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A qualitative exploration of cognitive and sociocultural influences on postoperative pain among urological patients in Ghana

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ABSTRACT

Background: Patients ascribe diverse meanings to postoperative pain (POP), usually based on personal beliefs. However, patients' perceptions about the causes of pain are usually influenced by their traditional beliefs and misconceptions, and cultural factors such as ethnic background serve as barriers to effective pain control. The study sought to explore the cognitive and sociocultural aspects of postoperative pain experience after urological surgeries.

Methods: The study employed exploratory descriptive qualitative research design. Twelve male participants who had undergone urological surgery in a teaching hospital were recruited using purposive sampling. Data were collected through individual face-to-face in-depth interviews, conducted in English and Akan languages. The interviews were audio-taped and transcribed verbatim. Ethical considerations such as informed consent, anonymity, and confidentiality were ensured. Concurrent data analysis was done engaging the processes of content analysis.

Findings: Cognitive aspects of the POP revealed three themes; the knowledge of the pain, attitude, and beliefs of the patients, and meanings the patients ascribed to the pain. Similarly, sociocultural aspects revealed two emerging themes; the family dynamics and roles influencing pain experience, and individual cultural background and belief systems. The participants' diverse views and experiences influenced their pain expression and experience after urological surgery.

Conclusions: Postoperative pain is a multidimensional experience and includes socio-cultural and cognitive aspects. Therefore, contemporary pain management strategies should focus on client-centered and culturally sensitive interventions.

1. Introduction

Postoperative pain (POP) is a very common and acute symptom resulting from surgical procedures or trauma to the tissues (Muhawenayo, 2017, Dalal & Bruera, 2012). Globally, 30–70% of patients experience moderate to severe POP depending on the type of surgery done (Muhawenayo, 2017; Wolf et al., 2014). Postoperative pain is presented as a multidimensional and subjective experience due to differences in pain threshold and ways of expression among individuals (Dalal & Bruera, 2012). Effectively managing POP positively influences the immune system and wound healing; resulting in early mobilization after surgery and discharge from the hospital (Hartwig, 2016; Ofori, 2016; Muhawenayo, 2017).

Clients who have undergone urological surgery experience two main forms of pain: incisional pain and/or discomfort and pain from bladder spasms, urethral irritation, and bladder distension (Aloweni et al. 2008; Belanger & VerLee, 2016; Merkel et al., 2015). In urology, some procedures which are either diagnostic or therapeutic such as urethral catheterization or dilation tend to inflict pain (Belanger & VerLee, 2016).

Though diverse pain scales have been developed to assess, analyze, and evaluate pain, there is a call for cultural-specific pain scales (Aziato & Adejumo, 2015a, 2015b; Machado-Alba et al., 2013). Pain assessment and control require the healthcare providers to be acquainted with patients' level of understanding, perceptions, previous experiences/knowledge, meaning ascribed to the pain, attitudes, and beliefs

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associated with the pain (Muhawenayo, 2017).

Patients ascribed different meanings to pain, mostly based on their personal beliefs (Ahles & Martin, 1992). However, causes of pain as perceived by patients is usually influenced by their traditional beliefs and misconceptions (Baker et al., 2014; Turner et al., 2017), serving as barriers to effective pain control (Cogan et al., 2014; Mavridou et al., 2017). Thus, formal knowledge will positively influence the pain experience by reducing the pain intensity, anxiety before surgery, also improving post-operative recovery as well as patient's satisfaction and sense of security and reliability (Aloweni et al., 2008; Mavridou et al., 2017).

The socio-cultural aspect of the pain experience includes cultural factors such as demographic characteristics, ethnicity, and family support (Crombez et al., 2013; Dunham et al., 2013). There are individual differences in the way patients' especially men seek help as well as their awareness of pain and subsequent treatment response. These differences are due to their understanding and considerations of indications of diseases /conditions across communities and nations (King-Okoye et al., 2017; Wool & Mor, 2005). Aziato and Adejumo (2014a, 2014b) revealed that one's culture is modified by the socialization process an individual is exposed to, this also influences their pain expression and intervention even for adults (Kwok & Bhuvanakrishna, 2014; Issahaku, 2018).

