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Older Black Adult Osteoarthritis Pain Communication

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Abstract

A quantitative descriptive secondary data analysis design was used to describe older Black adult communication of osteoarthritis pain and the communication strategies used to convey the pain information. Pain content from 74 older Black adults with persistent osteoarthritis pain was analyzed with criteria from the American Pain Society arthritis pain management guidelines that included type of pain (nociceptive/neuropathic), quality of pain, source, location, intensity, duration/time course, pain affect, effect on personal lifestyle, functional status, current pain treatments, use of recommended glucosamine sulfate, effectiveness of prescribed treatments, prescription analgesic side effects, weight management to ideal body weight, exercise regimen or physical therapy and/or occupational therapy, and indications for surgery. Communication strategies were analyzed with criteria derived from Communication Accommodation Theory that included being clear, using medical syntax, using ethnic specific syntax, being explicit, and staying on topic when discussing pain. The majority of communicated pain content included pain location, intensity, and timing. Regarding communication strategies, most of the older Black adults used specific descriptions of pain and remained on topic. Fewer used explicit descriptions of pain that produced a vivid mental image, and few used medical terminology. Use of medical syntax and more explicit descriptions might improve communication about pain between healthcare practitioners and patients. Practitioners might assist older Black adults with persistent osteoarthritis pain to communicate important clinical pain information by helping them to use relevant medical terminology and more explicit pain descriptions when discussing pain management.

Keywords

Black American; pain; communication; arthritis; osteoarthritis; older adult

A total of 54.0% of Black adults age 65 and older, report arthritis pain (Bolen et al., 2010). The American Pain Society (2002) and American Geriatrics Society (2009) clearly indicate patient education, acetaminophen, and exercise as initial treatments for persistent osteoarthritis pain in older adults, but only a small percentage of Blacks use optimal osteoarthritis self management (Albert, Musa, Kwok, & Silverman, 2008). Older Black adults are more likely to use topical ointments (Albert, Musa, Kwok, Hanlon, & Silverman

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2008; Silverman, Nutini, Musa, King, & Albert, 2008), and over the counter analgesics (Albert, Musa, Kwok, Hanlon, & Silverman; Ruehlman, Karoly, & Newton, 2005), and are less likely to use diet supplement or diet change (Silverman et al., 2008) than White older adults when treating osteoarthritis pain. Black adults use fewer medications (Albert, Musa, Kwok, Hanlon, & Silverman) and rate their osteoarthritis analgesics as only moderately helpful (Dominick, Bosworth, Hsieh, & Moser, 2004). Few Black adults talk with their pharmacist about their over the counter non-steroidal anti-inflammatory drugs (LaCivita et al., 2009), which is particularly worrisome given the strong recommendation from the American Geriatrics Society that older adults not use non-steroidal anti-inflammatory drugs due to the serious consequences of adverse drug events (American Geriatrics Society, 2009). It is therefore critical for older Black adults to talk with their primary care practitioner to secure safe, efficacious arthritis pain treatments. The purpose of the current quantitative study was to describe osteoarthritis pain information and pain communication strategies used by older Black adults.

Communication Accommodation Theory and Pain Communication

The theoretical framework for the current study was Communication Accommodation Theory (CAT) which describes how people adjust their communication in response to their own needs and the perceived behavior of the person with whom they are speaking (Fox & Giles, 1993; Giles, 1973).). Approximation, interpretability, discourse management, and interpersonal control are strategies that people use to adjust their communication (Coupland, Coupland, Giles, & Henwood, 1988). Approximation involves paying attention to the other person's speech rate. Interpretability involves use of clear, explicit terms that help convey important information such as describing pain interference with daily functions such as the ability to walk or drive a car. Discourse management involves selecting the topic, contributing to the discussion by taking turns in the discussion, and maintaining focus on the pain topic until all the important information has been conveyed. Interpersonal control involves recognizing one's own responsibility to communicate. Interpretability and discourse management strategies are the two CAT strategies relevant to the current study. Effective use of interpretability and discourse management strategies by older Black adults might enhance pain management discussions with their health care practitioners and reduce pain management disparities for older Black adults.

