A Qualitative Inquiry of Taiwanese Children’s Pain Experiences

Su-Fen Cheng • Roxie L. Foster* • Nancy O. Hester** • Chu-Yu Huang***

ABSTRACT: Little information was found in studying Taiwanese children’s pain experiences. Because pain is culturally shaped, health care providers should not assume Taiwanese children’s pain to be identical to those of children in the US. Thus, a qualitative descriptive study with semi-structured interview of 90 hospitalized Taiwanese children with acute pain was conducted to understand Taiwanese children’s pain experiences. Krippendorff’s (1980) content analysis was used to guide the data analysis. Seven themes from the interview data were presented, including definition of pain, quality of pain, previous pain experiences, pain expectation, pain acceptance, causes of pain and meaning of pain. Surprisingly, the results of this study revealed few differences in the experiences and meanings of pain. Most results are consistent with the studies done in the US. Differences are minor, including the interpretation of children’s crying and how Taiwanese parents talk with their children about pain, and are probably related to the sample sizes and methodology of the studies. Further research is necessary about the influence of culture upon children’s pain experiences.

Key Words: pain experiences, meaning of pain; cultural considerations.

Introduction

Nursing researchers have studied children’s pain for the last three decades and have found a general agreement that pain is a universal multidimensional phenomenon with physical, sensory, affective, cognitive, behavioral, sociocultural, spiritual, interpersonal and environmental dimensions (Gatchel, 1999; Liossi, 2000; National Institute of Nursing Research, 1994). In general, pain refers to an unpleasant, distressful and uncomfortable feeling. Recent studies note that pain may not be controlled completely even with state-of-the-art technology and pharmacologic therapies (Kotzer, 2000; Kotzer, Coy, & LeClaire, 1998; Kotzer & Foster, 2000). It seems that all the efforts of researchers still cannot adequately relieve children’s pain. Thus, prior to controlling pain, it is necessary to understand children’s pain experiences.

Most nursing research studies employed a descriptive design and explored the location, intensity and quality of pain when assessing children’s pain (Chiang & Mao, 1994; Fang & Chang, 1995; Ger, Ho, Wang & Cherng, 1998; Hodgins & Lander, 1997; Jerrett & Evans, 1986; Mao & Chiang, 1996). The developmental stage and gender were viewed as important factors during the assessment of the children’s pain. In conclusion, children had no problem to demonstrate their pain by marking the location and intensity of pain, and selecting pain words to describe their pain. Some scholars also asked children to describe the meaning of pain and causes of pain (Atherton, 1995; Crow, 1993; Woodgate & Kristjanson, 1996). It was reported that pain is viewed as a punishment by younger children (Hurley & Whelan, 1988).

In Taiwan, studies of children’s pain began in the 1990s and only a few studies and articles can be found. Most literature related to children’s pain has been translated from the textbooks and research articles of western cultures, but there was little information about the pain
experiences of children. Research and literature tends to focus on understanding children’s cancer pain, postoperative pain, caregiver’s concerns about children’s cancer and their pain, and diagnosis of specific diseases that induce pain (Chen, Wang, Hsu, Huang, & Lin, 2000; Yeh, Lin, Tsai, Lai, & Ku, 1999). Although the physiology of pain may be similar across cultures, the experiences and meaning of pain are different among cultures. An individual’s beliefs about pain reflect shared values of a specific culture or subculture. Cultural beliefs and values help explain how pain is viewed in the management of an individual’s health. Cultural differences can influence how individuals perceive, behave and manage pain (Morris, 1999). Taiwanese health care providers and students gain knowledge of pain from western cultures. The problem is that culture affects many aspects of pain experiences, and Taiwanese children’s pain experiences cannot be assumed to be identical to those of children in the US. Since only a few studies of Taiwanese children’s pain experiences are found, more research is needed to increase knowledge about Taiwanese children’s pain for the purpose of research, practice and education. Thus, the purpose of this study is to understand how Taiwanese children describe their pain experiences. The research question for this inquiry asks how hospitalized children verbally describe their experiences of pain.

