

Original Article

Ageing with Aches and Pains’: Lived Experiences of the Elderly in Ghana

Lydia Aziato, PhD, MPhil, FWACN, FFGCNM, BA (Nurs. & Psych.), RN, ONC
Lecturer, Department of Adult Health, School of Nursing, University of Ghana, Legon, Accra, Ghana

Lillian Akorfa Ohene (PhD (c), M’Phil, BSc, Paed.N, FWACN, FFGCNM, RN
Assistant Lecturer, Department of Community Health, School of Nursing, University of Ghana

Linda Norman, MPhil, FWACN, FFGCNM, BSc, RN
Assistant Lecturer, Department of Adult Health, School of Nursing, University of Ghana, Legon, Accra, Ghana

Hannah Ohemeng Antwi, BSc Nursing, RN
Teaching Assistant, Department of Adult Health, School of Nursing, University of Ghana, Legon, 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: Aging is associated with physiological and physical changes including musculoskeletal aches and pains. Studies have explored the phenomenon of aches and pains in the elderly to some extent. However, there is paucity of literature on the phenomenon of aches and pains among the Ghanaian elderly.

Objectives: This study sought to gain an in-depth understanding of aches and pain among the elderly in Ghana.

Methods: An exploratory descriptive phenomenological design was employed to conduct this at a tertiary physiotherapy department in Accra, Ghana. Purposive sampling was used to recruit elderly who were at least 60 years with musculo-skeletal pain. Individual interviews were conducted and transcribed verbatim. Data were saturated with 12 participants. The principles of content analysis were employed to analyse the data.

Findings: Themes generated were pain descriptions, causes of pain, pain effects, pain management (pharmacologic pain management and non-pharmacologic pain management) and challenges of living with pain. The Ghanaian elderly had aches and pains at different parts of their body and this impaired their mobility. Multiple diseases such as Diabetes and Hypertension impaired pain management.

Conclusion: The elderly and their care givers should be educated on physiological changes in the body as one ages that can contribute to pain and the effect of multiple diseases on pain management. Pain management among the elderly should be enhanced so that they can have a better quality of life.

Keywords: geriatric; musculo-skeletal; qualitative research; ageing; Ghana

Introduction

Ageing is associated with several physiological and physical changes that affect the well-being of the elderly such as changes in the renal, cardiac, nervous, musculo-skeletal and the sensory systems (Urban et al., 2010, Camacho-Soto et al., 2011, Baldea, 2015). Common changes that occur in the musculo-skeletal system are osteoporosis and osteoarthritis which result in aches and pains (Urban et al., 2010, Camacho-Soto et al., 2011). The ages of elderly vary from

one study to the other; however, those 60-65 years and above are generally referred to as old and physiological and physical changes commence at this age (Camacho-Soto et al., 2011, Gates and Walker, 2014). Although pain in the elderly is principally associated with ageing, some elderly experience pain from past and present injuries (Haozous et al., 2014, To et al., 2010, Dziubek et al., 2015). A previous author reported that 1 out of every 4 elderly experience one form of pain or the other with pain occurring

at the back, legs, arms, head, pelvis, abdomen and chest (Fouladbakhsh et al., 2011) and these findings have been supported by other researchers (Tsai et al., 2010, Kim et al., 2014, Niemela et al., 2011). The elderly experience mild, moderate or severe pain and the severity of pain increases with advancing age (Herr et al., 2010).

The chronic pain among the elderly affects various aspects of their life to the extent that some of them have impaired quality of life. Pain hinders mobility and because of that some elderly men and women are not able to perform their activities of daily living such as maintaining the home, moving from one point to the other and climbing the stairs (Tsai et al., 2004, Tomey et al., 2015, Chiou et al., 2009). Pain also impairs sleep among the elderly (Jacobson et al., 2009). More so, chronic pain leads to a high incidence of depression and anxiety among the elderly (Cino, 2014). Others also experience nausea, tiredness, weakness and dizziness when they are in severe pain (Cremens and Wiechers, 2010).