Family predetermined concepts of pain tend to influence the individual's concepts of pain (Pasero & McCaffery, 2011). The past experience of pain, feelings, thoughts, and sensations were identified to influence pain expression among postoperative patients (Issahaku, 2018). Therefore, this paper seeks to explore the cognitive and sociocultural aspects of pain experience after urological surgeries.

2. Methods

2.1. Design and setting

The study employed the exploratory descriptive qualitative approach to enable a comprehensive understanding of the sociocultural and cognitive experiences of post-operative pain of urological patients. This allowed an in-depth exploration of the phenomenon in the Ghanaian context. The study was conducted in a tertiary hospital in Accra. The hospital serves as a referral point where clients are admitted every week for urological surgeries. The facility through the Genito-urinary (GU) unit and surgical clinic served as an avenue for recruiting the participants.

2.2. Sample and recruitment

The study participants involved male patients above 18 years who had urological surgery at the facility, who gave their informed consent. Participants were all discharged home and recruited individually 14 to 90 days after surgery. The study employed the purposive sampling technique, excluding men still experiencing the post-operation pain of 4 and above on the NRS.

2.3. Data collection procedure

The study data focused on individual in-depth interviews of the participants conducted with the aid of a semi-structured guide, lasting between 40 and 65 min. The interview guide had open-ended questions and probes. The interviews were conducted in an open location, comfortable to the participants after a consent form explaining the details of the study were provided to seek their permission. Also, permission was sought to audio-tape the interviews with a digital voice recorder, which was conducted in three (3) Ghanaian languages; Twi, Fante, and English however, Twi was most preferred. It was endeavoured to avoid leading questions and encourage the participants to freely express themselves, beginning with clients' demographic data. Field notes on non-verbal cues and comments were also taken, participants were assured of anonymity and confidentiality, as well as their right to voluntarily participate and withdraw. Identification codes including M1 to M12 were used to represent the individual participant. Twelve participants were involved in the study because the saturation of data occurred as there was no new information generated.

Individual interview data were transcribed by the first author and the transcripts assigned the appropriate identification codes. Twi and Fante interviews were transcribed into English and those conducted in English were transcribed verbatim. Participants and other colleagues fluent in both languages reviewed the transcripts of the Twi and Fante audio data.

2.4. Data analysis

Concurrent data collection, audio transcription, and data analysis ensued, in addition to the field notes taken. A repeated read-through of the transcripts and field notes followed, to identify themes, follow-up on these themes emerging were done doing subsequent data collection. The steps of Braun and Clarke (2006) thematic content analysis were manually used to analyse the data. Therefore, the analysis began with repeated reading through data, generation of initial codes, themes, and sub-themes were searched and reviewed, themes were then defined and named with the production of a final report.

2.5. Rigour

Trustworthiness or Rigor qualitative research focuses on demonstrating the true value and allow for external judgments to be made about the consistency of its procedures and the neutrality of its findings (Lincoln & Guba, 1985; Siegle, 2017). The principles applied in this study involved the member check approach; the transcribed data was discussed with the participants to make clarifications if necessary and ascertain the true information given. Peer and supervisor examinations were another method used to achieve the credibility of the finding. A comprehensive account of the study was provided to guide another researcher to apply or determine the ability to transfer the findings to another setting. To achieve consistency, the same interview guide will be used to interview all the participants.

2.6. Ethical considerations

Ethical clearance and approvals were obtained from the Noguchi Memorial Institute for Medical Research (NMIMR – IRB 00001276) of the University of Ghana, Legon, and the Teaching Hospital's research review board. Participants' informed consent was sought for the study, providing full and open information on the scope of study, disadvantages, and obligations involved. The consent forms were signed, and permission was obtained to record interviews. They were also reminded of their voluntary participation and ability to withdraw at any point in the study. Anonymity and confidentiality were also ensured, therefore participants were assigned personal identification codes (M1-M12). The rights, safety, and protection of the participants were important and secured, as the signed consent forms, audiotapes, field notes, and typed transcripts are kept confidential after the study.