### Methods

This study employed a qualitative descriptive design. A semi-structured interview with identifying themes was used for data collection. Interview questions were designed based on specific inquiries (see Table 1), including open-ended and closed-ended questions. The interview questions for this study were based on Hester and Barcus’s (1986) pain history, Crow’s (1993) children’s pain perspectives interview, review of the literature and a group of content experts (four well-known nurse researchers and a child development specialist). A convenience sample of 90 children was obtained from five hospitals in southern Taiwan. The sample included Taiwanese children who were hospitalized and were having acute pain from their illness and needle-related pain. The inclusion criteria for the sample were: (1) hospitalized children aged 5-14 years with acute pain; (2) cognitively able to understand and verbally answer the researcher’s questions; (3) school grade appropriate to age; (4) able to understand and speak either Mandarin or Taiwanese.

### Procedure

An assent form and a consent form were obtained from the child and their parents prior to data collection. The researcher asked the children to state their perceptions about

<table>
<thead>
<tr>
<th>Table 1. Guide for Interview Questions About Children’s Pain Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview Questions</td>
</tr>
<tr>
<td>1. Tell me what pain is.</td>
</tr>
<tr>
<td>2. What does a child with pain look like?</td>
</tr>
<tr>
<td>3. How do you feel when you have pain?</td>
</tr>
<tr>
<td>4. What words do you use to describe your pain?</td>
</tr>
<tr>
<td>5. Have you ever had pain just like this time? Tell me about a time when you had pain.</td>
</tr>
<tr>
<td>6. Was the pain you had now different than pain you have had before?</td>
</tr>
<tr>
<td>7. Did anyone tell you that you might have pain? If yes, how did people tell you? Who told you?</td>
</tr>
<tr>
<td>8. What kind of pain did you think you would have?</td>
</tr>
<tr>
<td>9. Do kids in the hospital need to have pain? What kinds of pain do they have? (What causes their pain?)</td>
</tr>
<tr>
<td>10. How do you get pain?</td>
</tr>
<tr>
<td>11. Why do you get pain?</td>
</tr>
<tr>
<td>12. What is good about pain?</td>
</tr>
<tr>
<td>13. What is bad about pain?</td>
</tr>
<tr>
<td>14. Is there anything else at all that you want to tell me about pain?</td>
</tr>
</tbody>
</table>

**Note.** Not all questions and probes are included here.
their pain and then asked why they had answered this way. This strategy of interview encourages more discussion and elicits more explanation about the phenomenon of study (Fetterman, 1989). Although children sometimes chose not to answer verbally, they used body language to respond, such as raising their shoulders to say “I don’t know”, or nodding their heads to indicate “yes”. The researcher confirmed the children’s body language with them to ensure the correct response was written on the interview form. When children seemed to have difficulty answering the interview questions, prompts or examples were used. Most children gave short answers, usually only one or two sentences. During data collection, children responded to interview questions. At the beginning of data collection, the researcher audiotaped the whole interview process. However, children often provided only short answers, and audiotaping was not necessary to capture the children’s words. Thus, the researcher decided not to audiotape. Children’s answers with their facial expression of each interview question were written in the interview form.

Data Analysis

All interview data were analyzed by using the content analysis approach described by Krippendorff (1980). Krippendorff suggested summarizing the data by identifying themes. The unit of analysis for this study was the response phrases as they are related to the specific dimension (see Table 1). Results are discussed as they relate to the research question.

Results

Thirty children were in each age group with an equal number of each gender. Children 5 to 7 years old were categorized as the youngest group (M = 5.93, SD = .83); 8 through 10 as the middle group (M = 9.03, SD = .85); and 11 through 14 years as the oldest group (M = 12.43, SD = 1.07). Children with medical pain had been diagnosed with acute tonsillitis, acute bronchiolitis, acute pharyngitis, acute otitis media, parotid gland abscess, acute gastroenterocolitis (AGE), ileus, herpetic gingivostomatitis, headache, head injury, myocarditis, cardiac ischemia, acute pancreatitis, nephrotic syndrome and acute pyelonephritis as well as complications of enterovirus infection. Children with surgical pain had been diagnosed either with acute appendicitis, or fracture and spleen rupture caused by an automobile accident. Some children scheduled for surgery had been diagnosed with inguinal hernia or adenoidal hypertrophy. The children’s diagnosis, based on body system, is presented in Table 2 by age group. The findings are presented based on the dimension of pain inquiry, including the definition, quality, previous experiences, expectation, acceptance, causes, and meanings of pain.

