
Cultural Responses to Pain by Mark Zborowski

The ways that we respond to illness are strongly influenced by cultural factors. In this article, Mark Zborowski shows that even the physical sensation of pain is often interpreted differently by members of different American ethnic groups who tend to respond to pain in terms of meanings they learned in their own families.

Some Basic Distinctions

In human societies biological processes vital for man's survival acquire social and cultural significance. Intake of food, sexual intercourse or elimination - physiological phenomena which are universal for the entire living world - become institutions regulated by cultural values and social rules.... Human beings experience hunger for food and sexual desire, but culture and society dictate to the kind of food people may eat, the social setting for eating or the adequate partner for mating.

Moreover, the role of cultural and social patterns in human physiological activities is so great that they may in specific situations act against the direct biological needs of the individual, even to the point of endangering his survival. Only a human being may prefer starvation to the breaking of a religious dietary law or may abstain from sexual intercourse because of specific incest regulations. Voluntary fasting and celibacy exist only where food and sex fulfill more than strictly physiological functions.

Members of different cultures may assume differing attitudes towards these various types of pain. Two of these attitudes may be described as pain expectancy and pain acceptance. Pain expectancy is anticipation of pain as being avoidable in a given situation, for instance, in childbirth, in sports activities or to battle. Pain acceptance is characterized by a willingness to experience pain. This attitude is manifested mostly as an inevitable component of culturally accepted experiences, for instance, as part of initiation rites or part of medical treatment. The following example will help to clarify the differences between pain expectancy and pain acceptance. Labor pain is expected as part of childbirth, but while in one culture, such as in the United States, it is not accepted and therefore various means are used to alleviate it, in some other cultures, for instance in Poland, it is not only expected but also accepted, and consequently nothing or little is done to relieve it. Similarly, cultures which emphasize military achievements expect and accept battle wounds, while cultures which emphasize pacifistic values may expect them but will not accept them.

In the process of investigating cultural attitudes toward pain it is also important to distinguish between pain apprehension and pain anxiety. Pain apprehension reflects the tendency to avoid the pain sensation as such, regardless of whether the pain is spontaneous or

inflicted, whether it is accepted or not. Pain anxiety, on the other hand, is a state of anxiety provoked by the pain experience, focused upon various aspects of the causes of pain, the meaning of pain or its significance for the welfare of the individual.

Moreover, members of various cultures may react differently in terms of their manifest behavior toward various pain experiences, and this behavior is often dictated by the culture which provides specific norms according to the age, sex and social position of the individual.

The fact that other elements as well as cultural factors are involved in the response to a spontaneous pain should be taken into consideration. These other factors are the pathological aspect of pain, the specific physiological characteristics of the experience, such as the intensity, the duration and the quality of the pain sensation, and finally, the personality of the individual. Nevertheless, it was felt that in the process of a careful investigation it would be possible to detect the role of the cultural components in the pain experience.

The Research Setting

With these aims in mind the project was set up at the Kingsbridge Veterans Hospital, Bronx, New York, where four ethno-cultural groups were selected for an intensive study. These groups included patients for Jewish, Italian, Irish and "Old American" stock. Three groups - Jews, Italian, and Irish - were selected because they were described by medical people as manifesting striking differences in their reaction to pain.

Italians and Jews were described as tending to "exaggerate" their pain, while the Irish were often depicted as stoical individuals who were able to take a great deal of pain. The fourth group, the "Old Americans," were chosen because the values and attitudes of this group dominate in this country and are held by many members of the medical profession and by many descendants of the immigrants who, in the process of Americanization, tend to adopt American patterns of behavior. The members of this group can be defined as white, native-born individuals, usually Protestant, whose grandparents, at least, were born in the United States and who do not identify themselves with any foreign group, either nationally, socially or culturally.

The Kingsbridge Veterans Hospital was chosen because its population represents roughly the ethnic composition of New York City, thus offering access to a fair sample of the four selected groups, and also because various age groups were represented among the hospitalized veterans of World War I, World War II and the Korean War. In one major respect this hospital was not adequate, namely, in not offering the opportunity to investigate sex differences in attitude toward pain. This aspect of research will be carried out in a hospital with a large female population.

In setting up this project we were mainly interested in discovering certain regularities in reactions and attitudes toward pain characteristic of the four groups. Therefore, the study has a qualitative character, and the efforts of the researchers were not directed toward a collection of material suitable for quantitative analysis. The main techniques used in the collection of the

material were interviews with patients of the selected groups, observation of their behavior when in pain and discussion of the individual case with doctors, nurses and other people directly or indirectly involved in the pain experience of the individual. In addition to the interviews with patients, "healthy" members of the respective groups were interviewed on their attitudes toward pain, because in terms of the original hypothesis those attitudes and reactions which are displayed by the patients of the given cultural groups are held by all members of the group regardless of whether or not they are in pain although in pain these attitudes may come more sharply into focus. In certain cases the researchers have interviewed a member of the patient's immediate family in order to check the report of the patient on his pain experience and in order to find out what are the attitudes and reactions of the family toward the patient's experience.

