Introduction

From uncooperative patients to changing healthcare systems, physicians deal with many problems and frustrations everyday. One of the most difficult of these frustrations is assessing and treating pain. As a culturally influenced and experientially determined metric, pain, especially during childbirth, is perceived in a unique way by every person in every culture making the proper diagnosis by medical professionals immensely challenging. This research brief focuses on the growing Mexican immigrant population in the United States. The pain experienced during childbirth offers intriguing insights into the cultural aspects of pain and how these attributes affect the perception and understanding of pain cross culturally by medical professionals. The purpose of this collective research is to empower medical professionals to offer higher quality care for Mexican immigrants undergoing
parturition by providing a body of knowledge that will allow for a more profound understanding of their unique pain perception and expression.

“Pain is an ubiquitous feature of human experience” (Kleinman et. al 1994). Since the emergence of the human race, people have experienced pain as an evolutionary mechanism to signal an adverse result to a certain event, behavior, or emotional state. An entire division of modern medicine has been devoted to the study and treatment of pain illustrating its perceived importance in modern society. According to the National Center for Health Statistics, 76.2 million people report that they have a problem with pain (AAPM, 2006). This staggering number amounts to nearly a fourth of the entire United States’s populations and the number of people reporting pain is more than the next four categories for seeking medical attention combined (AAPM, 2006). Many researchers beginning with Mark Zborowski uncovered that pain encompasses much more than a simple signal to alert to tissue damage. Pain is a physiological response to tissue damage in addition to “behavioral and emotional responses expected and accepted by one’s cultural group” (Calvillo & Flakerud 1983).

Considering current medical capabilities, pain cannot be accurately nor objectively determined, which poses a
difficult problem for physicians in assessing pain in a consistent manner. The cultural background and previous experiences of physicians as well as patients affect the perception and expression of pain (Meinhart & McCaffery 1985). Due to the dual inconsistencies between every unique medical professional and every unique patient, the assessment of pain in an objective manner is nearly impossible. Despite the lack of reliability on diagnosing pain, medical professionals are still expected to assess and treat pain according to the severity of pain patients report. With current medical capabilities, medical professionals should work to understand the entire patient including relevant past experiences, cultures, and anxieties in order to produce as accurate of a diagnosis as possible.

Parturition

Birth, or the medical term parturition, refers to the emergence of a baby from his/her mother’s uterus. The way in which societies and cultures around the world view birth offers interesting insight into the way each society interprets life. Cultural norms regarding birth range from vehement refusal of pain medication and the use of midwives in the Netherlands to commonplace cesarean sections and the widespread use of pain medication in Brazil (Shalken 2015). In order to provide the best quality of care possible, medical professionals need to understand the cultural nuances that every patient brings to the examination room, whether it be a patient who believes that only completely natural births are acceptable or a patient who expects an epidural before contractions even begin.

Mexican American Birth

Mexicans and Mexican Americans are known for having large families, which stems from past rancho culture as well as Catholicism. Considering most of the families in rancho communities survived by growing their own food and raising their own livestock, there was a need for a large number of children to share the work required to maintain the farm and household. Also, the pressures to have many children “came most often from and overtly from the community’s men, who argued that a populous community was vital to the defense of the collectivity and its interests” (Browner, 1993).

As Mexico migrates toward modernity, the government has increased its interest in lowering the national birth rate. Since 1972, the Mexican government has promoted “family planning
aggressively” (Browner, 1993). The Mexican national fertility rate has decreased from 7 to 2.6 from 1960 to 1997, illustrating the success of the government’s family planning efforts (Hirsch, 2003). Although Mexican births have been declining in Mexico, they have been increasing rapidly in the United States. “In the United States, recent National Center for Health Statistics data on births of Hispanic origin notes that Mexican women have the highest fertility of any Hispanic group in the United States, with a TFR of 3.2” (Hirsch, 2003). Although the overall Mexican birth rate is declining, the Mexican American birth rate is skyrocketing, which can be seen in the above graph. The rapid increase in Mexican American births in the United States illustrates the need for a more profound understanding of Mexican pain during childbirth.

Ushered in by modernity, a change in Mexican marriages and childbearing is noted among the new generation of young Mexicans. As marriages shift from antiquated respeto marriages, where tradition and patriarchy reign, to modern confianza marriages, where compassion and equality are valued, Mexican birth rates have dropped due to the desire to explore a compassionate relationship before the arrival of children. Although this appears to be a growing trend among Mexicans, there is still “a strong social pressure to have a child soon after marriage” (Hirsch, 2003). Jennifer Hirsch, in her book A Courtship After Marriage, describes the pressures and scrutiny she felt while conducting fieldwork in Mexican American communities when she was married for four years and still childless (2003). “The older life informants said that it never occurred to them to delay the first birth—that the whole point of marriage is to have children” (Hirsch, 2003). Many of the women in the community asked why Hirsch was waiting so long to have children, which reinforced the cultural norm of having children quickly after marriage.

