

Exploring the Association between Religious Values and Communication about Pain Coping Strategies: A Case Study with Vietnamese Female Cancer Patients

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Abstract—This study explores the association between the values of dominant religions in Vietnam and the communication about pain coping strategies employed by Vietnamese women who have cancer. Data was collected by means of in-depth interviews with twenty-six Vietnamese female cancer patients. Content analysis was then utilised to describe and interpret the women’s pain talks. Participants proposed six religion-related pain coping strategies, including *accepting pain*, *bearing pain on one’s own*, *trying to change karma*, *being positive about pain*, *managing to forget pain* and *sharing pain when it becomes unbearable*. The findings reflected that the religious values of Confucianism and Buddhism are associated with the patients’ communication about the strategies they employed to cope with their pain. Moreover, the language of communicating pain coping could be mapped onto the categories of *passive language* and *active language*, within the religion framework. The research has thus also confirmed the role of language in the communication about pain experience.

Index Terms—pain coping strategies, religious values, Vietnamese culture, language of pain

I. INTRODUCTION

Amongst the cultural values that impact on pain communication, religion plays a particularly important role. Religion has been found to influence issues such as the quality of life, the communication about coping strategies and the mental health of those who undergo cancer treatment. Nonetheless, the available studies focus mainly on American, European, or South American samples with the predominant religions being Catholicism or Protestantism. In addition, most of these studies collected the data by means of a questionnaire, for example, the Intrinsic Religious Motivation Scale (Hoge, 1972). This study, which is part of a larger project of Vietnamese pain language, uses a qualitative methodology to explore the association between religious values and the communication about pain coping strategies employed by Vietnamese women who have cancer.

II. LITERATURE REVIEW

A. The Concept of Pain

As Livingston (1943) reasoned, any consideration of pain, by one approach alone, and without due regard for other potential approaches, is inherently incomplete. In fact, pain has been viewed as a whole phenomenon from either a physiological or psychological perspective (Livingston, 1943), in its biological and socio-cultural context (Zborowski, 1969), as a key biological, cultural and philosophical theme (Rey, 1998), or as a phenomenon characterised by physical, psychological and socio-cultural aspects (Lascaratou, 2007).

While several definitions of pain have been proposed, none of them has achieved complete acceptance. It is the diversity of the pain experience that explains why the definition of pain is controversial; this is also “a sign of the vigour, excitement and rapid development of the field” (Melzack & Wall, 1996, p. 46). The definition currently achieving consensus is Merskey’s (1964), which has been reworded by the International Association for the Study of Pain (IASP). Pain is defined as “[...] an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (Merskey & Bogduk, 1994, p. 250). It has been widely accepted that this definition views pain as a subjective bio-psycho-social phenomenon.

Since pain is a subjective phenomenon, the communication about pain may be associated with many factors, one of which may be the religious values that a person holds.

B. The Role of Religion in the Communication about Pain

Research has indicated that religion may have certain influence on people’s communication about pain. Within the religion framework, Keefe and his colleagues (2001) described pain coping strategies as either positive or negative. Specifically, positive religious strategies were things like believing that one’s life was part of a larger spiritual force, or

looking to God for support and guidance whereas negative religious strategies referred to beliefs such as God was punishing them or God was abandoning them for their sins. Research also reported that religious patients had lower levels of pain and less negative emotions (Shaw et al., 2007; Yates, Chalmer, James, Follansbee, & McKegey, 1981) and found it easier to accept pain (Bussing et al., 2009; Whitman, 2007).

Confucianism, Buddhism, and Taoism are three convergent religions in Vietnam and they are part of Vietnamese cultural heritage (Le, 2004; Tran, 1996). There have, thus far, been very few studies on the association between religious beliefs and the pain experienced by people with cancer in Vietnam.

