NON-PHARMACOLOGICAL STRATEGIES IN SYMPTOM MANAGEMENT IN PALLIATIVE CARE BY NURSES

Estratégias não farmacológicas na gestão de sintomas em cuidados paliativos, pelos enfermeiros

Estrategias no farmacológicas en el manejo de síntomas en cuidados paliativos por parte de los enfermeros

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ABSTRACT

Background: the average life expectancy has increased, demanding healthcare professionals to acquire new skills in caregiving. Managing symptoms in Palliative Care involves the use of pharmacological and non-pharmacological measures, contributing to minimize suffering and preserve dignity. Research Question: What are the non-pharmacological measures identified by nurses in symptom management in Palliative Care? **Objectives:** to understand the non-pharmacological measures identified by nurses in symptom management in Palliative Care. **Methodology:** qualitative, exploratory-descriptive paradigm, semi-structured interviews with 10 nurses from a Palliative Care Unit. Content analysis was conducted according to Bardin. Informed Consent, Free and Informed Consent, and favorable opinion from the Ethics Committee for Life and Health Sciences were obtained. **Results:** non-pharmacological measures in symptom management have the ability to promote the person's comfort. We found that communication, complementary therapies, environmental management, family involvement, and providing appropriate information for the situation play a central role in minimizing suffering. **Conclusion:** verbal and non-verbal communication is understood as a strategy in symptom management. Complementary therapies, family involvement, and understanding of the sick person are essential for individualized intervention.

Keywords: palliative care; symptoms; non-pharmacological interventions; nursing

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RESUMO

Enquadramento: a esperança média de vida aumentou, exigindo aos profissionais de saúde novas competências no cuidar. Gerir sintomas em Cuidados Paliativos implica utilizar medidas farmacológicas e não farmacológicas, contribuindo para minimizar o sofrimento e preservar a dignidade. Questão de investigação: Quais as medidas não farmacológicas identificadas pelos enfermeiros na gestão de sintomas em Cuidados Paliativos? **Objetivos:** conhecer as medidas não farmacológicas identificadas pelos enfermeiros na gestão de sintomas em Cuidados Paliativos. **Metodologia:** paradigma qualitativo, exploratório-descritivo, entrevista semiestruturada a 10 enfermeiros de uma Unidade de Cuidados Paliativos. Efetuada análise de conteúdo segundo Bardin. Obtido Consentimento Informado, Livre e Esclarecido e parecer favorável da Comissão de Ética Para as Ciências da Vida e da Saúde. **Resultados:** as medidas não farmacológicas na gestão de sintomas têm a capacidade de promover o conforto da pessoa. Verificamos que a comunicação, as terapias complementares, a gestão ambiental, o envolvimento da família, o fornecimento de informação adequada à situação tem um papel central para a minimização do sofrimento. **Conclusão:** a comunicação verbal e não-verbal é entendida como uma estratégia na gestão de sintomas. As terapias complementares, o envolvimento da família e o conhecimento da pessoa doente são fundamentais para uma intervenção individualizada.

Palavras-chave: cuidados paliativos; sintomas; intervenções não farmacológicas; enfermagem

RESUMEN

Marco contextual: la esperanza de vida promedio ha aumentado, lo que exige a los profesionales de la salud adquirir nuevas habilidades en el cuidado. El manejo de síntomas en Cuidados Paliativos implica el uso de medidas farmacológicas y no farmacológicas, contribuyendo a minimizar el sufrimiento y preservar la dignidad. Pregunta de investigación: Cuáles son las medidas no farmacológicas identificadas por las enfermeras en el manejo de síntomas en Cuidados Paliativos? **Objetivos:** comprender las medidas no farmacológicas identificadas por las enfermeras en el manejo de síntomas en Cuidados Paliativos. **Metodología:** paradigma cualitativo, exploratorio-descriptivo, entrevistas semiestructuradas con 10 enfermeros de una Unidad de Cuidados Paliativos. Se realizó un análisis de contenido según Bardin. Se obtuvo el Consentimiento Informado, Libre e Informado y el dictamen favorable del Comité de Ética para las Ciencias de la Vida y la Salud. **Resultados:** las medidas no farmacológicas en el manejo de síntomas tienen la capacidad de promover el confort de la persona. Encontramos que la comunicación, las terapias complementarias, el manejo ambiental, la participación de la familia y la provisión de información adecuada para la situación juegan un papel central en la minimización del sufrimiento. **Conclusión:** la comunicación verbal y no verbal se entiende como una estrategia en el manejo de síntomas. Las terapias complementarias, la participación de la familia y la comprensión de la persona enferma son fundamentales para una intervención individualizada.

