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Life Course Experiences, Pain and Suffering: A Case Study of an Older Mexican American Woman with Mobility Impairment

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Abstract

There is a dearth of literature examining how adversity shapes the experiences of pain and/or suffering in a middle aged Mexican American women. The purpose of this qualitative descriptive study was to understand pain and suffering from a life course perspective as described by a Mexican American woman aging with early onset mobility impairment. This Hispanic woman experienced episodes of abuse and rejection over the life course, which may have significantly influenced her pain and suffering experience in adulthood. This adds to the literature on how adversity influences later life pain experience and provides insight on why pharmacological treatment alone may not be as successful as a holistic intervention.

Hay escasez de literatura que examine cómo la adversidad da forma a las experiencias de dolor y / o sufrimiento en mujeres mexicana-americana mayores de edad. El propósito de este estudio descriptivo cualitativo fue comprender el dolor y el sufrimiento desde una perspectiva de ciclo de vida como descrito por una mujer mexicana-americana envejeciendo con inicio temprano de deterioro de movilidad. Esta Latina experimentó episodios de maltrato y rechazo, que se percibió haber afectado su experiencia de dolor y sufrimiento luego como adulta. Este estudio aumenta la literatura sobre cómo la adversidad influya la experiencia de dolor más tarde en la vida, y nos permite comprender mejor como el tratamiento farmacológico por sí solo no es tan exitoso como pueda ser una intervención integral.

Keywords

Pain; Suffering; Mexican American Women; Mobility Impairment

When women with severe mobility impairments are asked to reflect on their life course disablement experiences, they may tell of feelings of pain and suffering due to unresolved psychological traumas from multiple adversities. Suffering may be evident as women relate

their past experiences with abuse, neglect, and poverty, which may influence their emotional capacity to endure high levels of physical pain in later life. Indeed, it is theorized that it is through the interpretation of past life course experiences, coupled with unequal access to care, that pain may be manifested as suffering in later years (Kahn and Steeves, 1996; Smedley, Stith, & Nelson, 2003). Furthermore, pain manifested as suffering can lead to difficulty functioning physically and emotionally, isolation, and diminished quality of life (Turk & Wilson, 2009; Cassel, 1991). Without a clear understanding of how life course events can compound the interpretation of pain to the point of causing suffering, providers may not understand a woman's full interpretation of her pain experience.

The purpose of this case study is to detail the life course experiences perceived to influence the interpretation of pain and suffering in a Mexican American woman aging with mobility impairment. This case study is provided as an exemplar of how accumulative adversity over the life course may influence the perception of pain and suffering in later life. In order to accomplish this goal the paper will include the following: a theoretical framework that will aid in interpretation and a review of the literature in relation to pain and suffering among Mexican Americans. In addition, details from case study finding, which were pulled from a larger ethnographic study of health disparities in disablement among Mexican American women, will be presented. Lastly, implications for pain management will be discussed.

For the purpose of this study, pain was defined as the "subjective perception that results from the transduction, transmission, and modulation of sensory information. This input may be filtered through an individual's genetic composition, prior learning, history, current psychological status, and sociocultural influences" (Gatchel, Peng, Peters, Fuchs, & Turk, 2007, p. 582). Suffering was defined as an individualized state of severe distress related to events that compromise the wholeness of a person (Cassell 1991; Kahn & Steeves, 1996). Both definitions of pain and suffering were conceptualized from within a cultural perspective that relies on the human experience. Meaning is inferred from pain and suffering experiences within an individual's life course including one's perspective on coping with cumulative adversity (Turner & Lloyd, 1995).

Theoretical Framework

Theoretically, over the life course, multiple events may be given meaning in a way that could deplete a person's ability to endure future events, such as pain or disability (Baumeister, Faber & Wallace, 1999) and resources needed to respond to physical and emotional loss could be depleted over time. It is hypothesized that people must "regulate themselves so as to adapt to difficult circumstances" (Baumeister et al., p. 50). Baumeister and colleagues state, "An impulse to respond to failure or injustice by fighting for success must be stifled if the cause is hopeless" (p.55). Cultural variations may exist, however, in how to respond to the choices; the consequences of these variations in choices and responses may offer insight into reasons for health disparities.