Many Mexican women view childbirth and especially frequent childbirth as “physically stressful and even
debilitating” (Browner, 1993). Mexican women see “parturition as a threat to their health, believing that, during childbirth, the womb—and the rest of the body—must ‘open’ to expel the newborn and that this process increased the body’s already heightened vulnerability to aire” (Browner, 1993). Latinos have a long standing view of diseases and illness as something either hot or cold contacting the body, which causes a disruption of the proper balance (Currier, 1966). When the balance is disrupted, pain and illness afflict the body. Although many Mexican mothers view children as “pesky disturbances,” the husbands of these women along with social pressures have coerced the women to have many children, resulting in high birth rates (Browner, 1993).

**Anglo American Birth**

As one of the most developed nations in the world, people do not often view the United States as a place littered with rituals and ceremonious acts during birth. Contrary to popular belief, birth in America is one of the most ritualized processes in the United States. “A ritual is a patterned, repetitive, and symbolic enactment of a cultural belief or value; its primary purpose is alignment of the belief system of the individual with that of society” (Davis-Floyd, 1988). For women in the United States, “childbirth has been transformed into a rite of passage designed to initiate the birthing woman into the dominant core value and belief system of American society” (Davis-Floyd, 1993).

Typical parturition in America occurs in a hospital, while only 1.36 percent of American births takes place at home or at a birthing center (MacDorman et. al, 2014). American society has labeled parturition as “taboo” and walled the natural process off from society within hospitals (Davis-Floyd, 1993). As soon as the expecting mother enters the hospital, she is placed into a wheelchair illustrating the poignant theory that Americans view birth as a type of sickness. The woman is ill and disabled requiring assistance in the form of a wheelchair (David-Floyd, 1988). Once she is wheeled into the birthing room, the patient is connected to an external fetal monitor and an IV is inserted into her arm while she is placed into the lithotomy position, which consists of the patient lying flat on her back with her feet raised in stirrups. The position allows the obstetrician to see the birthing
canal better, but the lithotomy position offers no practical application for the patient in terms of delivering the baby. While in a position most advantageous for the physician, the patient is often provided with analgesics and anesthesia to mediate the pain. If labor proceeds for “too long,” the physician often injects the patient with Pitocin, which is a drug that speeds up contractions. All of these actions and techniques occur in almost all hospitalized births in order to bring all births into conformity with the “standard” birth.

![United States Cesarean Rate, 1970 - 2009](chart.png)

**Portrayal of the Increase in Cesarean Sections in the United States**

*Source: Center For Disease Control*

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**Pain & Dolor**

Pain is a common thread that all humans share, yet no human can objectively know the pain of another person. As Arthur Kleinman pioneered, the perception of pain is unique to every person due to the alteration of perception by cultural influences and past experiences (Kaplan- Myrth, 2007). The mechanism for the perception of pain has been a heavily debated topic since 322 BC, when Aristotle argued that the heart was the seat of all feelings and thus the center of pain reception. Pain was not even associated with the brain and psychological processes until 500 years later when Galen postulated that the brain was at the center of sensation (Perl 2007). Fast forwarding to present day, four major pain theories exist: the specificity theory, the pattern theory, the intensity theory, and the gate-control theory (illustrated in the graphic below). The most common of these theories is the gate-control theory prosed by Ronald Melzack and Patrick
Wall in 1965, which takes into account psychological processing before actual perception occurs. “Despite wide-spread discussion of the gate-control theory by researchers and the conclusions of many that such a theory is useful in addressing formerly puzzling aspects of pain, clinical medicine has been slow to adopt the theory” (Bates 1987). The theory, unlike the three prominent ones before it, explains the role of behavior, experience, and other neurological functions that may affect pain perception. 

Definitions

Proceeding with the theory that pain is not simply a physiological response to an external stimuli, but a summation of cultural, physical, and emotional states, I have divided the notion of pain into “dolor” for the Mexican-American context and “pain” for the Anglo-American context. “Perception, expression and management of pain are all embedded in a cultural context. The definition of pain, just like that of health and illness, is culturally determined” (Calvillo & Flakerud, 1992).