Palabras clave: cuidados paliativos; sintomas; intervenciones no farmacológicas; enfermería

INTRODUCTION

Inadequate symptom management in Palliative Care compromises the patient's quality of life and leads to increased suffering. Therefore, comprehensive symptom management is essential to ensure a dignified life until the end. Nurses are encouraged to acquire skills in early symptom detection and intervention, considering the meaning each symptom holds for the patient. The perception and significance attributed to symptoms can vary.

Pharmacological measures are, in most cases, the primary choice in symptom management, often involving higher costs. To mitigate this challenge, non-pharmacological measures should frequently be used in conjunction with pharmacological ones.

In this context, the nurse's role in assessment, diagnosis, planning, and execution of interventions is highly valued, as these steps lead to effective outcomes. This entire process aims to combine pharmacological and non-pharmacological measures for the benefit of the patient, in alignment with the guidelines of the National Institute of Health and Care Excellence (NICE, 2020).

BACKGROUND

In palliative care, pharmacological measures should be enhanced to mediate and manage symptoms. Equally important are non-pharmacological measures, which should be implemented not only as standalone interventions but also alongside pharmacological measures to enhance their effectiveness. Among non-pharmacological measures, communication stands out as a cross-cutting element in all therapeutic approaches, addressing the patient, caregiver, and family. Communication is highlighted as a non-pharmacological measure by Ramos et al. (2024), who place the nurse-patient communication at the core of symptom management.

Human relationships confirm one's existence and are essential for life. In these relationships, communication becomes indispensable, ensuring survival and strengthening bonds that foster problem-solving opportunities. It is known that communication facilitates societal integration and shapes objectives, behaviours, and attitudes expected in one's social group.

According to Machado & Ribeiro (2022), one of the axioms of communication is that "it is impossible not to communicate." Behaviour itself is a form of communication, meaning there is no such thing as non-communication. The term "communication," from the Latin *communicare*, means to share, exchange opinions, or make something common.

In palliative care, the quality of care is strongly based on communication, which is one of the most demanding skills in facilitating interaction between the nurse, patient, caregiver, and family. Communication promotes teamwork and encourages increasingly individualized and differentiated care practices (Correia, 2018).

The communication skills of healthcare professionals are a major focus of evaluation by patients in palliative care and their families. The more complex and demanding the healthcare situations, the higher the expectations from the patient and family regarding the healthcare professional's communication skills (Soares et al., 2024).

Thus, it is essential to develop strong and assertive caregiving skills to better meet the needs of the patient, caregiver, and family. Communication

becomes not only a basic tool in care provision and therapeutic relationships but also a professional skill that can be developed and enhanced.

Creating an individualized care plan to address the detected needs of the palliative patient is one of the nurse's responsibilities. This process involves deciphering and understanding the meaning of the messages conveyed by patients.

In palliative care, establishing a successful therapeutic relationship between the healthcare professional and the patient's family is crucial. Since family members often provide care, the nurse-family partnership is essential for implementing a care plan. This partnership ensures an effective and efficient care plan, supporting symptom control and patient comfort.

Ethical principles inherent to communication processes cannot be overlooked; these principles shape the information conveyed to safeguard all parties involved. This premise is valid in any situation, including palliative care, where human relationships take on new meanings in the face of difficult moments.

The palliative patient desires to be understood as someone who suffers; beyond physical pain, existential conflicts arise that no medication can address. Feeling cared for, understood, and comforted by those around them provides protection, solace, and inner peace (Araújo & Silva, 2012).

Today, managing an incurable illness without considering patients' feelings and reactions, without empathy, and without practicing active listening is inconceivable. Only in this way can humanized, individualized palliative care be achieved. Thus, the development of skills such as emotional intelligence in nurses enhances assertive behaviour, fosters respect and empathy, and creates a trusting environment for patients and their families.