A number of pain management options have been employed by the elderly including pharmacologic and non-pharmacologic. The non-pharmacologic approaches employed include massage, deep breathing exercises and music therapy (Tse et al., 2012, Herr et al., 2010, Abdulla et al., 2013). Other approaches include application of hot and cold as well as transcutaneous electrical nerve stimulation (TENS), meditation, relaxation, music and prayer (Abdulla et al., 2013, Haozous et al., 2014, Kemp et al., 2005). These approaches relieve pain to some extent and they help the elderly cope with their chronic pain. Massage is believed to be effective for muscle spasms, pain and stiffness and helps in relaxing the individual (Weigl et al., 2007). Massage may be done with the hands with a topical application which may be in the form of sprays or ointments (Cino, 2014). Sometimes massaging can be done mechanically with vibrators or machines for the elderly (Tsuji et al., 2014). Massaging improves circulation of blood and lymph (Weigl et al., 2007). It presupposes that although these non-pharmacologic approaches may not entirely relieve pain, the elderly derives some benefits from them. For example, application of a cold compress in addition to local pain relief decreases inflammatory responses when there is an injury (Weigl et al., 2007, Abd El-Maksoud et al.,

2011). Musculo-skeletal pain relieve include the use of assistive devices that helps the elderly to ambulate (Hammond, 2008).

Pharmacologic approaches to pain management among the elderly are influenced by the type of pain and the presence of other diseases for which the elderly is on medication. Thus the choice of analgesic would take into consideration the interaction and compatibility of the drugs being taken. The presence of diseases such as impaired renal and liver function and ulceration of the gastric mucosa seriously affect the choice of analgesics for pain management. Many authors reiterate that non-steroidal anti-inflammatory drugs (NSAIDs) should be used with caution when managing pain of the elderly (Gloth, 2011, Duong and Chang, 2011, Hix, 2007). Paracetamol (Acetaminophen) is recommended for managing the pain of the elderly (Gloth, 2011, Urban et al., 2010).

The literature has explored the phenomenon of pain among the elderly in many countries such as Taiwan, China, United States of America, and Finland. However there is paucity of literature on the aches and pain among the elderly in Ghana. This study sought to gain an in-depth understanding of the lived experiences of the elderly in Ghana

Materials and Methods

Design

The study adopted an exploratory descriptive phenomenological design to understand the lived experiences of aches and pain among the elderly in Ghana. An exploration of lived experiences is fully understood using a qualitative approach and phenomenology is the approach to employ (de Vos et al., 2011).

Setting

The study was conducted at physiotherapy department of a tertiary health facility. The department has facilities for treating various musculo-skeletal related pains. All age categories of clients access the facilities including the elderly. The elderly clients come from Accra and its environs for physiotherapy. An average of 50 elderly clients access physiotherapy services per week with varying pain complaints.

Population and Sampling

The study targeted elderly Ghanaians aged at least 60 years and were seeking physiotherapy

services for musculo-skeletal pain. Thus, purposive sampling technique was employed to recruit men and women who met the inclusion criteria and were not in severe pain at the time of the interview. Also, elderly men and women who could communicate verbally in English, Twi, Ewe and Ga with no cognitive impairment were recruited.

Data collection instrument and procedure

Data was collected with a semi-structured interview guide that sought experiences on living with aches and pains. Open ended questions were asked and probes used to gain in-depth understanding of participants' narrations. The areas of probes included the nature of pain, cause of pain, management of pain, the effect of pain and the challenges of living with pain. Follow-up questions were asked during the interview to gain full understanding of the experiences. The first author who is an experienced interviewer conducted all the interviews in this study. All the interviews were conducted in a quiet room at the physiotherapy department and lasted for 20 to 45 minutes. All interviews commenced after an informed consent was taken and permission of recording the interview was obtained. The participants used their language of preference during the interviews and these were transcribed verbatim. Strategic silences and summarizing were used to ensure that the participants' world was fully understood. Data saturation occurred with twelve participants.

Ethical considerations

Ethical approval for a wider pain assessment study was obtained from the Institutional Review Board of the Noguchi Institute of Medical Research of the University of Ghana. The head of the physiotherapy department gave consent for the study and individual participants also gave consent. The study was explained fully to the participants and issues of confidentiality and anonymity were also explained. The interviews were conducted after they have accessed the physiotherapy and only those who consented to be interviewed were included. It was emphasized that their refusal will not affect future physiotherapy services and they could stop even when the interview had started. Identification (ID) codes were used to present verbatim quotes such as OPM1 (old person male 1) and OPF1 (old person female 1). Thus, the ID codes were generated chronologically as participants were

recruited into the study. Any identifying information was removed from the data.

Data management and analysis

Data analysis occurred concurrently so that themes generated are investigated further during data collection. The transcripts were read several times to gain understanding of the participants' world. The principles of content analysis were employed where the transcripts were coded and similar codes were grouped to generate themes and sub-themes. The Nvivo software version 9 was used to manage the data. The research team discussed the themes and sub-themes.

