

Nursing Attitudes Toward Patients with Substance Use Disorders in Pain

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■ ABSTRACT:

The problem of inadequate pain management in hospitals is well documented. Patients who have substance use disorders (SUD) have many medical problems and are often in pain as a result of these problems. Nurses often lack knowledge of appropriate treatment of both pain and SUD, and have been identified as having negative attitudes toward patients with SUD. The negative attitudes may affect the quality of care delivered to patients with problems of pain and SUD. The purpose of this study was to identify and explore nurses' attitudes toward hospitalized patients with SUD who are in pain, to expand the knowledge about nurses' attitudes and interactions with patients with SUD in pain, and to generate theory that will contribute to a greater understanding of the problem. Grounded theory methodology was used to interview hospital-based nurses who work with patients with SUD who are in pain. Individual interviews, using a semistructured interview guide, were conducted with 14 nurses who worked with this population. Additionally, an expert addictions nurse was interviewed at the end of the study to validate the findings. Interviews were analyzed and coded with the use of grounded theory concepts. A model illustrating the categories and their relationships was developed based on the theory generated as a result of the study. The implications for nursing practice, education, research, and policy are discussed.

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The problem of inadequate pain management in United States medical settings is well documented (Institute of Medicine, 2011). This problem is made even greater when the patient is a person with a current or prior history of substance use disorder (SUD). Studies have revealed that chronic pain is up to two to six times greater in patients with a history of SUD (Gureje, von Korff, Simon, & Gater, 1998; Jamison, Kaufman, & Katz, 2000; Rosenblum, Joseph, Fong, Kipnis, Cleeland, & Portenoy, 2003; Verhaak, Kerssens, Dekker, Sorbi, & Bensing, 1998). Portenoy, Dole, Herman, Lowinson, Rice, Segal, and Richman, (1997) described the lack of knowledge and provider attitudes as barriers to effective pain management for the population of patients with pain and SUD. In the U.S., opiophobia, i.e., the widespread fear of opiate pain relievers, is a result

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of lack of information and the prevalence of the media and government 'war on drugs'. This attitude that exists in the public domain has had its effect on professional beliefs as well (Morris, 1999).

Pain affects quality of life in a negative manner if untreated or undertreated. This effect on quality of life may also negatively affect the relapse in a patient with SUD. Attitude and beliefs influence pain management behavior (Rokeach, 1970). Nurses are the health care providers who spend the most time with patients and provide medications and other interventions to treat patients' pain. Their attitudes toward pain, SUD and its effect on their treatment of patients is therefore of vital importance in the provision of good pain care.

REVIEW OF THE LITERATURE

Nurses Attitudes Toward Pain Problems

Xue, Schulman-Green, Czaplinski, Harris, and McCorkle (2007) reviewed nurses', physicians', and pharmacists' attitudes and knowledge about pain on an oncology service and found that medical oncology nurses believed that ~59% underreported their pain and 12% overreported their pain. Nurses who regularly cared for cancer patients were less likely than physicians to believe that patients overreported pain. The attitudes of the three groups all revealed positive and consistent attitudes about pain management, but also indicated the need for more education for all three groups.

In a seminal work, Fagerhaugh and Strauss (1977) identified three themes about pain management in institutions that continue to be relevant 35 years later. The themes were (pp. iii-v):

- 1) Pain management takes place within organizational settings that affect the character of the interactions between staff and patients in pain.
- 2) Political processes (such as persuading, appealing to authority, negotiating, threatening) are involved in the interaction between patients and staff.
- 3) Hospitals and the activities of the employees in hospitals are organized around a dominant model of acute care or a disease-oriented model that is often not appropriate for the needs of patients with chronic problems, which are often the majority of patients in pain.

The social world of the hospital or health care setting is subject to the same socialization processes as the larger social system, because those employed in the health care setting are also members of society at large. Therefore, many health care workers unknowingly perpetuate labels and contribute to stigmatization and marginalization of people with SUD. Volinn (1983) listed three categories of traits that are stigmatized

by health care professionals: 1) social characteristics, such as age, race, religion, and lower educational status; 2) patients' behavior, particularly behavior that rejects medical authority; and 3) physical characteristics, such as chronic and malignant disease, that don't respond well to treatment (Volinn, 1983, p. 388). Clearly, patients with SUD have some of these characteristics, such as rejection of medical authority, and chronic illness that does not respond well to treatment.

Nurses' Attitudes Toward Patients with Substance Use Disorders

Howard and Chung (2000a) reviewed the research of the previous three decades on nurses' attitudes toward patients with SUD. They noted that nurses' attitudes appear to be more positive than they were in the 1960s; however, a significant minority of nurses continued to have a negative stereotype of patients with SUD. Howard and Chung (2000b) also compared nurses' attitudes with those of other groups of helping professionals (physicians, psychologists, social workers, clerical personnel, and chemical dependency personnel) and found that nurses were more negative and punitive and had more authoritarian orientations toward patients with SUD than other groups and supported compulsory treatment of patients with SUD (Howard & Chung, 2000b). Younger nurses and those with more education held more favorable attitudes toward patients with SUD than those who were older and had fewer years of education (Howard & Chung, 2000a). The relationship between attitudes and negative overt behavior is not simple, or even necessarily linear; however, this is an important issue to examine in the treatment of patients who have SUD.