Empathy is a fundamental component in the communication process, as it enables effective involvement of the patient and their family in the entire therapeutic process. Empathy, as described by Ribeiro et al. (2024), is the ability to understand others in all their dimensions, guiding the nurse's actions toward the authenticity of what is perceived. Empathy is crucial, as its absence leads to a lack of understanding of the concept of Total Pain, defined as a syndrome affecting multiple dimensions of the self, including physical, psychological, spiritual, social, and emotional aspects (Gonçalves et al., 2024). Empathy redefines authenticity and congruence, fostering a trusting relationship.

Oliveira (2019) notes that caring for others goes beyond technical-scientific procedures and interventions; it requires helping relationships that demonstrate respect and understanding. For this reason, palliative care is redirected toward practices guided by principles reaffirmed by the World Health Organization (2002). These principles promote pain relief and alleviation of symptoms inherent to incurable diseases, adopting both pharmacological and non-pharmacological measures that can complement each other (Portuguese Palliative Care Association, n.d.).

According to some authors, including Vicente (2023), there is insufficient emphasis on the application of non-pharmacological measures in pain management and control. He highlights the need for protocol development to standardize symptom management practices, ensuring visibility for these measures,

which are often undocumented, underappreciated, and undervalued.

For these reasons, emphasizing the importance of non-pharmacological measures in symptom management and control is crucial. These measures can complement pharmacological approaches or function as standalone strategies, justifying the present study, which aims to highlight non-pharmacological strategies.

Research Question

What are the non-pharmacological measures identified by nurses in symptom management in Palliative Care?

METHODOLOGY

The research followed a qualitative, exploratory-descriptive paradigm, utilizing semi-structured interviews with nurses from a Palliative Care Unit.

Interview durations varied from approximately fifteen to forty-five minutes. Interviews were recorded to prevent information loss and later transcribed. The recordings were destroyed six months after transcription, with data collection occurring from May to June 2022. A pre-test was conducted with 2 privileged informants who did not participate in the study to validate the interview script. No changes were necessary following this pre-test.

The primary objective was to identify the non-pharmacological measures used by nurses in symptom management in Palliative Care. This aimed to empower formal and informal caregivers within a Palliative Care Unit to utilize non-pharmacological measures in symptom management.

The objectives were set based on existing literature on this topic. The study aimed to explore the use of non-pharmacological measures in symptom management in palliative care from the nurses' perspective, contributing to innovation and change in nursing care practices and improving health outcomes.

The guiding question for content analysis was, “In Palliative Care, symptom control can be achieved through pharmacological measures as well as non-pharmacological measures. Considering this statement, can you identify non-pharmacological symptom control measures in Palliative Care?” This question enabled the collection of relevant data about the non-pharmacological measures identified by nurses in symptom management in Palliative Care (Table 1).

The study population comprised all nurses from a Health Unit. Given the qualitative paradigm, the study included participants rather than a theoretical sample. Ten nurses were selected based on inclusion criteria: all nurses from the Health Unit providing care in the Palliative Care Unit, with a minimum of two years of service, selected by convenience. The selected nurses were aged between 23 and 38, with 2 males and 8 females, holding qualifications from bachelor's to master’s degrees. Their professional experience in Palliative Care ranged from 2 to 11 years. The convenience sampling was essential and most appropriate to ensure the objectives of the study were met, also considering the nurses' availability and willingness to participate.

The findings were analysed using content analysis, following Bardin's (2016) methodology. The data were categorized by grouping findings based on differentiation and re-grouping through ongoing comparison and inference among analysis units. This

process included identifying similarities, complementarities, divergences, and contradictions.

After data collection, all expressed content was transcribed and analysed to objectively and systematically describe lived experiences. Final conclusions should align with the study's established objectives. The categorization system was validated by two experts—one researcher in palliative care and one post-graduate clinical nurse—to ensure consistency and reliability.

In conducting research, it is essential to uphold human rights and dignity, protecting participants from harm due to their collaboration in the study and ensuring adherence to ethical standards throughout the process.

Before the study, authorization was formally requested from the Health Unit's technical director, and Informed, Free, and Informed Consent was obtained from all participants. To ensure participant anonymity, each was identified by the letter E followed by a number from 1 to 10, and data confidentiality was maintained.

