

Thai Perspectives on Pain

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This qualitative research aimed to study the meaning, the characteristics, and the dimensions of pain from a Thai point of view. It was conducted under the research project on the development of the quality of pain management for people in the hospital. The subjects were 62 patients, experiencing pain and receiving treatment in 4 hospitals in northeast Thailand. Data were analyzed through content analysis. The findings included: 1) concept from experience of pain, perceived pain as suffering physically and psychologically, 2) different characteristics between acute and chronic pain, 3) four levels of pain intensity: mild, moderate, high and severe, 4) pain effects on four dimensions: physical, psychological, behavioral and societal (family-social-economy), 5) two factors related to pain: alleviating factor and predisposing factor, and 6) pain management relies on beliefs, culture and religion i.e. good deeds in Buddhism affected six dimensions: physical, psychological, social, spiritual, treatment seeking and asking health personnel for help.

The results of the present study revealed the influence of culture beliefs on the meaning of pain, pain characteristics, and the effects of pain as well as pain management in terms of cultural contexts. The findings may be implemented for the development of pain assessment and the model development of pain management more appropriately according to cultural contexts.

Keywords: Meaning of pain, Pain characteristics, Dimension of pain, Thai perspective, Qualitative research

J Med Assoc Thai 2013; 96 (Suppl. 4): S91-S97

Full text, e-Journal: <http://jmat.mat.or.th>

All humankind experiences both acute and chronic pain. The English word “pain” derives from the Latin “poena” and the Greek “poine”, which signified punishment or penalty⁽¹⁾. From this perspective, pain has extremely negative psycho-social connotations; hence, it is not surprising for both physiological and psychological reasons that people want to avoid pain and/or mask it. Notwithstanding, pain has a lifesaving function as the first response to disorder in or to the body. There are differences in pain recognition and expression; depending on the cause, the intensity, and the complicated interplay of cultural, psychological and personal experience⁽²⁻⁴⁾. Importantly, when pain occurs, it tends to exacerbate illness and indeed increase the pain experienced, which depresses the quality of life. Unmanaged pain will further decrease health including psychological, social and spiritual so

much so that some patients turn to self-harm and/or commit suicide in order to get relief from that suffering^(5,6).

The International Association for the Study of Pain (IASP) defined pain as ‘feeling physical discomfort from tissue injury’ and/or ‘feeling emotional distress or trauma’. The IASP recognized the “personalness” (idiosyncratic aspect) of the experience, whether or not the pain could be externally verified. This conforms to McCaffery who defined pain as ‘whatever cum however the sufferer gives it meaning’ and that ‘pain persists as long as the sufferer thinks that it does’. Consequently, in order to treat pain effectively, the practitioner must consider (a) the descriptions of pain (b) age (c) sex (d) culture (e) beliefs (f) traditions (f) religion and (g) social, linguistic and environmental factors which might account for endurance of pain and the different expression of it⁽⁷⁻¹⁰⁾.

Religion is the anchor of the mind which can induce stoicism while social mores, culture, tradition, indoctrination affect the recognition, meaning, endurance and expression of pain. In the present study about the differences of recognition and response to

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pain, Native Americans, Italians, Jews, and Irish generally expect males to endure more pain than females. Males, therefore, are trained not to express their real feelings of pain. Muslims believe that pain is allowed by God who in turn enables the faithful to endure pain hence their reluctance cum refusal to take analgesics⁽⁵⁾.

The cultural and religious context of Thailand is different from the West. Currently, the modern understanding of pain is based on concepts, knowledge and research from the West. From the perspective of treatment efficacy, it is important to assess how Thais define pain and how closely the experience of pain matches reports in the literature⁽¹¹⁾. The authors therefore planned to survey Thai perspectives on pain. This was qualitative research based on the personal experience of pain to help (a) characterize and define pain from a Thai perspective (b) clarify the dimensions and effect of pain, and (c) document the management of pain. The results of the present study will provide preliminary data for further study and designing research on the development of the quality of hospital-based pain management.

Objective

To document how Thais define and describe pain; including its characteristics, intensity, effects, related factors, and management.

Material and Method

This qualitative, descriptive research was based on an interpretative perspective; based upon an evaluation of pain from personal experience, social interactions and cultural understanding vis-a-vis its impact on behavior (that is, expectations for how much suffering is acceptable, how one should express pain/suffering and when one should ask for relief).