When using a life course perspective, factors such as age, relationships, life transitions and social climates may influence a person's life from birth to death (Hutchison, 2007). Many of the stressors that accumulate over the life course may negatively impact mental and physical

health outcomes in elderly and disabled populations (Hatch, 2005). In a study examining older adults and life course socioeconomic positions, mental health outcomes, and quality of life, Otero-Rodriguez and colleagues (2011) found that socioeconomic position over the life course influenced quality of life and mental health outcomes in later life. Furthermore, in a study examining life course stressors and their influence on elderly Mexican migrants, Montes De Oca, Garcia, Saenz, and Guillen (2011) reported that many migrants reported unequal work conditions, isolation and lack of health care throughout their lives negatively impacted their mental and physical health in later life. Harrison (2009) recommended examining psychological, biological, cultural and social factors from a life course perspective in Hispanic women with disabilities. Stressors that have accumulated throughout a person's life can have strong implications on health outcomes and healthcare needs in later life (Zoltnick, Tam, & Soman, 2012; Hass, Kruger, & Rohlfen, 2012). In using this life course perspective further insight into the interpretation of pain and presence of suffering in a Mexican American woman with mobility impairment can be gained.

Background

Pain

Pain is a common problem among middle aged and older adults due to a higher rate of chronic disease and joint problems. Pain is often left untreated and unrecognized by health care providers and can influence health outcomes in elderly populations (American Pain Foundation, 2012). Overall, approximately 50% of community dwelling older adults experience pain and 85% of nursing home dwelling older adults experience pain (Hartford Geriatric Institute for Nursing, 2008). Pain can be a severe problem and lead to worsening of disease as well as physical and psychological decline (Baker, Buchanan, & Corson, 2008). As the middle aged and older adult population increases, the cost associated with treating pain will also dramatically increase (Weaver et al., 2009). In spite of the detrimental effects that pain can have on middle aged and older adults, there is very little known about pain and its effects, particularly in middle aged and older minority adults (Al Snih, Markides, Ray, and Goodwin, 2001; Horgas, Yoon, Nichols, & Marksiske, 2008).

Due to gender, age, and ethnicity, older Mexican American women may be at increased risk for experiencing complications from pain when they are compared to Non-Hispanics, and they frequently experience pain due to a high rate of illnesses and/or disabling conditions such as arthritis and fibromyalgia (Morbidity and Mortality Weekly Report, 2011; Roberto, 1997). In a study by Al Snih, Markides, Ray and Goodwin (2001) they reported that in a sample of 2,167 Mexican American women and men with mobility impairments, over 65 years of age, the rate of pain on weight bearing was 37.7% for the women and 24.0% for the men ($p < .001$). Christmas and colleagues (2002) found in a study of the frequency of hip pain in sample of 6,596 older adults that 16% of non-Hispanic White women, 14.8% of African American women and 19.3% of Mexican American women reported hip pain. The men in this study reported hip pain less frequently than women in general (Christmas et al.). Reyes-Gibby and colleagues (2007) examined pain among middle (51–64 years of age) to late age (65–74 years of age) Hispanic, non-Hispanic Black and non-Hispanic White adults

and reported that Hispanic participants reported higher rates of severe pain in comparison to non-Hispanic Whites (OR, 1.80; 99% CI, 1.26–2.56).

Furthermore, minority women are often medically undertreated for pain (American Pain Foundation, 2008). The use of religious coping through prayer and family-related social support has been documented frequently among Hispanic populations (Campbell et al., 2009). The effectiveness of these strategies has not been documented. It is unclear if the use of non-medical remedies is primarily due to their preference or their being offered fewer medical options. Researchers have reported a large emotional component within the pain phenomenon (Ruscheweyh et al., 2011; Gudmannsdottir & Halldorsdottir, 2009). Despite the acknowledgement of the emotional aspects of pain and suffering, there is a dearth of research on how life course experiences influence pain and suffering in later years among Hispanic populations.