Definition of Pain

Two interview questions were asked to describe children’s definition of pain (see Table 1). Most of the children defined pain as “uncomfortable or feeling bad or lots of pain”. Children who defined pain as lots of pain seemed not to really answer the question; however, “pain” was a common word children used to describe their pain in Taiwan. Some children referred to pain as the need to get help. When children were asked to describe a child with pain, their description focused on their observations of physical, affective and evaluative pain reactions of the child. Phrases used by children were categorized as six codes, including “Facial expressions which indicated crying and/or unsmiling face, screaming, and/or looks sad/bad”, “Vocalization” “Crying”, “Verbal reactions”, and “Events which referred to the pain cause such as ‘saw someone get hurt’”. In fact, to categorize crying as a vocalization may not be appropri-

Table 2.
Children’s Diagnosis for Each Age Group (N = 90)

<table>
<thead>
<tr>
<th>Body System</th>
<th>Total</th>
<th>Youngest</th>
<th>Middle</th>
<th>Oldest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and neck</td>
<td>10 (11)</td>
<td>3 (3.3)</td>
<td>4 (4.4)</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>% by age group</td>
<td>(10.0)</td>
<td>(13.3)</td>
<td>(10.0)</td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>18 (20.0)</td>
<td>10 (11.1)</td>
<td>5 (5.6)</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>% by age group</td>
<td>(33.3)</td>
<td>(16.7)</td>
<td>(10.0)</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>2 (2.2)</td>
<td>1 (1.1)</td>
<td>0 (0)</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td>% by age group</td>
<td>(3.3)</td>
<td>(0)</td>
<td>(3.3)</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>2 (2.2)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>2 (2.2)</td>
</tr>
<tr>
<td>% by age group</td>
<td>(6.7)</td>
<td>(0)</td>
<td>(6.7)</td>
<td></td>
</tr>
<tr>
<td>Digestive</td>
<td>44 (48.9)</td>
<td>12 (13.3)</td>
<td>18 (20.0)</td>
<td>14 (15.6)</td>
</tr>
<tr>
<td>% by age group</td>
<td>(40.0)</td>
<td>(60.0)</td>
<td>(46.7)</td>
<td></td>
</tr>
<tr>
<td>Urinary</td>
<td>7 (7.8)</td>
<td>2 (2.2)</td>
<td>1 (1.1)</td>
<td>4 (4.4)</td>
</tr>
<tr>
<td>% by age group</td>
<td>(6.7)</td>
<td>(3.3)</td>
<td>(13.3)</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>7 (7.8)</td>
<td>2 (2.2)</td>
<td>2 (2.2)</td>
<td>3 (3.3)</td>
</tr>
<tr>
<td>% by age group</td>
<td>(6.7)</td>
<td>(6.7)</td>
<td>(10.0)</td>
<td></td>
</tr>
</tbody>
</table>

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ate for Taiwanese children. In southern Taiwan, parents tend to educate children not to cry with a vocal sound; some children are taught that crying with vocal sound is not appropriate. They are allowed to use only a crying expression and tears. Thus, for Taiwanese children, crying is viewed as a facial expression, not a vocalization. However, the researcher did not ask in detail during the interview what children meant when they described "crying" as one way they identified that a child was in pain. Thus, crying can be viewed as a facial expression or vocalization.

Most youngest children relied on verbal response of a child with pain, such as crying, and telling mother, teacher or friend. Children said younger children especially would tell their teachers if they were in pain. Many children reported that a child in pain would cry. Some children said they could tell a child was in pain from the child’s facial expression, such as “looks uncomfortable/tired”. One child described facial expressions by saying the child with pain would “grit his teeth to control his pain”. Another child said a child with pain would “ask his teacher or mother to clean and bandage the wound”. Yet another child talked about the event that caused the pain, “I saw that child being hit by another child”.