The formula to calculate sample size for a randomized qualitative survey is,

$$\text{Sample size} = \frac{t^2 \cdot p(1-p)}{m^2}$$

as follows,

t = Confidence level also called standard errors of the Mean

p = Prevalence

m = Margin of error

According to the 2012 World Bank and the report of 2013 CIA fact books, the density of hospital beds in Thailand is 2.1 beds/1,000 people. Therefore, the confidence level is set at 98% for the research study

(t = 2.33). The prevalence is set at 21% or 0.0021. The margin of error is set at 98% confidence level (m = 2% or 0.02).

Then, Sample size = $2.33^2 \cdot 0.0021(1-0.0021)$

$$= \frac{0.02^2}{0.0021}$$

= 28.5 people

In order to assure the significance of the study, doubling the number is chosen. Hence, there were 62 participants in the study who had experienced either acute or chronic pain (30 acute and 32 chronic) from 4 hospitals (Srinagarind Hospital (n = 16), Khon Kaen General Hospital (n = 16), Chum Phae Hospital (n = 15), and Mancha Khiri Hospital (n = 15)). This study was a purposive sampling.

The authors created Two-part questionnaires were used to collect the data: (1) personal demographic and medical information, and (2) results of an in-depth group discussion, which included comprehensive questions on the experience, meaning, characteristics, intensity, effects of pain, its related factors, and its management. Data were collected during the in-depth group discussion through observation without taking in the discussion itself. The instruments included audio recorder and notebook computer for doing on-site data entry and analysis. The present study was approved by The Ethics Committee for Human Research, Khon Kaen University, Thailand.

Data analysis

The data were analyzed by using content analysis to calculate the percentage of the data.

Results

Demographics

All in the group of 62 were Theravada Buddhists. One-quarter (25.8%) of the participants were between 41 and 50 years of age (females = 54.8%). Most participants were married (75.8%), 37.1% were farmers, 62.9% had completed elementary school, 70.9% had the government supported health, 64.5% earned <5,000 baht/month, 61.3% had a leading role in the family and 48.3% of families had 4 to 5 members (Table 1).

Pain was alternatively described as physical and psychological suffering. The intensity of pain was rated as mild, moderate, high and severe (the last being associated with dying). Medically, the most common location of pain was in the reproductive system (30%). The locations of the greatest pain included the stomach, waist, and back (53.3%), and the most common method of pain relief was Paracetamol (25.8%).

Physical dimension

In the physical dimension, the pain caused by tissue injury is different from the word “hurt”. “Hurt” per se is stinging, sharp pain within the body,

Table 1. General characteristic of patients with pain (n = 62)

Variable	Number	Percentage
Age (year old)		
<20	3	4.8
21-30	8	12.9
31-40	9	14.5
41-50	16	25.8
51-60	14	22.6
>60	12	19.4
Sex		
Male	28	45.2
Female	34	54.8
Marital status		
Unmarried	11	17.7
Married	47	75.8
Divorce	4	6.5
Religion		
Buddhism	62	100.0
Occupation		
Farmer	23	37.1
Government worker	4	6.5
Merchant	2	3.2
Housewife	7	11.3
Employer	14	22.6
Out of work	4	6.5
Elder	8	12.9
Education of respondents		
Uneducated	6	9.7
Elementary	39	62.9
Secondary	8	12.9
Vocational	4	6.5
Bachelor degree	5	8.1
Medical benefit		
Civil servant medical benefits scheme	18	29.1
Social security scheme	44	70.9
Family income (thai baht/month)		
<5,000	40	64.5
5,001-10,000	14	22.6
>10,000	8	12.9
Role in family		
Head of the family	24	38.7
Household	38	61.3
Family numbers (person)		
2-3	24	38.7
4-5	30	48.3
>5	8	12.9

the exact location of which is difficult to pinpoint.

“Getting hurt from surgery is a stinging, shooting pain. The pain occurs inside the body and one cannot indicate the position. It seems as if something is running inside or throbbing with pain”.

(G, 30-year-old after abdominal surgery)

“Pain is something definite inside the body. There is a definite cause and it is not just psychosomatic”.