In countries that have similar religious observances, however, some findings have been noted. For example, these religions have been reported as having a strong influence on the perceptions and interpretation of pain and the types of pain coping strategies adopted amongst Chinese people (Chen, Miaskowski, Dodd, & Pantilat, 2008). First, followers of Taoism believe that pain occurs if there is disharmony within one's body and/or between one's body and the universe; therefore, maintaining harmony within oneself and with the universe will help release pain (Chang, 2000; Chen et al., 2008). Second, Buddhist tenets see physical and psychic pain in birth, aging, sickness, and death; moreover, Buddhist teachings also see pain as an inseparable part of life and a defining characteristic of the human condition (Anderson, 1999; Chen, 2006; Tu, 1987). In Buddhism, pain is originated from people's craving and aversion; therefore, coping for the followers of Buddhism involves the transformation of one's craving and aversion in order to free oneself from all of life's troubles and sorrows (Chen, 2006). Buddhism emphasises that if one can endure pain calmly, then one can achieve higher states of being (Smith-Stoner, 2003), and that pain ends when one cultivates and practises the eight disciplines of right speech, right action, right living, right effort, right mindfulness, right meditation, right thought, and right understanding (see Chen, 2006). Finally, Confucians also regard pain as an essential element in life and one is no longer considered human if one loses the sensation of pain (Chen et al., 2008; Tu, 1971). Since the Confucian golden rule is that you should not do to others what you would not want others to do to you, people who practise Confucianism may derive comfort from people around but characteristically endure pain without reporting it until the pain becomes unbearable (Chen et al., 2008; Tu, 1971).

A recent study in Vietnam has explored the association between the dominant religions in Vietnam and the communication about the nature of pain by Vietnamese women who have cancer (Nguyen, 2018). The research revealed both non religion-related and religion-related explanations for suffering pain with the religion-related explanations being pain as fate and pain as karma. When the patients could not find a plausible explanation for why they had cancer pain, they blamed fate. Vietnamese people believe that Ông-Trời, a concept with varied meanings, one of which refers to Heaven, can determine people's fate, which is unchangeable, irrational, and unapproachable. That Ông-Trời determines people's fate is a common understanding in Vietnamese folk culture. This is, however, rooted from Confucianism which explains Ông-Trời's/Heaven's will ruling over people's lives. Karma, on the other hand, is originated from Buddhism, which generally refers to an action or deed resulting in the entire circle of cause and effect (Hoang, 2011). In Buddhism, karma specifically involves one's volition expressed in one's physical actions, words and intentions. In other words, karma itself is one's volition, producing the circle of cause and effect. Karma keeps developing until it produces outcomes under appropriate circumstances. Unlike fate, which is beyond one's control, karma is believed to be controllable and changeable. The Buddhist patients attributed the nature of their pain to karma, which they understood as their misconduct in their previous life and they were therefore suffering in the present life as a way to pay for it. As a result, the Vietnamese understanding of pain as fate and pain as karma reflected the association with Confucianism and Buddhism, respectively. A thorough examination of the two concepts of fate and karma has shown the high tension within the patients themselves: accepting that it is one's unchangeable fate to suffer pain while at the same time considering pain as karma that is changeable. Moreover, within the religion framework, the language of communicating the nature of pain could be divided into two main categories: passive language and active language. Nguyen's (2018) research has thus also confirmed the role of language in the communication about pain experience.

This paper extends Nguyen's (2018) research findings by discussing how dominant religions in Vietnam are associated with their communication about pain coping strategies. The research participants in the current study were also a group of Vietnamese women living with cancer.

III. RESEARCH METHODOLOGY

A. *Participants*

Participants of the current study included 26 Vietnamese women with cancer recruited from one large hospital in Vietnam which provides support for patients from different parts of the country. Eight of the women had breast cancer, four had lung cancer, four had cancer of the head and neck, two had ovarian cancer, two had lymphoma, and the remaining six women had cancer of the pancreas, stomach, thymus, gall, liver, and of an unidentified organ. The stages of cancer ranged from 2 to 4, with higher stages indicating more advanced disease. Eight women were at stage 4, twelve at stage 3, five at stage 2, and one was at an unidentified stage at the time of interview but kept complaining about her unrelenting pain.

The women's age ranged from 37 to 79 ($M = 53.42$; $SD = 10.19$). Cancer patients were selected to participate in the study because the cancer incidence in Vietnam has been increasing very quickly with growing mortality and pain is a

frequent concomitant of cancer as has been documented in a number of studies (e.g., Krakauer, Nguyen, Green, Le, & Luong, 2007; Le, Mizoue, & Yoshimura, 2002). Female patients were the focus of research so that rapport between the patients and the female researcher who conducted the interviews could be established.