The American idea of pain centers around the presence of a noxious physical stimuli that is perceived by the brain as something that hurts and should be avoided. “In American society, illness is most often viewed as an intrusion by microorganisms... Our curing techniques emphasize the destruction or elimination of these agents” (Robbins, 2012). People in the United States focus on mainly physical components of pain, which is reflected in the way pain is treated. American medical professionals treat pain as a foreign foe that should be destroyed through the use of surgery or medication.
According to the Merriam-Webster dictionary, “dolor” is defined as “mental anguish” or “grief” (2015). Mexican wording for pain encompasses a pronounced understanding of the multifaceted nature of pain. “Mexican-American culture bearers [do] not dichotomize psychic or emotional ills and somatic diseases. To do otherwise would be to do violence to the logic of the system” (Rubel, 1960). The Mexican culture approaches pain and illness with a holistic approach, which takes into account the mind, body, and spirit.

For Mexicans, “illness may be attributed to witchcraft, sorcery, soul loss, or spirit possession,” which stems from a clash of ideas from indigenous cultures and the Spanish ideas brought during the conquest (Robbins, 2012). “Max Marwick points out that sorcery-induced illness or death does not strike randomly; it occurs when there is a conflict over judicial rights and claims or when someone fails to observe some social norm” (Robbins, 2012). People versed in Mexican culture understand the importance of social relationships and tensions in diagnosing illnesses. Another key aspect of the Mexican view of illness as pain is the need to maintain the body in a proper balance of hot and cold entities. "Proper balance of these [forces] was considered necessary for good health, and any imbalance resulted in illness” (Currier, 1966). All of these factors influence the nature of Mexican dolor and provide useful insight into how they perceive and project pain.

Perceptions

“When pain is occurring, physiological processes as well as the individual’s thoughts, cultural beliefs and values, and memories can influence whether pain impulses
reach the level of awareness” (Calvillo & Flaskerud, 1993). Due to the interplay of a multitude of factors on the perception of pain, medical professionals struggle to identify every patient’s pain accurately. Although exact determinations cannot be made in assessing a patient’s perception of pain, medical personnel can reach a deeper understanding of a patient’s suffering with in depth knowledge of the patient’s cultural background and previous experiences.

Mexican-American patients understand that pain and suffering is a part of life. “When an individual is ill, the person bears the illness with dignity and courage, this is because many Hispanics believe that difficulties are part of life and must be accepted without complaint” (Calvillo & Flaskerud, 1993). During labor and birth, many Mexican patients cry out and moan while in pain, which many health professionals may perceive as a plea for help. “In the Mexican culture, crying out in response to pain is an acceptable expression and not synonymous with an inability to tolerate pain” (Orque et al, 1983). “The pattern of crying and moaning may have the function for the patient of relieving pain rather than the function of communicating a request for intervention” (Calvillo & Flaskerud, 1993).

Anglo Americans express pain in a much different fashion than Mexican Americans. “According to Meinhart & McCaffery (1983), stoicism is valued by Anglo Americans” (Calvillo & Flaskerud, 1993). When they are experiencing pain, they try to “remain calm avoiding complaining, crying, screaming, or other manifestations of pain” (Calvillo & Flaskerud, 1993). Anglo Americans attempt to appease medical professions by not being a nuisance through the expression of their pain. As the norm in the United States for handling pain, deviation from this standard of pain expression causes medical professionals to misinterpret other culturally and personally influenced methods of portraying pain.

Management Techniques

As a result of advancements in medicine, medical professionals know many techniques to quell and manage pain. The American medical system treats labor and delivery pain in three main ways: an epidural, injected drugs or nitric oxide. “The epidural is the most efficient way of reducing labor pain. A total of 85-95% of woman report complete relief of pain during the two phases of delivery: cervical dilation and decent of the baby” (Tournaire & Theau-Yonneau, 2007).
Injected drugs are normally a type of opioid that enters the patient through an IV and acts on receptors in the brain to decrease the feeling of pain. “Recent reports suggest that the analgesic effect of these agents in labor is limited and that the primary mechanism of action is heavy sedation, which means that consciousness is reduced during delivery” (Tournaire & Theau- Yonneau, 2007). One of the less used methods of pain management during pregnancy is nitric oxide inhalation. Nitric Oxide gas is inhaled through a regulator that “produces a mild analgesic effect at subanesthetic concentrations” (Becker & Rosenberg, 2008). All of these methods and techniques act through mechanisms concerning the physical nature of pain, illustrating the American medical system’s tunnel view of pain and patients.