Addiction terminology has been found to affect the attitudes of professionals toward patients (Kelly & Westerhoff, 2009). In a recent study of mental health care providers, participants were given a survey with one of two vignettes. One vignette described an individual with "substance use disorder," and the other described a "substance abuser"; all other aspects of the vignettes were identical. Participants were asked to rate how much they agreed with the causes of the problem and whether the person should "receive more therapeutic or punitive action, was a social threat, and was capable of regulating his substance use behavior" (Kelly & Westerhoff, 2009, p. 2). The study found no difference between the two groups in terms of social threat or victim treatment, but those who were assigned the "substance abuser" term were more likely to elicit a response that the character was personally responsible for his condition and more likely to agree that punitive measures should be taken.

Importance to Nursing

Nurses are the health care providers who are in most frequent contact with patients with SUD seeking health care (Howard & Chung, 2000a). Howard, Walker, Walker, and Suchinsky (1997) documented that most nursing programs did not have adequate content about SUD. Lack of understanding about SUD may negatively affect the quality of nursing care delivered to patients with SUD, especially regarding management of painful medical conditions (Morgan, 2006).

PURPOSE OF STUDY

The present study is an extension of earlier research that examined patients with SUD's understanding of their interactions with nurses around pain management issues (Morgan, 2006). As a part of the previous study, two focus groups with nurses were conducted to react to the model developed that described patients' understanding of their interactions with nurses (Appendix A). The focus group findings suggested that nurses' attitudes toward patients with SUD needed further exploration. The aim of the present study was to expand the knowledge about nurses' attitudes and interactions with patients with SUD who were in pain, and to generate theory that will contribute to a greater understanding of the problem.

The research questions were:

- 1) What difficulties have you encountered in dealing with hospitalized patients with SUD who are in pain?
- 2) What are the difficulties that occur in your interactions with patients with SUD who were in pain?
- 3) How do you agree/differ with the model describing patients' understanding of their difficulties interacting with nurses around pain management (Morgan, 2006)?

METHODS

A grounded theory approach was used to interview hospital nurses that worked with patients with SUD who were in pain. Glaser (1978) described a priori conditions of grounded theory as having as few previous conditions as possible; therefore, no theoretical framework was used. Individual interviews were conducted. A semistructured interview guide (Appendix A) was used and consisted of a broad opening question and additional probes. Demographic data were also collected (Appendix B).

Following responses to the interview guide, the nurses were shown the model "Knowing How to Play the Game: Hospitalized Substance Abusers' Strategies for Obtaining Pain Relief" (Fig. 1) and were asked to comment on it. All interviews were audiotaped

and transcribed, and the transcriptions were reviewed with the audiotapes for accuracy. The study was presented to nurse leaders in a nursing department meeting and a flyer containing information about the study was posted on each hospital unit. Any nurse who volunteered was included. There were no specific exclusion criteria.

Description of the Setting and the Sample

A sample of 14 participants, 12 women and 2 men, was obtained from an urban public health hospital. One of the participants was interviewed twice, once at the beginning of the study and once at the end of the study. This participant was interviewed twice because she was very interested in the research topic and wanted to improve her attitudes and responses to the patient population of the research project. Participants' ages ranged from 31 to 61 years of age. Appendix B provides information about the demographic of the sample.

Interview Procedures

The Institutional Review Boards of both the university and the hospital where the study was conducted approved the study. The study was then introduced to nurse managers and head nurses in a nursing department meeting; contact information for the investigator was provided to the nurses, along with a flyer containing information about the study to be shared with nurses on each hospital unit. Nurses volunteered to participate in the study by contacting the investigator by e-mail or phone. After agreeing to participate in the study, an interview was scheduled at the nurse's convenience in a private area at the hospital. Informed consent was obtained at the beginning of the interview. All interviews were audiotaped; demographic data were obtained before beginning the interview.

The interview was conducted with the use of a semistructured format with an interview guide (Appendix A). A general question about the nurse's experience in managing pain with patients with an addictive disorder was used to begin each interview. As more interviews were conducted and analyzed, more in-depth questioning occurred in subsequent interviews, based on previous interview data. As concepts and relationships between concepts began emerging from the data, the investigator shared these concepts and relationships with the participants, and they were asked to comment on how their own experiences were different or similar to that of other participants. Additionally, participants were shown the model "Knowing How to Play the Game" (Fig. 1) and asked to comment on it based on their experience with the population.

As the model "Nursing Attitudes towards Patients with SUD and Pain" was being developed, it also was