Pain and Functional Decline

Having under-treated pain has consequences for the Mexican American women in our society (American Pain Foundation, 2008); pain has been shown to lead to spiraling levels of functional decline. Al Snih and colleagues (2001) found that pain in older Mexican American women, contributed to decline in activity in the lower body, and poorer scores on functional testing. In addition, Weaver and colleagues (2009) found that in a sample of 1,013 older Mexican American women, 49.7% of the women reported pain as a factor that impaired their ability to perform activities of daily living (ADL). According to the literature there can be significant implications to the under treatment of pain; if women are not receiving adequate treatment and continue to be in pain this may increase risk of functional decline, and decreased ability to perform ADLs (Miaskowski, 2010; Schneider & Cristian, 2008).

Pain and Suffering

The relationship between pain and suffering is complex and not well understood. In order to assist patients, researchers and healthcare providers must develop a better understanding of this relationship. Cassell (1991) posited that pain is related to suffering. He further posited that modern medicine focuses too much on the physical aspects of pain, and fails to consider the larger picture of human suffering (Cassell, 1991). When research has integrated more holistic methods such as incorporating culture, family and socioeconomic position into the patients' care when exploring pain, the relationship between pain and suffering was more clearly identified (Chiauzzi et al., 2010). For instance, in an ethnographic study that included 20 Mexican Americans, Villarruel (1995) found that pain and suffering was associated with a sense of loss. Furthermore, pain was associated with familial roles and it was culturally acceptable to endure pain without displaying emotions. Gudmannsdottir and Halldorsdottir (2009) conducted a phenomenological study with nursing home residents in Iceland. Narratives in the study provided a recount of the major losses that had occurred in the lives of participants. Those who had trouble reconciling with their losses seemed to endure the most pain and suffering. Baines and Norlander (2000) conducted a study with 92 hospice patients that examined the relationship between physical pain and physical, spiritual or personal suffering. They found more of the patients experienced suffering than experienced

pain; participants viewed suffering and pain as different entities, and the highest mean scores of suffering occurred in the severe pain category (Baines & Norlander, 2000).

There is growing literature on the factors that influence pain and suffering in many different groups. Missing from this literature is an examination of how cumulative life course adversities impact pain and suffering in older Mexican American women. Due to this dearth of literature there may be a knowledge deficit on how to adequately treat patients experiencing pain and suffering. When health care providers use only pharmacological methods to treat pain that is accompanied by suffering they may be failing to address the psychological component and can leave the person with undertreated pain and suffering (Gunderman, 2002; Turk & Wilson, 2009). It is imperative that all of the factors influencing pain and suffering in these women are considered to truly understand their pain experience. This study takes the necessary steps toward giving readers an insight into the experience of pain and suffering of a Mexican American woman with mobility impairment.

Design and Methods

The design of this study was an exploratory descriptive design using qualitative methods. The data used was from a larger interpretive ethnographic study that included over 450 interviews. This case study engaged four of those interviews, totaling 262 pages, to complete the analysis.

Sample

The sample in the larger study consisted of 60 Mexican American and 62 Non-Hispanic White women. The women were included based upon reporting being female, Mexican American or Non-Hispanic White, between the ages of 55 to 75 years with mobility impairment and residing in their community in Texas. Participants had to have two of four functional limitations as specified on the National Interview Survey- unable to stand for 20 minutes, unable to bend from standing position, unable to walk a quarter of a mile, and inability to walk ten steps without resting (Centers for Disease Control, 2009). Purposeful sampling was used in the larger study and recruitment was done via community liaisons, senior centers, healthcare centers and support groups throughout Texas (Harrison, 2011). The participant chosen as a case exemplar for this study was selected due to her rich descriptions of the stressors she had experienced throughout her life as well as her pain experience. Although she did not report the greatest number of adverse events or the most severe events, she did report the greatest variety of adversities throughout her life. These various adversities covered adversities experienced by various women, which made her case representative of multiple women's experiences.

Procedures

Data Collection and Management

After approval from the institutional review board, the second author (T.H.) met with the participant four times for data collection. The meetings lasted from 2 to 3 hours each. During the meetings the researcher conducted one life history calendar and three in-depth topical biographical interviews in English with the participant. The first meeting was used to

collect data using a life history calendar that traced the participant's experiences with mobility impairment from first memory to present day (Scott Ricks & Harrison, 2011). The last three interviews were open-ended topical biographical interviews focused on disablement experiences. Interviews were transcribed and checked for accuracy, by comparing original audiotapes of the interviews to the transcribed text.