3. Results

3.1. Participants demographic data

The twelve (12) participants involved in the study were all Ghanaian male post-operative urology patients. They were aged between 59 and 82 years and had the symptoms of the prostate condition within a duration of a few months to 15 years before undergoing the surgical intervention. They were Christians from a different ethnic background, have had some level of formal education and all married with 3 widowed. Most of the participants were retired and a few with part-time jobs. A total of two (2) main themes with accompanying seven (7)

subthemes emerged from the study data. The themes include the Sociocultural dimension of POP and the Cognitive dimension of POP. The study findings are presented below and laced with verbatim quotes of the participants.

3.2. Sociocultural dimension of POP

This theme described the sociocultural aspects of the POP experienced by the participants after the urological surgery. It acknowledges the individuality of the patients and the diversity in their upbringing, as well as belief systems and role relations, played in influencing their pain expression and experience. The subthemes: the participant's cultural background and belief system; and Family dynamics and roles were further explored and described.

3.3. Cultural background and belief systems

Most of the participants were brought up in the typical Ghanaian traditional/ village setting, where pain management focused mainly on traditional herbal treatment with a relation practising as a herbalist:

"My maternal grandmother was well vexed in herbs, especially for petty treatment for cuts, burns, etc … Well in the village there was no hospital, I was born and trained in a typical Ghanaian village" – M3

"Previously one thing is that my grandfather was an herbalist and when we were young when they prepare foods, we had some herbs that were put inside… In the morning when we wake up, in the olden days they boil the herbs- leaves and they gave us that as tea instead" – M7

However, others believed that family unity and upbringing which involved children in their activities helped individuals to accept and handle pain:

"Normally, we have gone through doing chores which today they call child labour … parents, of course, let say mother and grandmother help you to relieve pain or overcome it over time" – M6

Other participants also expressed certain views based on their culture, which influenced their perception and reactions to life events. Such as adultery committed in the past can result in death during the painful periods and presenting negative complains whilst on admission discourage clinicians in providing quality care:

"Hmmm even that day, I said that if you are a man and you do bad things especially you have been sleeping with your someone wife as I will die, I swear" – M2

"My father told me something before he died in 1981 … He said when you are on admission and always have complaints doing doctor rounds, you will be left to die. You know you are not fine but you say I am very fine. Then they tend to give you more medication and you recover" – M3

3.4. Family dynamics and roles

Some of the participants endured the pain and kept their experiences to themselves. This was perceived as a personal habit and not related to their family influence:

"…it has nothing to do with culture or my upbringing. It seems am someone who tries to keep things within himself so that why I say when the thing has become unbearable that is where you will know that something is happening to me." – M4

"I can really endure pain, for someone when they get a cut and feel the pain then they start shouting as for me I am not like that 'shakes head'. When I was admitted those also there when they are in pain then they begin to shout, I didn't do that at all" – M8

According to other participants, they learnt to endure pain and avoid expressing it based on their strict upbringing from a disciplined parent:

"My late dad was military personnel so you can imagine. Military personnel at the same time a headteacher and catechist. If you can stay with him for a lengthy period then you are a champion" – M5

"not the way they treated me, but we were told to keep mute on issues because it is not everything you see and talk about it" – M10

A few participants noted the differences in expression of emotions and pain among their siblings citing their birth positions and dynamics as factors in enduring pain:

"Heheee I was born into a family of 11, 10 boys and a lady … So, all my life, boys, boys you have to maintain your posture and composure as a man. Whether you are feeling the pain, you have to 'squeeze your face" – M1

"I didn't really express it because I don't have anyone to talk to and it's my individual thing, not my community. I was born the only male to my mother and I strive to make it in life early enough to care for my mum" – M12

The participants recognized that their family caregivers were very supportive during the painful periods. Thus, the caregivers felt and understood their pain even much more than expected:

"….let me talk about my cousin who has been very helpful to me through this surgery and also my wife, they have both helped me a lot, he has gone through different types of surgery, so he understands it" – M5

"they were rather feeling for me more than I felt for myself, because if am doing something they say 'take it easy' but I don't feel anything. They will be far away looking at me and feeling bad' – M4

Cognitive dimension of POP

This theme constitutes the meaning the patients/participants ascribed to the pain felt after surgery, their attitudes and beliefs elicited, cognitive and behavioural coping strategies employed, and knowledge received concerning the pain. The above components comprise the five (5) subthemes that emerged.

