

Assessing pain across the cultural gap: Central Australian Indigenous peoples' pain assessment

Received 7 March 2005

Accepted 30 January 2006

Clare Fenwick

Lecturer in Nursing

School of Nursing and Midwifery – Gold Coast

Griffith University,

PMB 50, Gold Coast Mail Centre

Queensland, 9726

ABSTRACT

Pain is a dynamic, unpleasant sensory experience with many physical, psychological, and social implications. Assessment of pain within a bicultural environment has the potential to cause ineffective pain management and unnecessary suffering amongst Indigenous people. It has been recognised that non-Indigenous nurses sometimes demonstrate culturally unsafe practices during the pain assessment process. These practices have arisen due to limited knowledge of what constitutes “cultural safety” and how nurses can apply this concept during pain assessment. Culturally safe pain assessment strategies have been developed based upon research findings and through consultation with Indigenous people.

KEY WORDS: Indigenous people, pain assessment, non-Indigenous nurses, cultural safety

INTRODUCTION

This paper will highlight the influences culture has upon pain expression by Indigenous people and the subsequent response non-Indigenous nurses have towards that pain expression. It will challenge nurses to consider how the principles of cultural safety may be applied to the pain assessment of Indigenous people. It will explore the limitations of pain assessment tools based upon the pain nuances as expressed by Indigenous people. This paper aims to change the way non-Indigenous nurses approach pain assessment and to critically analyse our practices of assessing pain in Indigenous people.

Information provided here draws upon findings from a grounded theory study conducted in Central Australia (Fenwick, 1998). The study produced a theoretical explanation of post-operative pain experiences of Indigenous women from the Pitjantjatjarra, Yankunytjatjara, and Arrente lands and the interpretation of these pain experiences by non-Indigenous nurses. This study encouraged both Indigenous people and the health care team to examine culturally appropriate pain assessment methods and the application of appropriate pain management strategies (Fenwick, 1998). The findings of this study were validated through direct consultation with Central Australian Indigenous women working as Indigenous health workers and educators at the time (Abbott, 1997, pers. comm., 25 July., Beer, 1997, pers. comm., 12 Aug., Hampton-Hayes, 1996, pers. comm., 19 Aug., James, 1998, pers. comm., 14 Feb., Turner, 1998, pers. comm., 14 Feb). This paper has particular significance for health professionals providing pain

management to Central Australian Indigenous peoples. However, many aspects of the discussion presented here can be transferred across other Indigenous groups.

Pain is a dynamic, unpleasant sensory experience with many physical, psychological, and social implications (Hallberg & Carlsson, 2000). Persistent pain will affect up to half of the world's population at some time (Breen, 2002, Kind, Dolan, Gudex & Williams, 1998). Acute pain is a sudden and unwanted experience commonly regarded as a protective occurrence in response to injury or disease (Horn & Munafo`, 1997, McCaffery & Pasero, 1999). Pain transcends all cultural boundaries, with no preference as to who will be afflicted. How an individual expresses pain is influenced by each individual's past experiences, age, gender, socioeconomic status, and in particular their cultural underpinnings (Fenwick, 1998). The cultural differences in the way individuals express their pain varies considerably. Individuals in pain will often seek assistance from health professionals to gain an understanding of the pain's origins and implications (Ashburn & Staats, 1999, Kenny, 2003). Therefore, it is important that health professionals, particularly nurses, have a good understanding of cultural effects on individual expressions of pain and subsequent assessments of pain.

Nurses have an ethical responsibility to provide accurate assessment of pain and administer appropriate pain relief interventions (Macintyre, 2001). However, if nurses are unfamiliar with the cultural characteristics that define an individual's pain experience, inaccurate and sometimes harmful responses may occur (Fenwick & Stevens, 2004). Commonly, culture is often used to define an individual's ethnic origins. However, culture encompasses not only nationality, but also an individual's customs, language, roles, social organisation, historical underpinnings, and

environmental perception of the lived world (McMurray, 2003). Culture is about being different (Ramsden, 2002, Spence, 2005). Aboriginal and Torres Strait Islanders are distinctly different from non-Indigenous nurses who provide health care (Gould, 2005). This is not to say either culture is better or worse than another, instead it recognises that each culture is unique to the experiencing individual. The interchange between different cultures can be an enriching experience however, in times of illness and vulnerability a cultural mismatch could also prove catastrophic. For example, if pain assessment fails to address the unique manner in which people express pain there is a significant risk of ineffective treatment, dissatisfied clients, and sub-optimal care (Kazanowski & Laccetti, 2002). Pain assessment is dependant on individuals effectively communicating their pain experience to nurses, and nurses making accurate interpretations of that pain experience.