The Mexican approach to pain begins with a verbal cry, which functions as a pain relieving tool, not a request for help or intervention (Calvillo & Flakerud, 1993). Mexicans have a rich history of engaging in traditional medicine to relieve pain. Traditional medicine encompasses a wide range of techniques and processes to alleviate pain. Many Mexicans perceive pain and illness as social tension or a deviation from social and cultural norms. “The individual survives by virtue of his ability to manipulate his/her social relationships, so that he/she is rendered neither vulnerable because of over-involvement with others nor insecure because of lack of involvement with others” (Currier, 1966). A healthy individual is one who has all of his/her parts in balance (Rubel, 1960). Curanderos, healers or people who practice traditional medicine, often consult patients to determine if any social relationships are out of balance, and if one is found to be in an improper state, a curandero will suggest a method to mend the out of balance social relationship, which in theory would relive the pain.

Another common method employed by Mexican healers is the use of natural plants and herbs. Some examples of plants include Nectandra and Heliocarpus glanduliferus, which are used to speed up birth and provide the woman with strength for labor and delivery pains (Smith-Oka, 2008). Another staple of the curandero’s Pain and Dolor

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**Madrigal v. Quillagan**

Madrigal versus Quillagan was a class action lawsuit brought against many physicians at the Los Angeles County Medical Center (LACMC) for allegedly coercively sterilizing a multitude of Latina women. “It all began when a resident at LACMA, Dr. Bernard Rosenfeld, approached attorney Antonia Hernandez with the cases of nearly 200 women with mostly Spanish surnames who he felt were being coercively sterilized while at he hospital for childbirth” (Martinez, 2009).

The doctors would withhold pain medication until the women signed the consent forms for sterilization. Also the residents and physicians would use colloquial terms such as “tubes tied” to describe the sterilization, which many Latina women understood as a reversible process (Martinez, 2009). The lack of information and transparency was heinous. Many of these doctors felt as if they were doing a favor to society by limiting the “hyper fertility of Latina women” in order to help solve the problem of overpopulation (Minna Stern, 2005).
toolbox is a spiritual cleansing. Mexicans believe that the spirit is inextricably linked to sickness and pain. A curandero will traditionally rub the patient's body with an herb and oil followed by an egg in order to “absorb the impurities” inside the person’s body (Grande, 2012). After the initial cleansing, the curanderos will often blow some sort of smoke or steam over the patient's body while praying. The entire experience is a relaxing process and normally ends with the patient asleep (Grande, 2012).

One of the most used methods employed by Mexican Americans to alleviate pain is social networks. While in pain, whether it be emotionally or physically based, Mexicans and Mexican Americans often turn to their friends and family for support through difficult and painful experiences (Gomberg-Muñoz, 2011). Pain is a multi dimensional illness that can and should be managed in ways that coincide with the patient’s particular narrative—cultural, physical, spiritual, and emotional.

Cultural values and frameworks permeate how we think and experience the world around us. For this reason, the examination of pain as unique to every person may simply be a product of the Western culture, which values uniqueness and individuality. Since pain cannot be objectively measured, there is no definitive way to test the uniqueness theory as fact or fiction. Nevertheless, there is value in understanding pain as unique to every patient, for it will foster a drive to understand every patient in a more holistic manner rather than attempting to standardize every condition to the norm.

Memorial Hospital of South Bend

Memorial Hospital of South Bend offers many services for parturition to assist in the process including Spanish translators. The hospital offers aromatherapy, a birthing ball, hydrotherapy, massages, relaxing music, and the freedom to walk around. Memorial provides the option to train a support person in relaxation techniques in order to help expectant mothers through the birthing process. The hospital offers doula training sessions for their nurses, medical translators, and the community. A doula functions as a caretaker empowering and comforting the mother during labor and delivery. “Clear benefits with physical, emotional, and financial implications are repeatedly found in studies of doula support” including an increase in natural childbirth (Trueba et al, 2000). Memorial has taken beneficial strides to accommodate the unique nature of each patient experiencing the pain involved during childbirth.
Medical Professionals

Medical professionals include almost anyone who is involved with a person requiring medical assistance. Assessing pain is most likely one of the most difficult challenges facing medical professionals today. Many times their own culturally prescribed biases affect the lens through which they interpret other people’s pain and suffering. Medical professionals may never be able to understand a patient’s pain exactly; however, they may be able to understand it on a deeper level than previously imagined. This would be possible through an increased knowledge of the patient’s culture and previous experiences.