Meaning of pain

The pain was understood as normal and expected by most of the participants, some related it to the surgical procedure or incisional cut received.

"It's just normal you know human being, I have been cut with the knife so normally there will be some pain, not any excruciating pain at all … It's not like giving birth"- M1

"It is expected, specific to pain after the surgery … I didn't know how long it was going to last because there is a mark (cut) that had to heal and I know that my bladder too was opened so they could remove something from it."- M6

However, the POP was also linked to the reducing efficacy of pain medications administered during the surgical procedure or a probable complication of the surgery:

"oh well I have never done an operation before so I thought it was a complication of the operation since this is the first, I have done. Hmmm so I thought that when you do the operation you will never be the same as before" – M9

The pain felt during urination or defecation after the surgery was interpreted by some of the participants to occur because of straining. The severe and burning pain also explained as due to the warmth or alkaline nature of the urine:

"It is really painful when you have been advised not to strain too because it is a fresh wound after surgery, sometimes clots are within thus blocks the catheter. 'aaah Jesus', you feel like urinating and it is not flowing so you are forcing it – M5

"Actually, after the surgery, I was in pain even when the urine passes through the catheter. But as long as you are human you will experience pain, especially when the warm and salty urine was to flow through the catheter" – M11

3.5. Attitude and beliefs

According to the majority of the participants, the pain was not due to spiritual attacks even though the attribution to spirituality was held and suggested by some relatives.

"A spiritual attack? No no, since when the sickness started and they passed urethral catheter for me, here too they pass catheter oh. I was admitted to the ward and I saw a lot of people there too. So, knew I wasn't alone." – M8
"Even my family people were suggesting it might be spiritual since am a 'family head', let us seek treatment somewhere else but all my life I don't believe that. I just tell them it is just the condition and it might be my time" – M12

Likewise, other participants exhibited trust in the competence of healthcare service providers thus the pain was not perceived to result from surgical complications:

"I didn't think something serious was happening, so, I saw the pain as normal … the reason why I say I don't think like that because I know that doctor, they say he is a specialist" – M2

However, all the participants were Christians rather entrusted their hope in God throughout the surgical and postoperative periods. Most of them believed God for their healing:

"No attack will succeed because I follow God's laws, so His angels are protecting me … I told you earlier that I was a policeman but now I am a Christian, with God all things are possible" – M3
"I just plead for God to heal me since he is the healer since I am really suffering from too much pain. I didn't think of other things because I knew the pain is because of the condition" – M12

3.6. Knowledge of pain

This sub-theme focuses on the information the participants received on postoperative pain, the disease, and surgery. Only one participant received information on pain and the disease before the surgery:

"yes, the pain was mentioned. The doctor said one needs courage before doing the thing so in such cases I need patience with the sickness. Ooh, they said prostate has enlarged at my lower abdomen" – M8

However, based on the lack of pain information before surgery; most participants perceived that the healthcare providers avoided discussion on pain to avoid putting fear in them:

"no but as long as they cut you as a human you will feel pain, if they discuss pain then you will be scared then and the person might change his mind and not give the consent" – M11
"You know before the operation I was saying I was lectured on at the clinic so I knew something, they didn't touch on pain at all, if you touch on pain there then the patient will run away, eeeeh" – M1

Notably, five (5) participants received some information on pain after the surgery. The information on pain and coping styles were mostly provided by doctors:

"eerrh Dr. A. spoke to me about the pain, she advised me on deep breaths and sort of things you see, so I was able to cope with pain … she sometimes comes to me because we speak the same language so we talk about those things" – M5

However, other participants who did not receive education on POP from the health workers resorted to bits of information shared by other patients who had a similar experience. Others based on the knowledge from previous surgeries:

"I talked to other patients and they said oh it is like I woman who has gone to deliver so it takes like 3 to 6 months before you would yeah. I didn't have any idea as to how long for it will take to heal I rationalised it" – M6
"Hmmm I have done so many surgeries oh… So, I just make them normal, so I am not afraid of surgeries at all. I have been cut here once and down there twice, the first one was the fistula and the second one was the varicocelectomy" – M1

Prior information on details of the surgical procedure including the risk involved and activities to aid healing was however received by some participants:

"Also, the doctor that operated on me was a female and she informed me afterward that I should be exercising my legs on the bed … I was informed to move and not to sleep at one place with my urine bowl which aids in the healing" – M10

In contrast, other participants bemoaned the scanty information on the surgical procedure which were needed to help clear their doubts:

"*All I learnt are those things from my folder, if I hadn't been that educated am not sure I would have been told. Rather, when I had signed the consent form for the surgery, then a young man asked me do I know what is going to happen to me and I said yes, an open prostatectomy and cysto – something" – M6*

3.7. Cognitive coping techniques

These involved the psychological strategies employed by the participants to endure, ignore, or distract themselves from the pain experienced. Some participants chose to endure the pain without showing any outward signs:

"I try to keep it to myself unless it is unbearable before somebody will know, that is if it is beyond me" – M4
"I crack 'jokes with them even when I was in pain, I tried to contain it … so I was able to cope with my situation. Everyone and their level of pain threshold" – M5

Other participants chose to ignore the post-operative pain or avoid thinking about it in other to cope with it:

"I was not thinking of anything ha-ha, I knew the medication was taking care of the pains, me it's like you see I knew that there will be pain anyway" – M1

Additionally, other participants preferred distraction techniques such as; reading the bible, watching TV, writing of notes, and listening to music/radio:

"… but you see what I normally do at night is that I have my phone radio on so I chose to focus on that other than think about the pain because it was quite severe … but since I came home I listen to the radio, watch TV, read or get occupied one way or the other on the computer"- m6
"oh me if I am in pain, I use to take my bible to read so that I concentrate on the words I am reading so that I don't think about the pain" – m10

However, some of the participants could not achieve the desired distraction even with the techniques mentioned above; due to the severity of the pain and the associated discomfort:

"…I wasn't even listening to music, I was just, I try to close my ears because the pain was too much"- M5, M2

3.8. Behavioural coping techniques

These are the physical activities done to cope with their pain; such as praying, sleeping, and pacing about. However, some participants tend to

reduce their movement and preferred to lay still in bed:

"I try to remain station at one place, not to move so lying at my back all the time, that relieve me a lot from the pain even though I would have loved to turn, I sleep mostly on my side but because I was forced to …" – M1, M2

Whereas some chose to lie down and reduce activities to help relieve the pain, a participant said post-operative pain was relieved with sleep:

"To be frank with you, the pain after a while subsides on its own and when I feel severe pain n I doze off, by the time I wake up I am relieved" – M3

However, some participants employed worship and singing to their supreme being during their post-operative pain periods:

"Quietly, when the pain is severe I don't move anything oh, I just lie still on my bed just praying or singing for God to intervene" – M2, M3, M10

Non-strenuous ambulation or strolling when pain is unbearable was another strategy employed by some participants to cope with their pain. These were however usually encouraged by the health workers:

"yes, after the third day the doctor will come to urge and advise you to try to start walking around bit by bit, gradually to help with the pain" – M5
"so far since I went back home, I have only been doing a little walking without straining, it helps" – M6

Few participants had the prescribed pain medications administered upon reporting the pain, which usually becomes bearable afterward:

"On admission, I only report to them when I feel the pain, they prescribed drugs for me to take. I could not do anything else" – M6

4. Discussion

The findings from the study were predominantly consistent with previous studies in the literature. The participants in this study had prostate surgery were all elderly men and mostly retired from active work, with an average age of 70 years. Similarly, Prostate conditions such as benign prostatic hyperplasia (BPH) occur among elderly men over the age of 60 years and currently common with the aging population in most countries (Alaali & Irwin, 2015; Fitzmaurice et al., 2015). Also, the patients were exposed to formal education which might have influenced their understanding and management of the POP (Baker et al. 2014). They reported the POP as expected and normal, linking to individual beliefs and appreciation of the surgical process (Ahles & Martin, 1992). The pain was therefore not attributed to any spiritual attacks, worsening disease, or surgery failure. Thus, formal education appears to serve as a precondition in participants' appreciation of the pain experienced and the care received. Misconceptions and traditional beliefs also influence patients' appreciation of the causes of the pain experienced, serving as a barrier to effective pain control (Baker et al., 2014; Cogan et al., 2014; Turner et al., 2017).