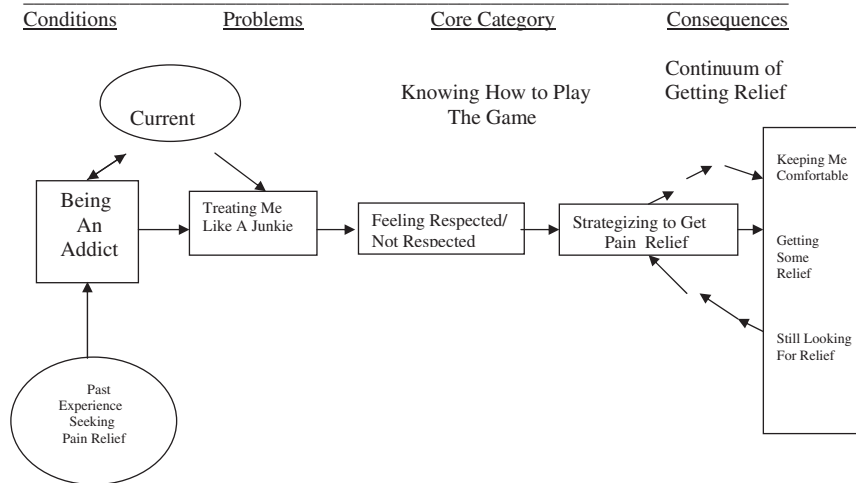


FIGURE 1. ■ Knowing how to play the game: hospitalized substance abusers' strategies for obtaining pain relief (Morgan, 2006).

shared with participants, and their feedback was solicited on whether or not this model reflected their experiences with the population of patients with pain and SUD. Written field notes were made during the interviews, following the interviews when the investigator listened to the tapes, and while reading the transcripts to highlight observations not captured on the tape, and describe the investigator's thoughts on the interviews.

One final interview was conducted with a nursing expert in the field of addictions. This participant was a doctorally prepared nurse who worked in the setting, and she reviewed the final model and commented on the categories and their relationships as they related to her understanding of the problem and the population of both patients and nurses in the setting.

Data Analysis

Data analysis began with the first interview. Field notes were used after each interview to describe nonverbal information and the investigator's impressions of the interview. Each audiotape was reviewed after the interview and transcribed, and the transcription was reviewed with the tape to assure accuracy of the transcript. Beginning concepts were identified after the first interview, and in each subsequent interview the concepts were compared with those from the other interviews. Concepts were grouped, and categories developed from these groups. Variations and differences among each category were developed based on interview data. Memos documenting the investigator's thoughts during these steps of data analysis assisted in refining follow-up questions in subsequent interviews. A tentative theory emerged from this process, and the theory was

described to participants who commented on its applicability to their own experiences (Morgan, 2006).

Open coding or line-by-line analysis was performed after each interview. As further interviews were conducted, axial coding was used to demonstrate the relationship of subcategories and the variation among categories (Charmaz, 2002; Strauss & Corbin, 1998). Interviews were conducted until saturation occurred, that is, no new information was obtained. Strauss and Corbin (1998) described theoretical saturation as when no theoretical variations were found.

Trustworthiness is the measure of data collection and analysis used in qualitative research. Trustworthiness includes credibility, transferability, dependability, and confirmability, concepts described by grounded theorists Glaser and Strauss (1967), Lincoln and Guba (1985), and Strauss and Corbin (1998). The description of each step of the process, along with the coding and development of the theory, is listed deliberately by the grounded theorist as a way to establish the "groundedness" in the data (Morgan, 2006; Morse, 2001).

Credibility describes the neutral stance of the investigator toward the data and is demonstrated when the investigator does what they say they are going to do in the research process (Glaser & Strauss, 1967; Morgan, 2006). The detailed descriptions of how data were collected, analyzed, and presented indicate the credibility of the information. Transferability or generalizability is limited in qualitative research because of the context of the setting and the time of the study (Morgan, 2006). Dependability indicates a way to determine the reliability of the data and is demonstrated by the audit trail of the research process. All of the notes, data, audiotapes, memos, and transcripts are available to determine the dependability of the data.

Confirmability is demonstrated by the use of thick descriptions from the data that clearly show that the findings can be deduced from the data (Glaser & Strauss, 1967; Lincoln & Guba, 1985; Morgan, 2006; Strauss & Corbin, 1998).

Model Development

After the third interview, model development was initiated to demonstrate related categories as they emerged from the data. The model was shared with participants in each subsequent interview and changed with the variations that participants described in the interviews. Strauss and Corbin (1998) described this process of diagramming as a way to force the investigator to analyze the logic of the relationships. Discussion of the model with participants and the nurse expert in the field helped to further refine the questions in the final interviews and the final depiction of the model. The final model is depicted in Figure 2.

THE MODEL: "NURSING ATTITUDES TOWARD PATIENTS WITH SUD AND PAIN"

The model included two core action categories: "Labeling/Not Labeling Pain Behavior" and "Encountering Barriers." In this model, the word labeling is used as tool for recognizing and understanding; that is, labeling is not always a negative construct. These two core categories were preceded by contributing conditions of "Nurse's Attitudes About Pain and Addiction" and "Patient's Pain Behavior." These contributing conditions affected the problem identified in the model "Reacting to the Behavior/Understanding the Behavior." The pathways to the core categories and the consequences of the "Patient" and "Pain Treatment" are pictured by three different pathways that the participants described (Fig. 2).

The model presents three pathways from the point of the problem, "Reacting to the Behavior/Understanding the Behavior," continuing through to the Core Categories and the Consequences. The first pathway indicates that "Reacting to the Behavior" results in "Labeling the Pain Behavior" and the participant then "Encounters Barriers" and stops trying to manage the pain (Fig. 2, #1). The second pathway begins with the participant "Understanding the Behavior" then "Encountering Barriers" but participants in this pathway described continuing to push through the barriers to get to the "Patient" and "Pain Treatment" (Fig. 2, #2). The third pathway begins with "Understanding the Behavior" then skirting the barriers and/or going around the barriers to get directly to the "Patient" and "Pain Treatment" (Fig. 2, #3). Participants described how they or other nurses that they worked with fit into these three different pathways. The model (Fig. 2) maps out the components of the model and the pathways.

