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Pain Management Experiences and the Acceptability of Cognitive Behavioral Strategies Among American Indians and Alaska Natives

Emily A. Haozous, PhD, RN[1], **Ardith Z. Doorenbos, PhD, RN, FAAN**[2], and **Susan Stoner, PhD**[2]

[1]University of New Mexico, Albuquerque, NM, USA

[2]University of Washington, Seattle, WA, USA

Abstract

Purpose—The purpose of this project was to explore the chronic pain experience and establish cultural appropriateness of cognitive behavioral pain management (CBPM) techniques in American Indians and Alaska Natives (AI/ANs).

Design—A semistructured interview guide was used with three focus groups of AI/AN patients in the U.S. Southwest and Pacific Northwest regions to explore pain and CBPM in AI/ANs.

Findings—The participants provided rich qualitative data regarding chronic pain and willingness to use CBPM. Themes included empty promises and health care insufficiencies, individuality, pain management strategies, and suggestions for health care providers.

Conclusion—Results suggest that there is room for improvement in chronic pain care among AI/ANs and that CBPM would likely be a viable and culturally appropriate approach for chronic pain management.

Implications—This research provides evidence that CBPM is culturally acceptable and in alignment with existing traditional AI/AN strategies for coping and healing.

Keywords

American Indian; Alaska Native; chronic pain; cognitive behavioral pain management

Introduction

Chronic pain poses unique challenges to the U.S. health care system, including ever-escalating costs, unintentional poisonings and deaths from overdoses of painkillers, and

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Corresponding Author: Emily A. Haozous, College of Nursing, MSC 07 4380, 1 University of New Mexico, Albuquerque, NM 87131, USA., ehaozous@salud.unm.edu.

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incalculable suffering for patients as well as their families. Pain is the leading reason patients visit health care providers (Hing, Cherry, & Woodwell, 2006). Approximately 100 million adults in the United States are affected by chronic pain, with treatment costs and losses in productivity totaling $635 billion annually (Institute of Medicine [IOM], 2011). There is limited access to specialty pain care, particularly for rural and tribally based primary care providers (Momper, Delva, Tauiliili, Mueller-William, & Goral, 2013). The American Indian/Alaska Native (AI/AN) population is particularly vulnerable to the impact of chronic pain because it remains underserved by the health care industry (Jimenez, Garroutte, Kundu, Morales, & Buchwald, 2011; Joe, 2003). Although opioid analgesics overdose rates among AI/ANs are disproportionately high (Warner, Chen, Makuc, Anderson, & Minino, 2011), there is a scarcity of published literature exploring the experiences of pain and pain treatment among AI/ANs (Haozous et al., 2012; Haozous & Knobf, 2013; Haozous, Knobf, & Brant, 2010; Jimenez et al., 2011).

Used alone or in conjunction with pharmacological treatment, empirically supported cognitive behavioral pain management (CBPM) techniques, such as diaphragmatic breathing, progressive muscle relaxation, distraction, meditation, and guided imagery have been shown to significantly reduce pain (Kim, Schneider, Kravitz, Mermier, & Burge, 2013; MacFarlane et al., 2012; Sturmberg, Marquez, Heneghan, Snodgrass, & van Vliet, 2013; Tatrow & Montgomery, 2006). CBPM does not take long to administer and is endorsed by several national organizations, including the American Pain Society, the American Geriatric Society, and the Joint Commission as an important component of a comprehensive pain management approach (American Geriatric Society, 2014; American Pain Society, 2013; Berry et al., 2003). Furthermore, current thinking on pain control has moved beyond the original World Health Organization’s three-step pain ladder to include nonpharmacological interventions (Leung, 2012).

