FACTORS INFLUENCING NURSES' DECISIONS TO USE NON-PHARMACOLOGICAL THERAPIES TO MANAGE PATIENTS' PAIN

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ABSTRACT

This study investigated nurses' beliefs and attitudes toward the use of non-pharmacological therapies as adjunct pain management strategies. Registered nurses (RNs) (n=37) from the medical, surgical, oncology/palliative care and critical care areas of two Australian hospitals participated in a series of focus group discussions that explored the use of non-pharmacological therapies to help manage patients' pain in a hospital setting. Results from the discussions identified that nurses believe non-pharmacological therapies offer several advantages to the management of patients' pain and general well being. For example non-pharmacological therapies were recognised to be useful as adjuncts while waiting for medications to take effect. However significant barriers such as lack of organisational and professional support were also identified as hindering nurses' current usage of non-pharmacological therapies. Further investigation of the key issues from this study is recommended to improve non-pharmacological pain management and enhance patient outcomes.

BACKGROUND

There is considerable literature relating to the prevalence and severity of pain amongst hospitalised patients (Najman 1993; Donovan, Dillon and McGuire 1987; Melzack et al 1987), with some studies suggesting that up to 75% of patients experience moderate to severe pain and that in many cases this pain is not relieved adequately (Miaskowski 1993; Agency for Health Care Policy and Research (AHCPR) 1994; Donovan et al 1987).

Unrelieved pain may result in distress and suffering (AHCPR 1994; Havily et al 1992; Rankin 1982; Mayer 1985; Ward et al 1993), decreased ability to participate in activities of daily living (DePalma and Weisse 1997; Rankin 1982; Ward et al 1993), decreased patient satisfaction and increased health care costs (AHCPR 1994).

Traditionally, pain management tended to emphasise the use of pharmacological agents. However, pain is influenced by an array of physical and psychosocial factors, and patients differ in their response to pain and to analgesics. Therefore, it is important to have a range of options, including non-pharmacological therapies available, in order to manage patients' pain most effectively. Guidelines produced by the World Health Organisation (WHO) and the Agency for Health Care Policy and Research (AHCPR) recommend the inclusion of non-pharmacological therapies for pain, where appropriate, to ensure optimal pain control is achieved (AHCPR 1994).

Despite the persistence of unrelieved pain and the potential benefit of using non-pharmacological therapies to help relieve pain, an under-utilisation of non-

pharmacological therapies by nurses managing patients' pain has been identified in the literature.

Chart audits carried out by Clarke et al (1996) confirmed that 90% (n=82) had no documented evidence of the use of any non-pharmacological interventions to relieve pain. Similarly, in a study by Dalton (1989), although nurses had knowledge about non-pharmacological therapies, only 25% reported actually implementing them in practice. Ferrell et al's (1990) study of decision-making by RNs for patients in pain also found that non-pharmacological pain treatments were used by the respondents in only 6% of the patient situations.

This documented under-utilisation of non-pharmacological therapies for pain management raises questions and the need to understand the factors influencing the use of such therapies in a hospital setting. The purpose of this study was to examine nurses' perceptions of the use of non-pharmacological therapies for the management of pain, and to identify factors that influence nurses' usage of these therapies.

METHODOLOGY

This study involved a series of focus group interviews with RNs from two metropolitan hospitals in Brisbane, Australia. Focus group interviews are a recognised qualitative research approach carried out using a small targeted group who are led in a discussion about a topic that is central to the research investigation (Krueger 1988). This research approach was selected as an appropriate method to gather qualitative data on the factors that may influence nurses' usage of non-pharmacological therapies as adjunct pain treatments.

Table 1: Nurse focus group demographics (n=37)

Gender	**n**	**%**
Female	35	95
Male	2	5
Years of practice		
Two years or less	3	8
2.1-5 years	5	14
5.1-10 years	9	24
10.1-20 years	11	30
Greater than 20 years	9	24
Area of practice		
Medical/surgical	19	51
Oncology/palliative care	11	30
Critical care	7	19
Level of employment		
Registered Nurse (level 1)	15	41
Clinical Nurse (level 2)	16	43
CNC/Educator (level 3)	6	16

Participants

RNs from the medical/surgical, oncology/palliative care, and critical care areas of one private hospital and one public hospital were invited to participate in the focus group discussions. A total of 37 nurses participated in the discussions. As shown in Table 1, the majority of these were female (94.6%), and had been nursing for more than 10 years (54%). The focus groups were held in locations identified as convenient by the participants from the various clinical settings. The sessions were also scheduled at a time of day (during the handover period between day and evening shifts) which enabled nurses to participate in the discussions with the least interruption to their clinical work. Participation in the focus group discussions was voluntary and anonymity was assured.