Since Confucianism, Buddhism, and Taoism are three convergent religions and they are part of Vietnamese cultural heritage (Le, 2004; Tran, 1996), the researcher took the position that the values of these three religions are associated with the Vietnamese daily-life communication, to varying extents. With 53.85% of the Vietnamese cancer patients in the current research reporting practising Buddhism officially, it was expected that these patients would show their understanding into the teachings of the religion.

B. Data Collection Methods

Ethical approval for the study was obtained from both The University of Queensland Behavioural and Social Sciences Ethical Review Committee and the Research Committee at the hospital in Vietnam.

Data collection took place in nine months. The researcher was introduced to potential patients by one of the treating doctors in the hospital. Each of the twenty-six participants who agreed to take part was advised about the informed consent in both written and oral forms in Vietnamese. Permission was also obtained from the patients to record the conversation. All of the communication with the patients was in Vietnamese in order to facilitate their natural and free communication.

Semi-structured interviews were conducted with the patients about the pain coping strategies that they used. The researcher audio-recorded and took notes of the patients' responses to the interview questions.

C. Data Analysis Methods

The data analysis of this descriptive qualitative study was conducted in two phases. In the first phase, the data was transcribed and analysed following Patton's (2002) empirical phenomenological psychological approach. The chief investigator read the transcripts, broke them into meaning units, and ascribed descriptive labels to the units. These labels were then reorganised into themes of pain coping strategies. A second Vietnamese coder with similar educational background to the chief investigator was recruited to repeat the procedure of data analysis. The inter-rater reliability was 91.83%. The chief investigator and the second coder had a discussion to resolve the discrepancies; they explained how and why they coded the data differently. At the end of the discussion, they reached an agreement regarding those discrepancies. Finally, the data was translated into English by the chief investigator and checked by the other two investigators in the research team.

In the second phase, content analysis was employed both quantitatively and qualitatively. Qualitative content analysis involves "a second-level, interpretive analysis of the underlying deeper meaning of the data" whereas qualitative content analysis indicates the objective and descriptive account of the surface meaning of the data (Dörnyei, 2007, p. 246). In the current study, quantitative content analysis allowed the strategies of pain management to be presented using descriptive statistics. Qualitative content analysis was then employed to interpret the patients' pain talk in the light of the literature on pain and religion.

IV. FINDINGS AND DISCUSSION

All of the women reported that they were kind and generous, and that it was their nature to do good deeds whenever possible. Therefore, they felt heartbroken that they had developed cancer and were suffering pain. They questioned themselves about what they had done wrong. Some complained about why life did not treat them well and why Ông-Trời was so unfair and harsh to them by making them suffer cancer pain. They were mocking and doubtful about the value of being a kind person, as it had not protected them from suffering. They did not wish to think about ways to deal with pain. Nonetheless, the patients finally offered to report how they coped with pain, with the pain coping strategies being both religion-related and non-religion-related.

The non-religion-related strategies of pain coping occurred in 9 pain expressions, where the patients admitted using methods of pain relief such as taking palliative medicine (1) and (2), or doing physiotherapy (3). In these non-religion-related pain coping strategies, the patients were not passive, but actively attempting to control pain:

- (1) Khi chị đau hung quá thì uống thuốc-giảm-đau.
When sister-1st per.sing.pro. hurt cruel too much then drink palliative medicine.
When it hurts too much, I take palliative medicine.
- (2) Mỗi lần (cá chân) nhức là chích morphine thì mới đỡ đau.
Each time (the leg) ache then injection morphine I only less hurt.
Whenever my leg aches, only a morphine injection can help reduce pain.
- (3) (Mệ) đau (bụng) thì xoa-bóp dầu lên đó.
(Grandma-1st per.sing.pro.) hurt (stomach) then massage oil onto that.
When it hurts in my stomach, I massage the stomach with some treatment oil.

In the next sections, the religion-related strategies of pain coping occurred in either pain expressions or groups of sentences, and can be classified into six main themes. These six groups of strategies help them manage their pain, and are relevant to the religion-related nature of pain, including *pain as fate* and *pain as karma* (Nguyen, 2018). The

religion-related pain coping strategies were: accepting pain, trying to bear pain on one's own, trying to change karma, being positive about pain, managing to forget pain, and sharing pain with others when it becomes unbearable.