With the limited number of Indigenous nurses practicing in Australia (Gould, 2003), an onus is placed upon non-Indigenous nurses to become more proactive in learning about the uniqueness of Aboriginal and Torres Strait Islander culture, particularly related to pain assessment. To ensure quality pain management of Indigenous clients, non-Indigenous nurses need to develop culturally safe pain assessment practices. Currently there are limited resources informing non-Indigenous nurses about the concepts of pain, pain assessment, and pain relief amongst Indigenous people (Fenwick, 1998, Fenwick & Stevens, 2004).

Cultural safety

Pain assessment occurs within a bicultural environment. A bicultural environment transpires when one individual, the client, expresses the uniqueness of their pain experience, and the other

individual, the nurse, attempts to accurately interpret the resulting pain expression. Within any bicultural environment there is the risk of misunderstandings, power struggles, and inequalities (Ramsden, 2002). Congress of Australian and Torres Strait Islander Nurses' chair, Sally Gould challenges nurses to critically observe the Western health model to recognise how it promotes separation, hierarchy, and power struggles and also denies the emotional, social, spiritual, and political aspects of Indigenous health (Gould, 2005). If the Western health model does not enhance Indigenous health due to the loss of emotional, social, spiritual, and political support, it may be considered that the care delivered is culturally unsafe.

Delivering culturally safe care is not a new concept. It is a process that can occur in any situation where the health provider and the health recipient experience different cultures. Cultural safety was derived from the lived experiences of Maori nurse, Irihapeti Ramsden, during the 1980s. Ramsden developed the concept of cultural safety to address issues of power, racism, and discriminatory attitudes amongst nurses faced with managing clients who were from a different culture. Power, racism, and negative attitudes are the same barriers that Gould (2003) raises as obstacles in delivering culturally safe health care to Australian Indigenous peoples. Ramsden (1992) explains that being culturally aware and sensitive are progressive steps toward being culturally safe. Developing cultural awareness arises as the nurse acknowledges that individuals are different. Becoming culturally sensitive occurs as the nurse engages in self exploration of their own culture, recognising the potential positive and negative impact their own culture has upon another. Whilst each of these concepts may lead to cultural safety neither defines the notion of cultural safety.

Cultural safety is about being able to care for a person by recognising and respecting differences in that person with regard to their social, political, and economical position within society (Ramsden, 2002, Syme & Browne, 2002). Eckermann, Dowd, Martin, Nixon, Gray and Chong (1992) explain that people are defined by their physical, political, economic, and social environments, their perceived needs and wants, and by the historic and current situations they experience. Delivering culturally safe care is not achieved solely by recognizing and respecting cultural differences between the client and health provider, it is achieved through the establishment of trust (Ramsden, 2002). Cultural safety is acquired when the recipient of care acknowledges that the provider of care is trustworthy to deliver culturally safe care. For example, an Indigenous person experiencing post-operative pain is the only person who can truly determine the level of pain they are experiencing. Subsequently, the Indigenous person is the only one able to determine if the nurse has accurately assessed the pain experienced. As the recipient of the pain assessment, the Indigenous client becomes the only person able to determine if the nurse is culturally safe.

The recipients of care, the clients, can deem nurses to be either culturally safe or unsafe. To be culturally unsafe is to perform an act that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (Nursing Council of New Zealand, 2002). For example, labelling an Indigenous person as “stoic” if they fail to vocally express their pain may turn out to be a culturally unsafe act directed towards that individual. Some Indigenous people are silent during the pain experience for a variety of reasons. Evaluating this silence as “stoicism” could lead to inadequate pain relief and demean the cultural identity of the client. For Indigenous

peoples, application of culturally safe pain assessment practices will certainly improve the overall pain management provided to clients.

