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Culturally Responsive Pain Management for Black Older Adults

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Pain is multi-billion-dollar public health concern and a significant cause of disability—particularly amongst older adults. Older adults with chronic health conditions such as osteoarthritis, diabetes mellitus, peripheral vascular disease, chronic respiratory disease, sickle cell disease, and cancer are most likely to have pain. Of particular concern are Black older adults, or Americans over the age of 65 who are the descendants of US slaves primarily from Africa, as they experience great disparities in pain management and secondary health declines. Though ample research has been completed over the past ten years that links chronic pain to psychological distress and reductions in overall physical health, adequate pain control remains problematic for Black older adults. This concern sheds light on the importance of nursing engagement and persistence in effective pain management for this population. As first line health providers, nurses are in a unique position to push forward national standards for culturally appropriate services for Black elders by ensuring that quality care is not only effective, equitable, understandable, and respectful, but also that this care is responsive to the diverse cultural health beliefs, practices, and health literacy levels of the patients they care for (USDHHS, 2016). The following article provides a framework for the culturally responsive treatment of pain in older Black adults.

Pain in the Black Older Adult

Up to 78% of Black older adults experience chronic pain (Bazargan, Yazdanshenas, Gordon, & Orum, 2016; Karter et al., 2015). Unfortunately, these elders are not as likely as White, non-Latino elders, to discuss pain concerns. This may be related to the noted difficulty minorities have in effectively communicating pain needs to clinicians in ways that are clearly understood and believed (Shavers, Bakos, & Sheppard, 2010). However, when pain is reported, Black elders are more likely to describe higher levels of pain, suffering, and depressive symptoms than White elders (Booker, Pasero, & Herr, 2015; Limaye & Katz, 2006; National Center for Health Statistics, 2006). Although systemic provider and patient pain management practices account for much of this disparity (Cintron & Morrison, 2006), some of the variation may be attributable to genetic differences between Blacks and Whites.

Black Americans have a biological predisposition for lower pain tolerances and thresholds which causes them to be more sensitive to pain (Cruz-Almeida et al., 2014; Riley et al.,

2014). This means that not only is pain experienced at lower intensity levels, but also, the maximum tolerable pain level is lower. Although ethnic identity is associated with lower pain tolerance and threshold for Black American and Latino groups as compared to non-Latino Whites (Rahim-Williams et al., 2007), it has been widely documented that Black Americans are more likely to receive poorer quality of care with less access to services than White Americans (Agency for Healthcare Research and Quality, 2010). Additionally, minority patients are more likely to receive lower doses of pain medications than White patients and experience longer wait times to receive those medications despite consistently higher pain scores (Institute of Medicine of the National Academies, 2011; Shavers et al., 2010). Clearly there is a disparity in the management of pain for Black Americans—and particularly for Black older adults. The provision of culturally responsive care can help to reduce this disparity. Before considering how to improve culturally responsive care in practice, it is important to have a good understanding of the core term culture.

What is Culture?

Culture is a term frequently used in healthcare, but often misunderstood. The word commonly brings forth images of people from distant lands, foods of exotic tastes, and social practices poorly understood. However, culture may be aptly summed as the learned patterns of behavior, beliefs, and values shared by individuals of particular social groups (Robinson, 2013). Famed anthropologist Bronislaw Malinowski (1944) notes that culture influences what is most important to individuals and allows them to cope with the concrete, specific problems [such as changes in health] which will arise during the life course. It is widely recognized in the literature that cultural and ethnic affiliation directly impacts health experiences as well as the identification and selection of appropriate care (Brondolo, Gallo, & Myers, 2008; Griffith, Metzl, & Gunter, 2011; Jackson, Knight, & Rafferty, 2010; Karlsen & Nazroo, 2002). Nurses are best able to aid the patients they are charged to care for by appropriately considering the unique attributes of the population they are working with and understanding the ways in which culture may affect health choices and care expectations. When nurses practice culturally congruent care, they are lifting up the values, beliefs, and lifeways of individuals, groups, and communities by supporting diversity, encouraging cultural awareness, ensuring cultural sensitivity, and requiring cultural competence (Schim, Doorenbos, Benkert, & Miller, 2007).