Data collection

Three focus groups were held at each of the two participating hospitals (one for nurses from each of the clinical specialities targeted in this study). Each focus group ran for approximately one hour and was audio taped with participants' permission. A member of the research team who was also a staff member at the given hospital moderated the sessions. Trigger questions, used as a basis for the discussion, were developed by the research team using the PRECEDE model of health behaviour (Green 1980). This model identifies key factors influencing health behaviour (here, nurses' use of non-pharmacological therapies) to be predisposing, enabling, and, reinforcing. ***Predisposing factors*** such as beliefs, attitudes, values and perceptions facilitate or hinder a person's motivation to perform the desired behaviour. ***Enabling factors*** include the skills and resources necessary to perform the behaviour. ***Reinforcing factors*** comprise the feedback provided by people such as co-workers, doctors, and patients that influence the continuance or discontinuance of the behaviour. Examples of the trigger questions are shown in Table 2.

Participants were also asked to complete a brief demographic questionnaire that asked for information including years of nursing practice, level of employment, and types of non-pharmacological therapies used in the past 12 months.

Data analysis

The audio recordings of each focus group discussion were transcribed verbatim. Two research team members ('primary analysts') independently analysed three of these transcripts to identify key recurring themes related to the

Table 2: Nurse focus group trigger questions	
1	Some nurses choose to use treatments that are non-pharmacological to help manage patients' pain. What do you know about these non-pharmacological therapies?
2	Tell me about the times when you chose to implement non-pharmacological therapies to manage pain. What prompted you to implement these therapies?
3	Tell me about the times when you chose not to implement non-pharmacological therapies for pain What made you decide not to implement them?
4	How do you think people felt about you implementing non-pharmacological therapies?
5	What do you believe are the benefits/advantages of implementing non-pharmacological therapies?
6	What do you believe are the limitations/disadvantages of using non-pharmacological therapies?
7	What needs to happen to encourage the appropriate use of non-pharmacological therapies for managing pain?

main components of the PRECEDE framework. After meeting together to discuss their results, a list of tentative themes was developed. The remainder of the research team then reviewed these themes after they had read the same three transcripts. Some minor revisions to the codes were made to clarify definitions and labels of the themes. The resultant list of themes was then used to re-code the original three transcripts and code the remaining three transcripts. Of the remaining three transcripts, one each was coded by the two 'primary analysts' and the third by both 'analysts' to check for coding consistency. Correlation between the coders' analysis of the last transcript showed a high degree of consistency with the application of the coding schemes.

RESULTS

Extent of use of non-pharmacological therapies

Analysis of the demographic questionnaire indicated that 89.2% of the participating nurses reported that they had previously implemented non-pharmacological therapies to manage hospitalised patients' pain. Previous classifications of non-pharmacological therapies as **physical** (eg massage), **cognitive behavioural** (eg relaxation) (AHCPR 1994), or **meridian/energy-based** (eg therapeutic touch) (Clavarino and Yates 1995), were applied to group the therapies previously used by the focus group participants. Results showed that physical modalities were used most commonly (41%). These were closely followed by cognitive/behavioural therapies (38%) and to a much lesser extent meridian/energy based therapies (15%). A small percentage (5%) of therapies used (eg creating a calm environment, giving patients control) were classified as 'other'. Table 3 provides a complete list of the reported non-pharmacological therapies previously used by focus group participants to manage patients' pain.

Table 3: Non-pharmacological therapies used by nurses		
Therapy used (n=138*)	**n**	**%**
Massage	22	16
Relaxation	19	14
Distraction (eg music)	18	13
Heat	16	12
Counselling/education	11	8
Cold	10	7
Aromatherapy	7	5
Reiki/therapeutic touch	7	5
Acupuncture/acupressure/reflexology	7	5
Touch	5	4
Imagery/visualisation	5	4
Positioning	4	3
Other	7	5
Number of nurses (n=37) who had implemented one/more non-pharmacological therapy for pain management.	33	89

(* Multiple therapies used by some nurses)

Factors influencing the use of non-pharmacological pain therapies

Positive and negative factors identified by nurses as influencing their decisions and ability to use non-pharmacological therapies are presented in Table 4. In the discussion that follows, the dominant issues from the interviews are described in more detail incorporating examples from the data to illustrate the issues more clearly.