(NG, 34-year-old with cervical cancer)

Psychological dimension

In the psychological dimension, pain reflects the emotions and/or response to pain. This pain is like that of an impending faint or nearness of death. Sufferers feel that they want to get away from the pain which seems more terrifying than death itself.

Intense or oppressive burden is the pain of anguish. The hands and feet are flexed and kinked; the person is feverish and has dyspnea. Sometimes sufferers would rather die and many consider committing suicide.

“When I get this pain I cry. The only one thing to do is beg for relief. It is all right to die instead of getting pain because this pain is torture. I am afraid of so much pain and wonder will I survive? Pain becomes fear because I think I will not recover. There is nothing to compare it with. It aches, then tortures both body and mind”.

(NG, 34-year-old, cervical cancer)

“When I had the pain, there was nothing to compare it with. There was so much suffering like I was dying, without hope of recovery. It was like friction inside; like I had been thrust through with a piece of wood. My body felt squeezed from the outside to the inside. I’d often writhe at bedtime”.

(P, 45-year-old, uterine fibroids)

“I usually convulsed when I got the pain. Like the throes of death, aching, chilled, shivering, unable to recognize people, my hands and feet were numb”.

(T, 41-year-old, pyelonephritis)

“When I was in pain, it seemed that I was dying. I told my children to give me pain medicine. I wanted to die to decrease my torture. If I die, I will have no more pain. There is nothing to compare with because it is so much suffering”.

(S, 30-year-old, migraine)

Social dimension

The social dimension examines the relationship between family members when someone

is suffering from acute or chronic pain. Some facing intense pain, do not want social interaction to meet, talk or even to answer questions. If disturbed, they are moody (irritable) or angry.

"I feel dispirited; do not want to work because of discouragement. I need surgery. I wanted to send my relatives away. I cried automatically. Family could not imagine the pain I suffered".

(N, 53-year-old, suffering from carcinoma of stomach)

"I have a befuddled brain and have no idea when I'll be in pain. I feel so uneasy-it is hard to describe. This leads to stress and moodiness. If the pain causes too much suffering, I do not want to talk to others, do not want to hear more questions because it is annoying".

(S, 30-year-old, migraine)

"... whatever will be, let it be, I only want to recover. When the pain occurs, I do not want to see anyone, do not want to answer any questions. When I take medicine, it's still the same: annoying, dying, and sweating".

Some patients get severe and unbearable pain and they want somehow to escape from the pain in any way, even to the extent that they consider suicide. So much so, that they begin saying their goodbyes to relatives.

"During intense pain, I think that I cannot survive. I feel I should say goodbye to my children, for I cannot endure anymore".

(P, 45-year-old, uterine fibroids)

Some patients are more philosophical and think of pain in a positive way-like a great opportunity to get close with their children. This response results helps others to think of pain in terms other than a tyranny.

"I have a good time with my children so when I had severe pain, my children were frightened and took me to Kranuan Hospital. Most of my relatives visited me at hospital".

(R, 70-year-old, carcinoma of stomach)

Spiritual dimension

In the spiritual dimension pain is described in terms of the supernatural, some sort of non-human action or control, like fate. Pain may also be seen as a result of sin, a ghost, black magic or a curse.

"Pain seems like a ghost, evil spirit. It is like a spell was cast upon me. If the pain decreased, perhaps the spell had been broken".

(S, 30-year-old, migraine)

"I do not want to see it, I have never seen it. Some people think that I have an evil spirit. When I went to see the Buddhist monk at the temple, they gave me sacred water. However, getting cancer is only waiting for death".

(NG, 34-year-old, cervical cancer)

The pain is related to kharma (fate). It is the recompense for sinful actions in a previous existence, so we cannot control or avoid it. It brings unhappiness, but we must accept it and be resigned to it.

"I am going into labor, suffering, but I have to endure because it is my kharma".

(D, 27-year-old, after Caesarean section)

"I felt unpleasant when I got a pain, but since I thought that it is the result of my past deeds. I was determined to endure it. Pain is awful, one can never recover".

(R, 70-year-old, carcinoma of stomach)

Pain characteristics

The characteristics of pain were described in the local dialect, I-San. Acute pain was described as shocking, shooting, friction, burning, throbbing, with spasms, retarding, twisting, flexing, like painful defecating, like being stabbed with a needle, or like delivering a baby.