Additionally, approval was sought from the Ethics Committee for Life and Health Sciences, with favourable opinion number 31A/2022 issued for this study.

RESULTS

Throughout the content analysis, and considering the guiding research question, the information obtained during the interviews was found to be rich in concepts and ideas. It is clear that, despite the limited years of experience of the interviewees in this area of care, they possess considerable logical notions regarding communication as a non-pharmacological measure for symptom control in palliative care patients.

The data obtained aligns with previously published studies, confirming findings from other authors who highlight communication as a non-pharmacological measure for symptom control, as seen in studies by Alves (2023), Potter et al. (2013), Phaneuf (2005), and Correia et al. (2021).

Data analysis, following Bardin's (2016) methodology, revealed six categories. The category "communication" (n=4) encompasses procedures that support the overall well-being of the patient and can be employed in various ways. This category includes several subcategories identified through participant discourse: active listening (n=4), anxiety control (n=1), therapeutic touch (n=2), posture (n=1), tone of voice (n=1), and eye contact (n=1). Each of these elements falls under communication as a means to enhance patient care.

In the "complementary therapies" category (n=6), interviewees described interventions regarded as complementary to the care process and effective when combined with other treatments to improve health outcomes. Subcategories identified within this theme include oriental medicine (n=1), music therapy (n=6), therapeutic massage (n=4), aromatherapy (n=2), meditation (n=1), thermotherapy (n=2), and diet (n=1), which serve to enhance well-being alongside other pharmacological or non-pharmacological measures.

Additionally, the analysis identified other categories: "environmental management" (n=4), "family involvement in the care process" (n=1), "positioning/alternation of positions" (n=4), and "knowledge of the person" (n=3), all of which

contribute to the comfort of the patient and are included as non-pharmacological measures for symptom control and management in palliative care.

Among these non-pharmacological symptom control measures, communication and complementary therapies were the most frequently highlighted by participants, mentioned specifically in interviews E6 and E7, respectively.

Table 1

Non-Pharmacological Symptom Control Measures in Palliative Care

Non-Pharmacological Measures Identified by Nurses in Symptom Management in Palliative Care		
Category	Subcategory	Unit of Registration
Communication (n=4)	Active Listening (n=4)	*"(…) From what I know, even though it's not always practiced here in this unit, communication as a non-pharmacological strategy, specifically active listening (…)" E1; "(…) Active listening, related to communication (…)" E3; "(…) Active listening (…)" E7; E9*
	Anxiety Control (n=1)	*"(…) This also depends on the type of symptoms; anxiety sometimes exacerbates symptoms from pain to dyspnea. Controlling anxiety through communication is quite useful in many cases to control symptoms or at least alleviate what they are feeling (…)" E2*
	Therapeutic Touch (n=2)	*"(…) Therapeutic touch (…)" E7; "(…) Touch (…)" E8*
	Posture (n=1)	*"(…) In my practice, non-pharmacological care measures for palliative care patients involve everything from how I enter the room to how I leave, including posture (…)" E8*
	Tone of Voice (n=1)	*"(…) The tone of voice we use (…) Tone of voice is crucial (…)" E8*
	Eye Contact (n=1)	*"(…) Visual interaction and maintaining eye contact make a big difference (…)" E8*
Complementary Therapies (n=6)	Oriental Medicine (n=1)	*"(…) Other complementary therapies include oriental medicine (…)" E1*
	Music Therapy (n=6)	*"(…) Music therapists and musical therapy (…)" E1; "(…) As non-pharmacological measures, I can mention music therapy (…)" E4; "(…) We can play music if the patient accepts and enjoys it (…)" E5; "(…) Some non-pharmacological measures that come to mind include distraction techniques like music (…)" E6; "(…) Distraction through music (…)" E7; "(…) Non-pharmacological measures I recognize include music therapy (…)" E9*
	Therapeutic Massage (n=4)	*"(…) Therapeutic massage (…)" E4; "(…) Massages (…)" E5; "(…) Massage, especially for pain control (…)" E7; "(…) Full-body massage (…)" E9*
	Aromatherapy (n=2)	*"(…) Aromatherapy (…)" E4; E9*
	Meditation (n=1)	*"(…) Meditation/guided imagery (…)" E6*
	Thermotherapy (n=2)	*"(…) For pain, the application of heat or cold (…)" E6; "(…) Thermotherapy for pain (…)" E7*
	Diet (n=1)	*"(…) Tailored diet (…)" E10*
Environmental Management (n=4)		*"(…) Environmental management (…)" E1; "(…) Environment optimization (…)" E3; "(…) Creating a calm, patient-focused environment (…)" E5; "(…) Environmental control (…)" E9*
Family Involvement in Care (n=1)		*"(…) Family involvement in the care process (…)" E1*