The participants in this study each described their own attitudes and behavior and commented as well on their perceptions of the attitudes and behaviors of the nurses with whom they worked. This expanded information allowed for a greater variety in responses than the response of only the participant. Each participant described the population involved in response to the broad beginning question "Can you think of an example of a patient with these two problems and how you were involved with their care while they were in the hospital?" (Appendix A) of each interview. One participant stated:

You offer other ways to treat them, like, what if I turn you on your side or if I give you some extra pillows, or what if I change your position or something, if I ..., you know, some other way that the pain can be relieved. And, uh, they don't want it, they don't want to bear it. They don't even ... "Just give me the pills" and that kind of approach. They have very poor tolerance for the pain. They get very upset if you want to even

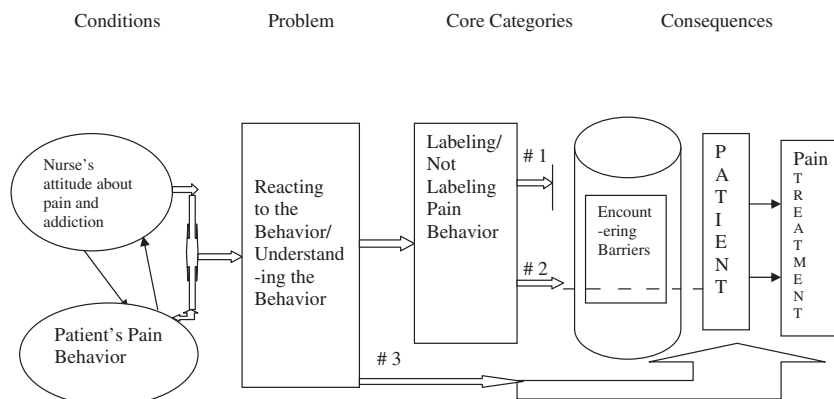


FIGURE 2. ■ Nursing attitudes toward patients with substance use disorders and pain.

approach them with something different. They just want the pill and they want it now. Or they want their injection or they want the needle but they want it now. In my experience they usually don't even want to hear any other suggestion and they get very upset: "My doctor ordered this for pain, my doctor said that he wanted me to have this." Almost like you're trying to prevent them from getting the pills.

Another participant described a particular patient with pain and as SUD problem:

Since he was 11 or 12—drugs, drugs, drugs, and then heroin. So, I mean, he had done everything under the sun, um, so that alone, um, I think some of it, I think a lot of it can also be the people He was pretty well together. He wasn't screaming, he wasn't yelling. He wasn't being obnoxious and swearing and cussing out everybody and all that. But it was just amazing the amounts of meds that it took for him to "get down" [in control of his pain]. His pain level was 10 across the board, at all times. I did medicate him with exorbitant amounts of medication ... [he] never blinked, never flinched, never dozed off I would expect that someone would've fallen asleep at least momentarily generally after giving large amounts of narcotics ... that they would at least doze off.

Each of the categories in the model will now be explained in detail.

CONTRIBUTING CONDITIONS

Contributing conditions included nurses' attitudes about pain, SUD, and the combined problems of pain and addiction, as well as the patient behaviors as a result of their pain. These conditions are described in the participants' words.

Nurse's Attitudes About Pain and Addictive Disorders

Nurses provided information about background factors that affected their attitudes about both pain and addictive disorders. Issues such as their own cultural background, years of experience as a nurse, education, personal experience of pain, family attitudes and values about pain and addiction and resources in their country of origin were issues that were commonly discussed in the interviews. A common comment about patients with pain and a SUD was: *"They think that the patient ... has a drug addiction ... they worry that it's [opiates] going to affect them ... they don't want to encourage addiction, so they don't want to give it."* One participant said:

In my culture ... some people get toughened. They don't believe in aspirin unless it's unbearable, but ... [not me] because I personally, I have my own [problems with chronic pain] ... I think because it's chronic my

body kind of like gets used to the pain ... I do take pain meds when it gets really bad ... I identify with that ... I'm sure they need to be believed, so I can sympathize with them.

Another nurse talked about the need for education:

They [other nurses] need to be educated about what addiction is and how it comes about ... nurses didn't think it was important at all to have all of these drug and alcohol counselors, and ... what are you thinking about? If somebody has cancer, you're going to find out what you can about cancer. If somebody's got a hernia you're going to find out what's wrong ... It's something that people have and you need to be educated about it.

One nurse felt that her years of experience as a nurse helped her and compared herself to less experienced nurses:

I'm not a new grad and I've evolved in my nursing career as well as from a personal standpoint too. Years ago I would not have had the patience to deal with somebody that was carrying on. Now I look at it from the standpoint that I'm not walking in their shoes ... so I can not begin to judge them based on what their history is So you kinda learn and I think new nurses and new grads, this is a difficult role to do, because they don't have the experience and they don't have a lot of confidence yet.