A. Accepting Pain

Pain acceptance is a relatively common reaction that is practised by patients with chronic pain (McCracken & Vowles, 2006). Research has shown that patients with higher scores of acceptance reported less pain and physical limitation; moreover, higher acceptance patients had slower growth rates of depression (Pinto-Gouveia, Costa, & Marôco, 2013).

In their fight against cancer, all the patients in the current study saw accepting pain as the best way to deal with their situation. They accepted pain because they considered pain as an inseparable part of their existence, as well as part of the circle of **sinh, lão, bệnh, tử** (*birth, aging, sickness, and death*) in human life, a belief originated from Buddhism, which defines pain as a characteristic of human life (Anderson, 1999; Chen et al. 2008; Chen, 2006; Conze, 2001; Tú, 1971, 1987). The fact that one can realise and understand that pain exists, and that *birth, aging, sickness, and death* involve suffering is the practice of *right thought* - one of the eight ways to end the path of pain, according to Buddhist teaching (Chen, 2006; Chen et al., 2008). In addition, the patients accepted pain because they thought they could not change their fate, which had already been determined by Ông-Trời (Heaven), a belief rooted in Confucianism (Chen, 1997; Lau, 1979; Nguyen, 2011). These patients' perception is also influenced by Confucianism in that people are no longer considered human beings if they lose the sensation of pain (Chen et al., 2008; Tu, 1971). For example, the woman in example (4) expressed her acceptance of pain, which is in keeping with the teachings of both Buddhism and Confucianism, reflected in her utilisation of '**sinh, lão, bệnh, tử**' (*birth, aging, sickness, and death*) and **ý Trời** (*It's Trời's will*), respectively:

(4) [...] **Mình đã sống trên này, mình có đau-đớn, cũng là chuyện bình-thường. 'Sinh, lão, bệnh, tử' mà. Hơn nữa, giờ đi đang đau ung-thư thể này, đó là ý Trời, d ì kh ông thể thay-đổi gì cả, phải chấp-nhận thôi.**

[...] *That we live in the present world means we are supposed to suffer. It's the circle of 'birth, aging, sickness, and death'. Moreover, now that I am suffering cancer pain, it is Trời's will, which I cannot change and which I have to accept.*

Zborowski (1969) regarded pain acceptance as the *willingness* to tolerate the pain sensation. However, he stressed that, people are reluctant to accept pain. In the current research, the patients knew that pain came as an absolute certainty, but it remained difficult for them to tolerate pain willingly. This explained their repeated use of phrases like **phải chấp-nhận thôi** and **phải chịu thôi** (*having to accept this*) in order to express their acceptance of pain in an unwilling manner:

(5) **Mình đau thì phải chịu thôi; cái số-kiếp bắt mình đau thì mình phải chấp-nhận thôi.**

I have to accept the fact that I suffer pain; suffering pain is my fate and I have to accept it.

In summary, the Vietnamese patients accepted pain, though unwillingly, as a pain coping strategy associated with the religious values of Confucianism and Buddhism.

B. Bearing Pain on One's Own

The acceptance of pain, which was practised by all the Vietnamese patients taking part in the interviews of the present study, has suggested a preference to bear pain on one's own. *Bearing pain on one's own* was a frequently practised strategy by the patients (n=21, 80.8%). The patients chose to keep silent, cry, or groan alone. They felt reluctant to let their families know that they were in pain, since they did not want to upset their families. In particular, one woman was concerned that her crying would badly influence her children, thus she kept trying to bear the pain until she could no longer. These patients emphasized that their pain was their own concern, and thus it was not good to make people other than themselves suffer. This reflected the association with Confucianism of which the golden rule, according to Tu (1971), is that you should not do to others what you would not want others to do to you. The most common phrases employed by the patients include **chịu** or **chịu-đựng** (*bearing [the pain]*), **im-lặng chịu-đựng** or **cẩn-răng chịu-đựng** (*bearing [the pain] in silence*), **cố-gắng chịu-đựng** (*trying to bear [the pain]*).

(6) **(Chị) đau vừa-phải thì ìn chịu được. Chị im-lặng chịu-đựng, kh ông la-h ót, r ên-rĩ, ph àn-n àn.**

If I suffer moderate pain, I can bear it. I endure in silence, without screaming, groaning, or complaining.

(7) **Như theo tư-tưởng của d ì nếu (d ì) có đau nữa thì ìn cũng cố-gắng chịu-đựng cho tới lúc trút hơi-thở cuối-cùng.**

In my philosophy, if I continue to suffer, I will try to bear the pain until the moment I die.