Aboriginal culture

To enable cultural safety, the cultural identity of Indigenous people needs to remain intact (Nursing Council of New Zealand, 2002). For many non-Indigenous nurses there is a poor understanding of Aboriginal and Torres Strait Islander cultures in relation to pain experiences (Fenwick, 1998, 2001, Fenwick & Stevens, 2004). It is acknowledged that recognising differences between non-Indigenous and Indigenous people underpins the ability to develop collaborative relationships based on trust (Ramsden, 2002, Spence, 2005). Establishment of trust relationships are essential to the acquisition of cultural safety. Therefore it is significant that Indigenous culture is briefly explored to inform non-Indigenous nurses of some difficulties in establishing these relationships and the impact this will have upon pain assessment. This section was written with the assistance of Indigenous people who have willingly shared their culture to provide detailed understandings of Indigenous culture in relation to pain (Abbott, 1997, pers. comm. 25 July., Beer, 1997, pers. comm. 12 Aug., Hampton-Hayes, 1996, pers. comm. 19 Aug., James, 1998, pers. comm. 14 Feb., Turner, 1998, pers. comm. 14 Feb).

For Indigenous people the discussion about pain may lead the conversation into the political areas of the stolen generation and land rights (Abbott, 1997, pers. comm. 25 Jul). It may be prudent to ask what connection these issues of land and children have with the experience of pain. For many Indigenous people there is connectedness with the land, their kin and the spirit world (Abbott, 1997, pers. comm. 25 Jul., Hampton-Hayes, 1996, pers. comm. 19 Aug). If these

three concepts are in harmony Indigenous people are well. However, if an imbalance is present many Indigenous peoples may consider themselves to be in pain or sick. For example, the origins of pain for Central Australian Indigenous people has been described as an illness that is caused by the north winds bringing with it little black stones that induce pain, stomach ache, or diarrhoea (Japanangka & Nathan, 1983). Non-Indigenous nurses need to be mindful that healthy lands, good family relationships, and respecting the spirit world are important for Indigenous peoples. For some Indigenous people returning home to be with family may be more important than receiving treatment for a painfully infected abscess.

According to Honeyman and Jacobs (1996) Indigenous people suppress pain behaviours and demonstrate reluctance to discuss their pain experience with others. Beer (1997, pers. comm. 12 Aug) believes that Indigenous people are reluctant to express pain due to the oppression and suppression these people have endured since colonisation. Fenwick and Stevens (2004) explored this concept further to explain that Indigenous people do not fraternise with words, hence, their presumed reluctance to engage in conversation concerning pain. Given the opportunity, Indigenous people do demonstrate just as prominently and regularly unique pain behaviours and language, albeit differently from European culture (Beer, 1997, pers. comm. 12 Aug., Fenwick, 1998, 2001). To explain this phenomenon it is necessary to briefly look at history where from 1788 to the present day, Australian Indigenous peoples have systematically endured the loss of social, political, economical power, and more importantly the loss of some basic human rights (Eckermann et al., 1992, Gould, 2005, McMurray, 2003, Reid & Trompf, 1991, Siggers & Gray, 1991). Loss of social, political, and economic power coupled with the experience of pain places any individual in a position of vulnerability, potentially weakening the individual's physical,

mental, and emotional endurance. Pain, viewed as a human weakness combined with an oppressive view of the world, leaves little doubt as to how Indigenous people fail to draw attention to their pain experience. Non-Indigenous nurses operating from a Westernised view of culture where social, political, and economic power is more heavily weighted may find it difficult to bridge this cultural gap of understanding (Gould, 2005, Sanderson, 2000).