Predisposing factors

Factors that may predispose an individual to engage in a particular behaviour include knowledge, attitudes, values and perceptions (AHCPR 1994). In the present study, nurses described several beliefs about pain and pain management that may influence their decisions concerning whether or not to use non-pharmacological therapies.

Beliefs about the nature of pain

A majority of participants identified that pain is multi-dimensional and that using non-pharmacological therapies, in combination with medications, offers a more

Table 4: Positive and negative factors influencing nurses' use of non-pharmacological therapies (NPT)		
PREDISPOSING FACTORS	**POSITIVE FACTORS**	**NEGATIVE FACTORS**
Beliefs about the nature of pain	• NPT treat multidimensional aspect of pain • Psychosocial benefits of NPT	
Beliefs about the benefits of NPT	• Overall improvement to patients' pain • Increases nurses' 'quality' time with patients • Enhances nurse/patient relationships • Offer patients' a sense of control over pain	
Commitment to NPT		• Lack of priority given to NPT • Lack of continuity with NPT administration
ENABLING FACTORS		
Time	• Nurses' time saved through improved patient status and satisfaction	• Nurse's lack of perceived time to implement NPT
Knowledge and skills	• Nurses have basic knowledge and skills for administering 'basic' therapies	• Nurses' lack expert knowledge and skills for administering complex therapies • Lack of consistent level of knowledge and skills may lead to haphazard administration of NPT
Organisational support		• Lack of priority placed on NPT • Conflicting ability for nurses to implement NPT independently • Lack of hospital policy and guidelines • Lack of professional endorsement • Difficulties associated with medical model • Nurses lack of authority to administer NPT
REINFORCING FACTORS		
Patient attitudes		• Patients socialised to expect pharmacological pain relief not non-pharmacological
Health professional attitudes	• Acceptance of anecdotal evidence supporting NPT usage	•Lack of scientific evidence supporting NPT usage • Lack of support from nursing peers • Lack of support from medical staff and other health professionals
Organisational factors	• Hospital mission statements advocating holistic care	• Lack of resources/priority allocated to NPT administration

holistic approach to pain management than using medications alone. One nurse summed this up by saying:

'... most times, the pain they have is multifaceted, and so an injection of morphine and some relaxation therapy, or some counselling, or some acupuncture to me is appropriate, because you are not dealing with one sort of pain.'

Some participants also acknowledged that psychosocial issues can exacerbate pain and non-pharmacological therapies offer particular advantages in addressing such issues. For example:

'I think a lot of pain is manifested by excess stress and when they [patients] talk they get rid of a lot of that, and they relax and they can then choose not to have the narcotic or even Panadeine forte - they just relax, so I think it's worthwhile.'

Beliefs about the benefits of non-pharmacological therapies

A common theme in nurses' comments regarding their decisions to use non-pharmacological therapies related to the perceived benefits of such therapies with respect to pain relief. Benefits most commonly endorsed by participants included:

- non-pharmacological therapies offer pain relief whilst 'waiting for' pharmacological agents to work;
- non-pharmacological therapies allow a reduction in the amount of opioid medication required by patients;
- non-pharmacological therapies distract patients during painful procedures;
- non-pharmacological therapies help patients' emotional pain and anxiety; and
- non-pharmacological therapies provide patients with some control over their pain management.

Furthermore, nurses also agreed that these therapies provide other benefits such as the opportunity for enhanced communication between nurses and patients. One nurse shared her experiences:

'I have found that massage is a very good opening for touching the patient and just letting them know that you have got time for them, and that they have got the opportunity to talk if they like, they can use the massage to relax and get rid of that pain.'

It was commonly felt that such verbalisation was therapeutic for patients:

'Yes, and with communication - just the fact that they can express what they want to express can take a lot off their shoulders and make them feel better.'

