the nurses?

5 What measures do you normally apply to alleviate your pain?

Probing:

Tell me more about the involvement of your family while you are in hospital.

Tell me more about your views on the nurses' scientific pain relief interventions.

6 What do you expect from the nurses in helping you to deal with your pain?

Probing:

Tell me more about your level of satisfaction about the nursing care that you receive

OBSERVATIONAL GUIDE: CLIENTS

1. PAIN SENSATION

- Verbal clues
- Non-verbal clues

2. PAIN COMPLAINTS

- Verbal
- Non-verbal

3. PAIN MANAGEMENT

- Whom do they turn to for help?
- What expectations do they express towards those who assist?
- What kind of assistance do they receive?
- What are their reactions to the kind of assistance received?

4. OUTCOME

- What are the observed outcomes of the pain alleviation strategies?
- To what extent was culture congruent care rendered?

ANNEXURE E

INTERVIEW GUIDE: NURSES

BIOGRAPHIC DATA

- 1 What is your highest nursing qualification? _____
- 2 How many years of professional experience do you have? _____
- 3 How many years of service in the UAE do you have? _____
- 4 How old are you? _____
- 5 What is your country of origin? _____

INTERVIEW QUESTIONS:

- 1 What are the underlying reasons for the pain that the clients experience?
Probing:
Tell me more about the reasons beyond science which you have mentioned.
- 2 What are your views on the clients' way of expressing their pain?
- 3 What are your views about the clients' pain management measures?
Probing:
Tell me more about your views on herbal remedies.
Tell me more about your views on incense.

Tell me more about your views on the religious interventions..

Tell me more about your views on the involvement of the clients' family members in the wards.

4 What nursing interventions do you apply to alleviate the clients' pain?

Probing:

Tell me more about the problems which you mentioned.

5 What are your views on the client's expectations with regards to pain management?

6 What are your views on the clients' pain alleviation expectations?

Probing:

Tell me more about your own expectations.

Tell me more about the problems you encounter with establishing a therapeutic relationship

OBSERVATIONAL GUIDE: NURSES

1 PAIN SENSATION

- Responses to the client's verbal cues that pain is present
- Responses to the client's non-verbal cues that pain is present

2 PAIN COMPLAINTS

- Responses to the client's verbal pain complaints
- Responses to the client's non-verbal expression patterns

3 PAIN MANAGEMENT

- What are the nurse's responses to the client's expectations?
- What expectations does the nurse place on the client?
- What kind of assistance does she render?

4 OUTCOME

- What are the main characteristics of the observed therapeutic relationship?