Validity was maintained during analysis by having the coding process conducted by the first author (J.W.) verified by the second author (T.H.); categories and themes were reviewed and verified continually during the analysis process. In addition, methodology and analysis guidelines were conducted as recommended by Miles and Huberman (1994) in order to ensure trustworthiness and validity.

Data Analysis

The data were analyzed using qualitative content analysis as recommended by Miles and Huberman (1994). For this analysis, the interviews were coded line-by-line and reflections were written in the margin of the interviews. Next, the coding was read and organized based upon similar phrases and relationships between data. The data were separated based on differences and similarities and then considered for further analysis. After the line-by-line coding was completed, the coded data was cut out and sorted. Based on similarities and differences in the data, categories were created within the different periods of her life. The data were then placed under the respective categories. Finally, putting the data into small groups based on generalizations, and then critically looking at the groups as compared to preexisting knowledge followed the recommendations of Miles and Huberman (1994). The analysis was concluded by the development of themes and the verification that all data in categories and subcategories were related. Finally, all identifying information was deleted and the participant's name was changed to protect her confidentiality.

Findings

Liliana was a 56-year-old Mexican American woman with three children. She was single and lived with her daughter. She was fluent in Spanish and English. Liliana was diagnosed with degenerative bone disease at the age of 13 and had a work related injury at the age of 34. She listed her other diagnoses as chronic pain, obesity, cardiomyopathy and depression. Liliana was 5 feet one inch and weighed 210 pounds. She used an electric wheelchair, walker, cane and crutches as accommodation devices. She also used braces on her left and right arms as needed. Liliana frequently saw a pain management physician where she received prescriptions for the Fentanyl patch 75% every 48 hours, and hydrocodone tablets as needed.

Liliana described multiple life course traumatic events. During her childhood she reported periods of homelessness and abuse. Her father had been imprisoned for most of her childhood. Liliana described her early years as difficult. She stated, "we were very poor" and "we lived in a mattress under a tree." By the time she had enrolled in the study, she was divorced. Nevertheless, she described her ex-husband as emotionally and mentally abusive. Liliana had previously been seeing a psychiatrist.

Overall, Liliana reported that she experienced an accumulation of painful memories that were “emotions that just stayed with” her and manifested as physical and emotional pain throughout her lifetime. The physical and emotional pain she experienced may have led to the pain overcome with suffering that she experienced, which will be demonstrated using the themes from this analysis. The five qualitative themes: ‘Abuse,’ ‘Ignored and Rejected,’ ‘Silencing of Voice,’ ‘The Bad Days When Movement was Limited’, and ‘Playing the Part,’ represented the difficult experiences Liliana had throughout her life that likely led to pain and suffering during her middle adulthood years. The theme of ‘Pain’ and ‘Suffering’ demonstrated the residual pain and suffering experienced by Liliana later in her life. The final theme ‘Maintaining Hope’ revealed that she was able to find strategies to help her maintain hope. Liliana stated she maintained hope by “finding things that give me space from where I am.” This hope that she maintained may have kept her from completely surrendering to her pain and suffering.

Abuse

Liliana began experiencing abuse as a young child and it followed her through adulthood. She explained that the abuse started while she was very young; her mother was an alcoholic and nearly beat her to death. The beatings she received from her mother became so bad that she had to go live with her grandmother. Furthermore, a family friend sexually abused Liliana as a child. As an adolescent her friends held her down while a man raped her. In her early adulthood, ages 23–30, Liliana married without her mother’s permission. When her mother learned of the marriage she came to Liliana’s home and pulled her out of her home, beating Liliana naked in the street. Liliana thought marriage was an escape from her mother; however she found that she had only escaped the physical abuse. Her new husband abused her emotionally, which she perceived was just as bad as the physical abuse she had experienced during her early years. Physical and emotional abuse can leave women with disabilities with severe harmful effects and decrease their strength (Gilson, Cramer, Depoy, 2001; Graf, Reed & Sanchez, 2008). Liliana stated, “a lot of the stuff that has happened to me not only in my disabilities, but in life and growing up affected me.” Liliana stated that the “emotions and feelings I experienced from abuse never left me.”