Other comments further suggested that these aspects of non-pharmacological therapies were important as they helped contribute to therapeutic nurse-patient relationships. One clear example of this was:

'Quite often using pharmacological (agents) means giving them a pill, or an injection and that's it. If you stay and apply some of these other therapies, you're giving them time to ventilate and you're nurturing them.'

Moreover, some nurses believed that non-pharmacological therapies offer patients the opportunity to be more 'in control' of their pain. This was recognised as an important advantage of using non-pharmacological therapies for the following reasons:

'I suppose it might make the person feel a bit less impotent, a bit less reliant on doctors giving them pain killers, if they think, hey, I can do this, and I can do that, or I can get my husband to massage my back, or I can tilt the bed this way, or whatever it is - it gives them a bit of power.'

'I think most people want to know a little bit more about how they can be more in control by choosing some other form themselves.'

Enabling factors

Factors which may be considered as enabling within the PRECEDE model include the availability and accessibility of resources, and the skills of the individual themselves. The participants in this study identified issues pertaining to both these types of enabling factors.

Time and resource allocation

All participant groups expressed concerns about the time needed to implement non-pharmacological therapies. Common themes in participants' comments with respect to this issue included (1) the significant amount of nursing time required to implement non-pharmacological therapies properly, and (2) the implications this had in practice:

'Sometimes I think - our days are very busy anyway caring for the patients, and then you add on a bit of reflexology and a bit of massage, and it's all time - it's time with the patient, but it's also time away from other things - something has to give to get this done.'

Participants commented that non-pharmacological therapies were not always discussed with patients if there were more seemingly urgent things to do:

'Depending on your workload - it's quicker to give a drug than it is to sit for 20 minutes rubbing someone's back, or talking to them'.

Participants generally felt that non-pharmacological therapies are not considered 'standard practice' and their implementation does not always receive a high priority within the hospital environment. With current economic rationalisations, nurses felt they were already over-extended on a shift, and struggling to meet the many demands placed on them by other nurses, hospital administration and patients, without the burden of including non-pharmacological therapies. One nurse aptly described the problem:

'Well, the situation is at the moment, that because of the lack of resources, we have a situation in the ward where staff are stretched to the very limits, so therefore, they are having trouble actually providing basic care, which I think is probably standard around a lot of institutions at the moment, so what I was saying is that we would actually like to have the resources to give that (basic care), and then, we would actually like the resources so that we could actually improve upon it.'

Although nurses were largely supportive of non-pharmacological therapies, their ability to implement such interventions were often counterbalanced by perceived restrictions such as lack of time and resource allocation. Paradoxically, some participants made the point that the implementation of non-pharmacological therapies can lead to less demands from patients and therefore a saving in overall nursing time:

'It's rewarding nursing because you really feel like you are getting to know the inner person - it's not as time consuming when that happens - if you give a person time and, I believe touch, that touching whether it be massage, or comfort based, it's amazing how much difference that makes in terms of their demands of nursing time - it really cuts that down, so that in the short term, it might be an effort to do that, but in the long term, I think you benefit in terms of not such a demanding shift.'

Participants in one of the medical/surgical focus group also discussed the perceived benefits of having a resource nurse primarily responsible for implementing non-pharmacological therapies to patients. This idea was well supported in the group as having benefits for patients (through regular access to non-pharmacological therapies), and for the resource nurse (through increased job satisfaction).

Nurses' skills in administering non-pharmacological therapies

Several nurses identified that the incorporation of non-pharmacological therapies in 'routine' nursing care requires certain levels of knowledge and expertise. It was

recognised that basic forms of non-pharmacological therapies, e.g. the use of hot and cold packs, were already part of nursing practice. However, to include other more specialised therapies such as massage, aromatherapy and imagery, it was suggested that specific training would be required:

'If nursing staff are going to initiate complementary therapies, our knowledge and expertise is very variable - we're all comfortable with heat packs and touching our patients, and talking with our patients and so on, but we all have a varying degree of expertise and knowledge about other therapies.'