(8) **(D ì) đau có lúc là phải chảy nước-mắt nhưng mà phải cẩn-răng chịu-đựng.**

Sometimes it hurts so much that I move to tears but I have to bear the pain in silence.

(9) **Mà (d ì) đau cỡ nào ìn cũng cẩn-răng chịu được hết; ìn vượt-qua hết.**

I can bear the pain in silence to whatever extent it hurts; I can overcome all the pain.

These examples illustrate the patients' strength of will in trying to bear and overcome pain. However, according to what the Vietnamese health professionals revealed, this strategy was not considered effective from the health professionals' perspective, since the patients' effort to bear pain on their own may prevent the health professionals from providing more timely medical support.

Accepting pain and trying to bear pain on one's own, however, did not mean that the patients were passive. The women also proposed several other strategies that they used in an attempt to change the situation.

C. Trying to Change Karma

The patients who believed that cancer pain was their karma, a belief originating in Buddhism, said they were trying to change this bad karma by praying and doing more good deeds in their daily lives. In other words, these patients' view of pain as karma not only resulted in their acceptance of pain, but also gave them more hope and determination in cultivating themselves in order to reduce the effects of karma. As one woman reasoned:

(10) **Mình đau thì mình chấp-nhận. Nhưng mình muốn thay đổi. Mình không thể ngồi chờ chết được.**

I suffer pain and I accept it. But I want to make a change. I can't wait for the (agonizing) death to come.

The patients (n=13, 50%) said that they were trying to change karma by praying to Buddha, either at home or in hospital. As the patients claimed, praying helped them to concentrate their thoughts on Buddha and feel protected by Buddha. They were aware that Buddha could not terminate pain, but thinking about Buddha could bring them positive feelings, which helped them to reduce the pain, sleep well, and forget the pain, sadness, anger, and fear. The Buddhist patients also believed that their practice of praying could eventually help change their karma in a positive way, so that they would not have to suffer agonizing pain before they died. Some patients also believed that their practice of praying would help them to have a better next life, as well as prevent their family from suffering cancer pain:

(11) **(Đi) đau thì đi niệm Phật. Niệm Phật làm mình quên đi đau-đớn. Nghĩ về đức Phật mà cái đầu mình cứ lâng-lâng, rồi ngủ thiếp đi.**

When I suffer pain, I pray to Buddha. Praying helps me forget the pain. Thinking about Buddha makes me feel comfortable, and fall into sleep easily.

(12) **(Mẹ) đau thì chỉ c ó niệm Phật thôi. Niệm Phật để đức Phật gia-hộ cho mình, để mình bớt đau. Để khi chết không phải chịu đau-đớn.**

When I suffer pain, I keep praying to Buddha. I pray so that Buddha would support me and help me, so that I would suffer less, so that I wouldn't have to suffer pain before I die.

(13) **Lúc-nào đau thì đi chỉ biết niệm Phật chứ biết làm gì nữa. Niệm Phật để quên đi đau-đớn, cầu-mong cho kiếp sau không phải đau-đớn thế này, cầu-mong cho người-thân của mình không phải đau-đớn như mình.**

Whenever I suffer pain, the only thing that I can do is pray to Buddha. Praying helps me forget pain. I also pray for my next life not having to suffer. I also pray for my family not having to suffer like me.

These patients were trying to bring about some change to their current state of suffering. They resorted to praying to Buddha, which they believed would help change their karma. Praying to Buddha and concentrating their thought on Buddha so that they could forget pain is the practice of *single-minded concentration* – one of the eight right ways in Buddhism to free people from pain, as discussed by Chen (2006) and Chen et al. (2008).

D. Being Positive about Pain

Half of the patients (n=13), who claimed to practise Buddhism as their formal religious affiliation, chose to be positive as a way of coping. They contended that being optimistic, cheerful, and patient enabled them to feel more hopeful about the future. As a result, these patients, when in pain, were still able to face pain, accept it, and try to cope with it. In particular, one patient stressed her good fortune in still being alive after fighting the cancer for more than five years. She reasoned that her optimism and her family's great support gave her strength to survive pain:

(14) **Mỗi-khi chị lên cơn-đau, chị lại nghĩ rồi cơn-đau sẽ đi qua, sẽ nhanh thôi, nên chị cũng không thấy đau nhiều. Rồi gia-đình mình đang ở đây với mình. Chị lại thấy như có thêm sức-mạnh để vượt-qua.**

Whenever I have pain, I think the pain will go away, it will go away soon, so I don't feel hurt much. Moreover, my family is here. I feel like I am given more strength to overcome the pain.