Subsequently, the individuality of the study participants and the diversity in their upbringing about the cultural background and belief systems influence their pain expression and experience. This view is supported by Ahles and Martin (1992), which establishes that there are ethnic-based individual responses to pain, as pain tends to affect one's social relationships and quality of life. Similarly, in a previous ethnographic study by Aziato and Adejumo (2015b) revealed that pain response and experience is usually influenced by their socio-cultural context. Most participants had the traditional upbringing which relied heavily on herbal management of pain and ailments. They were encouraged to acknowledge pain based on the diverse cultural views instilled into them during their upbringing. This confirmed the findings of previous findings which noted that differences in pain experience and response are based on one's understanding of indications of diseases across communities and nations, influenced by the availability of healthcare services (King-Okoye et al., 2017). Thus, a participant was of the view that the family believed that one must sound positive in presenting complaints to a doctor, so not to irritate or dishearten their care provision. In accordance, other studies viewed the interpersonal relationship between patients and clinical staff as well as spirituality and purpose of life as factors that can impact one's cultural influence on pain beliefs and health-seeking behaviour (Aziato and Adejumo, 2014a, 2014b, 2015b; King-Okoye et al., 2017; Kwok & Bhuvanakrishna, 2014; Schreiber, 2014). Thus, measures implemented to improve ones' quality of life may not be limited to ensuring a decline in pain interference and intensity; and pain education. Because other factors involved other than pain may influence ones' consciousness of quality of life.

Other participants preferred to endure the POP rather than report to the healthcare givers. This, they believed is an individual conviction not necessarily as a result of their upbringing. Aziato and Adejumo (2015b) reported that based on personal inclinations some patients preferred to endure their pain experiences and probably report when the pain severe; as opposed to the influence of their cultural background (Kwok & Bhuvanakrishna, 2014). This attitude can be linked to the perception of healthcare worker's indifference to their symptom experience as well as delays in its management (Aziato & Adejumo, 2015b; King-Okoye et al., 2017; Kwok & Bhuvanakrishna, 2014). However, the difficult lifestyle and strict parental-upbringing experienced by some participants mainly by their 'paternal figures' played a major role in their views of life as well as their reactions towards pain. Similarly, Aziato and Adejumo (2015b) concluded that the social environment and individual somewhat strict or difficult upbringing usually led to their ability to bear the pain, thereby influencing their pain response. As such, family predetermined concepts of pain, culture, and family socialisation of an individual during the formative years even in their adulthood influences their concepts of pain, pain expressions and management (Aziato and Adejumo, 2014a, 2014b, 2015b; Pasero & McCaffery, 2011). Likewise, their concepts of masculinity and views of trust in the health care system (King-Okoye et al., 2017). Thus, in ensuring effective pain assessment and management in the provision of optimum health service, definite culturally suitable pain assessment tools must be employed (Aziato & Adejumo, 2015b).

Additionally, the experience derived from previous exposure to any form of surgical intervention as well as severe pre-operative pain experiences might have altered their POP expression and response. This finding is incognizant with the view that knowledge from earlier pain experiences and negative attitudes of clinicians regarding pain management can influence the patients' personal inclination towards pain response (Aziato and Adejumo, 2014a, 2014b; Issahaku, 2018). Health caregivers especially were noted in a study in Ghana to usually avoid inquiring about their patients' pain experience but preferred to dwell on the pain behaviours the patients exhibited (Aziato & Adejumo, 2014b). Patients' involvement in care interventions and cooperation with assessment and use of analgesic is diminished with poor healthcare providers' attitude towards the pain experience (Francis & Fitzpatrick, 2013). However, pain expressions involving orientations with sociocultural-influences must be encouraged among the patients to help in clarifying misconceptions (Aziato & Adejumo, 2015b).