Whilst it was recognised that education in non-pharmacological therapies was included to some extent in undergraduate nursing courses, many nurses felt that a more uniform approach to non-pharmacological therapy education and training would be necessary before these therapies could be successfully implemented. The importance of skilled administration of these therapies was emphasised:

'I think it would be fairly important that you didn't have a whole lot of people charging off half cocked in different directions, implementing stuff that they thought was a good idea, but weren't actually skilled at' and, *'I think there is something to be gained by learning to do it properly.'*

Nevertheless, nurses' ability to provide comfort and 'healing' to patients even through simple touch, listening and 'being there', was seen to be as important as the implementation of more technically complex therapies:

'I don't think you have to be terribly skilled to communicate through touch - you don't have to be a qualified masseuse to be able to rub somebody's feet and back - it's just the contact, the fact that you are doing it, and the fact that you have caring energy.'

On the face of it, such comments suggest somewhat contradictory views about the nature of non-pharmacological therapies, and the types of knowledge and skills required to implement such therapies effectively. On the one hand, such therapies require specific education to be used effectively, while on the other, they are considered in some circumstances to be an extension of 'basic' nursing care.

Reinforcing factors

In the PRECEDE model, reinforcing factors refer to attitudes and behaviours of peers, family or other health professionals. In the present study, several important attitudes that are likely to influence nurses' decisions regarding their use of non-pharmacological therapies were identified.

Patient attitudes

Although nurses felt that non-pharmacological therapies offer patients many benefits in terms of pain relief, distraction, emotional and comfort measures, they also identified that they could not successfully implement the therapies if patients did not believe in their efficacy or value the use of such therapies. For example:

'You've really got to have a belief in what is happening before you find some sort of result and I think people either have to experience that or believe in that pathway themselves before they get a positive result - it's very hard for you to be effective if you are trying to talk somebody into it.'

The socialisation of hospitalised patients was believed to be a factor that may deter patients from accepting non-pharmacological therapies. One nurse summed this up:

'Coming into an acute care setting means they will receive pharmacological agents... in acute care settings the patients are socialised into expecting to receive pharmacological agents, they are not socialised into the opposite.'

Another nurse stated that:

'Some people certainly aren't wanting anything else (other than medication) - that's the way that's acceptable to them - the only solution that's acceptable to them, and they won't accept anything else you give them.'

Nurses suggested that although some patients were receptive to non-pharmacological therapies, acceptance from patients for their use ***in a hospital setting*** was essential to successful implementation of such therapies.

Health care professional attitudes

Support from nursing peers, medical officers and hospital administration was identified as affecting nurses' ability to administer non-pharmacological therapies. Several nurses commented that their fellow nursing colleagues often had mixed opinions about non-pharmacological therapies. Whilst some organisational support for their inclusion in patients' pain management was acknowledged, participants strongly felt that significant nursing, medical staff and hospital management did not place priority on the administration of such therapies. Some nurses felt a lack of confidence in themselves and their peers to independently incorporate the therapies in their nursing practice fearing reactions of their colleagues (including doctors):

'There is a fear - fear of how we will be accepted by colleagues if we are behind the curtain doing this weird stuff.'

If was also perceived that, if non-pharmacological therapies are not accepted by others (eg nurses, doctors and hospital administration), it would be difficult for

nurses to validate the time and resources spent administering the therapies:

'There are those that would say why are you bothering with that, get on with the real work - and that attitude is still very strong.'

Some nurses felt that increased knowledge and exposure to non-pharmacological therapies would result in greater acceptance for the inclusion of non-pharmacological pain management in nursing practice:

'We have to educate everyone regarding non-pharmacological pain management and the benefits that it will bring.'

Some reference was also made to the need for a greater evidence base to support non-pharmacological pain management before medical staff and hospital administration would accept these therapies:

'The acceptance basically comes from getting research - facts and figures of what we are talking about' '... to be able to have something scientific [showing] that there are benefits would be great.'

It was interesting to note, however, that in some circumstances, some nurses were content to implement non-pharmacological therapies if they believed patients benefited, even without having this scientific evidence supporting the usage of non-pharmacological pain management. For example:

'It's nice to have those things to back you up, but if you don't have the statistics to back you up, it's not going to stop you from putting a hot pack on someone.'

Organisational factors

Overall nurses found it difficult to justify using their time implementing therapies that are not perceived as a high priority by other nursing colleagues, or hospital and nursing management:

'It's a conflict sometimes, you feel that you would like to do more of that sort of thing, but you feel you should go on with all the practical, technical stuff that has to be done as well.'