Most middle and oldest group children described pain as discomfort, or lots of “pain”. The descriptions of pain from the youngest and/or middle group children were limited to physical discomfort. One child in the middle group stated, “Pain means my body feels pain”. The middle group children observed the facial expressions of the child with pain. One child said, “Her facial expression looks bad. It is a squint and not a smile. It also looks not healthy because she may walk very slowly and bend over in pain”. Some children identified the child with pain by noticing crying or verbal reactions. They said children tell their mother, teacher or friends if they are in pain.

The oldest children described pain not only as physical discomfort but also as psychological discomfort. Most children in this group said the child with pain would say s/he is in pain. They also liked to use their past experiences as an example to describe pain and included the symptoms of disease or pain, such as shortness of breath. One child said “Pain is like a toothache. Or when you want to poo poo and you can’t push the poo poo out, that is really sad”. Lots of children said a child with pain would say s/he is in pain. In addition, the oldest children said children in pain would tell their classmates more often than their mother or teacher; only one child said a child in pain would see a nurse. Unlike the youngest and/or middle group children in the study, the oldest children observed the child with pain by comparing the child’s behavior with previous behavior. One child said, “It is just different than how they are supposed to act”.

Quality of Pain

“It hurts” or “it hurts a lot” was the predominant descriptor of quality of pain for all children in each age group. However, the middle group children more frequently used other descriptors such as facial expression. Responses for children in the oldest group varied more than in the youngest children and the oldest children more frequently included discomfort, facial expression, and symptoms of disease, e.g., “feeling soreness”.

The majority of the youngest children described their pain as “pain or discomfort”. The children described the symptoms of disease as pain, such as sore throat or feeling like throwing up, or provided examples to describe pain, e.g., “Just like I was bitten by red ants”. One child included an example of pain relief. She said “I feel a lot of pain and need to use tiger balm”. The majority of the middle group children used the words “pain”, “a lot of pain” and “uncomfortable” to describe the feeling of pain. Five children added the words “feeling bad”, “irritable”, “couldn’t stand it”, “crushed” and “scared”. One child said “Scared. I am afraid I will still have pain”. The oldest children used words similar to the youngest and middle group of children but they also included more emotional or evaluative words such as “feeling of death”, “nobody cares about you” or “feeling something wrong with his/her body”. Nine children described symptoms of diseases to describe how they felt about their pain, such as “feeling of soreness”, “continuing to throw up” or “feeling shortness of breath”. Some children described the causes of their pain. For example, one child said “my tummy hurts, I must have eaten something bad”.

Previous Pain Experiences

Overall, 63 (70%) children reported having had previous pain that was just like the pain experienced during this hospitalization. However, 27 children (30%) had never had pain like their current pain. Only two children said they couldn’t remember their worst pain. Although 20-27% of children across age groups had previously experienced pain that was similar to pain during this hospitalization, the majority of previous worst pain experiences for all children were attributed not to other hospitalizations, but to acci-
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Pain Expectation

Children learned about pain from their previous hospital experiences and from the experiences of their parents or siblings. Thirty-five children were told they would have pain during their hospitalization. These children received pain information from doctors, parents, their own past experiences or their siblings’ experiences. Most of the children’s doctors or parents only told the children they needed to be hospitalized without mentioning how much pain they might be experiencing. Some parents did not tell their children about the purpose of hospitalization; these parents told lies in order to reduce their children’s anxiety. For example, two mothers of children in the youngest group told them they would not have surgery, when in fact the children did need surgery. One child said, “Mama said I needed to have some tests. I asked Mama whether I would have pain, but Mama said no. I guess she lied to me”.

One youngest child said “Mama only told me I needed to be hospitalized, but I knew I would have an IV line because I was in the hospital before”. A middle group child said he knew he might have pain because of what he had seen on television and his mother’s hospitalization experience after a car accident. A child in the oldest group explained: “A doctor said I needed to be admitted. I did not know I needed to have an IV until I was in the ward. One bottle of fluid is followed by another bottle and another and keeps dripping into my body. Then I learned I would have pain after I was admitted to the hospital. I felt so irritable”.