Ignored and Rejected

Liliana reported that she often felt ignored and rejected by those close to her. For example, at 16 years of age, after Liliana gave birth to her son, her mother took the baby and cared for him without expressing concern for Liliana. Liliana described this as feeling “unloved and ignored by my own mother.” Later in Liliana’s life, she explained that the actions of her significant other left her with feelings of rejection; he left her to care for his mother. She remembered that she felt like a nobody to him, and when they “laid in the bed together he would go to the end of the mattress and he would put like a pillow in the middle of his legs to be sure that he was protected from my [her] touch at all times.” In addition Liliana explained that she felt her son didn’t accept her. She stated that “my son saw me as worthless, and hated that I was broken and blamed me for not being there for him.” Liliana explained that this rejection left her depleted; she stated “I felt dirty and low.” Liliana even had a hard time accepting herself; she described that as an adult after multiple surgeries and

a decline in her mobility, changes in her body were “unpleasant” and stated “it was hard for me to accept them as a woman.”

Silencing of Voice

Liliana explained that due to the adversities she experienced throughout her lifetime she felt like she “no longer had a voice.” Liliana described the beginning stages of her silence in her early childhood, she said: “And then a lot of times back then when I started being really disabled and stuff it was almost like I didn’t have a voice.” She said “I was just a young girl being abused by my mother that didn’t have a voice.” Even into her thirties Liliana felt her voice had been silenced. She explained that due to her past experiences with abuse she felt no one could understand what she was going through, and she couldn’t express it to make them understand. When a person is able to communicate the internal suffering he or she has experienced the suffering takes on a reality and the person may experience less of a burden (Kahn & Steeves, 1996). Liliana perceived that she did not have a voice and was not able to communicate her experiences with others.

The Bad Days When Movement was Limited

Liliana would have days when she had limited movement and she was in pain, however she realized there may have been more to it than just the physical component. In Liliana’s middle adulthood years, when she was still working, Liliana recalled days where her “back would give out” and her legs could no longer keep her up. In her late adulthood she described being immobile, bedridden and incontinent. Liliana said that it was not just her “physical symptoms that were deteriorating, but there was something wrong mentally that I had not been able to see before.” She realized there was more to her pain and limitations than just the physical manifestations, there was a mental/emotional component as well.

Playing the Part

Liliana reported that society judged her based on how she played the part of what they thought a disabled woman should look and act like. She felt she had to accentuate her limitations in order to receive the assistance that she needed. For example, she stated: “I was once judged by a caseworker because I was crocheting”. According to Liliana, the caseworker did not think she needed a personal care assistant if she had the ability to crochet. The caseworker subsequently cut her attendant care hours from 34 to 17 hours. Liliana struggled with playing this part and still participating in activities that she felt were beneficial. She stated society wanted to “see a handicap person or woman or man look dreadful, ” and be completely immobile. Liliana felt that she couldn’t always openly enjoy things that helped her, like crocheting, because she had to play the part of a woman who was completely debilitated to ensure that she received the attendant care that she needed. She says, “I have to keep moving to be able to keep using my limbs and stuff.” She stated that she felt devalued and some days really struggled physically.

Pain

According to Liliana, pain was something she had dealt with all her life starting in her early childhood. She explained that the pain in her early childhood was “just really painful on the

limbs, the upper torso and the lower limbs.” Liliana stated that her knees would “pop-out” and kept her from participating in physical education as well as many other outside activities. During the time of her childhood, surgery was not a common treatment for her diagnosis, so she made frequent visits to the doctor and used different injections, lubrications, and ointments to combat pain. She used these forms of pain management throughout her 20’s. During this time she described getting a series of shots every three months for pain; she received injections in her shoulders, neck, and spine. Liliana described her pain as a “surging pain” that came through her left hip into her spine, describing it as a pain that “hurt bad” and was “non-stop.” Furthermore, in describing her pain Liliana stated at times she wished she had “enough pain medication to just wipe it out, wipe the pain out, because it hurts that bad.”