Nurses also expressed the belief that implementing non-pharmacological therapies not only offered benefits to patients, it also helped authenticate hospital philosophy and achieve the goals of hospital mission statements:

'Actually, it's not only the staff and the patients that benefit from it - I mean the staff get something back, the patients, certainly, I think, respond better to it, but it also says something about the hospital, I think if you are prepared to go that little bit further ... it will make a difference in terms of promoting the hospital and the type of nursing care, and the staff here, and as has been said, it helps start to achieve that mission statement and puts some truth back into it.'

DISCUSSION

The purpose of the present study was to explore, through focus group interviews, factors that may influence nurses' decisions to use non-pharmacological therapies. The main issues that emerged from the focus group discussions were the perceived benefits associated with using the therapies, the lack of time to implement these therapies, and a degree of ambivalence regarding the acceptance of such therapies by patients, medical staff, other nursing staff and hospital administration.

The opportunity that non-pharmacological therapies may offer in areas such as improved communication between patients and nurses are clearly important issues for further investigation. Participants in this study generally believed that implementing non-pharmacological therapies would provide nurses with a unique opportunity to further develop their therapeutic relationship with patients. This would facilitate patients' verbalisation of concerns and allow nurses to address psychosocial issues, which may be influencing the patient's pain.

Nurses also believed that patients gained a heightened sense of reassurance that nurses were concerned about their welfare and available when needed. These notions are consistent with research findings that have shown that non-pharmacological therapies are associated with psychosocial benefits such as decreased anxiety, tension, increased sense of control, and physical benefits such as decreased pain (Arathuzik 1994; Beck 1991; Strong et al 1989). Focus group participants stated that after receiving non-pharmacological pain relief, they believed that patients placed less demands on their (nurses') time, that patients achieved a greater sense of control, were more relaxed and settled, and were more able to participate in activities of daily living (such as mobilisation and sleeping).

Despite the perceived benefits of non-pharmacological therapies, several barriers were also identified which may be hindering the effective use of non-pharmacological therapies. Of particular note is that there are several apparent contradictions surrounding the implementation of non-pharmacological therapies in daily practice. For example, of primary concern is that the value placed on non-pharmacological therapies in managing patients' pain in today's health care setting is not high. Although nurses identified several important benefits of non-pharmacological therapies associated with improved pain management, improved patient satisfaction, feelings of self control, enhanced nurse/patient relationships and ability to fulfil hospital goals and mission statements, they also acknowledged that implementing non-

pharmacological therapies was not always a priority. The primary reason for this was a perceived lack of time to implement non-pharmacological therapies due to organisational pressures to complete more 'traditional nursing tasks'. A degree of perplexity was expressed by nurses relating to hospital mission statements that advocate a holistic approach to practice with emphasis on excellence in care, yet do not provide nurses with the necessary time and resources to implement 'excellent care'.

Nurses also felt uncertain about the degree of acceptance of non-pharmacological therapies by patients, nurses, and doctors and the significance of this acceptance. Whilst it was acknowledged that patients would have to agree to use non-pharmacological therapies before they received them, different opinions existed about the degree of support and acceptance toward non-pharmacological pain management offered by nursing and medical peers. What was agreed, however, was that for the administration of non-pharmacological therapies to be successful, negative opinions expressed to patients (either from nurses or doctors) would have to be minimised. Participants identified that lack of support for non-pharmacological therapies from other nurses and doctors could potentially prevent patients from agreeing to the implementation of non-pharmacological therapies, and could also prevent nurses from administering these therapies through fear of recrimination and ridicule. It would seem that the reality of daily practice is that non-pharmacological therapies don't receive the priority they deserve because they are not recognised as 'standard' care, and thus lack support from nursing and medical colleagues. Some also emphasised the lack of scientific evidence that is essential to gaining this support. Such contradictions and tensions exemplify the difficulties surrounding the routine implementation of non-pharmacological therapies in the contemporary health care context.

The constraints associated with the effective use of non-pharmacological therapies that have been identified in the present study are consistent with other writings in this area. That is, non pharmacological therapies are typically seen as being underutilised due to: time constraints placed on the delivery of care (Ferrell et al 1991); nurses' beliefs that non-pharmacological therapies are too 'simple' to use in a hospital setting (Kelvinson and Payne 1993); nurses' lack of knowledge or skills in implementing non-pharmacological therapies (Edgar and Smith-Hanrahan 1992); the lack of scientific evidence supporting non-pharmacological therapy usage (Mayer 1985); the fear of recrimination from peers, a willingness to conform to ideals and practice within the 'medical model', and a reluctance to practice without specific orders (Astberger 1995; Rankin-Box 1995; Snyder 1992). Despite this there is some evidence to suggest that there is an increasing interest in the use of non-pharmacological therapies.