Although the patients did not specifically state how Buddhism was related to their being positive about pain, the practice of thinking about pain positively can be understood as making *right efforts* in the Buddhist framework of values. Practising *right efforts* helps to conquer the evil side and promote the good side of a phenomenon (Chen, 2006; Chen et al., 2008). When the patients practised *right efforts* by being positive about pain, they could conquer the depression caused by pain as well as gain more strength to face and bear the pain. The coping strategy of being positive about pain is therefore associated with Buddhist ideals.

E. Managing to Forget Pain

About a third of the women (n=9, 34.6%), all of whom claimed to practise Buddhism, managed to refrain from thinking about pain by concentrating on other things such as practising breathing, taking a walk, talking to others, or even doing household chores. For example, a woman described how she was coping with pain as follows:

(15) **Khi đi tập trung vào hơi-thở, đi thấy dễ-chịu hơn. Khi đi nhắm mắt lại, đi thấy mình đang dõi theo hơi-thở của mình. Những lúc đó, đi không nghĩ về cơn-đau nữa.**

I feel more comfortable when concentrating on my breath. When I close my eyes, I see myself watching my breath. I don't think about the pain then.

(16) **Ban-đêm, mỗi khi chị đau là chị đi tới đi lui. Đi hoài vậy cũng làm mình quên cơn-đau đi.**

At night, when I have pain, I keep walking back and forth. Walking helps me to forget the pain.

These patients actually practised *single-minded concentration*, where their mind focused on one particular subject (e.g., their breath, their walking, their conversation with others, or the household chores) so that they could ignore pain. *Single-minded concentration* was also practised by those praying to Buddha and thinking about Buddha in order to forget the pain. The Buddhists believed that *single-minded concentration* would lead them to peace (Chen, 2006; Chen et al., 2008) and that the right path to relieving pain was to develop a disinterested attitude toward it (Tu, 1980). As a result, it can be said the Buddhist teaching of how to free people from pain was reflected in the Vietnamese patients' discourse, concerning their proposing to cope with pain by managing to forget it.

F. Sharing Pain When It Becomes Unbearable

It is considered inappropriate for Vietnamese subjects of this study to follow the typically Western practice of communicating one's pain or misfortunes with others in order to "share the burden". One should rather respect the calm good feelings of others and of the group. However, when the pain became unbearable, over half of the patients (n=15, 57.7%) reported revealing and sharing pain by screaming, crying, talking to, or seeking help from their family, and by consulting healthcare professionals. In these cases, language plays a useful role in the patients' expressions of pain:

(17) **Tui đau mà chịu không nổi. (Tui) đau mà la mà hét um sùm. Thì cũng phải khóc, phải hét, phải la thối. Cũng đỡ được phần nào.**

I suffered pain to an unbearable extent. It hurt so much that I screamed and yelled noisily. I felt the need to cry, scream, and yell. I felt a little better (after crying, screaming, and yelling.)

These patients maintained that they preferred bearing the pain on their own, but they had to share it when the pain overwhelmed them. This strategy, therefore, still corresponds to Confucian teaching since it showed that the patients had a deep concern for the others' feelings.

Amongst the six pain coping strategies, "accepting pain" (100%), "bearing pain on one's own" (80.8%), and "sharing pain with others when it becomes unbearable" (57.7%) were employed the most. As the discussion suggests, the first strategy corresponded to philosophies of both Confucianism and Buddhism, whereas the other two were Confucian. Moreover, "trying to change karma" (50%), "being positive about pain" (50%), and "managing to forget pain" (34.6%) were examples of the patients' practice of Buddhist teachings.

In general, the coping strategies all demonstrated the patients' struggle: finding it difficult to accept pain, accepting pain, bearing pain on one's own, and then looking for ways to fight against it. The strategies also implied that accepting pain and bearing pain on one's own did not necessarily mean being passive. Each patient was indeed active and developed multiple pain coping strategies.