Nonpharmacologic Options for Pain Management

Complementary and alternative medicine (CAM) therapies are emerging as viable approaches in managing chronic pain. The National Institutes for Health lists CBPM as a complementary health approach within the National Center for Complementary and Alternative Medicine (2013). Current research suggests that CBPM techniques have a neuroprotective effect from neurologic alterations caused by chronic pain (Bushnell, Čeko, & Low, 2013; Lee, Crawford, Teo, Spevak, & Active Self-Care Therapies for Pain [PACT] Working Group, 2014). Unfortunately, limited access to provider training is a major barrier to widespread use of CBPM, especially in rural clinics and those that serve AI/ANs.

Although it has been established that CBPM strategies are broadly applicable across medical conditions in which pain tends to occur, caution is warranted when seeking to extend CBPM strategies across cultures. Key tenets of culturally congruent care dictate that the clinician is aware of her own biases and values, has an awareness of her patient’s culture, worldview, and expectations of care, and delivers care that is mindful of the patient’s culture (Sue, Zane, Nagayama Hall, & Berger, 2009). Although CBPM approaches are being established as viable nonpharmacologic treatments for chronic pain in the general population, demonstrated acceptability of CBPM in AI/ANs has not yet been documented.

The purpose of this project was to build a better understanding of the pain treatment experience among AI/ANs living with chronic pain, and to determine whether the use of CBPM strategies would be culturally acceptable to AI/ANs.

Method

This project used focus groups with AI/AN participants with chronic pain to gather descriptive qualitative data about their experiences with pain and their preferences for delivery of nonpharmacological pain management approaches including CBPM. Three focus groups, which took place in the Southwest and Pacific Northwest regions of the United States, asked a series of questions about chronic pain and about use of CAM and CBPM in AI/AN communities. (See Table 1 for the interview guide.) Eligible participants were English-speaking adults older than 21 years who self-identified as AI/AN, were able to give consent, and had experienced persistent pain for 12 weeks or greater (Merskey & Bogduk, 2002).

The research was reviewed and approved by local institutional review boards and tribal councils. The University of New Mexico Human Research Protections Office reviewed the Southwest focus group, and the University of Washington Human Subjects Division reviewed the Pacific Northwest focus groups. Each focus group participant received an incentive of $50 in recognition of his or her time and of the potential difficulty of the topic discussed.

This project aimed to build knowledge about the pain experience from the perspective of the AI/AN participants. The focus groups were scheduled in locations and at times that were most convenient to the participants; when possible the groups were scheduled during regularly scheduled meetings to minimize impact and maximize familiarity and social support among group members. One focus group was conducted via telehealth during a monthly cancer support group (Doorenbos et al., 2010). All focus groups met in the evening and started with a dinner, followed by discussion.

The focus group facilitator for the Pacific Northwest in-person and telehealth focus groups was well-known to the community; although not AI/AN herself, she has been an active participant in community events, cofacilitates the monthly telehealth cancer support group, and provides consultation in cancer and pain management to the tribes. The high familiarity among the participants and the research team was an important component of the research process, providing a bridge to the historic mistrust of research in similar vulnerable populations (Guadagnolo, Cina, & Helbig, 2009). Participants were recruited from existing support groups, from which participants were informed of the research study and self-selected to participate based on their personal experiences with chronic pain.

The Southwest focus group took place in an urban educational center, central to several tribes. A paid AI recruiter with a strong community network distributed recruitment fliers in the region to recruit a convenience sample of AI men and women who were living with chronic pain and met the study criteria. The recruiter provided an excellent sample of participants, and as it would have been considered extremely impolite to turn away individuals who had made the commitment to the recruiter to participate, the scheduled focus group continued with the larger than optimal group. An AI nurse researcher who has experience conducting focus groups and facilitating group discussions on difficult topics facilitated the Southwest focus group, taking special care to elicit responses from all participants on all topic areas.

Credibility was established through maintenance of careful analysis notes throughout the data analysis process, frequent research team meetings, and presentation and dialogue regarding research findings with patients and clinicians from the target populations, to confirm that results reflected the experiences of the population represented by the sample. The results were confirmed through the rich representation of participant quotes to indicate that analysis conclusions reflect the authentic experiences of participants.