Trustworthiness

The trustworthiness of this study was maintained by employing the same semi-structured interview guide to collect the data. Also, one person conducted all the interviews to ensure that any researcher influence during interviews was annulled. Participants' accounts were summarized and confirmed during the interviews to ensure the right understanding was obtained. The first author analysed the data and the research team discussed the themes and sub-themes generated to ensure that the true accounts of the participants were represented. An audit trail of the study was maintained and thick descriptions were provided to give readers a sense of the experiences of the participants.

Results

Participants' demographics

The study comprised 12 elderly participants made up of 7 females and 5 males. They were aged between 60 to 81 years and were all Ghanaians. Eleven were Christians and I was a Muslim. They had children ranging between 1 and 9. Their occupational histories included: trader (2), teacher (1), secretary (1) Reverend Mother (1), fashion designer (1), lecturer (1), electrical engineer (1), self-employed (meat processor) (1), banker (1), fishing (1), business (1). Their marital status were: married (8), single (2), Separated (1), and Divorced (1). Their ethnicity were: Akan (5), Ewe (4), and Ga (3). The number of years of pain experience were: 10 years (2), 2 years (1), 15 years (3), 3 years (1), 4 years (2), 5 years (1), Over 5 years (1), and 20 years (1).

The themes that were generated from the data were: pain descriptions, causes of pain, pain effects, pain management (pharmacologic pain

management and non-pharmacologic pain management) and challenges of living with pain. These themes are described with verbatim quotes from participants.

Pain Descriptions

This theme describes the onset of pain, nature of pain, body part involved and psychological pain. Musculo-skeletal pain affected different parts of the body such as the waist, back, shoulder, knee, joints, legs and neck.

'It began as if I was having waist pains, as time went by, I started having back pain. (OPF1);

my waist and joints really hurts and the whole leg' (OPF7);

'At times I will have pains in my neck and the shoulder and then I was also having pains in my legs' (OPF1);

'I complain about my neck, my shoulder and my knee and then with time my legs were involved (OPF6);

the waist, then it extended to my back' (OPF1).

Pain was present from a month to over 20 years.

'The pain started like a month ago' (OPM2); 'The pain at my knee started about 5years ago' (OPM3);

'my waist pain is even more than 15 years' (OPF5);

'This pain started when I was a little over 50 years; that is about 20 years ago' (OPF2).

Participants described their pain as 'severe', 'very severe', 'pounding' and some cried when the pain was severe.

'I just can't tell what actually happened but the last severe pain that I had, it was so severe that I cried' (OPF2).

'It was a very severe pain I felt' (OPF1);

'It just became serious within these two years. Now when I am walking I have so much pain; when I stand up, it's like my left leg is pounding' (OPF2).

The severity of the pain varied over time.

'I feel the pain so much but at times it reduces and at times it's high. Like this morning it was so painful but as the day progresses, it reduces a little' (OPF2).

Therefore, depending on the severity, some did not show any sign of pain.

'I do not show any sign of pain; no groaning, no sound' (OPF7); 'Oh, I did not cry; men don't cry' (OPM2).

They believed that an individual should learn to 'endure' pain.

'In everything, one needs to endure. One needs to endure to be able to go through all of this pain' (OPM2).

The pain intensity was varied for different days.

'Sometimes I wake up feeling fine; no or mild pain; but sometimes the pain is just too much that I cannot control myself' (OPF7).

Some felt their legs were heavier than usual with tingling sensations. Some felt 'strange' when the pain commenced. The painful extremities were sometimes swollen.

'I feel very strange when the pain begins' (OPF3); 'I feel tingling sensations all over my legs and at times my legs are heavy, I feel they are heavier than normal; and sometimes also they are swollen or they get bigger than usual' (OPF7).

Pain was 'moving' from one part of the body to the other and was associated with weakness and numbness.

'The pain moved from my waist to my hip and then my legs which were becoming weak. My fingers were numb and painful and the palm and even the hand, it is numb and pain painful' (OPF6).

Some were not able to describe what they felt.

'...the pain will be at the lower back, then to the buttocks down up to the legs. Oh, at times I am not even able to describe what I feel' (OPF2).

Some participants believed that pain among the elderly can be psychological especially when the person is not working or did not have a house or a comfortable retirement.

'The pain is psychological, when you are thinking too much when you retire without a house or enough money; you feel a lot of psychological pain. When you are also in the house and you are not doing anything too, at times you feel so bored and that makes the pain worse' (OPM1)

Causes of Pain

Pain was attributed to a number of factors such as ageing, spinal disease and injury.

Ageing is also a factor, as we grow you will see some changes in the body and these are associated with aches and pain (OPF3);

'my problem is spondylosis, my neck; they told me there is a prolapse of the cervical spine 4, 5, 6 (OPF6);

'They said my back bones are not aligned. There is no space between them, making them stiff (OPM2).