Furthermore in describing her pain she attached emotional descriptions to her pain. She described the pain as being so bad it “made me want to cry.” She hated the pain and it caused her to become “agitated, irritated and edgy.” In describing a time that she was attempting to watch her grandchildren, she described how “frustrated, angry, and agitated” she became with them. She expressed feeling bad that she got angry while taking care of her grandchildren, but her condition created pain and she stated “it caused me to be upset and hurt that I can’t do regular stuff.” She considered the “regular stuff” the normal activities that were expected of her by family. She was glad when her grandchildren came to visit but she admitted she was often glad when they left. Liliana stated that “at times I bend down in attempts to interact with him [her grandson] and it just aggravates my situation.” Her pain impacted her role as a grandmother and mother and the activities she was able to participate in.

Intertwined in Liliana’s descriptions of her pain were emotional descriptions that Liliana attached to her pain. She used words such as “angry, agitated, upset” and crying, which could indicate that her pain is not just physical but emotional as well. Life course experiences that intensified emotional distress also may have intensified Liliana’s pain, making it difficult for her to discriminate between the two. This inability to discriminate between her emotional distress and physical pain may have made it difficult to determine the best coping mechanisms she might use. As a result of her not being able to find ways to adequately cope with her pain she withdrew from social roles.

Suffering

Liliana believed that there was more to her physical discomfort than her physical pain. She said she had developed a “jerking movement” and in the beginning thought it was from her pain medication but later concluded it was a “result of my stress.” She said after the various surgeries to her legs and back, and all of the losses she experienced throughout her life, she felt “raped.” Furthermore, Liliana said that her abuse and other life experiences elevated her “stress level and the pain level.” She explained that her mother’s behavior took a toll on her “emotionally” and also “hurt physically.” She said “I am at a point in my life that I don’t know how much more I can take. I know I can’t take anymore surgery right now, I really know that.” Harris (2007) posited that when people experience suffering many times they become isolated and confused to the world around them and all they understand is their pain.

It seems the suffering impacted Liliana's overall well being and influenced her treatment choices.

Maintaining Hope

Although Liliana experienced a great deal of adversity throughout the course of her life, she was able to maintain hope and focus on some of the positive aspects of her life. After an attempt to commit suicide she stated "I couldn't keep on like that. I was killing myself, I was dying." She found hope in her daughter and other women. Liliana identified that her "daughter was her "joy ." She said they were "like twins, and would laugh together." Liliana recalled that when she tried to commit suicide her daughter was there to stop her. She perceived her daughter to be the one person in her life who "understands me." Furthermore, she stated that she felt hope when she shared her story with other women that had gone through similar situations. She stated it gave her "fulfillment", and made her "feel whole." People who have experienced suffering often find meaning in their suffering by helping others that have experienced suffering (Morse, 2001).

Discussion

Generally, pain is poorly understood among Hispanics (Campbell et al., 2009). There is epidemiological evidence suggesting that the prevalence of pain is greater in Mexican Americans than in Non-Hispanic Whites (Anderson, Green & Payne, 2009), but there is a paucity of literature examining the various stressors that occur throughout their lives that shape their experiences of pain and/or suffering. Without knowledge of how pain and suffering are experienced through the cultural lens of Hispanics, the foundations for cultural variation in outcomes between ethnic groups cannot be understood. Holistic interventions that incorporate culture are needed in order to ease the emotional and physical distress of this growing population within our society. Hence, this study builds upon theoretical and empirical evidence suggesting that life course cumulative adversities may impact the interpretation of pain in later years creating perceptions of suffering.

In this paper, the adversities experienced throughout the life course of Liliana, a Mexican American woman living with early mobility impairment may have contributed to suffering in her adulthood. Throughout her life course, Liliana experienced abuse, rejection, silencing of voice, and often felt pressured to play the role of a debilitated woman. These adversities may have built up to the extreme pain and suffering that she experienced later in her life. Liliana identified that she maintained hope by spending time with her daughter and sharing her story with others. In spite of the hope she found, the suffering experienced by Liliana influenced her ability to deal with her pain as well as her treatment choices for her pain. In order to understand Liliana's pain experience it is imperative that we understand her suffering. Continual suffering in Liliana's life posed a threat to her integrity and wholeness as a person (Cassell, 1991). If providers fail to understand the influence or importance that suffering has on these women and only treat the pain, they may be failing to grasp the entire experience of these women and not effectively helping them through their pain and suffering.