Three research questions were addressed. What type of pain information is communicated by older Black adults with osteoarthritis pain? How much pain information do older Black adults communicate? What communication strategies do older Black adults employ to communicate their pain information?

Method

Design

A descriptive secondary data analysis design was utilized. Data was from a larger post-test only experiment that tested the effect of pain question phrasing on type and amount of pain information provided by older adults with chronic osteoarthritis pain (McDonald, Shea, Rose & Fedo, 2009).

Sample

The sample consisted of transcripts from the entire subsample of 74 older Black adults who participated in the larger study on chronic osteoarthritis pain. Inclusion criteria for the current study were Black adults age 60 years or older who reported having osteoarthritis pain presently at an intensity level of 4 or greater on a 0 to 10 pain intensity scale; and who

spoke, read, and understood English. Excluded were people with cancer pain. Participants were screened for eligibility prior to data collection.

Procedure

Summary of larger study procedure—The setting for the larger study was elderly low income congregate housing sites in urban and suburban settings. The Brief Pain Inventory was used to measure current pain intensity, pain interference with activity, and percent of pain relief from treatments. Demographic data including gender, age, and race were also obtained. All participants watched a video of a Black practitioner asking them about their osteoarthritis pain, and were asked to verbally respond to three questions. The participants were randomized to one of three initial pain questions: a) “Tell me about your pain, aches, soreness, or discomfort?” b) “What would you rate your pain aches, soreness, or discomfort on a scale of 0–10 (0 being no pain and 10 being the worst pain possible)?” c) “How are you feeling?” All of the participants were then asked the same two follow-up questions: a) “What else can you tell me?” and b) “What else can you tell me about your pain, aches, soreness, or discomfort?” The audio tapes were then transcribed verbatim and content analyzed by two independent raters blind to participant condition, to measure important osteoarthritis pain information. Criteria from the American Pain Society (2002) “Guidelines for the management of pain in osteoarthritis, rheumatoid arthritis, and juvenile chronic arthritis” were identified a priori and used to identify important pain information for practitioners to assess. The a priori criteria included type of pain (nociceptive/neuropathic), quality of pain, source, location, intensity, duration/time course, pain affect, effect on personal lifestyle, functional status, current pain treatments, use of recommended glucosamine sulfate, effectiveness of prescribed treatments, prescription analgesic side effects, weight management to ideal body weight, exercise regimen or physical therapy and/or occupational therapy, and indications for surgery. As reported in the larger study, inter-rater reliability of the osteoarthritis pain information for the full sample of 312 was .73 and percent agreement was 86.5% (McDonald et al., 2009). Pain information resulting from the content analysis was previously reported for the full sample (McDonald, 2009), and a subsample of Hispanic older adults (Jorge & McDonald, 2011), but not for the subsample of older Black Americans.

Current study procedure—In the current study, Krippendorff’s (2004) components for content analysis were utilized to examine CAT communication strategies used by Black older adults. Krippendorff’s components include unitizing, sampling, coding, and inferring. Unitizing is the process of examining a word or phrase that describes one of the a priori criteria. The unit of analysis was a word or phrase from the verbatim transcripts that described the five criteria derived from CAT: clarity, medical syntax, ethnic specific syntax, explicitness, and topic cohesion. One point was given for each of the criteria if a word or description that met the criteria definition was used. Repeated content was not awarded additional points. Thus, a total of five points was possible. Table 1 contains definitions and examples for the five CAT criteria. Coding was conducted independently by the authors.

Coding was compared, and disagreements noted and resolved through discussion. Krippendorff’s (2004) alpha, a more rigorous reliability estimate than percent agreement, was calculated to determine inter-rater reliability. The current study and larger study were approved by the university Institutional Review Board.