The discussion of the material presented in this paper is based on interviews with 103 respondents, including 87 hospital patients in pain and 16 healthy subjects. According to their ethno-cultural background the respondents are distributed as follows: "Old Americans," 26; Italians, 24; Jews, 31; Irish, 11; and others, 11. In addition, there were the collateral interviews and conversations noted above with family members, doctors, nurses and other members of the hospital staff.

Pain Among Patients of Jewish and Italian Origin

The Jews and Italians were selected mainly because interviews with medical experts suggested that they display similar reactions to pain. The investigation of this similarity provided the opportunity to check a rather popular assumption that similar reactions reflect similar attitudes. The differences between the Italian and Jewish culture are great enough to suggest that if the attitudes are related to cultural pattern they will also be different despite the apparent similarity in manifest behavior.

Members of both groups were described as being very emotional in their responses to pain. They were described as tending to exaggerate their pain experience and being very sensitive to pain. Some of the doctors stated that in their opinion Jews and Italians have a lower threshold of pain than members of other ethnic groups, especially members of the so-called Nordic-group. This statement seems to indicate a certain confusion as to the concept of the threshold of pain. According to people who have studied the problem of the threshold of pain, for instance Harold Wolff and his associates, the threshold of pain is more or less the same for all human beings regardless of nationality, sex or age.

In the course of the investigation the general impressions of doctors were confirmed to a great extent by the interview material and by the observation of the patients' behavior. However, even a superficial study of the interviews has revealed that though reactions to pain appear to be similar the underlying attitudes toward pain are different in the two groups. While the Italian patients seemed to be mainly concerned with the immediacy of the pain experience and were disturbed by the actual pain sensation which they experienced in a given situation, the concern of patients of Jewish origin was focused mainly upon the symptomatic meaning of pain and upon the significance of pain in relation to their health, welfare, and eventually, for the welfare of the

families. The Italian patient expressed in his behavior and in his complaints the discomfort caused by pain as such, and he manifested his emotions with regard to the effects of this pain experience upon his immediate situation in terms of occupation, economic situation and so on; the Jewish patient expressed primarily his worries and anxieties as to the extent to which the pain indicated a threat to his health. In this connection it is worth mentioning that one of the Jewish words to describe strong pain is *yessurim*, a word which is also used to describe worries and anxieties.

Attitudes of Italian and Jewish patients toward pain relieving drugs can serve as an indication of their attitude toward pain. When in pain the Italian calls for pain relief and is mainly concerned with the analgesic effects of the drugs which are administered to him. Once the pain is relieved the Italian patient easily forgets his sufferings and manifests a happy and joyful disposition.

The Jewish patient, however, often is reluctant to accept the drug, and he explains this reluctance in terms of concern about the effects of the drug upon his health in general. He is apprehensive about the habit-forming aspects of the analgesic. Moreover, he feels that the drug relieves his pain only temporarily and does not cure him of the disease which may cause the pain. Nurses and doctors have reported cases in which patients would hide the pill which was given to them to relieve their pain and would prefer to suffer. These reports were confirmed in the interviews with the patients. It was also observed that many Jewish patients after being relieved from pain often continued to display the same depressed and worried behavior because they felt that though the pain was currently absent it may recur as long as the disease was not cured completely.

From these observations it appears that when one deals with a Jewish and Italian patient in pain, in the first case it is more important to relieve the anxieties with regard to the sources of pain, while in the second it is more important to relieve the actual pain.

Another indication as to the significance of pain for Jewish and Italian patients is their respective attitudes toward the doctor. The Italian patient seems to display a most confident attitude toward the doctor which is usually reinforced after the doctor has succeeded in relieving pain, whereas the Jewish patient manifests a skeptical attitude, feeling that the fact that the doctor has relieved his pain by some drug does not mean at all that he is skillful enough to take care of the basic illness. Consequently, even when the pain is relieved, he tends to check the diagnosis and the treatment of one doctor against the opinions of other specialists in the field. Summarizing the difference between the Italian and Jewish attitudes, one can say that the Italian attitude is characterized by a present-oriented apprehension with regard to the actual sensation of pain, and the Jew tends to manifest a future-oriented anxiety as to the symptomatic and general meaning of the pain experience.