Patients' Pain Behaviors

Nurses discussed pain behaviors that they felt had an effect on how they managed the patient's pain. A common theme was expressed by one of the participants: *"They're very demanding, very demanding people; very difficult to please."* Another nurse described a situation: *"I go right to the bedside and say, 'Two Percocets, right, here are your Percocets,' and I open them up right in front of them because they get very suspicious. They get very suspicious ... To alleviate the anxiety in them—'Did she give me the right amount?'"*

Other participants discussed patient pain behaviors: *"Calling me all kind of names doesn't, is not going to make anything any different"; "When you yell at your nurse, or scream at your nurse, how do you think they're going to treat you?"*

Problem

The problem in the model "Reacting to the Behavior/Understanding the Behavior" described nurses response to the underlying conditions of nurses' attitudes and patients' pain behavior. Nurses demonstrated and described reacting behavior as well as understanding that contributed to how they proceeded with the process of managing pain. Participants often described how

other nurses had negative reactions to patients with addictive disorders and pain and reacted to behavior rather than describe their own reactions that might be perceived as negative.

Reacting to the Behavior/Understanding the Behavior

Participants described negative reactions by other nurses: "People have a bad attitude about people with substance abuse issues, you know ... they ought to have a little more compassion for those people because of what made them a drug addict."

Participants also described understanding the behavior they see in patients with addictive disorders and pain:

I've heard stories that would just make your hair curl and then I thought I can not possibly bear anything as bad ever again. And then a week later, somebody comes in with something even more horrific, and you know, you begin to understand, you know ... Why is it that we all aren't abusing drugs to, you know, avoid the traumas of life? Some people just don't have the same resilience that other people have in terms of, you know, making it through a trauma. And then they choose the method of just, you know, putting themselves into oblivion.

Another participant struggled with the reacting/understanding and stated:

Believe me, I'm trying to find ways because it is hard to give good care and when you have this negative feeling, it's hard to give good care, very hard, so I try ways to justify their behaviors so I can really work with them.

CORE CATEGORIES

The core categories in the model included "Labeling/Not Labeling Pain Behavior" and "Encountering Barriers." The interaction between these two core categories had a major effect on how the participants described the response to the patient and the pain treatment delivered to the patient, which is depicted in the three pathways that emerged from the data.

Labeling/Not Labeling Pain Behavior

Participants described a number of factors that contributed to whether or not the patients' behavior, and thus the patient, was labeled as "drug-seeking." The result of this label was not a positive one in terms of attention being paid to the patient needs. Issues that contributed to labeling (negative labeling) were the request for specific pain medications, asking for as needed (PRN) pain medications at the same time as regular pain medications were given, being accustomed to high doses of opiates,

walking around or "looking OK" until reminded of pain, not discussing other aspects of care (just focusing on the pain), and high doses of pain medication in general.

One participant described others' reactions:

Sometimes we say [to another nurse] "Why do you think that [that patient is a drug-seeker]?" "Oh, because he's a clock watcher. Oh, because, you know, he would ask for pain meds and the next thing you know, he's off the floor. So I don't think he's in pain."

Encountering Barriers

Participants described real barriers in the work place that affected their ability to provide pain treatment to patients. Barriers included low staffing patterns, high acuity, inability to contact prescribers, documentation problems, policies (such as mandatory pain education), and lack of resources, such as access to other providers who might include alternate strategies for pain management (acupuncture, relaxation, massage).

Multiple participants talked about the demands of computerized medical records to the point where "Nursing the Computer" was a consideration for a title of an earlier model. One participant stated:

And you have, I'll say 14 patients for example, so the medication nurse is thinking about finishing her meds and yes, she still has to document, so right there it's already, "Oh my God, will I ever finish?" So there's really no time to enjoy the patient, or listening to "what really is your pain?" ... and, I, you know, it's the computer, I think, is pulling us from our bedside nursing, it's preventing us from being at the bedside.

Many participants talked about being in the middle and having to negotiate with the prescriber for pain medications:

The patient was just writhing in pain and the orthopedic surgeon and the anesthesiologist were standing there and they were saying out loud, "I don't believe you." And then I looked at them and I said, "Wow," I said, "I sincerely hope that someday you're lying in a bed and the doctor and anesthesiologist come to you while you're in intractable pain and say, 'I don't believe you.'"

CONSEQUENCES

The consequences in the model are the "Patient" and "Pain Treatment." Participants described three different pathways to get to the patient and pain treatment. The first pathway (Fig. 2, #1) was described in terms of other nurses' responses to patients, that is, no participant described his/her own behavior in terms of this pathway. One participant described: "Like, we have one nurse here, and she will go off the floor when

a patient [with a substance abuse problem] asks for pain medicine. She will walk off the floor when they're talking about pain meds." Another participant who did speak about her own negative thoughts talked about her initial negative reaction and how she tried to deal with it; she did walk away, but also came back after she was able to regain her composure: "It's a very trying profession, you know and I've always found the instant the hairs on the back of my neck go up, it's stop ... get away from the situation and come back, because, you know, something is not quite right." And another participant described: "When they [nurses] think that somebody is addicted, they tend to overlook their pain. They think that those addicted patients have no pain. They're making it up and that's why they don't want to give it."