Analyses

The newly coded data for the CAT communication strategies were entered into a PASW version 18 database. Frequencies means and standard deviations were conducted to describe

sample characteristics, communicated pain management content, and the CAT strategies used by the Black older adults.

Results

Participants resided in low income elderly congregate housing. Housing ranged from large inner city high rises to smaller suburban housing units. The majority consisted of high school educated women, 35% of whom were widowed. The 74 older Black adults ranged in age from 62 to 91 years, with a mean of 73.0 years ($SD = 7.30$). They reported moderate pain intensity and moderate pain interference with activity. Table 2 depicts frequencies, means, and standard deviations of the pain intensity, pain interference with activity, and demographic data.

Older Black adults responded with a mean of 5.8 ($SD = 3.41$) and a range of 0 to 16 items of important pain information in response to all of the pain questions. Table 3 contains the frequencies for the type of pain information responses to all of the pain questions, and includes the total frequency for the pain content, and the number and the percentage of older adults communicating that content. The majority of older Black adults described pain location, pain intensity, and timing of the pain. A total of 43.3 % described their pain treatment, and 27.1% described treatment effectiveness in reducing pain. No one described use of glucosamine sulfate, treatment side effects, weight, or possible surgery for their osteoarthritis pain. Correlation of total pain information and pain intensity was $r(74) = .23$, $p < .05$, but non-significant for total pain information and pain interference with activity.

Almost all of the older Black adults used specific descriptions of pain $n = 68$ (91.9%), such as participant #31 who described, “The pain starts in the shoulder, ah, up to the side of the neck all the way down to the fingers...” While only $n = 29$ (39.2%) used explicit descriptions of pain that produced a vivid mental image. Participant #177 explained, “I can’t even hardly dress myself or take baths and stuff. A lot of times I have to have help.” Participant #299 also provided an explicit description of pain that reflected his decreased mobility, “Sometimes I can’t put my feet off the bed because of my knees are all swollen up. And they tingle. A lot. And they are paining me.” Only a few $n = 20$ (27%) used medical terminology or syntax in their responses, mostly to name the type of pain medication used such as Tylenol, Motrin, and Oxycontin. No ethnic specific terminology was identified. The majority $n = 64$ (86.5%) did not change away from the topic of pain before describing all pain information. Table 4 illustrates the frequencies of pain communication strategies used by Black adults. Content analysis for pain communication strategies resulted in 4 disagreements and 366 agreements across a total of 370 observations producing an inter-rater reliability of 0.98.

Discussion

The majority of older Black adults described pain location, intensity, and timing, similar to the pain content previously reported by the larger sample in the primary study (McDonald et al., 2009). Nearly half of the older adults described information about their pain treatments, which suggests that many are able to discuss pain treatments with their practitioner. Little more than one-quarter also talked about the effectiveness of their pain treatments. Treatment effectiveness might be critical to discuss when older adults continue to experience moderate or greater pain intensity and pain interference with daily functioning. Practitioners should query older Black adults about their current pain treatments and treatment effectiveness when pain intensity and functional interference remains moderate or more, or unacceptable to the older adult.

Older Black adults in the current study reported slightly lower pain intensities and less functional interference from pain than those in the primary study (McDonald et al., 2009). The lower self reported levels of pain and functional interference may be due to Blacks' tendency to underreport their disabilities (Burns, Graney, Lummus, Nichols, & Martindale-Adams, 2007). Conflicting data exists about the level of pain and disability reported by Blacks, however. Horgas, Yoon, Nichols, and Marsiske (2008) reported findings of increased disability among Whites. This is in contrast to the majority of other studies which report that pain and functional limitations are greater for Blacks than Whites (Allen, 2010; Bolen et al., 2010; Green, Baker, Smith, & Sato, 2003; Ruehlman, et al., 2005). Several studies indicate that Blacks report similar levels of pain and functional interference as their White counterparts (Burns, et al., 2007; Edwards, Moric, Husfeldt, Buvanendran, & Ivankovich, 2005). The conflicting results may be due to variation in research method. In any case, older Black adults in the current study reported moderate pain intensity and interference from their pain.