Data Analysis

A paid transcriptionist transcribed the 60- to 90-minute focus group transcripts, with the Southwest group lasting the longest. These transcripts were reviewed by the facilitators to verify accuracy, then qualitative data were analyzed to determine themes related to pain management and cultural acceptability of pain treatment options. The qualitative evaluation used content analysis and thematic description of focus group participants' discussion of the pain experience to identify major topics within and across the different focus groups (Ayres, Kavanaugh, & Knafl, 2003). Analysis involved a close reading of the transcripts, followed by in vivo coding of the transcripts. These in vivo codes were clustered into categories, and those developing categories were coded based on content. The categories were examined by the research team and grouped into clusters, which were analyzed to identify general themes (Hsieh & Shannon, 2005). The emerging themes were discussed during research team meetings, and then the team identified quotes exemplifying key themes. Early results were member checked with participants to verify findings. Finally, a summary list of specific themes related to CBPM was created.

Results

There were a total of 25 participants in the three focus groups, consisting of the Southwest ($n = 14$), the Pacific Northwest ($n = 5$), and rural Pacific Northwest telehealth support group ($n = 6$). The participants did not complete demographic data forms, but based on qualitative data provided during their introductory comments, their approximate ages ranged from 20 to 80 years. The participants were predominantly from Southwest, Pacific Northwest, and Alaska Native tribes, although they included tribal nations from across the United States. Participants described a variety of pain conditions, including idiopathic chest pain, chronic headache or migraines, chronic cancer-related pain, chronic back pain, osteo- and rheumatoid arthritis, and chronic musculoskeletal pain from past injuries.

The dominant themes about participants' pain experiences and cultural appropriateness of pain management techniques were: empty promises and health care insufficiencies, individuality, pain management strategies, and suggestions for health care providers.

Empty Promises and Health Care Insufficiencies

Although some participants were able to claim appropriate management for their chronic pain, many more reported stories of providers and health care systems repeatedly failing to provide adequate pain management. Participants detailed vivid stories of pain reports being ignored, undertreated, or overlooked; and of feeling that their pain was disregarded. In the Pacific Northwest, where there is a system in place for pain management and consultation, there were more reports of successful pain management. In contrast, the participants in the Southwest were less positive, and had a common agreement that their pain management and overall health care was not evidence-based or sufficient.

> He [the doctor] asked me what kind of pain are you in, and I said I can't go to sleep on my back, I have to toss and turn all night. And that's as far as he went. I asked him, "Could I get some painkillers or something?" All he gave me was some ibuprofen, and I was like, "I don't want that."

The Southwest participants had knowledge of health care and treatment beyond pain management, as shown by this participant's knowledge of pediatric care:

> I mean they even do that with the antibiotics, you know, they give children amoxicillin, if there's a child with chronic ear infections, in the private sector, if amoxicillin don't work the majority of them go to augmentin right away, but there is that cost difference, I mean amoxicillin is the least amount, the augmentin is like 40 dollars, it varies.

In these quotes, participants are describing the undertreatment of their pain, the dismissive response they received for their pain complaints, their knowledge of standards of care and that they were not receiving the same quality of care that is given outside the Indian Health Service (IHS) system. They were familiar with the available pharmacological treatments, and they demonstrated knowledge about the analgesic benefits of ibuprofen compared with other pharmacological approaches. When participants detailed being prescribed ibuprofen after describing pain that affected their daily lives, sleep, and personal relationships, they were telling a story not just about the insufficient care they were receiving but also about the insult that went with not being heard for their complaints of debilitating pain.

In all the regions, participants told stories of feeling frustrated by the empty promises given by health care providers, with no follow-through or long-term improvement in their overall pain outcomes. These participants agreed that the betrayal of having a health care provider fail to follow through—after assuring them that there was sure to be a solution to their pain, and that the provider would be there through the different treatment trials until a solution was found—was extremely difficult.