The second pathway (Fig. 2, # 2) resulted in participants struggling to move through the "Labeling/Not Labeling" and the "Barriers" to eventually reach the "Patient" and "Pain Treatment." This group struggled with barriers as already described as well as fears about legal issues; they spent a great deal of time worrying about whether the pain management they provided was going too far. One participant spoke of the frustration:

It's very difficult and I understand the frustration that we face because I feel it myself, I feel it myself and, you know, when you have to bring the doctor's order to the patient, then you have to bring the medication to the patient, then you have to call three times before the doctor answers your call, to tell the patient that you are working, trying to get more pain medication for him, and you are, have another patient you should be dealing with right now. That is when you feel it, honest to God the frustration is so high that I feel like screaming at them, you know, something, ... "I know you're in pain but what do you want me to do?" You have to deal with it. I mean that's a true feeling.

Legal concerns were mentioned several times. One participant said:

I'm advocating for the patient even though I know that the patient is taking a lot [of pain medication]. But at the same time I know that his tolerance is very, very high ... Even though, you know, I'm the one asking for more [pain medication from the doctor] because I really and truly believe that the patient needs more or is it just because I want to get him out of my face? ... It's not the right thing to do to give him more just to shut him up Secondly what worries me is like we say "Oh his tolerance is very high, but when are we going to cross that line? When are we going to get him a little bit too much?"

The third pathway (Fig. 2, # 3) was described by several participants. This group focused on the patient, their relationship with the patient, and the need to

provide quality pain management. This group discussed skirting the "Labeling/Not Labeling" and "Barriers" categories, and occasionally defying the rules to provide what they felt was quality care for the patient. One participant said:

I always said, I would rather do something to help somebody and lose my nursing license than to sit back and say, "Well it's not within the scope, you know ... I mean, I've done lots of things there were no doctor's orders for ... You gotta do what you gotta do, you know, especially if you're right there and you have some experience. As I got older I got more bold, you know, in terms of, you know, I'm not here, you know, other than to make sure that you have a good experience and that you get well. That's my job, you know? And I'm going to do it however I have to. I think it's part of my nature, um, but, as you get older, too, you throw caution to the wind.

Another participant stated:

The relationship between patients and nurses is, you know, is very important, and if you think about it, they've left their homes, or if they have homes or not, they're here, and to me nursing, like I tell other nurses, somebody's life is in your hands. They are trusting you ... and their life is in your hands. So if you don't look at pain, and then you don't treat them, you know ... it's like you are contributing to their condemnation or whatever way you put it So long as the person is here and we've taken a vow to care for the patient, I think we should do it with all our heart.

And another participant stated: "You're there to help them. There's something, you know, and we make things complicated, but there's something simple on some level, and it's an art."

DISCUSSION

In this model, participants described three different pathways to providing pain management for patients with SUD and pain in a hospital setting. These three pathways indicate variation among participants in their approach to managing pain for patients with SUD in the hospital. Nurses are often given a fair amount of control over pain management such that, despite educational programs for prescribers, pain medication orders are often written on an as-needed basis rather than around-the-clock or routine orders. The effects of "Reacting to Pain Behavior" and "Labeling Pain Behavior" may result in inadequate response to needs for pain management (first pathway) or delayed response to needs for pain management (second pathway). Nurses who chose the third pathway did not necessarily constitute the norm for response to pain for patients with SUD and discussed the fact that they had difficulties with

administrative personnel for their responses and/or attitudes. All participants discussed the stigma related to SUD and the effect of the stigma on health care providers and response to pain in this population.

Corley and Goren (1998) discussed the “dark side of nursing” and examined the effect of stigmatizing, labeling, and stereotyping of patients on quality of patient care and the nurses themselves. They found dissatisfaction among patients and the nurses providing their care. Meleis, Hall, and Stevens (1994) examined the potential for marginalization, and a subsequent decrease in quality of care. McCreadie, Lyons, Watt, Ewing, Croft, Smith, and Tocher (2010) discussed the decreased tolerance for aberrant behaviors and “ethical erosion” (p. 2,736) that can occur among nurses who work with people with pain and SUD. The participants in the present study of patients with SUD and pain also discussed stigmatization and effect of labeling, as well as the effect on quality of pain management and on the participants themselves. The participant who was interviewed twice discussed her concern with her negative reactions to patients and her struggle with her reactions.

Johnson and Webb (1995) found that nurses spent less time with patients who were viewed negatively, providing only physical care but not really talking with those patients. Nurses also delayed care, failed to advocate for patients, were hurried or rough, criticized patients, and demonstrated disapproval of patients who were angry or hostile (Johnson & Webb, 1995; Kelleher, 2007; Lovi & Barr, 2009; McCreadie et al. (2010); Pallikkathayil & McBride, 1986; Sines, 1994). Being labeled or stigmatized can result in premature discharge and neglect, and can cause the patient to feel frustrated, scared, depressed, angry, and upset (Lorbar, 1975; Rieman, 1986). Participants in the present study portrayed nurses who fit into pathway #1 in a similar fashion.

Nurses’ negative responses to patients also affect the nurses themselves. Nurses have reported psychologic stress with their own “irrational” responses to persons with AIDS (Swanson, Chenitz, Zalar, & Stoll, 1990). Feelings of guilt and a moral dissonance about not liking a patient have been identified by nurses (Johnson & Webb, 1995), as well as feelings of guilt, shame, and grief about not acting professionally (Fisher, 1995).