Pain assessment

Current pain assessment tools are varied and many have limited use in bicultural situations (McCaffery & Pasero, 1999). For example, the numerical pain assessment tool is popular amongst nurses because it is easy to use. This tool uses a scale of one to ten, one means no pain and ten reflects the worst pain experienced. The numerical pain assessment tool when used with Indigenous people is more likely to produce inaccurate pain readings as some Indigenous languages do not have a conceptual recognition of the numbers above five (Fenwick, 1998, 2001). Discussions with Indigenous health workers reveal that Indigenous people exhibit a unique and subtle pain behaviour and language, a head turned away with eyes averted; a slight upward nod of the head with downcast eyes when asked if in pain; the whispered response, “paining Sister;” and, the act of feigning sleep (James, 1998, pers. comm. 14 Feb., Turner, 1998, pers. comm. 14 Feb). As one Aboriginal woman said, “[s]ister the pain was so bad I had to sleep.” These discussions also revealed that non-Indigenous nurses can overlook these pain cues as they are often unskilled in culturally safe pain assessment (Beer, 1997, pers. comm. 12 Aug., Fenwick, 1998). As another Aboriginal woman noted, “[t]he nurse come to me and ask me if I have pain. If they don’t ask I don’t tell.”

Evidence suggests that non-Indigenous nurses misinterpret the nuances of Aboriginal and Torres Strait Islander languages and may misconstrue the meaning of pain behaviours exhibited by Indigenous people (Fenwick, 1998, Fenwick & Stevens, 2004). For example, an Indigenous person may choose not to discuss the origins of their pain because it resulted from breaking Aboriginal law. Informing non-Indigenous nurses of the language nuances and unique pain behaviours of Indigenous people will narrow the cultural gap and ensure nurses are safe enough during their pain assessment of Indigenous people. Some simple strategies have been outlined below to inform non-Indigenous nurses of ways to improve pain assessment of Indigenous people.

Language nuances

Many Central Australian Indigenous people are considered to be multilingual, fluent in several Aboriginal and Torres Strait Islander languages with English being a fourth or fifth spoken language (Fenwick, 2001). Two thirds of all Northern Territory Indigenous people speak a language other than English at home (Australian Bureau of Statistics, 2002). Despite the multilingual capabilities of Indigenous people, it is essential to recognise that most have a very good understanding of English and can communicate effectively. However, it is also important to recognise that Indigenous people have different priorities to that of non-Indigenous people during a communication exchange (Fenwick, 1998). Communication disparities most often occur from the manner in which conversations are addressed rather than actual words spoken. Within each culture an unspoken set of communication rules exists. Indigenous culture is no different. To be culturally safe non-Indigenous nurses need to be aware of the following

language nuances that exist in Indigenous languages: social conversations, nonsense questions, silence, and combination questions.

Social conversations

Entering healthcare institutions many Indigenous people are more likely to engage in conversations of a social nature rather than conversations focussing on their pain. For Indigenous people language sharing and the exchange of life stories are essential to the development of trust relationships with non-Indigenous nurses (Beer, 1997, pers. comm. 12 Aug). However, for some non-Indigenous nurses this type of conversation may be viewed as time wasting or irrelevant during nursing assessments. To be culturally safe it is important to recognise that social conversation is an important component of communicating with Indigenous people in order to establish a level of trust. Trust is the basis from which cultural safety is constructed.

Nonsense questions

Many Indigenous people do not feel obligated to respond to questioning, particularly if the answer is obvious (Fenwick, 1998, 2001). This language style may be associated with the manner in which traditional health interviewing was conducted. In traditional times an Indigenous person would seek assistance from an Indigenous healer when unwell or in pain. The Indigenous healer would observe the person, palpate the area of concern, and inform the person of the correct course of action required to obtain relief (Abbott, 1997, pers. comm. 25 Jul). Pain assessment was based upon the Indigenous healer knowing what was wrong, therefore, there was no need to ask the obvious question, “Are you in pain.” In contrast, when Indigenous people enter Westernised healthcare institutions they undergo intense verbal scrutiny by nurses who

enquire if they are experiencing any pain. For example, if an Indigenous person sustains a fractured leg it is obvious that this would cause considerable pain. Why then do nurses ask the Indigenous person, “Are you in pain?” or “Does your leg hurt?” For many Indigenous people the question is a nonsense question that is not worthy of response. For non-Indigenous nurses it is assumed that no response means either a lack of understanding or that it must not hurt. To be culturally safe in these situations non-Indigenous nurses should acknowledge the pain the Indigenous person is experiencing by stating, “I can see you are in pain,” then continue on to more detailed pain assessment.

