

Original Article

‘I was in real pain’: Surgical nurses’ personal pain experiences in Ghana

Lydia Aziato, PhD, MPhil, FWACN, ONDEC, BA Nursing and Psychology (Hons), RN
Department of Adult Health, School of Nursing, University of Ghana

Lillian Akorfa Ohene, PhD student, MPhil., BSc. Paed.N, FWACN, RN
Department of Community Health, School of Nursing, University of Ghana

Florence Dedey (BSc, MB.ChB, FWACS)
Department of Surgery, University of Ghana Medical School, Accra, Ghana

Joe Nat A. Clegg-Lamptey, MB.ChB, FRCSEd, FWACS, FGCS, CBA
Department of Surgery, University of Ghana Medical School, Accra, Ghana

Correspondence: Lydia Aziato, School of Nursing, College of Health Sciences, University of Ghana, P.O. Box LG 43, Legon, Accra, Ghana. Email – aziatol@yahoo.com laziato@ug.edu.gh

Abstract

Background: Nurses are known to inadequately manage pain. Patients and other care givers allude that nurses do not empathize and cannot appreciate the pain they go through.

Aim: This study sought to explore nurses’ personal pain experiences such as types of pain, the response to pain, effects and management of pain.

Methods: A qualitative interpretive design was adopted for the study. Purposive sampling was employed to recruit 17 nurses who had at least two years working experience on the surgical ward. The study was conducted at two hospitals in Accra, Ghana. Data was collected through individual face-to-face in-depth interviews. Interviews were conducted in English, audio-taped and transcribed verbatim. Anonymity and confidentiality were ensured. Trustworthiness or rigor was ensured through member checking and prolonged engagement. Data was analyzed concurrently following the processes of content analysis.

Results: All the nurses had experienced some form of severe pain with negative consequences. Nurses described the types of pain experienced such as dysmenorrhea, labor pain, post-operative pain, abdominal pain, and pain from whitlow and carbuncles. Responses to pain included reluctance to report pain because of personal preferences and dislike of analgesic intake. Some nurses felt that it was embarrassing for other to know their inability to bear pain if they reported pain. The effects of pain included decreased productivity, absenteeism, insomnia, and emotional consequences. Nurses managed their pain with orthodox analgesics in the form of injections, oral, and suppository, herbal medicine, and non-pharmacologic approaches based on the type of pain.

Conclusion: Nurses had personal experiences of pain and considered pain as an unpleasant phenomenon. It is important that nurses remain conscious of their personal pain experiences so that they can empathize with patients in pain and manage their patients’ pain effectively.

Key words: Qualitative research; interview; pain management; nursing; pain effects

Introduction

Nurses care for surgical patients whose pain continue to be inadequately managed (Qu et al., 2008, Clegg-Lamprey and Hodasi, 2005). Nurses have been found to poorly manage post-operative pain due to lack of knowledge, fear of addiction, culture, and disbelief of patients' report of pain (Aziato and Adejumo, 2014a, Abdalrahim et al., 2010, Lovering, 2006, Fenwick and Stevens, 2004). Inadequate pain management has negative effects such as inability to ambulate early, insomnia, and prolonged hospital stay (Francis and Fitzpatrick, 2013, Mac Lellan, 2006). The nurse is thus required to manage pain effectively to prevent complications.

Nurses may apply their knowledge on pain management to control their own pain rather than seek medical attention. Thus, depending on the cause of the pain, the nurse may use either pharmacologic or non-pharmacologic approaches (Pasero and McCaffery, 2011). Nurses experience inadequate pain management in hospital (Wessman and McDonald, 1999) and this may trigger some nurses to manage pain effectively.

For example some nurses found pain so unpleasant that they wished to be unconscious so that they will not feel the pain (Patiraki-Kourbani et al., 2004). Nurses experience different types of pain such as dysmenorrhea, cancer pain, labor pain, post-operative pain, headache, and bone and dental pain (Wessman and McDonald, 1999). Nurses with previous experience of very severe pain show more empathy for patients in pain (Holm et al., 1989, Abdalrahim et al., 2010).

