Culturally Responsive Pain Management for Black Older Adults

Pain is a multi-billion-dollar public health concern and a significant cause of disability, particularly among 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 older than 65 who are the descendants of U.S. slaves primarily from Africa, as they experience great disparities in pain management and secondary health declines. Although ample research has been completed over the past 10 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 older adults by ensuring that quality care is not only effective, equitable, understandable, and respectful, but also that this care is responsive to the

ABSTRACT
The management of pain for Black older adults has received inadequate attention by health care professionals despite evidence of greater pain intensity, depressive symptoms, and functional disability compared with White American older adults. Pain management for this population may be significantly improved with more careful attention to the provision of culturally responsive care. As professionals concerned with the optimization of health and reduction of suffering throughout the lifespan, nurses have an ethical, moral, and professional responsibility to provide culturally responsive care to the populations they serve—particularly when clear disparities in health exist. By considering how culture affects important health beliefs, values, preferences, and customs, and integrating this understanding into practice, quality of life is likely to be improved. [Journal of Gerontological Nursing, 43(8), 33-41.]

Sheria G. Robinson-Lane, PhD, RN; and Staja Q. Booker, MS, RN
diverse cultural health beliefs, practices, and health literacy levels of the patients they care for (U.S. Department of Health and Human Services [USDHHS], 2016). The current article provides a framework for the culturally responsive treatment of pain in Black older adults.

**PAIN IN BLACK OLDER ADULTS**

Up to 78% of Black older adults experience chronic pain (Bazargan, Yazdanshenas, Gordon, & Orum, 2016; Karter et al., 2015). Unfortunately, these individuals are not as likely as White, non-Latino older adults to discuss pain concerns. This reluctance may be related to the noted difficulty minority individuals 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 older adults are more likely to describe higher levels of pain, suffering, and depressive symptoms than White older adults (Booker, Pasero, & Herr, 2015; Limaye & Katz, 2006; National Center for Health Statistics, 2006). Although systematic 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 Black and White individuals.

Black American individuals have a biological predisposition for lower pain tolerances and thresholds, which cause them to be more sensitive to pain (Cruz-Almeida et al., 2014; Riley et al., 2014), meaning 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 White individuals (Rahim-Williams et al., 2007), it has been widely documented that Black American individuals are more likely to receive poorer quality of care with less access to services than White American individuals (Agency for Healthcare Research and Quality, 2010). In addition, 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, 2011; Shavers et al., 2010). Clearly, there is a disparity in the management of pain for Black American individuals, particularly for Black older adults. The provision of culturally responsive care can help 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 health care, but often misunderstood. The word commonly brings forth images of individuals 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 (e.g., changes in health) that arise during the life course. It is widely recognized in the literature that cultural and ethnic affiliation directly impact health experiences as well as the identification and selection of appropriate care (Brondolo, Gallo, & Myers, 2008; Griffith, Metzl, & Gunter, 2011; Jackson, Knight, & Rafferty, 2010; Karlson & Nazroo, 2002). Nurses are best able to aid 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 upholding 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).

Black American individuals are a common cultural group in the United States who share a history of enslavement, acculturation (i.e., 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 American individuals represent approximately 14% (42 million) of the U.S. population and 8% (approximately...
3.2 million) of all older adults (U.S. Census Bureau, 2010). A history of racial inequalities in the delivery of health care services and significant disparities in health outcomes has led to substantial provider mistrust and a long history of unmet health needs, such as unrelied chronic pain (Arnett, Thorpe, Gaskin, Bowie, & LaVeist, 2016; Cuevas, O’Brien, & Saha, 2016; Hammond, 2010; Moseley, Freed, Bullard, & Goold, 2007).

Black American individuals’ 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 health care, Black American individuals 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 to receive federal funding. Although the Medicare Act caused almost immediate hospital integration, Black American individuals receiving benefits under Medicare, Medicaid, or the Veterans Administration fund continued to receive poorer quality of care compared to White American individuals (Palanker, 2008).

Black adults 65 and older were born prior to 1951 during times of severe racial tension and government-mandated segregation. Thus, most Black older adults have experienced racism and significant disparities in health care during their lifetime. This inferior care has led to poor health outcomes for many (Mays, Cochran, & Barnes, 2007). Studies have found that Black older men who experienced various types of social discrimination have higher bodily pain intensity levels (Burgess et al., 2009; Edwards, 2008) and increased blood pressure (Williams, 2003; 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 American individuals 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).

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 health care providers how to interact with Black American older adults 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 reassess/evaluate pain and goal-based pain management plans in Black American older adults. This model is described in more detail elsewhere (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 patients’ cultural beliefs and behavior systems by engaging them 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 Black American older adults may not have the ability, or willingness, to self-report pain and 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 et al., 2015).

As noted previously, despite intense pain, Black older adults are hesitant to report or openly talk about pain. This reluctance may be related to the common cultural perception that talking about pain or claiming pain (i.e., 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 (Booker, 2015). For example, when one Black older adult 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, p. 80). This comment, and the related behavior, is consistent with research that shows that Black American older adults minimize pain (Jones et al., 2008) and may serve as a cultural-specific coping phenomenon.

With this knowledge, culturally responsive nurses will be proactive in asking Black older 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 older adults 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 (can substitute other words such as aching or paining; Booker et al., 2015) anywhere?” 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. Research indicates that Black and Hispanic long-term care residents have a greater sense of comfort reporting pain to female providers than male providers (Dobbs, Baker, Carrion, Vongxaiburana, & Hyer, 2014). These types of actions, and other similarly culturally adaptive interventions, support cultural congruency and promote cultural humility.