Silence

During the pain assessment of Indigenous people it is not uncommon for periods of silence to occur. For non-Indigenous nurses a silent response to the question of pain may warrant a repeat of the question, “Have you got pain.” For some Indigenous people it is considered impolite to answer a question straight away, hence the pause before a reply (Hampton-Hayes, 1996, pers. comm. 19 Aug). The more respect an Indigenous person has for an individual the longer the pause. This repetition of information happens frequently during Indigenous and non-Indigenous conversations causing frustration for both parties. As one nurse states, “[y]ou’re trying to interpret the silence. They’ll stand there and you know that they want something but you’re not exactly sure what. I sometimes wonder if they get what they really want...It’s all part of a guessing game.”

Non-Indigenous nurses need to be mindful that Indigenous people may delay their answer as a demonstration of respect for the nurse’s status (Fenwick, 1998). To be culturally safe it is

appropriate to accept the moment of silence. If no response is forthcoming, acknowledge the Indigenous person with a statement similar to, “You must be concerned about what has brought you to the hospital, would you like to talk about this.” Nurses engaging in social conversations will develop trust relationships with the Indigenous client thus facilitating cultural safety.

Combination questions

Nurses will often ask combination questions to acquire information about pain, such as, “Does this hurt if I touch here? and “Can you tell me how bad it is?” For some Indigenous people the importance of the question is distorted if it holds two questions within the one sentence (Hampton-Hayes, 1996, pers. comm. 19 Aug). This occurs as each question demands personal attention that is not forthcoming when joined within one sentence. Combination questions challenge Indigenous people as they attempt to identify which question holds the most importance. This communication discrepancy can cause havoc for non-Indigenous nurses who may be unaware of this cultural gesture (Fenwick, 1998). Non-Indigenous nurses may falsely assume that the lack of response by the Indigenous client signified an indifference to their pain state, or implied a level of comfort (Fenwick, 1998). To be culturally safe in this situation once again acknowledge the pain experience and then ask additional questions, such as, “I can see that you are in pain, can you point to where the pain travels to.” The language of pain is an important concept when conducting a pain assessment. Equal importance is given to recognising the unique pain behaviours of Indigenous people.

Pain behaviours

Pain behaviours are a unique collection of physical and psychological manifestations of the pain experience. Within many ethnic groups, stereotyping of pain behaviours has occurred, such as the “stoic Asian” or the “gregarious Italian.” Stereotyping is a hazardous practice as it implies expected behaviours during the pain assessment. Unfortunately stereotyping of pain behaviours demonstrated by Indigenous people is evident in pain assessments by non-Indigenous nurses (Fenwick, 1998). Indigenous people who do as they are told and appeared happy to accept the process of care, are considered to be “well behaved” (Fenwick, 1998). Many Indigenous people do not draw attention to themselves and non-Indigenous nurses labelled them as ‘unobtrusive’ when in pain (Fenwick, 1998). Some non-Indigenous nurses have implied that Indigenous people do not seem to worry about receiving pain relief. This behaviour has been labelled as “stoicism.” Clinical observation reveals that Central Australian Indigenous people are in fact reserved and non-obtrusive when experiencing pain, however, this should not imply that they do not experience pain. Strehlow (1970) and Honeyman and Jacobs (1996) believe this phenomenon enhanced the belief that Indigenous people do not feel pain and have an extraordinary high pain tolerance. Regrettably if these practices are acted upon there will certainly be inadequacies in the pain relief provided. To be culturally safe, non-Indigenous nurses need to be mindful of extraneous factors that define pain behaviours such as: body language, caretakers, measuring tools, and suggestive assessment.

Body language

Recognition of the subtle body signals exhibited by Indigenous people is a valuable part of pain assessment. If limited understandings of Indigenous culture exist these body expressions may be overlooked or downplayed by the nurse conducting the pain assessment. It is quite possible that