"Before surgery, I was in agony, like stabbing, and I felt helpless. Even after surgery, I had shooting pain, felt crowded inside my body, as though my bones were broken".

(K, 28-year-old, broken leg bones)

"After surgery, I had shocking pain but I did recover later".

(D, 27-year-old, after operating on caesarean section)

Patients suffering chronic pain used several descriptors such a stitching pain like electric shock, throbbing pain like cauterizing, pain like something overlap, pain like the chest was being hit, punched and stomped.

"The pain occurred around my waist, in my belly. When the cancer spread, I had throbbing pain that came and went every 5 minutes. It was like being electrocuted, it snuck up on me".

(NG, 34-year-old, cervical cancer)

"I had nervous pain along the nerve from shoulder to my toes: throbbing pain like a burning along my tendons".

(M, 45-year-old, tendon pain)

"I had pain in my chest, throbbing in my heart like it was punched and stomped".

(Ta, 70-year-old, carcinoma of stomach)

Effects of pain

Pain was described in various dimensions based on the experiences related to community and cultural context including: (1) Physical effects included disturbing meals, sleep, bodily movement, daily life, comfort and the mind, (2) Psychological effects ranged from minimum to most severe (i.e., in pain and annoyed, moody, do not want to see anyone, afraid of pain and depression), (3) Behavioral effects included changes in verbalization of pain and reticence or psychological agony, and (4) Socio-economic effects included the inability to work, family members having to miss work to take care of the sick, loss of income.

Other related factors

There are two related factors that affect the intensity of pain: (1) Alleviating factors: changing position, massage, encouragement and distraction and (2) Predisposing factors: organ failure, and the external and internal physical environment. The patient's internal environment includes elements such as dressing, walking, movement, clothing, irritants, including psychological factors such as anxiety. The external environment includes sensory irritants (noise, light and smells).

Pain management

The method of pain management differed according to culture, society, tradition and beliefs and included 6 approaches: (1) the physical by directly decreasing pain using massage, compresses, herbal medicine, changing positioning, using pillows, relaxation and analgesics, (2) the psychological by encouraging, distracting, practicing breathing exercises, singing, crying, mediating, mindfulness, and comforting, (3) the social by encouragement, providing for needs, intimate care and sympathy/empathy from family, doctor or nurse, (4) the spiritual relies on prayer and meditation, being compassionate, invoking the sacred, seeking help from respected persons (i.e. father, mother, teacher and the Buddhist writings/teachings), (5) treatment including sacred water, aroma therapy, herbal medicine, and spells. Lastly, (6) asking health professionals directly: 'What would be appropriate?'

Discussion

The descriptions of Pain was personal (idiosyncratic), complex and terse. Tissue damage induced feelings of discomfort and loss of hope. As a

consequence, albeit the physical cause of pain started the story, psycho-social factors alleviated or exacerbated the experience of pain. Whatever the definition, the experience of pain remains as long as any of the factors remain unresolved.

In the Northeast dialect of Northeast Thailand (Isan (which is somewhat like Laotian), the relative rank of acute pain was: shocking, agony, shooting, chronic as throbbing, itching and electric shock. Mongkol tawornchai ranked the Thai language descriptors for pain (most to least pain) as: throbbing, indistinct, piercing, deep, and tight.

Pain intensity was based on the experience of the patient and was divided into 4 levels: mild, moderate, high, and severe (being dying). The intensity of pain in words was correlated to verbal descriptor scale.

Wells et al did a survey on pain among 577 cancer patients. The most common alleviating factors were: change of mental focus, moving into a new position, relaxation, distraction, exercising, and touching. The predisposing factors included: not joining in activities, moodiness, daytime anxiety. According to Wells et al, 7.3% of patients did not know what the predisposing factor might be, and 3.6% did not know the alleviating factor. The researcher needs to explain why this might be so and give an example to provide more understanding to the patient during the interview.

The authors can see that pain management agreed with other studies in America and Thailand; in which patients used optional treatment, and an alternative for pain relief, or uselessness of analgesic drugs such as distraction, massage, exercise, deep breathing, and changing movement. Our study is also relevant to the one by Sangchart et al, who studied pain in 200 cancer patients. The results indicated that most patients have their own pain modifying strategies (i.e. 74% prayed/meditated, 73% used positive thinking, 65.5% listened to music, and 64% watched or listened to Dharma programs).