As women age, cultural expectations and response behaviors may change (Harrison, 2009). The description of Liliana's pain experience showed that her life course experiences and emotions significantly impacted the intensity of her pain and decisions on how to cope with her pain. In a study of pain responses of Mexican American and non-Hispanic White women, Calvillo and Flaskerud (1993) found that nurses' described the non-Hispanic White women as having more pain than the Mexican American women. Both groups, however, reported their pain to be more severe than what the nurses assessed it to be.

It is important that healthcare providers, such as nurse practitioners, physicians, and even bedside nurses, who are managing the pain of Mexican American women take into consideration culture, age, and life course experiences that surround the assessment and management of pain in middle aged and older adult Mexican American women. Once further research is done to understand the various events that influence pain and suffering in the middle and older adult lives of minority women aging with mobility impairments, health care providers can focus efforts on risk prevention of these various factors. Due to the restraints of time and resources it may be difficult for health care providers to assess the life course history of each patient, however health care providers can have targeted questions to develop risk profiles of their patients that may have already experienced many adversities throughout their life courses. If the providers have knowledge of what life course events have occurred throughout their patients' lives, they can tailor the interventions and treatments for each patient. For example, if a Mexican American woman has chronic pain and is also experiencing pain and suffering from an extensive history of abuse, the primary health care provider may need to collaborate with mental health care providers in order to treat her pain holistically.

Furthermore, in discussing delivering patient centered care for minority patients, Campionha-Bacote (2011) posited that nurses need to formulate a treatment plan that is mutually derived and culturally appropriate. Levine, Like, and Gottlieb (2000) recommended a tool called ETHNIC (Explain, Treatment, Healer, Negotiate, Intervention, Collaboration) to assist health care providers in assessing pain in minority patients. Using this tool the provider would encourage the individual to Explain the pain and explore with the patient what Treatments had been tried for physical and psychological pain. The provider would respectfully consider the possible influences of cultural Healers, family or friends in coping with pain. The patient and provider may need to Negotiate to find the optimal pain Intervention. The most holistic pain management approach will become a Collaboration of resources that are psycho-socially, culturally, and spiritually important to the individual (Levine et al., 2000).

Furthermore, in order to treat the pain experienced by older Mexican American women experiencing pain and suffering healthcare providers need to consider non-pharmacological treatments for pain. Gunderman (2002) posited that healthcare providers often deny the existence of suffering because it cannot be treated pharmacologically like pain; however, when healthcare providers ignore suffering they trivialize the life experiences of their patients. Tse, Au, and Wong (2011) reported that multisensory coping therapy (use of all bodily senses to cope) significantly decreased pain intensities ($p < .05$) and anxiety ($p < .05$) in older adults living with chronic pain. Linton and Shaw (2011) posited that combining

psychological interventions such as holistic patient centered care and a basic assessment of beliefs and experiences related to pain into physical therapy and pain treatments can create better outcomes for people experiencing chronic pain. In order to manage suffering and its associated symptoms, healthcare providers have to think beyond the body and its associated pathophysiology. Health care providers must think in terms of the person (Cassell, 1991). Morse (2001) posited that healthcare providers need to be able to recognize behavioral patterns exhibited by patients who are suffering, and use the patterns to form the appropriate therapeutic interventions.

Limitations of Present Study

This study is limited to the experience of one Mexican American woman with disability. However this case study is a significant contribution to the literature in understanding how pain and suffering in a middle aged Mexican American woman with mobility impairments. For Mexican American women the study of pain and suffering is overdue. Studying pain and suffering is highly relevant to national health given the psychological, physical and fiscal consequences of pain and suffering.

Conclusions

Researchers need to further investigate suffering and how life experiences, culture and even healthcare environments can contribute to suffering (Kahn and Steeves, 1996) in middle aged and older adult minorities. Further work is needed to examine pain and suffering and the many factors that shape the experiences of the pain and suffering in aging minorities. Researchers can also investigate ways to help healthcare providers appropriately assess the pain and suffering experiences of middle aged and older adults and provide them with the appropriate and most effective interventions.

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