It has been stated that the Italians and Jews tend to manifest similar behavior in terms of their reactions to pain. As both cultures allow for free expression of feelings and emotions by words, sounds and gestures, both the Italians and Jews feel free to talk about their pain, complain about it and manifest their sufferings by groaning, moaning, crying, etc. They are not ashamed of this expression. They admit willingly that when they are in pain they do complain a great

deal, call for help and expect sympathy and assistance from other members of their immediate social environment, especially from members of their family. When in pain they are reluctant to be alone and prefer the presence and attention of other people. This behavior, which is expected, accepted and approved by the Italian and Jewish cultures often conflicts with the patterns of behavior expected from a patient by American or Americanized medical people. Thus they tend to describe the behavior of the Italian and Jewish patient as exaggerated and overemotional. The material suggests that they do tend to minimize the actual pain experience of the Italian and Jewish patient regardless of whether they have the objective criteria for evaluating the actual amount of pain which the patient experiences. It seems that the uninhibited display of reaction to pain as manifested by the Jewish and Italian patient provokes distrust in American culture instead of provoking sympathy.

Despite the close similarity between the manifest reactions among Jews and Italians, there seem to be differences in emphasis especially with regard to what the patient achieves by these reactions and as to the specific manifestations of these reactions in the various social settings. For instance, they differ in their behavior at home and in the hospital. The Italian husband, who is aware of his role as an adult male, tends to avoid verbal complaining at home, leaving this type of behavior to the women. In the hospital, where he is less concerned with his role as a male, he tends to be more verbal and more emotional.

The Jewish patient, on the contrary, seems to be more calm in the hospital than at home. Traditionally the Jewish male does not emphasize his masculinity through such traits as stoicism, and he does not equate verbal complaints with weakness. Moreover, the Jewish culture allows the patient to be demanding and complaining. Therefore, he tends more to use his pain in order to control interpersonal relationships within the family. Though similar use of pain to manipulate the relationships between members of the family may be present also in some other cultures it seems that in the Jewish culture this is not disapproved, while in others it is. In the hospital one can also distinguish variations in the reactive patterns among Jews and Italians. Upon his admission to the hospital and in the presence of the doctor the Jewish patient tends to complain, asks for help, be emotional even to the point of crying. However, as soon as he feels that adequate care is given to him he becomes more restrained. This suggests that the display of pain reaction serves less as an indication of the amount of pain experienced than as a means to create an atmosphere and setting in the pathological cause of pain will be best taken care of.

The Italian patient, on the other hand, seems to be less concerned with setting up a favorable situation for treatment. He takes for granted that adequate care will be given to him, and in the presence of the doctor he seems to be somewhat calmer than the Jewish patient. The mere presence of the doctor reassures the Italian patient, while the skepticism of the Jewish patient limits the reassuring role of the physician.

To summarize the description of the reactive patterns of the Jewish and Italian patients, the material suggests that on a semi-conscious level the Jewish patient tends to provoke worry and concern in his social environment as to the state of his health and the symptomatic character of his pain, while the Italian tends to provoke sympathy toward his suffering. In one case the function of the pain reaction will be the mobilization of the efforts of the family and the doctors towards complete cure, while in the second case the

function of the reaction will be focused upon the mobilization of effort toward relieving the pain sensation.

On the basis of the discussion of the Jewish and Italian material two generalizations can be made: (1) Similar reactions to pain manifested by members of different ethno-cultural groups do not necessarily reflect similar attitudes to pain. (2) Reactive patterns similar in terms of their manifestations may have different functions and serve different purposes in various cultures.

Pain Among Patients of "Old American" Origin

There is little emphasis on emotional complaining among "Old American" patients. Their complaints about pain can best be described as reporting on pain. In describing pain, the "Old American" patient tries to find the most appropriate ways of defining the quality of pain, its localization, duration, etc. When examined by the doctor he gives the impression of trying to assume the detached role of an unemotional observer who gives the most efficient description of his state for a correct diagnosis and treatment. The interviewees repeatedly state that there is no point in complaining and groaning and moaning, etc., because "it won't help anybody." However, they readily admit that when pain is unbearable they may react strongly, even to the point of crying; but they tend to do it when they are alone. Withdrawal from society seems to be a frequent reaction to strong pain.

There seem to be different patterns in reacting to pain depending on the situation. One pattern, manifested in the presence of members of the family, friends, etc., consists of attempts to minimize pain, to avoid complaining and provoking pity; when pain becomes too strong there is a tendency to withdraw and express freely such reactions as groaning, moaning, etc. A different pattern is manifested in the presence of people who, on account of their profession, should know the character of the pain experience because they are expected to make the appropriate diagnosis, advise the proper cure and give the adequate help. This tendency to avoid deviation from certain expected patterns of behavior plays an important role in the reaction to pain. This is also controlled by the desire to seek approval on the part of the social environment, especially in the hospital, where the "Old American" patient tries to avoid being a "nuisance" on the ward. He seems to be, more than any other patient, aware of an ideal pattern of behavior which is identified as "American," and he tends to conform to it. This was characteristically expressed by a patient who answered the question how he reacts to pain by saying, "I react like a good American."