For instance, Black Americans are a common cultural group in the United States who share a history of enslavement, acculturation (a modification of culture made by adapting to or borrowing traits from another culture), and racial oppression—which distinguishes this cultural group from others and influences their behavior, values, lifestyles, and creative expressions (Scott, 2005). According to the most recent census reports, Black Americans represent nearly 14% (42 million) of the US population and 8% (about 3.2 million) of all older adults (U.S. Census Bureau, 2010). A history of racial inequalities in the delivery of healthcare services and significant disparities in health outcomes has led to substantial provider mistrust and a long history of unmet health needs, such as unrelieved chronic pain (Arnett, Thorpe, Bowie, and LaVeist, 2016; Cuevas, O'Brien, and Saha, 2016; Hammond, 2010; Moseley, Freed, Bullard, and Goold, 2007.).

Black American distrust of the medical system dates long before the Tuskegee syphilis experiments to slavery era times when medical experimentation, such as pain studies, smallpox vaccine development, and experimental surgeries (sans anesthesia), were tested on involuntary subjects (Palanker, 2008). Despite radical changes in science and healthcare, Black Americans remained excluded from mainstream health institutions for the first 65 years of the 20th century until the passage of the Medicare Act in 1965. This Act required hospitals to desegregate in order to receive federal funding. Although the Medicare Act caused almost immediate hospital integration, Black Americans receiving benefits under Medicare, Medicaid, or the Veterans Administration fund continued to receive poorer quality of care as compared to White Americans (Palanker, 2008).

Black adults aged 65 and older were born prior 1951 during times of severe racial tension and government mandated segregation. As a result, most Black elders have experienced racism and significant disparities in healthcare during their lifetime. This inferior care has led to poor health outcomes for many (Mays, Cochran, and Barnes, 2007). For instance, studies have found that older Black men who have experienced various types of social discrimination have higher bodily pain intensity levels (Burgess et al., 2009; Edwards, 2008) and increased blood pressure (David R. Williams, 2003; David R Williams & Neighbors, 2001) which can exacerbate other health conditions. Tripp-Reimer and Fox (1990) question if nurses should consider “whether the objectification of African-American culture has created greater limitations or greater access to patients” (p. 545). The historical treatment of Black Americans as objects insensitive to pain may explain some of the significant disparities in access to care and inferior pain assessment and treatment (Ezenwa & Fleming, 2012; Washington, 2006).

As evidenced, culture plays a significant role in the pain experience, particularly how to communicate pain, how much pain is tolerable, to whom to report pain, and the types of pain that should be reported. Cultural frameworks inform nurses and healthcare providers how to interact with older Black Americans and how to approach and explain pain management to these patients. The screen, intervene, and reconvene (SIR) model of pain management is one culturally-sensitive method to systematically assess, treat and manage, and re-assess/ evaluate pain and goal-based pain management plans in older Black Americans. This model is described in more detail elsewhere (S. S. Booker & Herr, 2015). Cultural responsiveness, or the recognition and integration of important social, ethnic, religious, and community values into care is an important means of addressing health disparities, such as disparities in the treatment and management of pain, and provision of effective, equitable, and respectful, quality care and services (USDHHS, 2016).

Cultural Responsiveness

Culturally responsive care emphasizes the capacity to respond to patient’s cultural beliefs and behavior systems by engaging patients in care, integrating cultural values into the plan of care, and adapting care to align with their culture (Carteret, 2011). In the context of pain, this entails understanding the reasons why older Black Americans may not have the ability, or willingness, to self-report pain and to positively counter this with respect, rapport building, dispelling misconceptions about pain reporting, and using culturally-sensitive

communication and culturally-valid and preferred pain intensity tools (Booker, Pasero, & Herr, 2015). For example, as was noted previously, despite intense pain, older Black adults are hesitant to report or openly talk about pain. This may be related to the common cultural perception that talking about pain or “claiming pain” (acknowledging/declaring pain/putting it in the atmosphere) is *spiritual taboo*, in that talking about pain increases its intensity and power in one’s life (Staja Q. Booker, 2015).