> I have learned to be very leery of doctors who say, "Do this, it will take care of your pain and you will never have it again." Well I've been to a place where they have promised that. Like one neurologist said, "Oh we will help you. You won't have to suffer headaches." Well, I tried this different medication and when I took a call back to the office and said, "This isn't working, what else can I try?" "Oh we don't have anything else," is what goes through the receiver. And he promised in the beginning that he was going to help me.

Participants attributed poor pain management to the federally funded loan repayment program within the public health service, which places new clinicians in IHS clinics for limited periods of time as a training and student loan repayment opportunity. They noted that this "revolving door" prevented patients from developing effective relationships with their providers that facilitated good pain management.

> At my clinic at home there are so many doctors that come and go from the area it is kind of hard to get used to one because you are lucky if the doctor will stay around. So you have a group of doctors come over and then you have to get to know them over again. It's pretty difficult to have good communication between so many different doctors. It's hard to get really close with one person when you don't know how long they will be there.

The cumulative effect of these empty promises and health care insufficiencies was an overwhelming sense that the health care system that is supposed to serve AI/AN health care needs is instead providing second-class care by doctors who have lost their compassion. In the Southwest focus group, participants were particularly attuned to this failing because much of their health care is delivered through tribal clinics and IHS clinics, and few participants had private health insurance. They noted that friends and family who had private insurance or Medicare received different care from their same tribal and IHS clinics, and this contributed to the sense that their care was substandard. For this group of patients, their best chance at pain management was to receive a referral out of the IHS system.

> Unless a Native person has insurance you know then they'll go ahead and refer out, but if they don't have insurance then the process is difficult for individuals. And for me, once I got on disability and I got on Medicare and it's like once I got on Medicare all my referrals are being okay because IHS isn't footing the whole bill themselves.

This theme of a lack of trust in the health care system was less acute in the Pacific Northwest focus groups, where many tribes provide private insurance for their members. In addition, the telehealth pain management system that is in place in the Pacific Northwest coordinates chronic pain care for AI/ANs in remote villages that would otherwise not have access to pain specialists. Although there was less overt frustration and anger with the health care system in the Pacific Northwest focus groups, there was still a strong observation of empty promises among those patients who had found that their providers had not followed through with their treatment promises.

Individuality

Individuality was an important distinction that participants from all focus groups made regarding both cultural care and pain. Participants desired health care from providers who were knowledgeable of their unique tribal cultures and needs. Likewise, they observed the uniqueness of the pain experience, and agreed that pain requires individualized care from knowledgeable providers. Participants discussed the nuances of pain treatment, and made the analogy that treating pain syndromes with a generalized approach was as inappropriate as assuming that all AI/AN cultures were the same. Participants were weary of receiving the same advice for management of their pain conditions. As one participant said,

> It might have helped for somebody else, but everybody is unique. What works for me, it may or it may not work for somebody else. So each person really has to travel their own road.

Pain Management Strategies

Across the focus groups, participants employed multiple pain management modalities to control their chronic pain, including allopathic medicine, CAM, and traditional AI/AN medicine (see Table 2). In their attempts to gain adequate and lasting pain management, participants employed strategies to manage pain that were in alignment with their cultural and personal values.

Allopathic Pain Management Strategies—Participants used allopathic approaches for pain management that ranged across the therapeutic spectrum. Those approaches were largely focused pharmacologic interventions such as prescription and over-the-counter medications. Participants also relied on procedures for pain management such as nerve blocks and steroid and Botox injections.

The participants in the Southwest focus group reported particular difficulty in obtaining pain relief. A recurring refrain in their stories was their different health clinics' reliance on ibuprofen for analgesia. Participants expressed disappointment with this treatment strategy, especially given the systemic difficulties in seeing a provider: "You sit for 4 hours and then they listen to you, load you up with ibuprofen, and send you home."