Countertransference occurs commonly among health care providers working with patients with SUD (Forrest, 2002; Morgan, 2006). When nurses are not given the education and tools to manage their negative reactions to patients with SUD and pain, adequate pain care may not be delivered. Education and support for nurses who provide care to this population has not been adequate and needs improvement (Kelleher, 2007; Kelleher & Cotter, 2009; Lovi & Barr, 2009).

In summary, participants in the present study described their own and other nurses’ responses to patients with SUD and pain who were hospitalized and how their response effected delivery of pain management to the patients. Participants reacted to or understood patient pain behaviors, based in part on their own attitudes about pain and SUD. This reaction or understanding led to labeling or not labeling of pain behavior, which in combination with real barriers in the hospital led to three pathways of managing the patient and their pain. This study examined the responses of a small number of participants in an urban public health hospital and is not necessarily generalizable to a larger sample in different settings.

IMPLICATIONS FOR NURSING PRACTICE AND RESEARCH

This research study provides information about the need for education and further research in the areas of SUD and pain management. The model requires further testing in a variety of clinical areas and diverse settings. Awareness of the impact of stigmatization and labeling of patients and the impact on care delivery is vital, yet not often discussed in health care settings (Morgan, 2006). Nurses need more education about both pain management and SUD and how to cope more effectively with patient behaviors when both problems are present. Encouraging nurses to examine their own belief systems and how they may affect care is one way to provide nurses with further tools to manage their own responses. Support for nurses when they experience the negative reactions to patient behaviors that can commonly occur with this population is essential, yet rarely provided to staff nurses. Educational programs that include case scenarios and role-playing situations may be of great benefit. Routine staff support groups on inpatient units are an additional way to provide education and support for nurses (Morgan, 2006; Morgan & White, 2009). McCreadie et al. (2010) suggested that nurses “should reclaim” communication and interaction with patients (p. 2,738). Maintenance of effective nurse-patient relationships is often overlooked in our fast-paced medical environment; the importance of these relationships is probably more pressing now than in past decades and needs to be reemphasized not only in nursing education, but in clinical settings as well.