For example, when one Black elder was asked why he chose not to talk about his pain he said, “I don’t talk about it a lot because I believe that words have a lot of power and you have to be careful what you speak out into existence.” (Robinson, 2015). This comment, and the related behavior, is consistent with research which shows that Black Americans minimize pain (Jones et al., 2008) and may serve as a cultural-specific coping phenomenon.

With this knowledge, the culturally responsive nurse will be proactive in asking older Black adults about their pain concerns in ways that convey respect and use relatable language. Nurses can establish rapport and engage in culturally-sensitive communication with all patients by considering the words they choose to use and how they address elders in relaying information. Special attention should be paid to tone of voice, body language, use of formal names—unless directed otherwise by the patient—and use of language that is reflective of the language the patient is using to describe a health concern. For example, rather than simply saying to a familiar patient, “Hi Mary, are you having any pain this morning?” or “Would you like a pain pill?” the culturally responsive nurse might begin with, “Hi Mrs. Smith, how are you feeling today?” as a means to engage with the patient and build rapport. Then, after allowing time for the patient to respond, the nurse might follow-up with “Are you feeling sore or uncomfortable anywhere (can substitute other words such as ‘aching’ or ‘paining’; Booker, Pasero, & Herr, 2015)?” Appropriate reassessment would then follow as necessary. If the Black older adult appears hesitant to report pain, it may be necessary to examine other dynamics of the patient-nurse relationship. For example, research indicates that Black and Hispanic long-term care residents have a greater sense of comfort reporting pain to female providers rather male providers (i.e., nurses, nursing assistants) (Dobbs, Baker, Carrion, Vongxaiburana, & Hyer, 2014). These types of actions, and other similar culturally adaptive interventions, support cultural congruency and promote cultural humility.

Cultural Congruency

Culturally congruent care is the process by which clinicians and patients are able to effectively communicate despite differences in values, beliefs, perceptions, and expectations about care. Cultural congruency is achieved by creating positive care environments based upon knowledge of the social communities from which the patients come. Schim and Doorenbos (2010) recommend a four-stepped approach that includes appreciation, accommodation, negotiation, and explanation, to achieve this desirable care environment (Figure 1).

Appreciation

Appreciation is simply the acknowledgement by the clinician of the varying personal beliefs, values, and life patterns patients may have. Appreciation can be achieved by working

diligently to understand differences by making observations and asking open-ended, related questions. For example, religious beliefs and spirituality is highest amongst Black Americans as compared to other cultural groups (Boyd-Franklin, 2010) and prayer is a common pain management technique used by Black elders (Booker, 2015; Jones et al., 2008; Park, Lavin, & Couturier, 2014; Robinson, 2015). One research participant, Adam, who uses prayer to manage his pain, explained why it was important to also pray with others in pain, he said, "Pray with them and let them know that when they are in that pain to never be forgetful that Jesus promised us healing. And by his stripes we are the healed," (Robinson, 2015). A nurse that goes to visit a patient in pain might find them with their eyes closed and quietly talking to themselves. After notifying the patient of their presence and waiting a few moments to be acknowledged, the nurse might say, "I'm sorry were you praying?" Then, if answered affirmatively, they might respond, "I didn't mean to interrupt your prayers. It seems like you aren't very comfortable right now and I would like to get you some medication that will work along with your prayers to relieve your pain." Although, many older Black Americans find prayer to be a helpful and important part of their care and recovery, it is important to communicate with them, in a respectful way, that prayer alone may not sufficiently control high levels of pain. In fact, engagement in more prayer has been associated with lower pain tolerance in Black Americans (Meints & Hirsh, 2015). Despite the noted contrast in the cultural belief and the expected clinical outcome, showing appreciation means recognizing the importance of this practice for many and making reasonable accommodation to integrate it into care.