Thus, the continued ineffective post-operative pain management may suggest that nurses who work on the surgical ward may not have experienced severe pain themselves. Few studies have investigated nurses' pain experiences and these are obsolete.

Therefore, this study aimed to explore surgical nurses' personal pain experiences to gain an understanding of their lived pain experiences.

Methods

Design

The study adopted an exploratory interpretive qualitative approach to gain full understanding of surgical nurses' personal pain experiences. The approach allowed in-depth understanding of the phenomenon under study.

Setting

The study was conducted in a tertiary (Korle-Bu Teaching Hospital) and a regional health facility (Ridge Hospital) in Accra, Ghana. The Korle-Bu Teaching hospital is the premier teaching hospital in Ghana and attracts patients from all over the country and the regional hospital also serves as a referral hospital for district level hospitals in Accra.

These hospitals have facilities for general and sub-specialist surgical procedures and nurses care for post-operative patients in pain. Different surgical procedures are performed in these hospitals such as general and specialist surgeries.

Sample and recruitment

The study included professional nurses who had worked on the surgical ward for at least 2 years and consented to be part of the study. It excluded non-professional nurses and those who had less than 2 years' experience the surgical ward. Nurses were recruited individually.

Data collection procedure

Individual in-depth interviews were conducted at a place and time convenient for the nurses. A semi-structured interview guide was used for data collection involving open-ended questions and probes such as;

'Please share with me any pain experience you had'; 'how did you behave when you were in pain?'; 'how did you feel about your pain?'; 'please tell me how pain affected your work'; and 'how did you manage your pain?'.

Interviews were audio-taped with a digital recorder with consent from the participants.

All the interviews were conducted in English and lasted for 30 to 45 minutes. Demographic data was taken before interviews were recorded. Field notes were written on non-verbal expressions, setting and key comments that helped to interpret the data. Participants were told there were no right and wrong answers and they were free to withdraw from the study at any time.

The first author conducted all the interviews and wrote her thoughts or reflections about the data in a diary to ensure that such thoughts did not bias the data collection process.

Data analysis

Data were analyzed concurrently applying the principles of content analysis. Transcripts were read several times to fully comprehend the world of the nurses. Data were coded and similar codes were grouped to generate themes and sub-themes (Silverman, 2001). The NVivo 9 software was used to manage the data. Themes and sub-themes were compared across the data set to ensure that all the participants' comments have been captured. Transcripts were compared with field notes and personal diary to ensure that the participants' views were truthfully represented. The authors discussed the themes in relation to the data to ensure that participants' experiences were fully captured. This process further enhanced the analysis of the data generated.

Rigor

Rigor or trustworthiness principles applied included member checking to ensure that participants' comments were truthfully captured. A detailed audit trail was maintained to ensure that other researchers can replicate the study in other similar settings. Probes and strategic silences were employed during interviews to enable nurses give detailed accounts and reflect on their experiences. Thick descriptions were used to present the findings which gave voice to the participants' world. Peer review of findings and coding of data by an independent coder ensured that themes generated were true

reflections of the participants' world (Parahoo, 2006, Creswell, 1998).

Ethics

The study was approved by the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, University of Ghana. Approvals were obtained from the two hospitals involved in this study and individual nurses gave individual informed consent. Anonymity and confidentiality were ensured. Participants were assigned identification codes (N1 to N17).

Results

Participants' Demographics

Seventeen (17) nurses, 15 female nurses and 2 male participated in the study. They had worked on the surgical ward for 2 to 20 years and were aged between 25 and 55 years. All the nurses were Ghanaians from different ethnic backgrounds. Ten of them were 10 junior nurses and 7 were senior nurses.