When given the opportunity to discuss their pain, older Black adults use helpful discourse management and interpretability CAT strategies by remaining on topic and describing their pain in specific detail, respectively. The use of open-ended pain questions by healthcare practitioners allows for the conveyance of more pain information (McDonald, et al., 2009). The results of the current study indicate that Blacks did not frequently use medical terminology in their pain discussions, however. Results were similar to those found for English speaking Hispanic older adults (Jorge & McDonald, 2011). In another study White older adults report significantly less difficulty in obtaining prescription medication for osteoarthritis than Black older adults, despite having similar insurance coverage for prescription medication (Albert, Musa, Kwoh, Hanlon, & Silverman, 2008). Increased use of medical terminology such as medication names might reduce difficulty in obtaining medications. Healthcare practitioners should familiarize patients with basic medical terms specific to their diagnosis and illustrate how use of basic medical terminology might help more clearly describe their pain self management to practitioners. For example, teaching a patient to say, "I take two Motrin every four hours" rather than "I took some pain pills."

A small but significant correlation was found between pain intensity and the amount of pain information conveyed by the older adults, supporting that older adults communicate more pain information as pain intensity increases. Increased amounts of pain information provide practitioners with more data on which to base pain treatments. The relatively small effect suggests that additional factors besides pain intensity might also impact the amount of pain information conveyed by Black older adults. Female gender was the single significant predictor of pain communication in a group of older adults with osteoarthritis pain. Pain intensity, pain interference with activities, race, ethnicity, and education level were not significantly related (Shea & McDonald, 2011). Practitioners should ask Black older adults with a history of painful osteoarthritis to tell them about any current pain problems.

Differences in pain communication among Blacks may be related to the use by some of African American English (AAE). AAE is a variation or dialect of the English language. "... it is a complex linguistic system whose rules for language form, content, and use differ from the characteristic of mainstream American English (MAE) dialects (Patton-Terry & Connor, 2010, p. 200). No ethnic specific syntax or AAE was identified in the current study however this may have been due to the study design. AAE may use English words, but with different intended meanings (Green, 2002). Without the ability to return to the study participants and question them about the meaning or use of particular words or phrases it is not possible to determine if ethnic specific syntax played a role in the pain communication in this study. If different meanings in pain communication are sometimes intended by older Black adults, practitioners might be unaware of the different meaning.

Empathy and perspective-taking might reduce practitioner in pain treatment decisions for Black adults. White nurses instructed to imagine how their patient felt while being examined, and how the patient felt about his or her pain, and how the pain affected his or her life responded with 55% less pain treatment bias in response to the Black patient film clip compared to nurses not instructed in perspective taking (Drewecki, Moore, Ward, & Prakachin, 2011). The laboratory experiment might not generalize to clinical practice, but the results suggest a possible source of pain management differences, and suggest a way for practitioners to improve pain management for Black adults.

Limitations

Study limitations must be considered when evaluating the results. The study was a secondary analysis. The older adults were asked to respond to a videotape of a Black practitioner, but they may have responded differently in a face to face discussion. In the primary study one data collector was Black and one was White. Participants might have responded differently to the Black practitioner video when data collection was conducted by the White versus the Black data collector. The nature of the primary study (responding to three questions about pain) might have encouraged the older Black adults to remain on topic, and might not reflect topic cohesion during discussions with practitioners. The participants in this study were self-classified as Black; however there are many different ethnic groups within the Black race. Each group may have different communication styles, health beliefs, or dialects. Participants were from low income elderly housing sites in urban and suburban settings, and might not be generalizable to older Black adults living in private homes, or those with higher socioeconomic status.