Accommodation

Accommodation is frequently described as a convenient arrangement, a settlement, or a compromise. When providing culturally congruent care, nurses accommodate the patients they are charged to care for by changing aspects of care as necessary so that the care is in alignment with the patients' beliefs, values, and preferences. Not only does this create a person-centered care environment, but the patients, families, and communities that are participating in care truly become care partners with individualized plans of care that more likely to be followed, and goals that are more likely to be achieved.

Black elders may have some initial distrust of the medical system and have difficulty relaying pain concerns in ways that are understood and recognized by healthcare providers. Knowing this, the culturally responsive nurse will accommodate the patient as needed, by adjusting the words that they choose to use when communicating about pain, by listening for and using familiar pain terminology. For instance, after conveying respect at the start of a conversation by making sure to address the older adult by their surname, unless asked to do otherwise by the elder, pain assessment questions should begin by asking patients if they are "hurting" or "aching." Black older adults typically reserve the word "pain" to indicate only severe pain and use words like "hurt," "sore," or "discomfort" to describe less-intense pain (Curtiss, 2010). In fact, Black Americans ranked the word 'pain' with the highest intensity, followed by the descriptors 'hurt' and 'ache' (Gaston-Johansson, Albert, Fagan, & Zimmerman, 1990). An emerging assessment area is determining how bothersome and tolerable pain is (S. Booker, Bartoszczyk, & Herr, 2016; S. Q. Booker & Haedtke, 2016) and corresponding treatment threshold (i.e., need for analgesia). To describe bothersome pain,

older Black Americans may use descriptors such as nagging, exhausting, miserable, or other pain descriptors (Booker et al., 2015).

In addition, older Black adults may not associate certain sensations with pain, such as chest tightness or neuropathic sensations of “pricking,” “burning,” or “tingling.” Older adults with chronic dull aching pain may answer “no” to questions about pain, because they do not perceive it in a way that they believe pain is “supposed to” present itself (Feldt, 2007). Although, the International Association for the Study of Pain (2011) suggests that “experiences which resemble pain but are not unpleasant, e.g., pricking, should not be called pain”; for some older adults, words like “pricking” may be a preferred means of describing pain.

Using culturally -sensitive communication may initially be uncomfortable to the nurse, and may even feel unnatural. However, by paying careful attention to word choice and being mindful of nonverbal communication, such as how body language and tone of voice is used to relay messages, nurses may develop increased levels of relatability to the persons they are caring for. Any uncertainties the nurse might have should be clarified with the patient or family at the start of care. Unfortunately, despite one’s best efforts, at times, mistakes will still occur. When they do, the misunderstanding should be corrected as soon as possible to maintain patient/provider relationships and facilitate trust. Furthermore, nurses should consider what level of communication is desired by the patient.

While most Black elders want to know the source of their pain, others may fear knowing the cause of pain. They may fear expensive or potentially painful tests and generally want to avoid “probing” or “looking for something.” There may also be a fear that pain is the result of cancer or other serious conditions. Nurses and healthcare providers can establish rapport and engage in culturally-sensitive communication by first addressing any fears Black elders may have regarding their pain and encourage self-report by informing them that “if you feel something, say something.” Nurses should make it explicit that reporting pain is not complaining of pain, nor is it an inconvenience for the nurse, but rather, it is important information to be related that aids in the reduction of discomfort and suffering. This is necessary as complaining is often viewed as a negative attribute in Black culture (S. S. Booker et al., 2015; Robinson, 2015). Although nurses can easily accommodate their patients by adjusting the ways in which they communicate, other aspects of pain management, particularly the use assessment tools are not so easily changed within institutions. This requires negotiation.

Negotiation

Negotiation, or the act of reaching an agreement in culturally congruent care, means finding a common ground where the professional standard of care may be maintained while cultural behaviors are recognized and accommodated as much as possible. Therefore, negotiation might mean that the nurse accommodates the patient by using culturally sensitive communication but maintains the use of pain intensity tools that have been validated across populations. Research has determined that scales such as the Faces Pain Scale-revised (FPS-r), verbal descriptor scale (VDS), and Iowa Pain Thermometer-revised (IPT-r) are valid, reliable, and preferred amongst older Black Americans with and without cognitive

impairment (Ware et al., 2015). Scales (e.g., IPT-r), or a combination of scales (e.g., FPS-r and VDS or VDS and Numeric Rating Scale), that target both the affective (unpleasantness) and sensory (intensity/quality) domains of pain is recommended (S. S. Booker et al., 2015). To measure pain intensity, patients should be asked to quantify (0–10 scale) and qualify (mild, moderate, severe) pain intensity by using pain self-report scales.