Limitations

Participation in the focus groups was voluntary, and as such it was expected that only those nurses interested or experienced in non-pharmacological therapies would participate. This does present some limitations with respect to generalisation of results, and also may mean that some usage issues would not be identified. However, this study was designed as a preliminary study to obtain information for questionnaire development that would further explore the pertinent issues with a broader sample including nurses not necessarily experienced or interested in non-pharmacological therapies. Therefore, some experience or interest in non-pharmacological therapies was beneficial.

CONCLUSION

Overall nurses in this study felt that although administration of non-pharmacological therapies was sometimes difficult with significant obstacles, benefits not only to patients but also to the organisation makes the pursuit of this activity worthwhile. During the discussions, nurses identified that non-pharmacological therapies are useful to implement in conjunction with pharmacological treatments, particularly to ease patients' pain while waiting for pharmacological analgesics to work; and, between doses of pharmacological analgesics. The benefits non-pharmacological therapies offer with respect to communication and allowing patients to verbalise any anxieties were also identified as useful in addressing the multidimensional nature of pain. Furthermore, nurses also felt that non-pharmacological therapies gave patients the means to feel more in control.

Despite these benefits, it was clear that the use of non-pharmacological therapies was not part of standard nursing practice. Perhaps one of the main reasons non-pharmacological therapies are not part of routine nursing practice is a lack of understanding and disagreement about the role that these therapies play in improving patients' pain management.

Throughout these focus group interviews numerous contradictions were reported. For example, on the one hand, non-pharmacological therapies were seen to require specific knowledge and skill, while on the other hand they were seen to be simply an extension of basic nursing care. It was apparent during the interviews that nurses tended to view non-pharmacological therapies generically, and were not perhaps as well informed about subtle differences between different therapies, or of how particular non-pharmacological therapies worked in particular situations.

These issues associated with the use of non-pharmacological therapies suggest there is an urgent need for further conceptual clarification of the nature and scope of specific types of non-pharmacological therapies as an

important starting point. For example, a taxonomy of non-pharmacological therapies, or clinical guidelines with more clearly defined evidence based information regarding the particular uses and benefits of specific therapies, may be of great assistance in clarifying the scope for such therapies. The development of such tools will require, however, a great deal more research into the efficacy of particular therapies in specific clinical situations.

Similarly, a further contradiction evident in this study is that while the holistic approach was an acknowledged feature of non-pharmacological therapies, and recognised as offering enormous benefits to patients, support at the organisational level, and from peers and other health professionals was not perceived to be forthcoming. These results highlight the significance of organisational and cultural factors in nurses' decision making, and indicate that adequate attention will also need to be given to addressing the many barriers that hinder the use of these therapies in a hospital setting.

It is important to note here, however, that one of the most promising findings from these focus group interviews is that nurses appear to have a keen interest in the adjunct use of non-pharmacological therapies to manage patients' pain. Such interest represents an excellent base on which to further develop the role of non-pharmacological pain management.

Nevertheless, the views expressed by nurses in this study indicate that, as well as address knowledge and information deficits of individual practitioners regarding non-pharmacological therapies, educational initiatives thus need to be targeted to address the cultural beliefs and attitudes within an organisation or unit which determine the value that is placed on non-pharmacological therapies. Furthermore, the results of this study suggest that support from nursing administration through allocation of time with patient acuity systems, and acceptance and/or support from medical officers for certain therapies to be implemented, may go some way to improving the use of non-pharmacological therapies by nurses. In the current climate of cost constraint, this is only likely to occur if nurses can clearly demonstrate through rigorous patient outcome studies, that benefits actually derive from the use of these therapies.

RECOMMENDATIONS

The authors intend to extend these research findings through the use of quantitative studies. It is anticipated that these studies will help support and clarify the findings from this pilot study. However, the usage and acceptance of non-pharmacological therapies would be enhanced further by research investigating:

- The efficacy of particular therapies in specific clinical settings;
- The impact of non-pharmacological therapy usage on patient acuity with respect to health care costs; and,
- The role of non-pharmacological therapies in nursing practice with respect to nurse/patient relationships, nursing autonomy and job satisfaction.