All children in each age group tended to expect pain from surgery, injections and symptoms of the disease that caused their pain. However, the middle group children tended to be more specific and compared differences between the actual pain and expected pain. One child stated she expected pain from a blood draw, as well as from an IV. Another child said “I thought having an IV would give me lots of pain, but it did not”.

The oldest children were more specific about what was painful. One child said “antibiotics” and another child said “only when they added the medicine”. Still another child said, “Both surgical and injection sites. Injection site is less painful, but still painful”.

Pain Acceptance

A total of 64 children (71.1%) believed hospitalized children need to have pain. Most children accepted pain from injections, medical diagnoses and surgery. However, 26 children (29.9%) said that pain was not necessary for hospitalized children and believed some children might have pain, but others might not.

Although responses were similar across age groups, the character of the responses varied somewhat by age. Children in the youngest group described the pain they might have from an injection, or illness such as a sore throat, headache, or tummy ache. One child said “Bleeding would give pain; taking the medicines might make me cry. And tummy ache”. A middle group child provided a more in-depth explanation: (Pain is) not necessary. In this room (four children were in the same room), only I have a fracture and the others have colds. Colds won’t hurt. Diarrhea, like egg drop soup, would hurt (laughing). If I had an injection, it would hurt.

Some of the oldest children included emotional pain in their answers to this question. Two stated that hospitalized children might have a broken heart. One of these two children had six fingers. He had had surgery when he was small to remove the extra finger. He had been admitted this time because of a deformity of his finger and explained, “Pain was from inside of the child’s heart. That would make this child hurt”. Another child, 12 years old, had had his lower left leg amputated when he was 7 years old. This child had had numerous surgical experiences each year. He said “If the child has pain, that must from the child’s mind. Maybe the child would have a broken heart because he just looks different from other children”.

Causes of Pain

The majority of responses (n = 66) related to medical illnesses and no doubt reflect the fact that the majority of children in this study were hospitalized for medical conditions. Children tended to describe symptoms of disease and/or the events related to how they got hurt.

Most children said they got pain from viruses, accidents and surgery and emphasized how germs caused their disease. Children described “germs” meaning “bacteria” or

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“a virus” which could make people sick. Some stated they were infected by others, such as their siblings, or had an accident. Explanations from the youngest children revealed their developmental understanding about infection. One child said, “A virus ran into my inside. I scratched the place I felt itching. So, the virus got in from the hole I scratched. I did not wash my hands, so the virus got in my body through the place I scratched”. Similarly, another child said, “Bacteria ran into my throat from my fingernails. Then, the bacteria jumped out. They needed to find a place that people would have a hard time finding”. The researcher asked the child where the place was. The child answered, “Throat”.

Although middle group children emphasized germs as causes of pain, this group of children tended to point out the specific things that made them sick. For example, one child said, “Food poisoning. I ate too much cauliflower at school. When I had just eaten it, it tasted bitter but I just ignored it. Then, I began having a tummy ache”. Two other children reported they had pain because they didn’t take their medicine on time and didn’t drink enough water.

The oldest children tended to have more than one answer for what caused them to have pain. One child distinguished each of her pains with an individual reason, “Tummy ache may be due to acute appendicitis. One of my classmates had the same symptoms as I did”. Some children believed stress, tiredness, side effects of medication, and eating dirty food were causative factors. One child stated that “Maybe it is because I had lots of pressure from my studies, my body is too weak. Maybe I was infected by my sister”.

Meaning of Pain
Most of the children perceived that there is nothing good about pain in their first responses to the researcher’s questions regarding the meaning of pain. However, as the researcher asked an additional question, “Does the pain let you recognize that something might be wrong with your body?”, some children viewed pain as a sign that indicated something was wrong with them physically. Some children talked about potential secondary gains, such as getting something they wanted, or taking a rest.