Negotiation also means effectively managing chronic pain by using recommended stepped, multi-modal approaches that integrate both preferred complementary and alternative strategies along with effective and proven prescription medications (Arnstein & Herr, 2013). Table 2 provides an overview of considerations for various medication classes used to treat mild, moderate, and severe pain in Black older adults. When treating severe pain in particular, nurses should be mindful that Black Americans report significantly greater cancer pain ($P<.001$), are less likely than Whites to have a prescription for a long acting opioids ($P<.001$), and are more likely to have a negative pain management index (score of how well pain is managed) ($P<.001$) (Meghani, Thompson, Chittams, Bruner, & Riegel, 2015). Furthermore, when Black elders do use a prescription opioid, they are more likely to take less than the prescribed amount. In one study, on sub-analysis, analgesic adherence rates for Black Americans ranged from 34% (for weak opioids) to 63% (for long acting opioids) (Meghani et al., 2015). A primary reason for decreased opioid compliance amongst Black older adults is concern about side effects.

Side effects are a commonly reported barrier to medication utilization and adherence in older Blacks adults (Staja Q. Booker, 2015; Meghani et al., 2015; Robinson, 2015). Not unlike other older adults, Black elders often have several comorbidities (i.e., 3 or more) with each requiring separate treatments and medications. The cumulative effect of multiple medications and subsequent side effects often discourages these elders from using prescribed opioid pain medications. Instead, they may attempt to reduce the number of medications, and severity of side effects, by foregoing pain treatment with medications, and opting to use more non-pharmacological strategies such as prayer, creams/salves, physical activity, or rest (Park et al., 2014; Robinson, 2015). Moreover, pain may not be their priority concern as compared to other health conditions, and this perception then also limits their use of pain medications.

An additional side effect related concern that may further limit the use of pain medications amongst Black elders, is that the inactive ingredients used in some medications may not be tolerated by the gastrointestinal systems of these patients (Campinha-Bacote, 2007). For example, lactose is used as a filler in some medications, but 70–90% of Blacks are lactose intolerant (National Medical Association, 2009). When practicing culturally responsive care, the nurse understands the hesitancy of some Black elders to take opioid analgesics and then uses negotiation as a means of identifying and integrating into care the most acceptable medications and treatments—which for many are a combination of herbal remedies, prescription medications, and topical analgesics (Cherniack et al., 2008; Robinson, 2015).

Often older Black adults serve as vessels of wisdom regarding knowledge of various folk remedies and many in the community seek their advice about how to treat pain and other health conditions. Nurses can convey respect, build rapport, and create a caring environment

by inquiring with the patient and family about the ways in which home remedies, such as alcohol rubs, Epsom salt soaks, heating pads and other treatments are typically used at home and then working to integrate some of these care practices into the patient's plan of care as feasible and desired. An older Black adult might be particularly appreciative of, and more receptive to, an effective oral analgesic when it is accompanied by a quick massage with a topical analgesic they are familiar with. When the nurse is not able to meet the patient's care expectations through appreciation, accommodation, or negotiation, an explanation is required (Schim & Doorenbos, 2010).

Explanation

Explanation or statements to make actions more clear and justified, is the final component of culturally congruent care. Explanation is required when the culturally responsive nurse is unable to accommodate patient and family wishes regarding care. More often than not, explanation is likely to occur when the patient desires a particular treatment or practice that would be considered unsafe in some way. For example, isopropyl alcohol with various additives such as menthol or capsaicin may be used by Black elders (Robinson, 2015). Although a patient may be accustomed to using this preparation in a home setting, nursing home and acute care regulations may prevent the use of this treatment considering it to be both ineffective and a safety hazard. The culturally responsive nurse would provide explanation to the patient and family and return to negotiation to find an acceptable middle ground. In this instance, it might be integrating the use of an approved commercial topical rub that has the cooling effect of isopropyl alcohol, the scent of menthol, or the heat from capsaicin.