The study generated three main themes and sub-themes: type and characteristics of pain (type of pain experienced, report of pain and associated behavior); effects of pain (decreased productivity and absenteeism, insomnia, emotional consequences); and pain management approaches (orthodox analgesia, herbal and non-pharmacologic approaches). The themes are described with verbatim quotes from participants

Type and characteristics of pain

This theme describes the types of pain nurses experienced such as dysmenorrhea, labor pain, post-operative pain, abdominal pain, and pain from whitlow and carbuncles. The theme also describes the intensity of pain and how nurses reported their pain and behaved when in pain. The sub-themes are described.

Type of pain experienced

All the surgical nurses had experienced pain. A few experienced more than one type of pain. Some female nurses had experienced dysmenorrhea. The severity of dysmenorrhea varied among nurses.

'...I have been experiencing severe dysmenorrhea since the day I started as a teenager' (N11);

'...I experience severe menstrual pain to the extent that I cannot even stand on my feet' (N9);

'...just a mild menstrual pain, not severe enough to be hospitalized or given pain medications; just mild cramps'' (N8).

Other female nurses recounted their labor pain experiences. Varying intensities of pain were reported and some felt the pain was beyond their expectation:

'...even though I knew labor was painful, it was beyond what I thought it would be ... the pain was more severe than I expected' (N2).

Pain was described according to the stages of labor:

'...During the first stage of the labor, I went through some pains for some hours before the second stage, the second stage is very, very painful especially when the head engages in the vagina. It is very, very painful; and even after the delivery, I had lower abdominal pains' (N7).

Some of the nurses experienced post-operative pain after surgeries such as caesarian section, myomectomy and hysterectomy. Nurses described post-operative pain as 'very painful' (N16) and 'it was hurting' (N10). Post-operative pain occurred when pain was not assessed and analgesics were not appropriately administered:

'...I was in severe pain and would call the nurses but they either ignored me or come around and say "other people come for this same surgery and go, but you are screaming wanting to be pampered' (N10).

'...The nurses delayed in giving my pain medication so I had severe pain at the site of surgery which however reduced anytime I was given and surged up again after sometime' (N12).

Several other types of pain were experienced:

'I have this sharp pain at my back. It's been happening to me for some time now' (N2);

'...I had severe abdominal pain at the epigastric region' (N4);

'...Whitlow pain pulsates and is very, very painful and even quite recently, I experienced conjunctivitis about a month ago and it was very, very painful' (N5).

'...I once had a boil at my armpit and that place was incised and it was done under local anaesthesia and it was very, very painful' (N2).

Participants also reported severe chest pain (N14) from chest infection, leg pain from fracture (N13) and headaches (N10) from migraine.

Report of pain and associated behavior

Most of the nurses were reluctant to report pain in their everyday experiences unless pain was severe:

'...I tell someone only when the pain is severe. I like to keep things to myself' (N12);

'...if the pain is very severe and unbearable, I do say it' (N3).

Others thought that they were naturally able to endure pain as a gift from God:

'...I am able to endure pain; ... maybe it is a gift from God' (N7).

The ability to bear pain without much behavioral expression was reported as follows:

'...Normally I just walk into the labor ward without any sign that I am in pain and when I tell them I am in labor, they feel I am just joking but when they examine me they will see that I have dilated maybe 3cm or over' (N7).

Participants did not report their pain because they did not want to burden others or felt it was embarrassing for others to know that they are not able to bear pain:

'...I do not want to stress others when I am in pain so I keep it to myself' (N1).

'...I think it is embarrassing. I do not want another person knowing that the pain is unbearable when am in labor especially when people kept saying "why are you making noise, it is a normal thing every woman goes through and you keep making noise" so I shied away and endure it quietly' (N10).

Also, some did not report pain because they did not like taking analgesics or felt as nurses, they should be able to help themselves:

'...and I do not like taking pain killers because I believe that when you sleep well with less activity it relieves you of your pain' (N8).

'...I suppress it. Nobody can change anything about the pain so I have to bear it myself and take my drugs. 'You are a nurse and you are in pain, what do you want someone to do for you?' You should know better' (N14).