REFERENCES

Agency for Health Care Policy and Research (AHCPR). 1994. Management of cancer pain. *Clinical Practice Guideline: number 9.*

Arathuzik, D. 1994. Effects of cognitive-behavioural strategies on pain in cancer patients. *Cancer Nursing*. 17(3):207-214.

Atsberger, D. 1995. Relaxation Therapy: its potential as an intervention for acute postoperative pain. *Journal of Post Anaesthesia Nursing*. 10(1):2-8.

Beck, S. 1991. The therapeutic use of music for cancer-related pain. *Oncology Nursing Forum.* 18(8):1327-1336.

Clarke, E., French, B., Bilodeau, M., Capasso, V., Edwards, A. and Empoliti, J. 1996. Pain management, knowledge, attitudes and clinical practice: the impact of nurses' characteristics and education'. *Journal of Pain and Symptom Management.* 11(1):18-31.

Clavarino, C. and Yates, P. 1995. Alternative therapies for cancer pain, in Lupton, G. and Najman, J. *Sociology of health and illness: Australian readings, 2nd edition*. Brisbane: MacMillian Education Australia.

Dalton, J. 1989. Nurses' perceptions of their pain assessment skills, pain management practices and attitudes toward pain. *Oncology Nurses Forum.* 16(2):225-231.

DePalma, M. and Weisse, C. 1997. Psychological influences on pain perception and non-pharmacological approaches to the treatment of pain. *Journal of Hand Therapy.* April-June:183-191.

Donovan, M., Dillon, P. and McGuire, L. 1987. Incidence and characteristics of pain in a sample of medical-surgical inpatients. *Pain.* 30:69-78.

Edgar, L. and Smith-Hanrahan, J. 1992. *Non-pharmacological pain management.* St Louis, Mosby Year Book.

Ferrell, B., Eberts, M., McCaffery, M. and Grant, M. 1991. Clinical decision-making and pain. *Cancer Nursing.* 14(6):289-297.

Ferrell, B.A., Ferrell, B.R. and Osterweil, D. 1990. Pain in the nursing home. *Journal of the American Geriatric Society.* 389(4):408-413.

Green, L. 1980. *Health education planning: a diagnostic approach.* California: Mayfield Publishing Company.

Havily, C., Gagnon, J., MacLean, R., Renz, J., Jones, O., De Witt, W., Nyberg, K., Burns, C. and Pohl, D. 1992. Pharmacological management of cancer pain. *Cancer Nursing.* 15(5):331-346.

Kelvinson, R. and Payne, S. 1993. Decision to seek complementary medicine for pain: A controlled study. *Complementary Therapies in Medicine.* 1:2-5.

Krueger, R. 1988. *Focus groups. A practical guide for applied research.* Newbury Park: Sage.

Mayer, D. 1985 Non-pharmacological management of pain in the person with cancer. *Journal of Advanced Nursing.* 10:325-330.

Melzack, R., Abbott, F., Zachon, W., Mulder, D. and Davis, M. 1987. Pain on a surgical ward. *Pain.* 29:67-72.

Miaskowski, C. 1993. Current concepts in the assessment and management of acute pain. *Medical Surgical Nursing*. 2:28-40.

Najman, J. 1993. Prevalence and perceptions of pain amongst hospitalised patients, (Unpublished data). University of Queensland: Brisbane.

Rankin, M. 1982. Use of drugs for pain with cancer patients. *Cancer Nursing.* 5:181-190.

Rankin-Box, D. 1995. *The Nurses' Handbook of Complementary Therapies.* Melbourne, Churchill Livingstone.

Snyder, M. 1992. *Independent Nursing Interventions, 2nd Edition.* Albany: Delmar Publications.

Strong, J., Cramond, T. and Maas, F. 1989. The effectiveness of relaxation techniques with patients who have chronic low back pain. *The Occupational Therapy Journal of Research*. 9(3):184-192.

Ward, S., Goldberg, N., Miller-McCauley, V., Mueller, C., Nolan, A., Pawlik-Plank, D., Robbins, A., Stormoen, D. and Weissman, D. 1993. Patient-related barriers to the management of cancer pain. *Pain.* 52:319-324.