Indigenous people, unless they have a heightened sense of self-awareness, will also fail to recognise the effect their body language has on the pain assessment process. Indigenous people, despite their silent complaints, exhibit subtle pain expressions (Beer, 1997, pers. comm. 12 Aug). Physical silence in Indigenous people materialises as distinct body languages such as, a head turned away on questioning; or hiding the head and body under a blanket (Fenwick, 1998, 2001). According to Sofaer (1992:44), “[i]llness and pain are fatiguing, sometimes patients react by being quieter than usual and by lying still simply because they are too tired to do otherwise.” Indigenous people might look tense, get a “paining look,” wince or grimace when experiencing pain. Grimacing is a classic non-verbal pain expression and is universally accepted as an indicator for pain (Chapman & Syrjala, 1990, Dick, 1995). Other facial expressions demonstrated by Indigenous people are crying, head shaking, and clucking of the tongue. Facial expressions are a small part of the pain picture, and it is only by looking at the total person that nurses will identify other pain signals. Observations of Indigenous people reveal that pain is also expressed through body positioning and mobility (Fenwick, 1996, 1998). Indigenous people in pain will often lie completely still or roll onto their side, averting their gaze from other people in the room. She, “...lowered herself into her chair and immediately retracted her legs up to her stomach, soothing herself with gentle rocking, avoiding eye contact” (Fenwick, 1996, p.28). Culturally safe assessment of pain behaviours requires astute observation skills as nurses separate the emotive response of hospitalisation from the emotive response associated to pain.

Caretakers

Pain assessment of Indigenous people is not isolated to the individual in pain, but often incorporates the extended kinship that embraces Indigenous culture. Nurses will often

find that indirect sources, such as family members, will contribute to the pain assessment (Fenwick, 1998). As one nurse said, “I don’t think it (family) lowers it (pain) I think it may act like a distraction of their pain, the comfort and the support.”

An Indigenous person may appear to be comfortable, however, once family members arrive the nurse may be told that their relative is suffering. This act of alerting nurses to the suffering of a relative is interwoven into the role responsibilities within the Indigenous family structure. The advantage of this intimate family relationship allows various family members to identify alterations in character or normal behaviour of other family members. To conduct a culturally safe pain assessment it is necessary to engage family members into conversations regarding the pain experience of their significant other. This is noted in the following exemplar, “[f]amily make me better, makes me happy” (an Aboriginal woman).

Assessment tools

Pain assessment uses nurses’ interviewing and observational skills to interpret pain languages and behaviours of the Indigenous client. Most nurses will also use some form of tool to objectify the subjective experience of pain, such as the visual analogue scale, pain faces scale, or numerical pain scale. The numerical pain scale is commonly used to assess pain amongst Indigenous people (Fenwick, 1998). This tool uses the numbers, one to ten: one being the level of least pain and ten the level of most pain. The popularity of the numerical scale is prevalent amongst nurses who find this tool convenient, as it does not require the carrying of extra instruments and is verbally based (McCaffery & Beebe, 1989, McCaffery & Pasero, 1999). However, the numerical pain scale has been demonstrated to be inaccurate

when used with Central Australian Indigenous people. Some Indigenous people had difficulties conceptualising the meanings used in this tool because some Central Australian Indigenous languages lack numerical recognition of numbers above three or five. Quite obviously a numerical scale of ten would have no significant meaning for a group of Indigenous people. It is important for non-Indigenous nurses to recognise that the absence or diminished use of numbers within language structures does not imply numerical ignorance for the speakers of that language (Theiberger & Mc Gregor, 1994). Using a pain assessment tool that has no significance to the Indigenous person inadvertently demonstrates displacement of power to the nurse. In this situation the non-Indigenous nurse is not providing culturally safe care. To ensure cultural safety, it is necessary that nurses adapt pain assessment tools to suit the recipient's culture, such as using verbal pain descriptors based on Indigenous languages; using numerical pain assessment tools limited to the numbers one to five; or by engaging Aboriginal health workers in the pain assessment process (Howe, Condon & Goodchild, 1998).

Suggestive assessment

Fenwick (1998) revealed that nurses adopted two main patterns to pain assessment, suggestive assessment and comparative assessment. Suggestive assessment is a process whereby the non-Indigenous nurse suggests a pain score based on their own experiences. They then ask the Indigenous person to validate this score. The Indigenous person is not consulted about the level of pain they are experiencing, rather they are informed of a suitable pain score. Commonly the Indigenous person will acknowledge the pain score being told to them as correct. For an Indigenous person to disagree with the nurse would bring too much

“shame,” and show disrespect to those who “know.” Initially this submissiveness exhibited by the Indigenous person may appear abnormal, however, these individuals are responding to the nurse within the context of oppression. According to Eckermann et al. (1992, p. 163), Indigenous people hold three distinct fears when entering a hospital environment: “a) [h]aving to talk to white people, b) being separated from their families and c) not understanding the language or procedures.” To provide culturally safe pain assessments it is important for nurses to recognise the fears Indigenous people may have. It is equally important that non-Indigenous nurses recognise the disproportionate amount of power they display by not engaging the Indigenous person into the self-assessment of pain.