Participants also communicated their pain through nonverbal cues and other forms of expressions:

'...I was squeezing my face when I was in labor' (N12);

'...I was tapping my finger when in labor' (N7); *'I groan when in pain'* (N5);

'...I was crying and screaming after the surgery' (N10).

'...The crying was just expressing how uncomfortable I felt and wished I was not experiencing the pain. So it was just an expression of how I was feeling and it was a window I was using to express myself' (N3).

Other participants did not cry when they were in severe pain:

'...It was severe but I am the type that does not cry easily' (N4).

Prayer was also resorted:

'...The pain was terrible and I was helpless and was just praying that the baby should come out so that I will be free because I knew that was the only way the pain will

stop. I was just screaming till the baby came out' (N2).

Effects of Pain

This theme describes various effects of pain such as inability to work effectively, absence from work, sleeplessness, and emotional changes such as change in mood, irritability and withdrawal from social interactions. The sub-themes describing these pain effects are delineated.

Decreased productivity and absenteeism

The participants were not able to work effectively when in pain. Some took a break when in pain while others tried to work with the pain to prevent displeasure from their bosses:

'...Sometimes when I am on duty and I feel pain at my back, I tell the colleagues I am on duty with and I will tell the person to just hold the fort, I want to take a rest and come back. Then I will take a pain killer and lie down for an hour or two and I will come back' (N2).

'...sometimes when I am in pain, I try to work somehow but when my matron comes and I tell her I have dysmenorrhea, it sometimes puts her off when every month I tell her I have dysmenorrhea' (N11).

Others tuned their mind to work:

'...during my dysmenorrhea, if I am for afternoon shift, then I will have enough rest or lay down and when its time, I go to work and the only thing I do is tune my mind and work although not too actively' (N6).

However, in severe cases of pain, participants were not able to go to work:

'...the whole day I do not go out, I don't go to work' (N11).

Insomnia

Participants were not able to sleep adequately when in pain. Insomnia was attributed to worse pain associated with carbuncles at night:

'...the pain gets worse at night so I could not sleep and I was awake the whole night' (N2).

The insomnia made the participants inactive the next day:

'...I will not be active because of the pain and not getting enough sleep' (N2).

Unbearable pain associated with whitlow interfered with sleep both during the day and in the night in some instances:

'...pain which was very unbearable and I could not sleep or do anything during the day and in the night' (N5).

Emotional consequences

Some of the nurses who went through severe pain reported empathetic feelings for patients in pain and that they endeavor to relieve patients' pain:

'...so as for me, when the patient says he is in pain, I feel for them a lot; I understand them because of the way I felt when I was in pain; I put myself in their shoes; so I try my possible best to give the prescribed drug or contact the doctors if necessary to help relieve the pain' (N14).

Nurses who experienced severe pain associated patients' pain with the severe pain they experienced and treated the patient as though he/she was in severe pain.

'...when I see somebody in pain, it reminds me of the pain that I go through. When a patient screams, it reminds me of mine. Anyone who is in pain, I feel the person is in the same pain I feel. Anywhere I hear pain, I associate it with the kind of pain that I feel so I treat the person like the person is in severe pain' (N11).

However, others who had their own pain mismanaged reported feelings of bitterness and anger when they recall their pain experiences

'...when I talk about it, it either makes me angry or bitter. I do not know which was worse the anger or the bitterness. I felt like people could have intervened and they did not. They were my own colleague nurses and

I was expecting them to intervene but they did not and that hurts and makes you angry' (N10).

Others had some negative feelings when in pain; *'I get depressed' (N11):*

'...sad especially if there is no one around to comfort you'.

'...Well I want to be alone and do not want to be disturbed... I do not want to be irritated so I will just withdraw' (N8);

'...I do not feel like talking to anybody, I just want to be left alone, usually I become moody' (N3);

'...My mood changes and sometimes I express anger' (N5).