'I was bathing and I had to clean my leg area so when I got up to bath my back, the stool I was sitting on had shifted and I did not know so I fell' (OPF4);

It started with a motorcycle accident (OPM2);

'...the pain started when my left foot slipped over a creeping plant' (OPM4).

Some believed that the spinal problem resulted from the use of soft mattresses.

'I realized that when the mattress is too soft, then my back becomes stiff and painful' (OPM1).

Others also believed that their pain was a result of 'hard work' during their youthful days especially carrying heavy load.

'It appears to me that the kind of hard work that we do in our youthful days is the one responsible for pain in our old age' (OPF1).

However some participants were not sure if this perception was true.

'I have done some hard works in the past such as carrying loads of cement, rice, meat and so on but I can't tell whether my pain is from those hard works' (OPM2).

Some female participants thought that the use of high heels led to their back and waist pain.

'I love wearing high heels. Even with my age I still love high heels. I feel it is part of the reasons why I have back and waist pain' (OPF3).

One female participant had a child at the age of 42 and attributed her pain to the late delivery and the many children she had.

'Formerly I was very strong; but after I got pregnant with my last child (8th child); that was when all the problems started with the pain. I

was too old to get pregnant and I delivered too many times; I was 42 years (OPF7).

However, some also did not know what caused their pain.

'I do not know what caused my pain. It just happened; nothing hit me and I was not injured' (OPM5); *'I don't know where exactly the sickness came from'* (OPM2).

Pain Effects

Pain had a number of effects on participants including impaired mobility and impaired activities of daily living. Also, pain led to tiredness and sluggishness.

'Sometimes I feel tired and unable to do anything and I could not walk (OPF1);

I feel that I have become sluggish and slow when in pain (OPM1);

I couldn't even climb the stair when I was in pain (OPF3);

I could not really walk straight; my gait was not the same (OPF7);

the pain intensifies when I try to walk; if I want to buy something, the pains won't allow me to stand up and go to buy it (OPM2).

Some found it difficult to get up in the morning. Others were bedridden and could not do anything for themselves

When I sleep and I wake up it becomes difficult for me to get out of bed then when I get down too I will be having the pains (OPF2);

'Before I came to the hospital, the pain made me bedridden. I spent one week in the room. I could not do anything (OPM2).

Some of the participants felt a lot more pain when they sat for about 30 minutes or more. Thus, some experienced pain at church because of the prolonged sitting.

'When I go to church, I feel the pains because we sit down for about 30minutes continuously. Later when I get up, walking becomes difficult for me. I really find it tough to walk' (OPM3).

Sometimes when I wake up, I can't even wake up fully and get up. So I have to be crawling before I can finally get up, but the most interesting thing is, immediately I enter into

the bathroom and shower, all the sickness is gone (OPM1).

It was noted that a few of the participants were able to perform some household chores unassisted such as cooking. However, cooking of food that was energy intensive and washing could not be done.

'I do my own things such as cooking; I am not bed ridden but I cannot pound fufu (local dish made from Cassava); I do not wash' (OPF6).

Pain Management

This theme describes both pharmacologic and non-pharmacologic approaches adopted for pain management and the sub-themes are described.

Pharmacologic Pain Management

Participants took different analgesics such as paracetamol (OPF1), corcodamol codeine (OPF5), Diclofenac suppository and Brufen (OPM1). Some of the analgesics were effective in controlling the pain. Some analgesics were bought over the counter and other analgesics were prescribed by health professionals. All the participants indicated that they did not take the analgesics regularly for fear of side-effects.

'When I take pain killers, phenpal or paracetamol, the pain gets better. I buy the drug myself but sometimes I go to the clinic and the doctor prescribes for me. I don't take it regularly so that I will not develop problems from the side-effects. I only take it again when I feel the pains or maybe when I am going to bed' (OPF1).

The participants believed that the analgesics controlled pain for some time and the pain surfaced again after the effect of the analgesic effect had diminished

'As soon as I take the pain killer, the pain goes away but the pain returns later' (OPM2).

Although the analgesics did not permanently control pain among the elderly, some participants' friends discouraged from taking regular analgesics

'Yes it hurts but my friends advised me not to take too much pain killers so when I do feel the pain sometimes, I take it; but when I am not in severe pain, I do not take any pain killer' (OPF5).

However, a participant was not on analgesic because of a renal disease

'I am not on any pain killers because I have some other problems like renal problems. They advised me against the pain killers' (OPF6).

Some of the pharmacologic agents were topical such as ointments

'I used ointments for rubbing the painful part but avoided those with menthol because of my Asthma' (OPF6).