CULTURAL CONGRUENCY

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

Appreciation

Appreciation is the acknowledgement by clinicians of the varying personal beliefs, values, and life patterns of patients. 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 are highest among Black American individuals compared to other cultural groups (Boyd-Franklin, 2010), and prayer is a common pain management technique used by Black older adults (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, saying, “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, p. 84). Nurses who visit patients in pain might find them with their eyes closed and quietly talking to themselves. After notifying patients of his/her presence and waiting a few moments to be acknowledged, the nurse might say, “I’m sorry, were you praying?” Then, if answered affirmatively, he/she 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.”

Accommodation

Accommodation is frequently described as a convenient arrangement, settlement, or compromise. When providing culturally congruent care, nurses accommodate patients they are charged to care for by changing aspects of care as necessary so that the care is in alignment with patients’ beliefs, values, and preferences. This accommodation creates a person-centered care environment, in which patients, families, and communities become true care partners with individualized plans of care that are more likely to be followed and goals that are more likely to be achieved.

Figure 1. Core concepts of cultural congruency (Schim & Doorenbos, 2010).
Black older adults may have some initial distrust of the medical system and difficulty relaying pain concerns in ways that are understood and recognized by health care providers. Knowing this distrust and difficulty, culturally responsive nurses will accommodate patients as needed, by adjusting the words that they choose to use when communicating about pain and listening for and using familiar pain terminology. For instance, after conveying respect at the start of a conversation by making sure to address older adults by their surname, unless asked to do otherwise, 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 such as “hurt,” “sore,” or “discomfort” to describe less intense pain (Cur-tiss, 2010). In fact, Black American individuals 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 (Booker, Bartosczyk, & Herr, 2016; Booker & Haedtke, 2016) and corresponding treatment threshold (i.e., need for analgesia). To describe bothersome pain, Black American older adults may use descriptors such as nagging, exhausting, miserable, or other pain descriptors (Booker et al., 2015).

Black older 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 Task Force on Taxonomy (2011) suggests that “experiences which resemble pain but are not unpleasant, e.g., pricking, should not be called pain” (para. 4), for some older adults, words such as “pricking” may be a preferred means of describing pain.

Using culturally sensitive communication may initially be uncomfortable to nurses, 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 are used to relay messages, nurses may develop increased levels of relatability to their patients.

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 nurses accommodate patients by using culturally sensitive communication and maintain 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

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Although most Black older adults 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 health care providers can establish rapport and engage in culturally sensitive communication by first addressing any fears Black older adults 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 reassurance is necessary as complaining is often viewed as a negative attribute in Black culture (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 of assessment tools, are not so easily changed within institutions. This institutional change requires negotiation.
Thermometer-revised (IPT-r) are valid, reliable, and preferred among Black American older adults with and without cognitive impairment (Ware et al., 2015). The use of 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 (Booker et al., 2015). To measure pain intensity, patients should be asked to quantify (e.g., 0 to 10 scale) and qualify (e.g., mild, moderate, severe) pain intensity by using pain self-report scales.

Negotiation also means effectively managing chronic pain by using recommended stepped, multimodal approaches that integrate preferred complementary and alternative strategies along with effective and proven prescription medications (Arnstein & Herr, 2013). When treating severe pain in particular, nurses should be mindful that Black American individuals report significantly greater cancer pain \((p < 0.001)\) (Meghani, Thompson, Chittams, Bruner, & Riegel, 2015). Furthermore, when Black older adults use a prescription opioid drug, they are more likely to take less than the prescribed amount. In one study, on sub-analysis, analgesic adherence rates for Black American individuals ranged from 34\% (for weak opioid agents) to 63\% (for long-acting opioid agents) (Meghani et al., 2015). A primary reason for decreased opioid drug compliance among Black older adults is concern about side effects (Chang, Wray, Sessanna, & Peng, 2011; Robinson, 2015).

Side effects are a commonly reported barrier to medication use and adherence in Black older adults (Booker, 2015; Meghani et al., 2015; Robinson, 2015). Similar to other older adults, Black older adults often have several comorbidities (i.e., three or more), with each requiring separate treatments and medications. The cumulative effect of multiple medications and subsequent side effects often discourages these patients 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 nonpharmacological 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 among Black older adults 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\% to 90\% of Black individuals are lactose intolerant (National Medical Association, 2009). When practicing culturally responsive care, nurses understand the hesitancy of some Black older adults to take opioid analgesic agents and use 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 analgesic agents (Cherniack et al., 2008; Robinson, 2015).

Black older adults often 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 patients and families 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 patients’ care plans as feasible and desired. Black older adults might be particularly appreciative of, and more receptive to, an effective oral analgesic agent when it is accompa-
miliar topical analgesic agent. When nurses are not able to meet patients’ 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 capsicain, may be used by Black older adults to reduce muscle pain (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 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 capsicain.

CLINICAL CARE INTEGRATION

Ultimately, there are many ways in which culturally responsive nurses 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. Although national guidelines outlined by the USDHHS (2016) describe the ways in which organizations can become more culturally competent in the delivery of health care 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 cannot be met.

CONCLUSION

Prudent nurses work diligently to provide culturally congruent care and are 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 life long 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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**ABOUT THE AUTHORS**

Dr. Robinson-Lane is Assistant Professor, University of Michigan School of Nursing, Department of Systems, Populations and Leadership, Ann Arbor, Michigan; and Ms. Booker is Doctoral Candidate, University of Iowa College of Nursing, Iowa City, Iowa.

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Address correspondence to Sheria G. Robinson-Lane, PhD, RN, Assistant Professor, University of Michigan School of Nursing, Department of Systems, Populations and Leadership, 400 N Ingalls Street, #4305, Ann Arbor, MI 48109; e-mail: grices@med.umich.edu.

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