Pain management approaches

Participants described pain management strategies adopted to manage their pain. They adopted orthodox pharmacologic analgesics, herbal medicine or traditional approaches and non-pharmacologic measures. Sub-themes regarding these findings are described.

Orthodox analgesic

The nurses took different types of analgesics in the form of injections, oral, and suppository, based on the type of pain. For example those who experienced post-operative pain had injections and suppositories initially and after they were able to tolerate oral intake, oral analgesics were used for pain. However, most of the nurses self-medicated due to the inadequate pain management.

'...The nurses gave me some suppository but when I do not take my own dose, I still experience pain. The one they gave me was not enough but when I complain, they will not give me more; that was why I took my own dose without telling them' (N10)

Some nurses also bought over the counter analgesics when in pain:

'...I buy paracetamol from the pharmacy when I have mild pain if it is persistent or severe then I report to the hospital' (N12).

Some of the nurses also reacted to the analgesics they were given at the hospital and pharmacy and they experienced a lot of pain due to the side effects.

Herbal and non-pharmacologic approaches

A few of the nurses took some form of herbal preparations for their pain at home. They were not able to give the specific names of the preparation. Also some used some traditional topical preparations for their pain.

'...I applied some green herbs to it. I do not know which type of leaves it is but it was mixed with palm oil. It was not helpful' (N2).

'...An Aunt of mine mixed some herbs and lime for me to put on it but it never worked' (N5).

The nurses also employed some non-pharmacological approaches to control pain associated with carbuncles and dysmenorrhea.

'...I placed cold compress on the finger thinking it will reduce the pain. So I put the ice block in the towel and try to be moving it around the carbuncle and it helped a little' (N2).

'...I take a lot of water and I try to rest and sometimes I use warm compress when I have menstrual pain and it helps to reduce the pain' (N9).

Discussion

Nurses' pain experiences are similar to the wider literature on pain although some of these studies did not involve nurses working on the surgical ward as in this study (Bernhofer and Sorrell, 2014). The types of pain experienced such as dysmenorrhea, labor pain, post-operative pain and pain associated with whitlow have been widely reported (Patiraki-Kourbani et al., 2004).

Very severe dysmenorrhea is associated with absenteeism from school and work (Iliyasu et al., 2012, Aziato et al., 2014a). Nurses in this study were 25 years and older and it could be possible that their dysmenorrhea had an

underlying pathology (Deb and Raine-Fenning, 2008). However, this study did not involve diagnostic tests to confirm the type of dysmenorrhea among nurses. Previous authors confirm that labor pain is inadequately managed and nurses' report of labor pain confirms findings from these studies (Leap et al., 2010). Also, post-operative pain management is inadequately managed as reported by previous studies (Abdalahim et al., 2010). Nurses' report of other types of pain and the severity of pain experienced pre-supposes that clinical nurses did not give particular attention to manage nurses' pain effectively. Rather, some nurses reported being 'tagged' by their own colleagues and were not given the necessary pain relief.

Inadequate pain management led to negative effects on nurses. Severe pain caused poor work output and others were not able to sleep which concur with previous findings (Johnson, 2006). Severe pain led to anger, bitterness and depression. Some nurses did not want to recall their severe pain experience as the memory triggered anger towards the nurses. This feeling of anger could interfere with team work if nurses who go through severe pain had to work with colleagues who manage pain poorly. Also, the conscious effort by nurses to forget their personal severe pain could contribute to their effective pain management as such reminders could lead to empathetic feelings for patients in pain (Mackintosh-Franklin, 2013, Holm et al., 1989). Negative emotional responses to pain have been reported by previous authors (Pais and Noronha, 2011, Bernhofer and Sorrell, 2014). The feeling of depression, sadness and being moody and withdrawn when in pain could interfere with interpersonal relationships both among colleagues and patients. Nurses' inadequate personal pain management could contribute to the inappropriate interaction with patients.