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REFERENCES

- Charmaz, K. (2002). Qualitative interviewing and grounded theory analysis. In J. F. Gubrium, & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 675-694). Thousand Oaks, CA: Sage Publications.
- Corley, M. C., & Goren, S. (1998). The dark side of nursing: Impact of stigmatizing responses on patients. *Scholarly Inquiry for Nursing Practice, 12*(2), 99-122.
- Fagerhaugh, S. Y., & Strauss, A. (1977). *Politics of pain management: Staff patient interaction*. Menlo Park, CA: Addison-Wesley.
- Fisher, A. (1995). The ethical problems encountered in psychiatric nursing practice with dangerous mentally ill persons. *Scholarly Inquiry for Nursing Practice, 9*, 193-208.
- Forest, G. G. (2002). *Countertransference in chemical dependency counseling*. Binghamton, NY: Haworth Press.
- Gureje, O., von Korff, M., Simon, G. E., & Gater, R. (1998). Persistent pain and well-being: A World Health Organization study in the primary care. *Journal of the American Medical Association, 280*, 147-151.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine, Atherton.
- Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociological Press.
- Hall, J., Stevens, P., & Meleis, A. (1994). Marginalization: A guiding concept for valuing diversity in nursing knowledge. *Advances in Nursing Science, 16*(4), 23-41.
- Howard, M. O., & Chung, S. S. (2000a). Nurses' attitudes toward substance misusers. I: Surveys. *Substance Use and Misuse, 35*(3), 347-365.
- Howard, M. O., & Chung, S. S. (2000b). Nurses' attitudes toward substance misusers. II: Experiments and studies comparing nurses to other groups. *Substance Use and Misuse, 35*(4), 503-532.
- Howard, M. O., Walker, R. D., Walker, P. S., & Suchinsky, R. T. (1997). Alcohol and drug education in schools of nursing. *Journal of Alcohol and Drug Education, 42*(3), 54-80.
- Institute of Medicine (2011). *Relieving pain in America: A blueprint for transforming prevention, care, education and research*. Washington, DC: National Academies Press.
- Jamison, R. N., Kaufman, J., & Katz, N. P. (2000). Characteristics of methadone maintenance patients with chronic pain. *Journal of Pain and Symptom Management, 19*, 53-62.
- Johnson, M., & Webb, C. (1995). Rediscovering unpopular patients: The concept of social judgment. *Journal of Advanced Nursing, 21*, 466-475.
- Kelleher, S. (2007). Health care professionals' knowledge and attitudes regarding substance abuse and substance users. *Accident and Emergency Nursing, 15*, 161-165.
- Kelleher, S., & Cotter, P. (2009). A descriptive study on emergency department doctors' and nurses' knowledge and attitudes concerning substance use and substance abusers. *International Emergency Nursing, 17*, 3-14.
- Kelly, J. F., & Westerhoff, C. M. (2009). Does it matter how we refer to individuals with substance-related conditions?: A randomized study of two commonly used terms. *International Journal of Drug Policy, 21*, 202-207.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.
- Lorbar, J. (1975). Good patients and problem patients: Conformity in a general hospital. *Journal of Health and Social Behavior, 16*, 213-216.
- Lovi, R., & Barr, J. (2009). Stigma reported by nurses related to those experiencing drug and alcohol dependency: A phenomenological Giorgi study. *Contemporary Nurse, 33*(2), 166-178.
- McCreadie, M., Lyons, I., Watt, D., Ewing, E., Croft, J., Smith, M., & Tocher, J. (2010). Routines and rituals: A grounded theory of the pain management of drug users in acute care settings. *Journal of Clinical Nursing, 19*, 2730-2740.
- Morgan, B. (2006). Knowing how to play the game: Hospitalized substance abusers' strategies for obtaining pain relief. *Pain Management Nursing, 7*(1), 31-41.
- Morgan, B., & White, D. (2009). Managing pain in patients with co-occurring addictive disorders. *Journal of Addictions Nursing, 20*(1), 41-48.
- Morris, D. B. (1999). Sociocultural and religious meanings of pain. In R. J. Gatchel, & D. C. Turk (Eds.), *Psychosocial factors in pain: Critical perspectives*. New York: Guilford Press.
- Morse, J. M. (2001). Situating grounded theory within qualitative inquiry. In R. Schrieber, & P. S. Stern (Eds.), *Using grounded theory in nursing* (pp. 1-17). New York: Springer.
- Pallikkathayil, L., & McBride, A. B. (1986). Suicide attempts. *Journal of Psychosocial Nursing, 24*(8), 113-118.
- Portenoy, R. K., Dole, V., Herman, J., Lowinson, J., Rice, C., Segal, S., & Richman, B. L. (1997). Commentary. *Journal of the American Medical Association, 278*(7), 592-593.
- Rieman, D. (1986). Noncaring and caring in the clinical settings: Patients' descriptions. *Topics in Clinical Nursing, 8*(2), 30-36.
- Rokeach, M. (1970). *Beliefs, attitudes, and values: A theory of organization and change*. San Francisco: Jossey-Bass.
- Rosenblum, A., Joseph, H., Fong, C., Kipnis, S., Cleeland, C., & Portenoy, R. (2003). Prevalence and characteristics of chronic pain among chemically dependent patients in methadone maintenance and residential treatment facilities. *Journal of American Medical Association, 289*, 2370-2378.
- Sines, D. (1994). The arrogance of power: A reflection on contemporary mental health nursing practice. *Journal of Advanced Nursing, 20*, 894-903.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage Publications.
- Swanson, J. M., Chenitz, C., Zalar, M., & Stoll, P. (1990). A critical review of human immunodeficiency virus infection and acquired immunodeficiency syndrome-related research: The knowledge, attitudes, and practice of nurses. *Journal of Professional Nursing, 6*, 341-355.
- Verhaak, P. F. M., Kerssens, J. J., Dekker, J., Sorbi, M. J., & Bensing, J. M. (1998). Prevalence of chronic benign pain disorder among adults: A review of the literature. *Pain, 77*, 231-239.
- Volinn, I. J. (1983). Health professionals as stigmatizers and stigmatized of diseases: Alcoholism and leprosy as examples. *Social Science Medicine, 17*(7), 385-393.
- Xue, Y., Schulman-Green, D., Czaplinski, C., Harris, D., & McCorkle, R. (2007). Pain attitudes and knowledge among RNs, pharmacists, and physicians on an inpatient oncology service. *Clinical Journal of Oncology Nursing, 11*(5), 687-695.

APPENDIX A**Interview Guide***Broad Beginning Question:*

I am interested in learning more about how nurses respond to hospitalized patients who have problems with substance abuse and pain. Can you think of an example of a patient with these two problems and how you were involved with their care while they were in the hospital?

Probes:

1. How was the patient's pain managed?
2. How did you feel about the pain management for this patient?
3. Was the patient's pain difficult to manage?
4. Were there problems encountered in bringing the pain under control?
5. How did other staff members respond to the patient's pain complaints?
6. How did the patient's problems with substance abuse affect his/her pain management?

Can you think of anything else that might be important for me to know to understand the issues encountered by nurses in the pain management of patients who have problems with substance abuse?

BSN	3	21%
BS	1	7%
What is the highest nursing degree that you have?		
LPN	3	21%
RN diploma	3	21%
Associate degree	3	21%
BSN	5	38%
Master degree	0	
Doctoral degree	0	
What is the primary shift that you work?		
Day shift	8	57%
Evening shift	5	38%
Night shift	1	7%

APPENDIX B**Demographic Data**

What do you consider your race?		
White (including non-black Latino)	6	43%
Black	5	36%
Native American	0	
Asian or Pacific Islander	2	14%
Mixed race	0	
Other	1	7%
What is your ethnic background?		
African American	1	7%
Latino	2	14%
European American	3	21%
Asian or Pacific Islander	2	14%
American Indian/Native American	1	7%
Mixed background	1	7%
Other	4	29%
How long have you been a nurse?		
<1 year	0	
1–5 years	1	7%
6–10 years	1	7%
11–15 years	1	7%
16–20 years	4	29%
21–25 years	3	21%
>25 years	4	29%
What was your basic nursing preparation?		
LPN	5	38%
RN diploma	3	21%
Associate degree	3	21%

(Continued)