Role in Parturition

As birth around the world becomes more and more medicalized, medical professionals are becoming more inextricably linked to birth. In America, nurses insert IV drips and prep the “patient,” while the obstetrician provides pain medication and delivers the baby to society (Davis-Floyd, 1993). The medicalization of parturition is rising in Mexico, but many births still occur outside of the hospital in clinics and at home with midwives. Midwives or more commonly known as “parteros” in Mexico empower women and allow them to take positions advantageous to giving birth. In hospitals, the woman is placed in a lithotomy position, which is more advantageous for the physician rather than the patient. Medical personnel play a large role in modern parturition, which illustrates the importance for them to know and understand certain cultural and personal nuances that may improve the quality of care for patients of different cultural backgrounds.

Understanding Patient Pain
In Arthur Rubel’s 1960 article, “Concepts of Disease in Mexican-American Culture,” he explains that, “Doctors do not understand caída de la mollera, empacho, mal ojo, or susto.” He does not simply mean that modern physicians do not understand these specific four illnesses, but more generally, that modern medical professionals do not understand the culture or beliefs of Mexican Americans that hide in the spaces of these Mexican diseases. Knowledge of these beliefs and cultural nuances could offer insight into improving care for that patient, which would be an invaluable resource for nurses, doctors, and other medical personnel.

Although consistent research have determined that Hispanics “are less likely to describe their pain as unbearable...the belief persists among Anglo health care workers that Hispanics are dramatic complainers who have a low tolerance for pain” (Calvillo & Flaskerud, 1993). Dudley & Holm discovered that nurses “tended to infer a greater deal of psychological distress than pain” resulting in “inappropriate management of suffering, that is, patients will be given psychological support but no pain interventions” (1984). Nurses and other medical professionals often under estimate pain and suffering due to the monotonous and numbing nature of experiencing patients in pain all day. In Calvillo and Flakerud's experiment, they found that on the Present Pain Intensity (PPI) scale, nurses scored patient’s pain at a mean of 75, while patients scored their own pain at a mean of 113 indicating that the nurses underestimated pain consistently (1993).

Not only do the cultural backgrounds of patients influence the perception of pain, but the cultural backgrounds and values of medical professionals also affect how pain is interpreted. In the United States, “nursing staff tended to uphold the dominant cultural values which strongly encourage stoicism during pain experiences and to believe that patients exaggerate their pain experiences” (Calvillo & Flakerud, 1993). In order to improve the quality of care of all patients, it is important to understand one’s cultural biases and the cultural values of one’s patient.

Conclusion

In the medical setting, an objective determination of a patient’s pain is nearly impossible for two main reasons. First, the cultural values and personal experiences of the patient affect his/her perception and communication of his/her own pain. Second, the medical professional, who is charged with assessing said patient’s pain, brings his/her own cultural biases and personal experiences to the examination room, which alters his/her understanding of the patient’s pain and needs. As a medical professional, the recognition of one’s own cultural and personal biases along with a deep understanding of each patient’s cultural values and personal experiences is paramount in providing the highest quality of care possible.

In light of these findings, I propose three suggestions for medical professionals to improve the quality of care for Mexican immigrants during parturition. To begin, take Arthur Kleinman's
advice, and listen to every patient’s entire story before attempting to interpret and diagnosis the illness or pain. On average residents and physicians interrupt patients “one fourth of the time,” before patients are finished speaking (Rhoades et al, 2001). Understanding not simply the cultural aspects, but also the personal ones will be invaluable in properly treating each patient. Secondly, research and understand the cultural significance and functions of certain behaviors. For example, when Mexican woman moan, they are using the crying out to relieve pain, not to indicate a need for intervention (Calvillo & Flaskerud, 1993). Finally, I urge medical professionals to take into account the entire individual—mind, body, and spirit. In the Mexican culture, medical treatments “make the individual whole once again” (Rubel, 1960). Without the cultural and personal knowledge surrounding each patient, the medical professional is attempting to solve the pain puzzle without all of the pieces.
Image Credits

Woman Inhaling Nitrous Oxide from http://www.sheknows.com/parenting/articles/1064345/labour-pain-relief-options

Arthur Kleinman from https://medanth.wikispaces.com/Arthur+Kleinman

Reasons for Medical Attention from The American Academy of Pain Medicine.

Increased Mexican American Birth in the United States from the Pew Research Center.


Percentage of Births Outside of Hospitals from the Center for Disease Control.

Portrayal of the Increase in Cesarean Sections in the United States from the Center For Disease Control.

Pain Perception Theories from the Scientific Journal Nature.


Factors Affecting the Perception of Pain from the Journal of Evidence Based of Complementary and Alternative Medicine.

Epidural Use by Race from the Center for Disease Control.


Memorial Hospital of South Bend from https://qualityoflife.org/news/.


Acknowledgments

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Mexican Immigration: A South Bend Case Study
ILS 45103, Fall 2015