Comparative assessment is the second form of pain assessment that has been observed (Fenwick, 1998). It is a process where current pain levels are determined using previously allocated pain scores. This is a hazardous way to conduct pain assessment, as the original pain score was most likely acquired by the ineffective process of suggestive assessment. For example, the non-Indigenous nurse may ask the Indigenous client, “Is your pain still 6 out of 10.” The Indigenous client will most likely affirm this number due to fear or shame of disagreeing with the nurse. Ultimately, an ineffective cycle of inadequate pain assessment and insufficient pain relief may ensue. Non-Indigenous nurses have naively created the suggestive and comparative pain assessments believing in the accuracy of these techniques (Fenwick, 1998, 2001). In culturally challenging situations nurses have failed to understand the cultural responses to pain by Indigenous people, and in doing so, have not modified traditional pain assessment tools such as the numerical pain scale (Fenwick, 1998).

Ultimately, non-Indigenous nurses have inadvertently attempted to mould Indigenous culture

to fit pain assessment techniques that are suitable for their own culture. This has resulted in a culturally unsafe act whereby non-Indigenous nurses have failed to recognise and respond to the differences of another cultural group, the Indigenous people.

Conclusion

Ineffective pain assessment occurs when non-Indigenous nurses fail to acknowledge the symbolic meanings pain has for Indigenous people. The recommendation for non-Indigenous nurses working within rich cultural environments is to listen to Indigenous people and respect the differences that exist. It is important to hear the Indigenous stories of pain and develop sensitivity to how pain has affected Indigenous people, family, community, and culture. To acquire cultural safety during pain assessments of Indigenous people, non-Indigenous nurses need to develop trust relationships. Acquisition of trust relationships between non-Indigenous nurses and Indigenous people occur when power differences between cultures are addressed, when changes in attitudes occur and when no prejudices exist concerning the people in our care. It is the responsibility of Indigenous people to award the non-Indigenous nurse the position of cultural safety, and it is the responsibility of the non-Indigenous nurse to be worthy of this title.

References

- Ashburn, MA & Staats, PS 1999 'Management of chronic pain' *Lancet*, vol. 353, no. 9167, pp. 1865 - 1870.
- Australian Bureau of Statistics 2002, 2001 Census Indigenous Profile: 701 Northern Territory - Bal (statistical division). Retrieved February 12, 2002, from <http://www.abs.gov.au/Ausstats/abs@census.nsf/343b70397d0e3967ca256b9d00208f91/056eced28072b080ca256bb4000bcf98!OpenDocument>
- Breen, J 2002 'Transitions in the concept of chronic pain' *Advanced Nursing Science*, vol. 24, no. 4, pp. 48-59.
- Chapman, CR & Syrjala, KL 1990 'Measurement of pain' in JJ Bonica (eds), *The management of pain*, Lea and Febiger, London, pp. 580-594