Relations and caregivers' support were available for all participants, they appreciated the supportive role played by their significant others specifically; personal care, finances, and guidance during the condition and pain periods. They strongly believed that relations tend to understand and are affected by their pain. In Africa, family forms a critical part of an individual life, providing support when one is ill especially the postoperative period. Depending on the surgical outcome, the family members exhibit emotional reactions influenced by the emotional ties shared (Aziato and Adejumo, 2014a, 2014b); affecting patient's decisions on health-seeking and understanding of conditions (Kwok & Bhuvanakrishna, 2014). However, some participants got support and advice from the other patients in the ward in handling their pain experience. Similarly, other studies noted that social interactions with either other patients or relatives influence the patient's response to pain

(Aziato and Adejumo, 2014a, 2014b; King-Okoye et al., 2017; Kwok & Bhuvanakrishna, 2014). Concerns shared and decisions made in seeking help affect the interpretation of their symptoms and the trusting relationship built among the family members.

The knowledge of the pain dwelled on the diverse information received during the pain experience which served as a source of relief to the participants. In this study, there was substantive post-surgery education received by a few participants as compared to the limited pre-surgery information on pain given. Consistently, adequate pre-surgery information that enhances the POP experience is noted to be limited which leaves the patients with unanswered questions of which they strive to answer (Mavridou et al., 2017). Usually, the answers received through unconventional means may result in ill pain experience and management. Pre-operation education on pain results in positive satisfaction with treatment and less anxiety, thus POP reduces remarkably with limited opioid consumption (Borracci et al., 2016; Mavridou et al., 2017). The desire to be educated is fuelled by their unfamiliarity with the POP duration and intensity, as well as available options and risks of pain control.

Usually, the intermittent low and severe urine-related 'sharp' burn seem new to the patients and cause undue post-surgery anxiety (Francis & Fitzpatrick, 2013). Avenues provided by the health workers to the patients to present personal concerns and discuss information about POP is usually brief and scarce (White & Kehlet, 2010). Post-operative education on pain must also be encouraged, as the focus is on other aspects of the surgery, not the pain experienced. This might limit the patient's pain expression, assessment, and increase the risk of persistent post-operative pain. Coping and early mobilization after surgery and discharge are also positively affected (Francis & Fitzpatrick, 2013; Hartwig, 2016; White & Kehlet, 2010). Health workers providing the needed information constituted mainly the doctors, Aloweni et al. (2008) sought to encourage nurses' participation in educating patients undergoing surgery, as the provision of essential information tends to allay anxiety and result in positive patients' attitudes (Francis & Fitzpatrick, 2013). Adequate information and pre-operative nursing pain intervention are implemented to influence the positive attitude that establishes a sense of trustworthiness and security (Francis & Fitzpatrick, 2013; Mavridou et al., 2017).

The coping measures the participants employed during the pain periods to adapt included, ignoring the pain, enduring, and hoping for a better outcome which was cognitive. Others also engaged in behavioural strategies such as praying, reading books, listening to music and pacing about to help deal with their pain. Fear and anxiety response induced by surgery can be managed by relaxation and distraction techniques such as ignoring the pain (Nelson et al., 2017). Additionally, incorporating listening to music as a treatment option is very necessary to allay anxiety (Nelson et al., 2017; Ozer et al., 2013). Health workers should assess all clients and observe their coping strategies since the adverse effects of medications can alter their attention, emotions, and psychomotor activities. These can be mistaken for mood disorders or cooperating on the side of the patient affecting the healing process (Adams et al., 2010).

In conclusion, it is important to note that postoperative pain is a multidimensional experience including the socio-cultural and cognitive experiences, which has a great influence on patient satisfaction of health service delivery. Effective pain management is crucial in POP experience, focusing on client-centered and culturally specific assessment and interventions.

4.1. Limitations and avenues for future research

In this study, during the transcription of the interview though the researcher did a direct translation of data from Twi and Fante to English. The researcher's inability to do back-translation may pose a limitation on the accurate description of the POP experiences. Additionally, the study sample was recruited from a single health facility in the country employing the purposive sampling technique. Thus, further studies are needed in considering other health facilities offering Genito-urinary surgical services to ascertain their patient's POP experiences with diverse cultural and ethnic orientation. Furthermore, future studies should explore the pre-operative pain experiences and relief interventions resorted to by the urological patients as this study concentrated on POP experiences.

4.2. Recommendations

Train health professionals on effective pain management principles and practice highlighting procedure-specific management.

Adopt a multimodal analgesic and multidisciplinary approach in pain management, especially the services of a clinical psychologist.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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