While 16 of the youngest children stated that there was nothing good about pain, some felt that staying home from school was an advantage. Even some of the youngest children, however, recognized that pain was a warning signal. One child said, “I feel something wrong. It is just like a machine which is almost broken”. Children in the middle and oldest groups frequently viewed pain as a warning. One middle group child said “I felt something wrong. I am afraid I am going to die because I have lots of pain”. Another child compared her current pain with her previous pain and said “I think am I going to have Systemic Lupus Erythematosus. A couple of months ago, my hair started to fall out, so I went to hospital and they found Systemic Lupus Erythematosus”.

Some oldest children explained what they might do with the warning pain could provide. “After I had pain, I would pay more attention to pain. Then, it won’t happen again because I pay attention already”. Because these children were in the higher grades, they had learned biology, science and other more advanced classes in school. One child even applied knowledge about antibodies and antigens in the conversation, although what he said was not correct. This child said, “Pain can kill the virus”. The researcher asked the child how this happens. The child said, “Maybe it will produce antibodies and antigens. If the antibodies and antigens combine together, they may fight the virus. I know I will feel better after the virus is gone”.

Across age groups, children most frequently said pain was bad because it hurt. Younger children were concerned about not being able to play outside. Older children were more concerned about whether or not they could catch up in class. Interestingly, one of the youngest children connected pain with hospitalization and potential diseases. She said the bad thing about pain was, “Uncomfortable, cannot go to school. I don’t like to be hospitalized because I may get some diseases from others”. Although absence from school was seen as a benefit of pain, nine children responded to this question by saying that not going to school was a bad thing about pain. One of the youngest children said, “I couldn’t go to school and that would make me stupid”. Responses of children in the middle and oldest groups were similar to those of the youngest children. They emphasized physical discomfort, less frequently mentioned concerns about hospitalization, and more often worried about catching up in class. Older children were also more concerned about pain preventing them from being with their friends.
Overall, children’s descriptions of pain experiences were similar across age groups. However, the youngest and middle group children tended to describe their pain based on what they see and the things around them. The oldest children tended to apply knowledge they had learned in school and to think more abstractly.

Discussions and Conclusion

The results of this study contribute to the description of children’s pain experiences. The major finding related to the definition of pain is that children defined pain and identified it in others based on their personal experiences and/or observations of others’ experiences. Although some of the youngest children were not able to describe pain, most of them identified pain in others by noticing a person’s facial expression. The oldest children identified pain through the verbal reports of the child in pain and defined pain not only as physical discomfort but also as emotional pain. These findings are congruent with those of Crow (1993) and Atherton (1995).

In their studies, Crow (1993) and Atherton (1995) reported that the description of pain in the preoperational stage emphasizes physical pain and expression of pain as predominately behavioral. Some children may also have difficulty describing pain or pain responses globally. Crow and Atherton also stated that children in the concrete operational stage in their studies had concrete rules for pain (such as eating too much), or reflected internationalization of the causal process (e.g., “pain is something in my body”). Children in the formal operations stage were able to communicate their pain experience to others. They described pain using generalized principles and physiologic processes, and had psychophysiologic responses. Both physical and psychological aspects of pain were involved. Thus, the findings of this study are consistent with those of Crow and Atherton.

In addition, the researcher in this study found that some Taiwanese children perceived that their parents lied about the possibility of their having pain during hospitalization. Some Taiwanese parents might be concerned that the truth may increase children’s pain and/or emotional reactions (such as, fear). No studies conducted in the US have reported this issue. Whether Taiwanese parents perceive lying about actual pain as an effective strategy to relieve their child’s pain is unknown. More research is needed to explore this issue.

The influence of cognitive development was also apparent in findings about the meaning of pain. The youngest children said pain meant not being able to play with others or eat their favorite foods. These findings are consistent with those of Savedra, Gibbons, Tesler, Ward, and Wegner (1982), and Crow (1993) who reported that children said there was nothing good about pain. Some children in their studies reported that pain made them feel something was wrong. Older children, more often than younger children in this study, tended to view pain as an awareness of physical problems or a warning signal. It seems children in this study tended to identify both positive and negative perceptions toward pain, whereas other studies often present either positive or negative perceptions of pain. In addition, the older children in this study often linked pain with concern for their academic performance. This finding has not been reported in previous studies. Probably, the adolescents tend to focus strongly on peer relationships and school performance. Success in the academic performance is part of the sources that contribute to their development of role identity and this result may also reflect how Taiwanese children perceive the importance of school entrance examinations.

