Pain Management Nursing 20 (2019) 1–2

Contents lists available at ScienceDirect

Pain Management Nursing

journal homepage: www.painmanagementnursing.org

Editorial

Complementary and Integrative Approaches to Pain and Patient Preference

There is increasing agreement that orthodox Western medicine, for all its achievements in diagnosing and treating disease, must embrace a more holistic, patient-centered approach, especially for chronic illnesses that lack scientific cures, like persistent pain. According to the National Institute for Complementary and Integrative Health (2018), more than 30% of adults and about 12% of children use complementary modalities in the U.S. Recent guidelines published by a number of healthcare and professional organizations underscore the importance of embedding complementary approaches into an integrative treatment plan for pain. For instance, the Centers for Disease Control and Prevention (CDC) (Dowell, Haegerick, & Chou, 2016) recommend that non-opioid pharmacologic therapy, along with complementary approaches, be the preferred treatment for chronic pain. The American Academy of Pain Medicine (2013) and the Federation of State Medical Boards (2017) also advocate for integrative approaches that include pharmacologic, interventional, and non-pharmacologic methods. In addition, the latest guidelines set forth by the Joint Commission (2017) stipulate that healthcare organizations provide non-pharmacologic pain treatment modalities that reflect a patient-centered approach.

Regard for patient preference is closely aligned with a patient-centered approach to pain management. It is an important component of evidence-based nursing practice, and research findings show that when patients receive treatment options they prefer, there are better health outcomes (Bishop, Bialosky, Penza, & Beneciuk, 2017). Patient preference is unique to the person and predicated on the person's values; it extends beyond treatment preference to include preference for a given health care state or a specific outcome. The concepts of options and choice are involved. When considering a given set of options, preference means that a person prefers and chooses one or some over others. Without choice, preference is not possible. In healthcare, patients cannot have a choice until they are apprised of all options. Nurses must be committed to earnestly inform each patient of possible treatment options and supporting evidence, make certain there is a clear understanding of options, invite discussions where preferences are revealed and examined, and integrate those preferences into a patient-centered plan of care. Our work as nurses entails being knowledgeable of pertinent guidelines and best practices for pain management, including evidence for specific complementary modalities, communicating relevant information to the patient, and respecting patient choice.

A recent systematic review and narrative synthesis of 152 published qualitative and quantitative studies of patients with pain related to musculoskeletal conditions (Corp, Jordan, & Croft, 2018) gives us a glimpse into why patients choose/continue or avoid/discontinue complementary alternative medicine (CAM).

- Practical aspects of care. Cost plays a role; CAM is used if it is perceived as a cheaper alternative to orthodox care and covered by insurance or employers. The ease with which individuals can access CAM influences use or non-use. Those who view orthodox medicine as a more practical option, tend to avoid the use of CAM. For many, use of CAM is linked to a doctor's formal referral, suggestion or approval, or a significant other's success with its use. Desperation can also be a motivating factor for some individuals.
- Clinical effectiveness of care. Perceived effectiveness is a major factor determining use, continuation, or discontinuation of CAM. Many individuals use of CAM to bring about a specific health outcome, such as improved sleep, or as a preventative measure, such as determent of pain-related reduced mobility. Confidence in CAM or CAM practitioners also influences use or non-use.
- Other outcomes of care. Satisfaction, disappointment and frustration with orthodox care oftentimes drive individuals to use CAM. Safety concerns are also involved. CAM is many times viewed as safe with few or no side effects. Side effects of orthodox medications frequently motivate individuals to use CAM, especially to help ameliorate side effects of medications, such as nausea.
- Philosophy of illness and care. Chronic or serious illnesses that progress quickly, especially in younger individuals, are related to CAM use. Non-serious conditions with mild or vague symptoms also elicit use. Perceptions of CAM being “natural,” “holistic,” “individualized,” “gentler,” and “enjoyable” generate its use. Beliefs about “taking control of” and “being proactive about” health care are also driving forces. A frequent barrier to the use of CAM is religious beliefs.

Nurses are at the forefront of studying complementary and integrative pain treatment approaches. This issue of *Pain Management Nursing* provides a rich range of levels of evidence for the use of a variety of complementary approaches with diverse patient populations across the lifespan who experience procedural, acute, chronic, cancer, and end-of-life pain. Findings from several studies provide support for the use of music with patients diagnosed with end-stage liver disease (Pathania, Slater, Vose, & Navarra, 2019), those undergoing bone marrow aspiration (Özdemir, Taşcı, Yildizhan, Aslan, & Eser, 2019), and infants in neonatal intensive care units (Tekgündüz, Polat, Gürol, & Apay, 2019). Relaxation is well-studied and often used with other complementary modalities. In this issue, Felix, Ferreira, da Cruz, & Barbosa (2019) present findings

https://doi.org/10.1016/j.pmn.2018.11.059
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from an integrative review of relaxation therapy with guided imagery for post-operative pain. Dikmen and Terzioglu (2019) give evidence for the use of reflexology and relaxation during chemotherapy for gynecologic cancer. And, Gonzalez et al. (2019) report the outcomes of an evidence-based eight-week "Relaxation Response Resiliency Program (3RP)" for patients diagnosed with musculoskeletal or headache pain. Several novel modalities are described in this issue, such as the use of comfort kits for cancer pain management (Blackburn, Abel, Green, Johnson, & Panda, 2019), yoga nidra for pain during colonoscopy (Li et al., 2019), and auricular acupressure for patients with a variety of pain diagnoses (You, Kim, Harris, & D'Alonzo, 2019). Lastly, findings from several studies in this issue extend the evidence for the use of established complementary modalities in different cultures, like mindfulness for Brazilian patients with musculoskeletal pain (Lopes, Vannucchi, Demarzo, Cunha, & Numes, 2019), aromatherapy for Turkish patients diagnosed with osteoarthritis (Arslan, Kutlutürkan, & Korkmaz, 2019), and therapeutic touch for Austrian patients with back pain (Mueller, Palli, & Schumacher, 2019).

We hope you enjoy this focused issue on complementary and integrative approaches for pain and use the knowledge gained to invite patient discussion, come to understand patient preference, and assimilate patient preference into a holistic plan of care. We hope that the articles stimulate thought and creativity for continued development and testing of complementary modalities with diverse populations, and in the course of time, contribute to promising pain outcomes.

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