Integrating into Clinical Care

Ultimately, there are many ways in which the culturally responsive nurse can facilitate effective and appropriate care that is most likely to meet the holistic needs of diverse patients such as Black older adults with pain. Integrating the SIR Pain Card (Figure 2) into clinical care is one way to facilitate culturally responsive care. While national guidelines outlined by the US Department of Health and Human Services (2016) describe the ways in which organizations can become more culturally competent in the delivery of healthcare services, individual clinician actions play a central role in the health outcomes of diverse populations. By recognizing the unique attributes of the patients they care for, particularly their values and important health beliefs, nurses are able to more fully engage patients in health promotion and optimization, and reduce suffering. Black older adults in particular have a long history of dealing with racism, chronic environmental stressors, and receiving less than optimal care from the health care system. Providing culturally responsive care for this population means taking extra effort to relay appreciation of cultural strengths and values by asking open ended questions about care goals and health beliefs and practices. Accommodations can then be made that allow for the integration of these important health beliefs and practices into care. It is understood that negotiation may have to take place at times to provide person-centered care and remain compliant within regulatory frameworks. Finally, explanations are provided in respectful and relatable ways when care expectations can not be met.

The prudent nurse works diligently to provide culturally congruent care and is cognizant of their own values and biases that have the potential to negatively affect the care they provide. As nurses begin to recognize their own cultural identities and remain open to engaging in lifelong learning about cultures that vary from their own, they begin to practice in a space that is other-oriented—one of cultural humility. When nurses begin to practice cultural humility, not only do they improve the health of Black older adults—they ultimately improve the health of the nation.

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Figure 1.
Core Concepts of Cultural Congruency

Screen: Pain Assessment Principles and Questions

- During all patient interactions, ask about pain more than once in various ways (See questions below).
- Address sensory, motor, or cognitive impairments and language interpretation needs to assure accurate and effective assessment.
- **Are you hurting or sore anywhere?** *Ex.: Older Black Americans may generally describe pain as misery, hurting, aches, or sore[ness]. (Booker, Pasero, & Herr, 2015).*
- **Do you have any pain or unpleasant sensations that shoot through your parts of your body?** Know how various cultures describe certain types of pain. *Ex.: Older Black Americans may describe rheumatoid arthritis pain as travelling pain (Robinson, 2015) or neuropathic pain as pricking or crawling.*
- **Tell me how much your pain is bothering or nagging you. Does it limit your ability to care for yourself, walk, or be in a good mood?**
- Ask about pain characteristics. Know how various cultures describe pain. *Ex.: Older Black Americans may self-report the intensity, location, and timing of pain (Puia & McDonald, 2014).*

Intervene: Treatment Considerations

- Develop goals for comfort (i.e., pain relief)-function (movement/self-care)-mood (CFM).
- Educate patient on treatment options that are available and appropriate.
- Determine preference for and use multi-modal therapies: medications, physical strategies, spiritual strategies, coping, and environmental modifications

Screen: Pain Communication Tools

- Use pain intensity tools to obtain self-report of pain severity. Various cultural groups are shown to have a preference for specific pain tools. *Ex.: Older Black Americans are shown to prefer the IPT-R and FPS-R (Ware et al., 2015; Taylor & Ware, 2003) compared to the standard NRS.*

IPT-R

Permission to reproduce IPT-R© given by Keela Herr, The University of Iowa.

Reconvolve: Re-assessment and Evaluation

- Re-assess pain at regular intervals and after all interventions and modify multi-modal treatment plan as needed.
- Assess for side effects or adverse effects.
- Re-evaluate CFM goals and modify as treatment plan evolves.
- Continue to provide pain education to patients and family.

Figure 2.

Screen, Intervene, & Reconvolve (SIR©) Pain Card