- Dick, MJ 1995 'Assessment and measurement of acute pain' *JOGNN*, vol. 24, no. 9, pp. 843-848.
- Eckermann, A, Dowd, T, Martin, M, Nixon, L, Gray, R & Chong, E 1992 *Binanj Goonj bridging cultures in Aboriginal health*, University of New England Press, Armidale.
- Fenwick, C 1996 'Communicators of pain' *Australian Nursing Journal*, vol. 4, no. 5, pp. 28-29.
- Fenwick, C 1998, 'Post operative pain experiences in Central Australian Aboriginal women: What do we understand?' B.Nursing (hons) thesis, Southern Cross University
- Fenwick, C 2001 *Pain management strategies for health professionals caring for Central Australian Aboriginal people*, Commonwealth Department of Health and Aged Care, Canberra.
- Fenwick, C & Stevens, J 2004 'Post operative pain experiences of Central Australian Aboriginal women. What do we understand?' *Australian Journal of Rural Health*, vol. 12, no. pp. 22-27.
- Gould, S 2003, 'Getting em n keeping em - a report of the Indigenous nursing education working group', paper presented at 7th National Rural Health Conference, Hobart, Australia, 1-4 March
- Gould, S 2005, CATSIN's new millennium journey to success: Preamble. Retrieved September 12, 2005, from <http://www.indigenet.com.au/catsin/preamble.html>
- Hallberg, LRM & Carlsson, SG 2000 'Coping With Fibromyalgia' *Scandinavian Journal of Caring Science*, vol. 14, no. 1, pp. 29-36.
- Honeyman, PT & Jacobs, EA 1996 'Effects of culture on back pain in Australian Aboriginals' *Spine*, vol. 21, no. 7, pp. 841-843.
- Horn, S & Munafò, M 1997 *Pain theory, research and intervention*, Open University Press, Philadelphia.
- Howe, PW, Condon, JR & Goodchild, CS 1998 'Anaesthesia for Aboriginal Australians' *Anaesthesia and Intensive Care*, vol. 26, no. 1, pp. 86-91.
- Japanangka, DL & Nathan, P 1983 *Health business*, Heinemann Educational Australia, Richmond, Victoria.
- Kazanowski, MK & Laccetti, MS 2002 *Pain*, Slack, Thorofare, N.J.
- Kenny, DT 2003, Constructions of chronic pain in doctor-patient relationships: Bridging the communication chasm. Retrieved 7 September, 2003, from http://www.sciencedirect.com/science?_ob=ArticleURL&_aset=W-WA-A-A-AB-MSAYZA-UUW-AUZBUZADWU-WWUAEACUZ-AB-U&_rdoc=1&_fmt=full&_udi=B6TBC-48KMM9T-1&_coverDate=05%2F14%2F2003&_cdi=5139&_orig=search&_st=13&_sort=d&view=c&_acct=C000006418&_version=1&_urlVersion=0&_userid=79777&md5=abde27fc3398b8a5551aebe51ee82ac8
- Kind, P, Dolan, P, Gudex, C & Williams, AJ 1998 'Variations in population health status: Results of a United Kingdom national questionnaire survey' *British Medical Journal*, vol. 316, no. pp. 736-741.
- Macintyre, PE 2001 *Acute pain management: A practical guide*, Saunders, London.
- McCaffery, M & Beebe, A 1989 *Pain: Clinical manual for nursing practice*, Mosby, St. Louis.
- McCaffery, M & Pasero, C 1999 *Pain: Clinical manual*, Mosby, Missouri.
- McMurray, A 2003 *Community health and wellness*, Mosby, Sydney.
- Nursing Council of New Zealand 2002 *Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori health in Nursing and Midwifery education and practice*, NCNZ, Wellington.
- Ramsden, IM 1992 'Teaching cultural safety' *New Zealand Nursing Journal*, vol. 85, no. 5, pp. 21-23.
- Ramsden, IM 2002, 'Cultural safety and nursing education in Aotearoa and Te Waipounamu', PhD thesis, Victoria University
- Reid, J & Trompf, P (ed.) 1991, *The health of Aboriginal Australia*, Harcourt Brace Jovanovich Publishers, Sydney

- Saggers, S & Gray, D 1991 *Aboriginal health and society*, Allen and Unwin, St Leonards.
- Sanderson, C 2000 'Addressing Aboriginal health inequalities' *Australian Nursing Journal*, vol. 7, no. 11, pp. 20-22.
- Spence, DG 2005 'Hermeneutic notions augment cultural safety education' *Journal of Nursing Education*, vol. 44, no. 9, pp. 409-414.
- Strehlow, TGH 1970 'Geography and totemic landscape in Central Australia' in RM Berndt (eds), *Australian Aboriginal Anthropology*, University of Western Sydney, Perth, pp.
- Syme, V & Browne, A 2002 'Cultural safety' and the analysis of health policy affecting Aboriginal people' *Nurse Researcher*, vol. 9, no. 3, pp. 42-56.
- Theiberger, N & Mc Gregor, W (ed.) 1994, *Macquarie Aboriginal words*, The Macquarie Library, NSW, Australia