In contrast, participants in the Pacific Northwest described ibuprofen use as an approach for individuals who were managing their chronic pain without medical assistance.

> A lot of people do not go to a doctor or a hospital—they self-treat. And so a lot of [people use] ibuprofen and acetaminophen and the incense—it gets old because they are not treating their own pain. They have discovered through trial and error what helps their own [pain].

Prescribed medications included opioids, steroid medications, benzodiazepines, muscle relaxants, antidepressants, and anticonvulsants such as gabapentin. In both the Southwest and the two Pacific Northwest focus groups, participants described difficulty in obtaining prescriptions for narcotics for pain relief. One participant, when talking about her tribal clinic said,

> In our clinic we have a really huge misconception that anyone that comes in with pain is seeking narcotics. What I would like to see is when someone comes in they are not seen as a drug seeker, they are met with compassion. … I don't like to be stereotyped or labeled because a person is in pain.

Participants' strategies for pain relief in light of the difficulties with prescribed medication included using prescribed medications to help themselves sleep through their worst pain:

> I take up to seven pills a day. Gabapentin I take for my hand, which also they use for seizures that just basically puts me to sleep so if I'm asleep I'm okay. Ambien too, and that's not a good combination to be mixing your own pills to sleep so

> you're not in pain, but that's where I'm at, where I have to mix those pain pills in order to just make myself go to sleep, I'm in that much pain.

Complementary and Alternative Medicine Pain Management Strategies— Participants in all focus groups used a wide variety of CAM pain management strategies, including approaches that align closely with CBPM techniques. The participants reported paying for chiropractic, acupuncture, and massage treatments, and receiving neurofeedback and physical therapy as part of their prescribed pain management treatments. They also relied on other strategies, such as distraction, diaphragmatic breathing, and guided imagery that they had developed themselves to help manage their pain. Although they had not been trained in these techniques, they were, in effect, using CBPM. Participants agreed that, when it was successful at controlling their chronic pain, CAM was preferable to pharmaceutical remedies.

> I've tried going to physical therapy, breathing, I'll try anything so I won't have to take the pain medicine. You know I've tried things if I can stand the pain. But I've tried different things like ask as much as I can—that's how I manage my [pain], if I can't I have no choice but to take the medicine but I'm all for trying different things.

Traditional Indian Medicine for Pain Management—Across the different focus groups, participants cited use of different traditional activities for pain management. These activities were all closely linked to prayer; while not every activity mentioned was connected to consultation with a traditional Indian medicine practitioner or medicine person, there was a strong sense of spirituality interwoven throughout this theme. Participants were descriptive in their use of traditional activities for distraction, coping, and for healing. Specific activities mentioned included drumming, traditional crafts such as beading and pottery, gathering and using traditional herbs, prayer, and working with a medicine person or traditional Indian medicine practitioner.

> I always pray, because I hear that's all I've been taught to [do] is pray. And I think that's part of the reason why I can tolerate as much pain as I can, because I can hear my elders telling me, pray. You know, when you get up and go in the morning, pray. They tell you, use all these things, and it works. I feel good when we have our traditionals [in the community] because those are the days I just go and can feel it. And it works for me.

The use of traditional Indian medicine, particularly when these activities included distraction through participation in traditional activities and guided visualization through prayer suggest that CBPM is culturally aligned with AI/AN healing practices.

Suggestions for Providers

When asked about suggestions for health care providers, study participants were generous in advice concerning improvement of care for AI/AN patients with chronic pain. They unanimously suggested that health care providers focus on careful and considerate communication with their AI/AN patients, with particular attention paid to cultural care in their communication style. Communication across systems and care coordination was also noted as an important area for care improvement. This theme was linked to the theme of empty promises and health care insufficiencies, as participants noted that frequent changes of medical staff limited their providers' ability to coordinate care.