Some nurses were stoic and did not report their pain while others did. Also different pain behavior exhibited such as crying and

screaming further substantiates the individual nature of pain (Pasero and McCaffery, 2011). Nurse who bore pain without reporting may expect a similar pain response from patients and this could account for nurses' negative attitude towards patients in pain. Thus, cultural implications of stoicism among post-operative patients within the context of the study is supported by an earlier study (Aziato and Adejumo, 2014d). Nurses who reported their pain were not given adequate pain relief and this further supports findings of inadequate pain management reported generally among patients (Qu et al., 2008).

Nurses pain management strategies were akin to those reported by previous studies (Pasero and McCaffery, 2011). Analgesics and non-pharmacologic approaches were employed to relieve pain. However, some nurses self-medicated and others did not like taking drugs and therefore suffered undue pain. The dislike of analgesics or drugs for pain could interfere with the goal of effective pain management. Also, the nurses' negative attitude towards intake of analgesics may transcend the nurses' practice regarding education of clients on pain medication. Personal desires and behavior may influence actions of individuals and this could include nurses' pain management practices. Therefore, nurses should be educated on pharmacologic management of pain so that they will be empowered to manage their own pain and that of patients adequately. Nurses' self-medication with analgesics in this study further gives the importance of increased education on pain management as this has been found to be inadequate in a previous study within the context of this study (Aziato and Adejumo, 2014a).

The use of non-pharmacologic and herbal preparations for pain management is consistent with the literature (Mac Lellan, 2006). The socio-cultural context of the study accommodates herbal medicine and non-pharmacologic methods for pain management. Nurses' use of these methods pre-supposes that some nurses' encourage the use of these approaches within the socio-

cultural context such as use of warm or cold compress and application of herbs mixed with palm oil on whitlow. However, it is emphasized that non-pharmacologic approaches do not supersede pharmacologic measures and are used in conjunction with analgesics. Thus, some of these non-pharmacologic approaches were not helpful without analgesics. Nurses did not benefit from advanced pain management techniques such as patient-controlled analgesia as these were available within the context of the study at the time of data collection. It is possible that those who experienced severe pain could have experienced better pain management if advanced techniques were used as they have been proven to result in improved pain management (Crisp et al., 2012).

Limitations and avenues for future research

Although the study derived an in-depth understanding of nurses' personal pain experiences, it did not triangulate findings with individual pain practices to relate previous severe pain with care. The number of participants involved in the study does not allow generalization of findings as in all qualitative studies. Future studies can include midwives, nurses on emergency wards, paediatric nurses and orthopedic nurses. Future studies could adopt multiple data collection methods to confirm personal pain experiences on pain management practices.

Implications and recommendations

The findings indicate that pain management is inadequate and nurses require education on pain management so that they will be empowered to manage pain more effectively. Nurses' severe personal pain experiences shows that pain management is complex and demands a multidisciplinary approach to achieve the desired outcomes. The nurses should be educated to change their attitude towards intake of analgesics so that they will not bear unnecessary pain which would interfere with their work output or cause absenteeism.