Some participants took vitamin supplements to help cope with their aches and pains such as folic acid, vitamin B complex and Lyrica

'sometimes I buy vitamin B Complex and Folic Acid like when I feel some body aches and it helps' (OPM5).

'I take Lyrica which is a strong vitamin B complex and it helps reduce my pain' (OPF2).

A few experienced some side-effects of pharmacologic products used and they were not adequately informed on the drugs

'Whenever I took the medicine I was given, I vomited and felt restless; I was not given enough information about the drug' (OPF3).

Non-pharmacologic Pain Management

The elderly employed a number of non-pharmacologic approaches for pain management such as exercising and use of hot water bottle/towel.

'I try to exercise every day and that helps the pain to be better somehow' (OPM3).

'I place a hot water bottle on the painful site when I got one but formerly, I was using a towel soaked in hot water on the painful site; sometimes it helps even the neck (OPF3).

Some slept on the floor when they experienced back pain and the pain was better. *'When my back pain is painful, I sleep on the floor and the next day, it is better' (OPM1).*

Another non-pharmacologic approach was massaging. *'A friend said massaging could help so I tried it and it helped to some extent' (OPF2).* Some felt lying down and resting also helped in controlling their aches and pains.

'When I have aches and pains, after eating in the morning, I lie down. Health professionals talk about getting enough rest so I try to rest, I don't go anywhere I just lie down' (OPF3).

Majority of the participants prayed about their aches and pains so that they will be free from pain.

'I pray over all the aches and pain I experience every day and after the prayers there is some form of relief' (OPF2);

'The prayers was considered an additional measure to the analgesics. As for the prayers you have to pray in addition to taking the medicines' (OPF4).

At the physiotherapy department, the participants used a number of non-pharmacologic approaches such as the use of a vibrator, transcutaneous electrical nerve stimulation (TENS), heat therapy and other forms of exercising and massaging depending on the condition of the participant. The physiotherapy received had different levels of effectiveness.

'They put the vibrator at my back where I have the pain and at the waist for sometime after that they use the TENS, I don't know the full name' (OPF2);

'Since I started, I exercise my hands, neck and shoulder. The effect has been erratic; sometimes effective, other times I don't feel any change in the pain' (OPF6); *'the exercise is also helping; after the exercise I feel fine'* (OPF7).

Challenges of living with pain

The major challenge for most of the participants in managing their aches and pains was the experience of multiple diseases such as hypertension and diabetes. These chronic diseases demand daily intake of medication and additional regular analgesic intake was not desired.

'I also have diabetes so I go for check up every month and take medicine every day' (OPF4); *'I was told I have BP and because of that I take medicine everyday so when the pain is too much before I take the pain killer which relieves the pain in my legs. I cannot take pain killer every day'* (OPF7).

Another challenge in dealing with aches and pain among some of the participants was lack of physical support in performance of activities of daily living especially for those without children or female children.

'It is difficult to care for myself when in pain; that is the problem; my family do not live with me' (OPM2);

'Some people help me and I pay them; I don't have my own children; it is always not easy for me but I try' (OPF6).

Some of the participants also had financial difficulties and this influenced their hospital attendance and purchasing of medication

'The money problems are always there so I buy some of the drugs prescribed when expensive and come to the hospital when the pain is so severe that I cannot cope' (OPM4).

However, others did not have any financial difficulties so they were able to report regularly to the hospital and buy all drugs prescribed.

'When it comes to money I do not have any problem so I come to my doctor anytime and I buy all my drugs' (OPF7);

'Financially God has blessed me and I am able to meet all my health cost; my only problem is the pain that will not go away completely' (OPM3).

In view of these challenges, the participants suggested that individuals should plan adequately for their ageing, train children of both sexes to carryout house-hold chores, be mindful of effect of labour intensive work on their spine and build a house. These they believed will help better cope with aches and pain during old age.

'Old age progresses well on adequate finance so I invested for my old age when I was working and built houses' (OPM3);

'We have to train both the boys and the girls to do house chores; we should not concentrate on their education alone' (OPF1);

'When working you must always think about your old age. Think about the effect of hard work on your back/waist and rest when tired. Try and build your house so that you will not be thinking too much in addition with the pain in old age' (OPF7).

Discussion

The description and location of pain among the elderly in this study is consistent with findings of previous studies that reported that musculo-

skeletal pain may affect the shoulder, knee, neck, waist, and legs (Tsai et al., 2010, Niemela et al., 2011, Kim et al., 2014). An important function of the musculo-skeletal system is movement (Tsai et al., 2004, Mottram et al., 2008).