> When I talk to one doctor, the next time I have to talk to another doctor. How often do we change doctors? It's like starting over and over again and not getting anywhere else. And I'm getting tired of it. I'm like a broken record up in the [clinic], same thing over and over.

Communication issues went beyond care coordination. Participants described the need to feel as if their providers listened and understood their pain complaints. They were dissatisfied with providers who had not taken the time to learn about their culture and those who were rushed or tried to apply a one-size-fits-all application to their pain complaints; this reinforced the feeling that the participants had not been listened to. They felt that cultural care encompassed careful listening and communication along with consideration of culture as part of treatment recommendations.

Participants in the Southwest focus group had an acute sense of funding barriers within the IHS that prevented comprehensive care. They observed that providers used funding limitations as a scapegoat for their inability to provide evidence-based care. As several participants repeated during the focus group, "Quit blaming it [inability to treat their pain] on funding." The participants perceived that they were not receiving evidence-based care, and didn't feel that funding barriers justified inadequate pain management. Their reports that health care providers stated that pain management decisions were based on funding, indicating that this group of participants were not satisfied with receiving excuses from their providers and wanted their providers instead to try different pain management strategies and keep funding issues out of the clinical conversation.

> They need to know that don't just bring you in and let you vent but sincerely have them listen to the individual, to the patient's complaints, and don't just brush them off with what was mentioned earlier expressing and sharing and going back again and again. I mean it should be noted they have the three strikes you're out. So three strikes, I mean, do something different. Get them [the patients] something, a different alternative. And quit blaming it on funding, that's what they [the doctors] all say.

Across all focus groups, participants expressed optimism in their efforts to achieve pain control, and they were supportive of each other in their shared struggle for chronic pain management. In addition, they were familiar with CAM strategies similar to CBPM techniques and saw these as a positive complement to their existing pain management efforts.

Discussion

The results of this study demonstrate the experience of undertreated chronic pain among AI/ANs in the U.S. Southwest and Pacific Northwest, the difficulty of managing chronic pain for these patients, and the many diverse ways in which AI/ANs seek out relief for their chronic pain. Participants in this study were similar to those reported in Kramer, Harker, and

Wong (2002). Kramer et al. report that urban AI/ANs with arthritis joint pain found nonsteroidal anti-inflammatory drugs ineffective for self-treating chronic pain is supported by the results from this study.

Communication and Pseudoaddiction

Participants desired clear communication with their health care providers. The Committee on Advancing Pain Research, Care, and Education reported in their 2011 IOM report that pain assessment and treatment will improve with comprehensive assessment and treatment. According to this same report, AI/ANs may be likely to downplay pain and level of dysfunction, which can contribute to undertreatment (IOM, 2011). The clinical conflict with chronic undertreatment of pain is the high potential of creating a population of patients with chronic pain who display pseudoaddictive behaviors. A patient with pseudoaddictive behaviors displays behavior similar to that of an addict seeking medication for recreational use, when the true cause is undertreated pain. Unfortunately, the false perception of addiction has the effect of perpetuating that same undertreatment that led to the initial suspicion of addiction, creating a feedback loop (Bell & Salmon, 2009). The results from this study suggest AI/ANs with chronic pain have difficulty receiving adequate pain management. With poor pain relief, the setting for pseudoaddictive behaviors is more likely, suggesting that erroneous perceptions of addiction by health care providers may be an issue for AI/ANs with chronic pain; this topic is worth further investigation.

Prayer, Traditional Activities, and Medicine

In their stories, the participants in this study referred to taking part in traditional activities as part of their pain management. Although not stated overtly, there was an understanding that participating in traditional activities provided healing, and that prayer and indigenous medicine are indistinguishable in these communities (Haozous et al., 2010). As context, participation in traditional activities is often seen by AI/ANs as prayer, so although an individual may, for example, be creating a beaded object, through the making of that object there is prayer infused into each stitch (Haozous & Knobf, 2013). In this manner, participation in traditional activities is a spiritual act and a form of ceremony that serves to distract attention from chronic pain.