References

- Abdalahim, M. S., Majali, S. A. & Bergbom, I. (2010). Jordanian surgical nurses' experiences in caring for patients with postoperative pain. *Applied Nursing Research*, 23, 164-170.
- Aziato, L. & Adejumo, O. (2014a). The Ghanaian Surgical Nurse and Postoperative Pain Management: A Clinical Ethnographic Insight. *Pain Management Nursing*, 15, 265-272.
- Aziato, L. & Adejumo, O. (2014d). An Ethnographic Exploration of Postoperative Pain Experiences Among Ghanaian Surgical Patients. *Journal of Transcultural Nursing*, DOI: 10.1177/1043659614526246.
- Aziato, L., Dedey, F. & Clegg-Lampsey, J. N. A. (2014a). The experience of dysmenorrhoea among Ghanaian senior high and university students: pain characteristics and effects. *Reproductive health*, 11, 1-8.
- Bernhofer, E. I. & Sorrell, J. M. (2014). Nurses Managing Patients' Pain May Experience Moral Distress. *Clinical Nursing Research*, doi: 1054773814533124.
- Clegg-Lampsey, J. N. A. & Hodasi, W. M. (2005). An Audit of Aspects of Informed Consent and Pain Relief in General Surgical Units of Korle-Bu Teaching Hospital. *Ghana Medical Journal*, 39, 63-67.
- Creswell, J. W. (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*, London, Sage Publications.
- Crisp, C. C., Bandi, S., Kleeman, S. D., Oakley, S. H., Vaccaro, C. M., Estanol, M. V., Fellner, A. N. & Pauls, R. N. (2012). Patient-controlled versus scheduled, nurse-administered analgesia following vaginal reconstructive surgery: a randomized trial. *American Journal of Obstetrics and Gynecology*, 207, 433.e1-433.e6.
- Deb, S. & Raine-Fenning, N. (2008). Dysmenorrhoea. *Obstetrics, Gynaecology & Reproductive Medicine*, 18, 294-299.
- Fenwick, C. & Stevens, J. (2004). Post operative pain experiences of central Australian Aboriginal women. What do we understand? *Australian Journal of Rural Health*, 12, 22-27.
- Francis, L. & Fitzpatrick, J. J. (2013). Postoperative Pain: Nurses' Knowledge and Patients' Experiences. *Pain Management Nursing*, 14, 351-357.
- Holm, K., Cohen, F., Dudas, S., Medema, P. G. & Allen, B. L. (1989). Effect of personal pain experience on pain assessment. *Image J Nurs Sch.*, 21, 72-5.
- Iliyasu, Z., Galadanci, H. S., Abubakar, I. S., Ismail, A. O. & Aliyu, M. H. (2012). Menstrual Patterns and Gynecologic Morbidity among University Students in Kano, Nigeria. *Journal of Pediatric and Adolescent Gynecology*, 25, 401-406.
- Johnson, N. (2006). Management of dysmenorrhoea. *Reviews in Gynaecological and Perinatal Practice*, 6, 57-62.
- Leap, N., Sandall, J., Buckland, S. & Huber, U. (2010). Journey to Confidence: Women's Experiences of Pain in Labour and Relational Continuity of Care. *Journal of Midwifery & Women's Health*, 55, 234-242.
- Lovering, S. (2006). Cultural Attitudes and Beliefs About Pain. *Journal of Transcultural Nursing*, 17, 389-395.
- MAC LELLAN, K. 2006. *Management of pain*, UK, Nelson Thornes Ltd.
- Mackintosh-Franklin, C. (2013). Registered Nurses' Personal Responses to Postoperative Pain: A Descriptive Qualitative Study. *Pain Management Nursing*.
- Pais, M. & Noronha, J. A. (2011). A correlative study on dysmenorrhea among rural village women of Udipi district, Karnataka. *International Journal of Nursing Education*, 3, 29-31.
- Parahoo, K. (2006). *Nursing Research: Principles, Process and Issues* Basingstoke, Palgrave Macmillan.
- Pasero, C. & Mccaffery, M. (2011). *Pain Assessment and Pharmacologic Management*, St. Louis, Mosby/Elsevier.
- Patiraki-Kourbani, E., Tafas, C. A., McDonald, D. D., Papathanassoglou, E. D. E., Katsaragakis, S. & Lemonidou, C. (2004). Personal and professional pain experiences and pain management knowledge among Greek nurses. *International Journal of Nursing Studies*, 41, 345-354.
- Qu, S., Sherwood, G. D., McNeill, J. A. & Zheng, L. (2008). Postoperative Pain Management Outcome in Chinese Inpatients. *Western Journal of Nursing Research*, 30, 975-990.
- Silverman, D. (2001). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*, London, Sage.
- Wessman, A. C. & McDonald, D. D. (1999). Nurses' personal pain experiences and their pain management knowledge. *J Contin Educ Nurs.*, 30, 152-7.