A major finding related to the causes of pain concerns children’s emphasis on germs and illnesses. Older children’s description regarding causes of pain involved emotional factors, such as stress. Notably, Taiwanese children used the term, “germ”, the same way American children would use it. Germs indicate bacteria and/or viruses that cause illness. These findings are consistent with the literature.

Atherton (1995) stated that pre-school children are not capable of understanding the relationship between cause and effect; school age children are able to think in a more reasoned and logical way; and adolescents are capable of more mature thinking and reasoning. Crow (1993) reported that the causes of pain for children were related to accidents or something in the body that causes the brain to receive messages from the nerves. Mao and Chiang (1996) reported that causes of children’s post-surgical pain were related to movement and/or treatment. Gaffney and Dunne (1986) reported that children in the preoperational stage described pain as caused by an external or concrete event, such as a fall. Contrary to this study, in which none of the children described pain as punishment, Gaffney and Dunne (1986) found that children in the preoperational stage and into the early formal operational stage viewed pain as punishment. Older children linked pain
with physical and psychological causes. Other studies and literature have also described punishment and pain as viewed by preoperational children (Hurley & Whelan, 1988).

Cultural Considerations

As mentioned early, the physiology of pain is expected to be similar across cultures, but the experiences and meanings of pain are different among cultures. Surprisingly, the results of this study revealed few differences in the experiences and meanings of pain. Most results are consistent with the studies conducted in the US. Differences are minor and probably related to the sample sizes of the studies. How culture affects children’s pain experiences remains unclear. One reason for the lack of differences between Taiwanese children’s pain experiences when compared with studies of US children may be that Taiwanese culture is very westernized. Or maybe children’s pain experiences are universal. Another factor that must be considered in the results of this study is that the researcher received 8.5 years of nursing education in the US, thus, her bi-cultural perspective might have influenced the interpretation of the results. However, none of predicting reasons can be found in the literature.

Two cultural differences were demonstrated in this study: the interpretation of children’s crying and how Taiwanese parents talk with their children about pain. In the US, the term “crying” includes vocalization; however, crying often refers to facial expression for school-age Taiwanese children. In fact, Taiwanese children are taught that vocal crying is inappropriate. Thus, when Taiwanese children describe another child as crying when in pain, they might be referring to a facial expression. Taiwanese health care professionals and researchers must therefore be cautious in applying western research about crying. In addition, this researcher found that some Taiwanese children perceived that their parents lied about the possibility of their having pain during hospitalization. Some Taiwanese parents might be concerned that the truth may increase children’s pain and/or emotional reactions (such as fear). No US studies were found that reported this issue. More research is indicated to explore this issue. Further research is needed.

References


台灣兒童疼痛經驗之質性探討
鄭夙芬  Roxie L. Foster*  Nancy O. Hester**  黃筑榆***

摘 要：探討有關台灣兒童疼痛經驗的文獻仍然在少數。因為疼痛與文化因素有很大的關係，健康照顧者不應直接運用于研究兒童疼痛經驗的結論來照顧台灣的兒童。因此，本研究運用半結構式的會談的方式，探討台灣兒童的疼痛經驗，計訪談 90 位 5 到 14 歲，具有急性疼痛的住院病童。資料採用 Krippendorff’s (1980)的內容分析，共有疼痛定義、疼痛性質、過去疼痛經驗、預期疼痛、疼痛接受度、疼痛原因及意義七個主題概念。研究結果大致上與國外的研究結果雷同，只有部分的疼痛經驗與疼痛意義與美國學者的研究結果不同，包括孩童對哭泣的解釋以及台灣孩童的父母如何向他們的子女解釋疼痛。不同處可能與取樣的數目及研究方法不同有關。建議再深入探討文化因素如何影響個人的疼痛經驗。

關鍵詞：疼痛經驗、疼痛意義、文化考量。


通訊作者地址：鄭夙芬  831 高雄縣大寮鄉永芳村進學路151號