In this same vein, ceremony is seen as healing, both to the individual and to the community. Within this context, distraction through participation in traditional activities may be seen as medicine within AI/AN communities, as is documented in the literature (Haozous & Knobf, 2013). Consistent with this research, a review by Jimenez et al. (2011) found multiple reports of AI/ANs managing pain through traditional healing modalities, including seeking treatment with a medicine man and using herbal remedies. This research provides evidence that CBPM strategies of diaphragmatic breathing, distraction, guided imagery or visualization, and goal setting are culturally acceptable and at times in alignment with existing traditional AI/AN strategies for coping and healing.

Limitations

This research involved focus groups of patients with chronic pain from multiple AI/AN communities, spanning a wide geographic region and representing a wide selection of

AI/AN populations. Limitations include the use of only one focus group at each site. To counter this limitation, the research team sought out member checking during the analysis period to verify research results. Another limitation was the differing recruitment approaches across the focus groups. Although convenience sampling was used in all the groups, a consistent recruitment approach would have strengthened the research. Finally, although the project sample represented groups from very different regions and tribal populations, there are more than 560 AI/AN tribes in the United States, and these results cannot be expected to be generalizable to all AI/ANs.

Implications

This research examined the experience of chronic pain and considered the potential suitability of CBPM in AI/AN communities residing in the U.S. Southwest and Pacific Northwest, finding CBPM an acceptable and appropriate accompaniment to pharmacologic treatment for chronic pain. AI/ANs participating in this study reported insufficient care in a health care system filled with empty promises; use of a wide variety of strategies for managing their pain, including integrative therapies; and desire for their individuality as tribal people and as people living with chronic pain to be honored. The participating AI/ANs also had specific suggestions for their providers, including clear communication, culturally congruent care, and a commitment to evidence-based care in spite of economic barriers. Based on these results, training for health care providers working with AI/AN patients with chronic pain should include CBPM strategies. Future research should investigate the efficacy of specific CBPM approaches in AI/AN people with chronic pain, and explore the feasibility of creating policy that mandates CBPM approaches as part of the treatment plan for chronic pain in health care centers that serve AI/ANs.

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Table 1

Interview Guide.

	Questions to guide focus groups on pain management for American Indians and Alaska Natives:
1	How do people in your community[a] describe pain/discomfort/distress?
2	How do people in your community express pain/discomfort/distress? Or, how do you know when someone in your community is experiencing pain/discomfort/distress?
3	What causes pain/discomfort/distress?
4	What do people in your community do to treat pain/discomfort/distress?
5	What do health care providers need to know about your community in order to better help treat community members who have pain/discomfort/distress?
6	Have you heard of ways to treat pain/discomfort/distress that your health care provider has not mentioned? If so, what are they?
7	Are there ways to treat pain/discomfort/distress that people in your community would like to know more about? If so, what are they?
8	Does your community have any stories about pain/discomfort/distress that you would like to share?
9	Any other suggestions or ideas?

[a] Based on previous experience conducting pain research with American Indians and Alaska Natives communities, the discussion of pain was not directed to the interviewees, but rather on a more abstract discussion of “people from your community” to avoid unintentionally bring the pain spirit on the person who was speaking.

Table 2

Pain Management Strategies Reported by Focus Group Participants.

Pain management strategies
Allopathic prescription medication
Ambien
Gabapentin
Hydrocodone
Hydrocortisone injections
Morphine/intravenous morphine
Hydrocortisone
“Pain pills”
Allopathic over-the-counter medications
Ibuprofen
Acetaminophen
Complementary and alternative medicine
Accepting the pain
Acupuncture
Cannabis
Chiropractic
Diaphragmatic breathing[a]
Distraction[a]
Exercise
Guided imagery[a]
Massage
Meditation[a]
Talk therapy
Physical therapy
Prayer
Sleep

[a] Cognitive behavioral pain management strategies.