Therefore an impairment in this system leads to impaired mobility which participants experienced in this study. The degree of impaired mobility and activities of daily living was related to the severity of pain. This impairment made the elderly dependent on others for their daily living requirements.

Those who did not have the required support from their family paid for the services of others to meet their daily life requirements. This finding draws attention to the need for the elderly to have the required support from their family members to maintain their activities of daily living.

The chronic nature of aches and pains in the elderly is supported in this study where some patients have lived with pain for over two years. The pain changed in severity from mild to severe and some elderly participants tried to bear severe pain while others cried. This supports previous studies in Ghana where some individuals are stoic and others express pain through moaning, grimacing and crying (Aziato and Adejumo, 2014d). The elderly's report of endurance of pain suggests that health care professional and informal caregivers should not wait for behavioural expression of pain before instituting pain management interventions. It also points to the need for the elderly to be educated on the importance to report their pain so that they can be free from pain.

Participants in this study attributed their aches and pains to the effect of normal ageing process and spinal disease (Camacho-Soto et al., 2011), trauma (To et al., 2010, Dziubek et al., 2015), sleeping on soft mattress (Jacobson et al., 2009, Ancuelle et al., 2015), wearing high heeled shoes (Barton et al., 2009), late or multiple childbirth and undertaking labour intensive work when they were younger (Worku, 2000). These findings are in consonance with previous studies that indicated that aches and pains in the elderly can have multiple causes (Iqbal et al., 2012, Camacho-Soto et al., 2011). Ageing is associated with osteoporosis due to hormonal changes and calcium and vitamin D deficiency (Camacho-Soto et al., 2011) and this is associated with pain at the affected site. Some did not know the cause of their pain. In view of this, there is the need for

thorough assessment of aches and pains in the elderly so that the most appropriate treatment modality and education can be employed. Also, the finding that some of the elderly in this study had financial difficulties implies that the treatment of choice should be affordable and acceptable to the elderly. Perhaps the use of vitamin supplements that helped in controlling pain could be linked to vitamin deficiency among the elderly. Deficiency in Vitamin D could lead to bone deformities (Brickley et al., 2014) and as such, the elderly should be cautious to prevent injuries.

Some of the elderly participants in this study had multiple diseases which interfered with pain management. For example, renal diseases do not allow excretion of by-products of analgesics and could lead to complications (Urban et al., 2010). The chronic nature of cardiac diseases such as hypertension may also result in restrictions in the use of analgesics since some analgesics such as NSAIDs may interfere with the action of antihypertensives (Khatchadourian et al., 2014). Similar to other findings, some participants bought drugs over-the-counter to treat their pain (Tsai et al., 2010) and it is possible that drugs such as NSAIDs which are not recommended for the elderly may be used. The use of unprescribed analgesics may predispose the elderly to complications that can impair their health.

Non-pharmacologic approaches helped the elderly to cope with aches and pains. The methods used such as hot or cold compresses, TENS and massage are supported by previous authors (Weigl et al., 2007, Johnson, 2010, Herr et al., 2010, Abdulla et al., 2013). Some elderly prayed about their aches and pains as adjuvants to taking their pain medications with the belief that the pain will be better. Literature supports the use of religious believes for individuals to cope with pain (Herr et al., 2010, Kemp et al., 2005, Haozous et al., 2014). Regular moderate exercises and range of motion exercises are helpful for managing pain among the elderly (Tsai et al., 2010). Therefore the elderly should be encouraged to engage in appropriate exercises so that their aches and pains could be minimized.

Limitations of the study

The study included the elderly seeking intervention for pain at the physiotherapy of one tertiary health facility and this may not be representative of all Ghanaian elderly men and

women in pain. Although qualitative research is not aimed at generalization, future studies could include larger sample size of the elderly to collaborate findings of this study.

Conclusion

The study gained an in-depth understanding on the lived experiences of the elderly in Ghana. The tendency of the elderly to endure pain and the presence of multiple diseases that can interfere with use of analgesics show that the elderly require education on pain management. It is necessary to encourage non-pharmacologic approaches for pain management so that the negative effect of long term use of analgesics would be prevented. The effect of aches and pains such as mobility impairment and inability to perform activities of daily living calls for support for the elderly in pain to ensure a better quality of life. Financial constraints can hinder effective pain management; therefore, policies for free healthcare and other social benefits for the elderly should be implemented.

List of Abbreviations

ID – Identification

NSAIDs – Non Steroidal Anti-Inflammatory Drugs

TENS - Transcutaneous Electrical Nerve Stimulation

Acknowledgement

The authors are grateful to the authorities of the physiotherapy centre who assisted in the recruitment of participants. We also thank Daniela and her team for transcribing the interviews. The authors self-funded the study.