Although "trying to change karma", "thinking about pain positively", and "managing to forget pain" were strategies corresponding to the Buddhist teachings, it cannot be denied that the patients employed these strategies to manage pain on their own. This implied the patients' reluctance to share pain with others and their endeavour to minimise the effect of their pain on others. The intertwining of Confucianism and Buddhism therefore could be seen in the patients' practice of these three strategies.

In addition, particular patterns of language used for the patients' communication about the pain coping strategies could be mapped closely on to aspects of religions. Within the religion framework, the language of communicating pain coping can be divided into two main categories: *passive language* and *active language*. *Passive language* refers to words, phrases, and sentences indicating the patients' accepting pain and bearing pain because what is associated with pain is uncontrollable (e.g.; *I suffer pain and I have to accept this; I can't change anything; I have to bear the pain, etc.*), whereas *active language* expresses the patients' attempt to control pain (e.g., *I want to make a change; I pray so that Buddha would support me and help me; I pray so that I would suffer less, etc.*).

V. CONCLUSIONS AND IMPLICATIONS

The findings describe the association between the religious values of Confucianism and Buddhism and the patients' communication about the strategies they used to cope with their pain. Confucianism was expressed in the patients' considering and accepting pain as their fate, in their common tendency to manage pain on their own, and finally in their sharing pain with others when they could not bear it for themselves any longer. Buddhism was revealed in the patients' practice of the right ways to release pain such as accepting pain as a part of their lives, striving to change their karma, being positive about pain, and managing to forget pain.

The findings in the current study correspond to Nguyen (2018) in that Confucianism and Buddhism were a central part of the Vietnamese patients' socio-cultural life when the patients' communication about pain coping is also associated with Confucianism and Buddhism. Moreover, the patients' ways to cope with pain indicated their understanding of pain as fate and as karma, two popular religion-related explanations for the nature of pain, as confirmed by Nguyen (2018). The findings also match Nguyen (2018) in that Taoism which stresses the harmony within one's body and/or between one's body and the universe (Chang, 2000; Chen et al., 2008), did not show to be influential in the way the Vietnamese women initiated pain coping strategies, although Taoism, Confucianism, and Buddhism are considered as three convergent religions with a common nature and origin, thus being regarded as a philosophical foundation of Vietnamese culture (Le, 2004; Tran, 1996).

Similar to Nguyen (2018), the findings support the available literature about the role of religion/spirituality, particularly that of Confucianism and Buddhism on people's communication about pain. The findings also help to extend the literature in terms of how religious values and communication about pain coping are related in Vietnamese culture. In addition, this study shows how patterns of language are mapped onto aspects of religions, including passive language and active language. The role of language has therefore been confirmed in the communication about pain coping.

The study has emphasized the association between religion and how Vietnamese women with cancer pain communicate the strategies they use to cope. While these findings come from one qualitative study, they raise the importance of a factor hitherto not routinely considered by health professionals. The findings suggest the value of health professionals' equipping themselves with knowledge about the patients' religion, for example, by attending custom-designed workshops (Meredith, Murray, Wilson, Mitchell, & Hutch, 2012) as this may assist them in learning how to listen to pain talk as an expression of religious belief, thus understanding how their patients perceive pain and decide upon certain strategies to cope. Moreover, knowledge about the patients' religion may facilitate the health professionals' development of trust and rapport with patients, which makes the difficult journey of fighting cancer pain more tolerable (Mitchell, Murray, Wilson, Hutch, & Meredith, 2010). For example, health professionals can encourage the patients to seek support from their religious community and to employ more frequently the strategies that the patients find useful. More importantly, if they develop a relationship of trust with the patients, health professionals can encourage them to share pain more easily in order to provide timely medical support. Although sharing pain might be considered inappropriate in the Vietnamese cultural context, the relationship of trust between health professionals and patients would help the patients come to understand that health professionals are willing to help them and that their sharing of pain is not a burden to others.

Given that most healthcare professionals are substantially unaware of the power of language in shaping their thoughts and understanding of their work (Loftus, 2011), the study contributes to Vietnamese healthcare professionals' understanding of how the patients communicate about their pain experience using language. The study has also established a foundation for Vietnamese applied linguists who wish to explore the language of pain, a new domain of applied linguistics extending beyond education to areas such as health, therapy, and counseling.

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