Suggestions

The results of this study on pain including its definitions, characteristics, intensity, effects, related factors and management need to be incorporated into nursing practices for pain management in patients in accordance with Thai law and religious and cultural considerations of the people. It can also serve as a guideline for further research on the evaluation and development of pain management so that it conforms to the cultural context of northeast Thailand.

Acknowledgement

The authors wish to thank (a) the patients and families (b) the administrators and staff at Srinagarind Hospital, Khon Kaen Hospital and Chum Phae Hospital, Muncha Khiri Hospital, Khon Kaen province (c) Ms. Nanthiya Silachai for translating from Thai to English and (d) The Center of CLP and Craniofacial Deformities, Khon Kaen University in association with the Tawanchai Project (e) Khon Kaen University and (f) Mr. Bryan Roderick Hamman for assistance with the English-language presentation.

Declarations

This paper has not been submitted elsewhere for publication. All of the authors participated in the design, execution, analysis, and writing up of the research. All of the authors have seen this final version of the manuscript and give their assent for it to be submitted for publication.

Potential conflicts of interest

None.

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ความปวดตามธรรมชาติของคนไทย

ศิริพร มงคลถาวรชัย, บำเพ็ญจิต แสงชาติ, อาริยา สอนบุญ, จงกตณี จันทศิริ

การศึกษานี้เป็นส่วนหนึ่งของโครงการวิจัยเพื่อพัฒนาคุณภาพการจัดการความปวด ทางกายภาพบำบัดในสถานบริการ มีวัตถุประสงค์เพื่อศึกษาความหมาย คุณลักษณะและมีติความปวดตามธรรมชาติของคนไทย โดยใช้ระเบียบวิธีวิจัยเชิงคุณภาพผู้ให้ข้อมูลเป็นผู้ที่มีประสบการณ์ความปวดและเข้ารับการรักษาในสถานบริการ 4 แห่ง ในภาคตะวันออกเฉียงเหนือจำนวน 62 ราย การวิเคราะห์ข้อมูลใช้การวิเคราะห์เชิงเนื้อหา

ผลการศึกษาพบว่า 1) ความหมายของความปวดตามประสบการณ์ตามการรับรู้ของผู้ที่มีความปวดระบุว่าความปวดเป็นความรู้สึกทุกข์ทรมานทั้งร่างกายและจิตใจ 2) คุณลักษณะของความปวดแบบเฉียบพลันและเรื้อรังมีความแตกต่าง 3) ความรุนแรงของความปวดมี 4 ระดับ คือ ปวดเล็กน้อย ปวดปานกลาง ปวดมาก และปวดรุนแรง 4) ผลกระทบของความปวดมี 4 ด้าน ได้แก่ ด้านร่างกาย ด้านจิตใจ ด้านพฤติกรรม และด้านครอบครัว สังคมและเศรษฐกิจ 5) ปัจจัยที่เกี่ยวข้องกับความปวด มี 2 ปัจจัย ได้แก่ปัจจัยที่ช่วยบรรเทาความปวดและปัจจัยที่ส่งเสริมความปวด 6) การจัดการความปวดขึ้นอยู่กับความเชื่อ วัฒนธรรมและความศรัทธาทางพุทธศาสนาในการทำมาดีประกอบด้วย 6 มิติ ได้แก่ มิติด้านร่างกาย ด้านจิตใจ ด้านสังคม ด้านจิตวิญญาณ การแสวงหาการรักษาและการขอความช่วยเหลือจากบุคลากรทางด้านสุขภาพ

ผลที่ได้จากการศึกษานี้ชี้ให้เห็นถึงอิทธิพลของวัฒนธรรม ความเชื่อในการให้ความหมายของความปวด อธิบายคุณลักษณะของความปวด ผลกระทบของความปวดตลอดจนการจัดการความปวดในบริบทวัฒนธรรม ข้อค้นพบจากการศึกษานี้จะนำไปสู่การพัฒนาแบบประเมินความปวด และการพัฒนารูปแบบการจัดการความปวดที่เหมาะสมกับผู้ที่มีความปวดในบริบทวัฒนธรรมมากขึ้น