References

- Abd El-Maksoud, G. M., Sharaf, M. A. & Rezk-Allah, S. S. (2011). Efficacy of cold therapy on spasticity and hand function in children with cerebral palsy. *Journal of Advanced Research*, 2, 319-325.
- Abdulla, A., Adams, N., Bone, M., Elliott, A. M., Gaffin, J., Jones, D., Knaggs, R., Martin, D., Sampson, L. & Schofield, P. (2013). Guidance on the management of pain in older people. *Age Ageing*, 42 Suppl 1, i1-57.
- Ancuelle, V., Zamudio, R., Mendiola, A., Guillen, D., Ortiz, P. J., Tello, T. & Vizcarra, D. (2015). Effects of an adapted mattress in musculoskeletal pain and sleep quality in institutionalized elders. *Sleep Science*, doi:10.1016/j.slsci.2015.08.004.
- Aziato, L. & Adejumo, O. (2014d). An Ethnographic Exploration of Postoperative Pain Experiences Among Ghanaian Surgical Patients. *Journal of Transcultural Nursing*, DOI: 10.1177/1043659614526246.
- Baldea, A. J. (2015). Effect of aging on renal function plus monitoring and support. *Surg Clin North Am*, 95, 71-83.
- Barton, C. J., Coyle, J. A. & Tinley, P. (2009). The effect of heel lifts on trunk muscle activation during gait: a study of young healthy females. *J Electromyogr Kinesiol*, 19, 598-606.
- Brickley, M. B., Moffat, T. & Watamaniuk, L. (2014). Biocultural perspectives of vitamin D deficiency in the past. *Journal of Anthropological Archaeology*, 36, 48-59.
- Camacho-Soto, A., Sowa, G. & Weiner, D. K. (2011). Chapter 58 - Geriatric Pain. In: Candido, K et al., (ed.) *Essentials of Pain Medicine (Third Edition)*. Saint Louis: W.B. Saunders.
- Chiou, A., Lin, H. & Huang, H. (2009). Disability and pain management methods of Taiwanese arthritic older patients. *Journal of Clinical Nursing*, 18, 2206-2216.
- Cino, K. 2014. Aromatherapy Hand Massage for Older Adults With Chronic Pain Living in Long-Term Care. *Journal of Holistic Nursing*, 32, 304-313.
- Cremens, M. C. & Wiechers, I. R. (2010). 44-Care Of The Geriatric Patient. In: Rosenbaum, T. (ed.) *Massachusetts General Hospital Handbook of General Hospital Psychiatry (Sixth Edition)*. Saint Louis: W.B. Saunders.
- De Vos, A. S., Strydom, H., Fouché, C. B. & Delport, C. S. L. (2011). *Research at Grass Roots: For the Social Sciences and Human Service Professions*, Pretoria, Van Schaik Publishers.
- Duong, S. & Chang, F. (2011). A Practical Approach to the Management of Chronic Non-Cancer Nociceptive Pain in the Elderly. *Canadian Pharmacists Journal / Revue des Pharmaciens du Canada*, 144, 270-277e.1.
- Dziubek, W., Bulinska, K., Stefanska, M., Wozniowski, M., Kropielnicka, K., Jasinski, T., Jasinski, R., Pilch, U., Dabrowska, G., Skorkowska-Telichowska, K., Wojcieszczyk-Latos, J., Kalka, D., Janus, A., Zywar, K., Paszkowski, R. & Szuba, A. (2015). Peripheral arterial disease decreases muscle torque and functional walking capacity in elderly. *Maturitas*, 81, 480-6.
- Fouladbakhsh, J. M., Szczesny, S., Jenuwine, E. S. & Vallerand, A. H. (2011). Nondrug therapies for pain management among rural older adults. *Pain Manag Nurs*, 12, 70-81.
- Gates, B. J. & Walker, K. M. (2014). Physiological Changes in Older Adults and Their Effect on Diabetes Treatment. *Diabetes Spectrum : A Publication of the American Diabetes Association*, 27, 20-28.
- Gloth, F. M., 3rd (2011). Pharmacological management of persistent pain in older persons:

- focus on opioids and nonopioids. *J Pain*, 12, S14-20.
- Hammond, A. (2008). Rehabilitation in musculoskeletal diseases. *Best Pract Res Clin Rheumatol*, 22, 435-49.
- Haozous, E. A., Doorenbos, A. Z. & Stoner, S. (2014). Pain Management Experiences and the Acceptability of Cognitive Behavioral Strategies Among American Indians and Alaska Natives. *Journal of Transcultural Nursing*.
- Herr, K., Titler, M., Fine, P., Sanders, S., Cavanaugh, J., Swegle, J., Forcucci, C. & Tang, X. (2010). Assessing and treating pain in hospices: current state of evidence-based practices. *J Pain Symptom Manage*, 39, 803-19.
- Hix, M. D. (2007). Pain Management in Elderly Patients. *Journal of Pharmacy Practice*, 20, 49-63.
- Iqbal, R., De, A., Mishra, W., Maulik, S. & Chandra, A. M. (2012). Study on lumbar kinematics and the risk of low back disorder in female university students by using shoes of different heel heights. *Work*, 41 Suppl 1, 2521-6.
- Jacobson, B. H., Boolani, A. & Smith, D. B. (2009). Changes in back pain, sleep quality, and perceived stress after introduction of new bedding systems(). *Journal of Chiropractic Medicine*, 8, 1-8.
- Johnson, M. (2010). 12-Transcutaneous electrical nerve stimulators for pain management. In: Longbottom, J. (ed.) *Acupuncture in Manual Therapy*. Edinburgh: Churchill Livingstone.
- Kemp, C., Ersek, M. & Turner, J. (2005). A descriptive study of older adults with persistent pain: Use and perceived effectiveness of pain management strategies [ISRCTN11899548]. *BMC Geriatrics*, 5, 12.
- Khatchadourian, Z. D., Moreno-Hay, I. & De Leeuw, R. (2014). Nonsteroidal anti-inflammatory drugs and antihypertensives: how do they relate? *Oral Surg Oral Med Oral Pathol Oral Radiol*, 117, 697-703.
- Kim, W., Jin, Y. S., Lee, C. S., Hwang, C. J., Lee, S. Y., Chung, S. G. & Choi, K. H. (2014). Relationship Between the Type and Amount of Physical Activity and Low Back Pain in Koreans Aged 50 Years and Older. *PM&R*, 6, 893-899.
- Mottram, S., Peat, G., Thomas, E., Wilkie, R. & Croft, P. (2008). Patterns of pain and mobility limitation in older people: cross-sectional findings from a population survey of 18,497 adults aged 50 years and over. *Qual Life Res*, 17, 529-39.
- Niemela, K., Leinonen, R. & Laukkanen, P. (2011). The effect of geriatric rehabilitation on physical performance and pain in men and women. *Arch Gerontol Geriatr*, 52, e129-33.
- To, T. H. M., Okera, M., Prouse, J., Prowse, R. J. & Singhal, N. (2010). Infancy of an Australian geriatric oncology program—characteristics of the first 200 patients. *Journal of Geriatric Oncology*, 1, 81-86.
- Tomey, K., Greendale, G. A., Kravitz, H. M., Bromberger, J. T., Burns, J. W., Dugan, S. A. & De Leon, C. F. (2015). Associations between aspects of pain and cognitive performance and the contribution of depressive symptoms in mid-life women: a cross-sectional analysis. *Maturitas*, 80, 106-12.
- Tsai, Y.-F., Liu, L.L. & Chung, S. C. (2010). Pain Prevalence, Experiences, and Self-Care Management Strategies Among the Community-Dwelling Elderly in Taiwan. *Journal of Pain and Symptom Management*, 40, 575-581.
- Tsai, Y.-F., Tsai, H.H., Lai, Y. H. & Chu, T.L. (2004). Pain prevalence, experiences and management strategies among the elderly in taiwanese nursing homes. *Journal of Pain and Symptom Management*, 28, 579-584.
- Tse, M. M., Vong, S. K. & Ho, S. S. (2012). The effectiveness of an integrated pain management program for older persons and staff in nursing homes. *Arch Gerontol Geriatr*, 54, e203-12.
- Tsuji, T., Yoon, J., Aiba, T., Kanamori, A., Okura, T. & Tanaka, K. (2014). Effects of whole-body vibration exercise on muscular strength and power, functional mobility and self-reported knee function in middle-aged and older Japanese women with knee pain. *The Knee*, 21, 1088-1095.
- Urban, D., Cherny, N. & Catane, R. (2010). The management of cancer pain in the elderly. *Critical Reviews in Oncology/Hematology*, 73, 176-183.
- Weigl, M., Cieza, A., Cantista, P. & Stucki, G. (2007). Physical disability due to musculoskeletal conditions. *Best Pract Res Clin Rheumatol*, 21, 167-90.
- Worku, Z. (2000). Prevalence of low-back pain in Lesotho mothers. *J Manipulative Physiol Ther*, 23, 147-54.