Research Implications

Further research might examine different Black ethnic groups. In addition, future studies should conduct qualitative research to explore the intended meaning of pain communication among Blacks and if any AAE is used. Blacks often use more nonverbal communication rather than language (Campinha-Bacote, 2009). Research is needed to investigate the relationship between verbal and nonverbal communication strategies among Blacks to effectively communicate pain. More pain information may be conveyed than detected by analyzing only verbal content. Research is also needed to test how teaching older Black adults about pain communication strategies may increase effective pain communication and thus improve pain management.

Conclusion

Older Black adults in the current study most frequently discussed pain location and intensity. They reported moderate levels of pain intensity and functional pain interference. While the older Black adults did stay on topic and use specific descriptions of pain, increased use of medical syntax and more explicit descriptions might improve communication about pain between healthcare practitioners and patients, and contribute towards greater pain relief for older Black adults.

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Table 1

Communication Code Definitions

Communication Codes	Definition	Examples
Clarity	Use of specific versus general or vague description of pain	Specific: "The pain in my right ankle is really bad. I use some Vicks that makes it feel better." Vague: "It hurts all over."
Medical Syntax	Use of any pain relevant medical terminology	"I took two Tylenol."
Ethnic Syntax	Use of uncommon pain communication related words or phrases	
Explicitness	Communication in a way that produces a vivid mental image	"I feel like the pain is pulling my leg apart."
Topic Cohesion	Staying on topic. No change away from pain topic before describing all pain information	

Table 2Participant Pain and Demographic Frequencies, Means, and Standard Deviations ($N = 74$)

Variable	<i>M (SD)</i>	<i>n (%)</i>
Age	73.0 (7.30)	
%Pain Relief ^a	73.4 (24.59)	
Pain Intensity ^b	4.6 (2.04)	
Functional Pain ^c	3.9 (2.71)	
Female		52 (70.3)
Male		22 (29.7)
Marital status		
Married		10 (13.5)
Widow		26 (35.1)
Divorce		20 (27)
Single		15 (20.3)
Separated		3 (4.1)
Education		
< High School		32 (43.2)
High School		33 (44.6)
> High School		8 (10.9)

^aPain relief percentage was measured on the BPI-SF 0 to 100% scale.

^bPain intensity was computed as the mean of the four BPI-SF 0 – 10 pain intensity items.

^cFunctional pain was computed as the mean of the seven BPI-SF 0 – 10 functional interference items.

Table 3Frequencies of Pain Information in Response to All Interview Questions ($N = 74$)

Pain Content	Frequency	<i>n</i>	Percent of Black Adults
Type	1	1	1.4
Quality	7	7	9.4
Source	21	14	19.0
Location	127	62	83.8
Intensity	66	44	59.5
Time	63	43	58.1
Affect	4	4	5.4
Lifestyle	8	7	9.5
Function	35	22	29.9
Treatment	47	32	43.3
Glucosamine	0	0	0.0
Treatment Effectiveness	23	20	27.1
Side effects	0	0	0.0
Weight	0	0	0.0
Exercise	4	4	5.4
Surgery	0	0	0.0

Note. The first question in the original study consisted of one of the following: Tell me about your pain, aches, soreness, or discomfort. What would you rate your pain aches soreness or discomfort on a scale of 0–10 (0 being no pain and 10 being the worst pain possible)? How are you feeling? Questions two and three were the same for all and respectively included: What else can you tell me? What else can you tell me about your pain, aches, soreness, or discomfort?

Table 4Black Adults Frequencies and Means of Pain Communication Strategies Use ($N = 74$)

Pain Communication Strategy	<i>n</i> (%)
Clarity	
Specific	68 (91.9)
General	6 (8.1)
Syntax (Medical Terminology)	
Used	20 (27.0)
Did Not Use	54 (73.0)
Explicitness	
Explicit	29 (39.2)
Not Explicit	45 (60.8)
Pain Topic Cohesion	
On Topic	64 (86.5)
Off Topic	10 (13.5)