An important element in controlling the pain reaction is the wish of the patient to cooperate with those who are expected to take care of him. The situation is often viewed as a team composed of the patient, the doctor, the nurse, the attendant, etc., and in this team everybody has a function and is supposed to do his share in order to achieve the most successful result. Emotionality is seen as a purposeless and hindering factor in a situation which calls for knowledge, skill, training and efficiency. It is important to note that this behavior is also

expected by American or Americanized members of the medical or nursing staff, and the patients who do not fall into this pattern are viewed as deviants, hypochondriacs and neurotics.

As in the case of the Jewish patients, the American attitude toward pain can be best defined as a future-oriented anxiety. The "Old American" patient is also concerned with the symptomatic significance of pain which is correlated with a pronounced health-consciousness. It seems that the "Old American" is conscious of various threats to his health which are present in his environment and therefore feels vulnerable and is prone to interpret his pain sensation as a warning signal indicating that something is wrong with his health and therefore must be reported to the physician. With some exceptions, pain is considered bad and unnecessary and therefore must be immediately taken care of. In those situations where pain is expected and accepted, such as in the process of medical treatment or as a result of sports activities there is less concern with the pain sensation. In general, however, there is a feeling that suffering pain is unnecessary when there are means of relieving it.

Though the attitudes of the Jewish and "Old American" patients can be defined as pain anxiety they differ greatly. The future-oriented anxiety of the Jewish interviewee is characterized by pessimism or, at best, by skepticism, while the "Old American" patient is rather optimistic in his future-orientation. This attitude is fostered by the mechanistic approach to the body and its functions and by the confidence in the skill of the expert which are so frequent in the American, in that the body is often viewed as a machine which has to be well taken care of, be periodically checked for dysfunctioning and eventually, when out of order, be taken to an expert who will "fix" the defect. In the case of pain the expert is the medical man who has the "know-how" because of his training and experience and therefore is entitled to full confidence. An important element in the optimistic outlook is faith in the progress of science. Patients with intractable pain often stated that though at the present moment the doctors do not have the "drug" they will eventually discover it, and they will give the examples of sulfa, penicillin, etc.

The anxieties of a pain-experiencing "Old American" patient are greatly relieved when he feels that something is being done about it in terms of specific activities involved in the treatment. It seems that his security and confidence increase in direct proportion to the number of tests, X-rays, examinations, injections, etc., that are given to him. Accordingly, "Old American" patients seem to have a positive attitude toward hospitalization, because the hospital is the adequate institution which is equipped for the necessary treatment. While a Jewish and an Italian patient seem to be disturbed by the impersonal character of the hospital and by the necessity of being treated there instead of at home, the "Old American" patient, on the contrary, prefers the hospital treatment to the home treatment, and neither he nor his family seems to be disturbed by hospitalization.

To summarize the attitude of the "Old American" toward pain, he is disturbed by the symptomatic aspect of pain and is concerned with its incapacitating aspects, but he tends to view the future in rather optimistic colors, having confidence in the science and skill of the professional people who treat his condition.

Some Sources of Intra-Group Variation

In the description of the reactive patterns and attitudes toward pain among patients of Jewish and "Old American" origin certain regularities have been observed for each particular group regardless of individual differences and variations. This does not mean that each individual in each group manifests the same reactions and attitudes. Individual variations are often due to specific aspects of pain experience, to the character of the disease which causes the pain or to elements of the personality of the patient. However, there are also other factors that are instrumental in provoking these differences and which can still be traced back to the cultural backgrounds of the individual patients. Such variables as the degree of Americanization of the patient, his socio-economic background, education and religiosity may play an important role in shaping individual variations in the reactive patterns. For instance, it was found that the patterns described are manifested most consistently among immigrants, while their descendants tend to differ in terms of adopting American forms of behavior and American attitudes toward the role of the medical expert, medical institutions and equipment in controlling pain. It is safe to say that the further the individual is from the immigrant generation the more American is his behavior. This is less true for the attitudes toward pain, which seem to persist to a great extent even among members of the third generation and even though the reactive patterns are radically changed. A Jewish or Italian patient born in this country of American-born parents tends to behave like an "Old American" but often expresses attitudes similar to those which are expressed by the Jewish or Italian people. They try to appear unemotional and efficient in situations where the immigrant would be excited and disturbed. However, in the process of the interview, if a patient is of Jewish origin he is likely to express attitudes of anxiety as to the meaning of his pain, and if he is an Italian he is likely to be rather unconcerned about the significance of his pain for the future.

The occupational factor plays an important role when pain affects a specific area of the body. For instance, manual workers with herniated discs are more disturbed by their pain than are professional or business people with a similar disease because of the immediate significance of this particular pain for their respective abilities to earn a living. It was also observed that headaches cause more concern among intellectuals than among manual workers.