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Positioning/Alternation of Positions (n=4)		*"(…) Changing positions helps alleviate symptoms such as dyspnea and pain (…)" E2; "(…) Alternating positions (…)" E5; "(…) Changing positions is essential in palliative care (…)" E7; "(…) Positioning adjustments, such as head elevation or added pillow support (…)" E8*
Knowledge of the Patient (n=3)		*"(…) Understanding the patient helps in symptom control (…)" E2; "(…) Recognizing patient preferences affects their responses (…)" E8; "(…) Non-pharmacological measures should consider the patient's degree of dependency, orientation, and clinical condition (…)" E9*

DISCUSSION

Authors such as Souza et al. (2021) indicate that studies have shown that non-pharmacological interventions and low-technology measures can significantly affect the comfort levels of patients.

Based on this study's results, there is a clear emphasis on communication and complementary therapies as fundamental components of non-pharmacological measures in symptom relief. Communication is recognized as an essential element in the care process, supporting Alves' (2023) study, which identified various subcategories related to communication. Active listening is immediately mentioned as a communication tool. Although theoretically well-known, its practical application is not fully realized. However, Potter et al. (2013) emphasize that active listening simplifies communication, fosters patient trust, acceptance, and respect. Thus, active listening is seen as essential for understanding the patient and improving and adjusting the care plan to meet individual needs.

Anxiety control is another subcategory, with interviewees indicating that poor anxiety management can worsen patient symptoms, making it essential to address this aspect in the communication process. This finding is supported by Castro et al. (2023), who explain that anxiety is linked to a diminished quality of life in palliative patients.

Therapeutic touch, cited by interviewees as a tool derived from communication, historically plays a central role in the healing process, conveying affection, emotional support, tenderness, and attention (Potter et al., 2013).

Posture, associated by the interviewees with the nurse's attitude toward the patient, is crucial in every interaction. Phaneuf (2005) notes that the nurse's posture and attitudes are essential, with body orientation toward the patient signalling interest.

Tone of voice and eye contact are also subcategorized, as voice and facial expression facilitate synchronization between the nurse and patient. The nurse should remain gentle, calm, and respectful (Phaneuf, 2005). Interviewees' responses align with Phaneuf's (2005) recommendations, suggesting that direct bodily orientation toward the patient is beneficial.

It is worth noting that anxiety control, posture, tone of voice, and eye contact were only mentioned by one interviewee each. This could indicate that many non-pharmacological measures derived from communication are not widely practiced in daily nursing care.

The interviewees' responses also categorized complementary therapies as key non-pharmacological measures. This was the most frequently mentioned measure, cited in six out of ten interviews,

highlighting its importance in nursing interventions. Castro et al. (2023) describe complementary therapies as frequently administered or taught by specialized professionals. However, nurses, as part of a multidisciplinary team, play an essential role in symptom control, making their involvement and complementary care contributions crucial.

Oriental medicine is one subcategory noted by one interviewee as a complementary therapy option in palliative care, although it requires specialized practitioners (Castro et al., 2023). Music therapy is another subcategory identified by interviewees as a distraction technique for symptom relief. Correia et al. (2021) highlight directed distraction as capable of alleviating symptoms, with music therapy fitting within this framework. This intervention was mentioned by six out of ten interviewees, possibly because it is one of the most commonly used techniques in the study setting.

Therapeutic massage, described by four interviewees, was associated primarily with pain relief. This aligns with Castro et al. (2023), who identify therapeutic massage as a common pain-relief practice, while cautioning that responses to treatment vary based on individual factors and massage techniques. The authors also emphasize the importance of this topic, considering existing systematic reviews.

Aromatherapy is considered by interviewees to be beneficial in palliative care. According to Silva et al. (2023), aromatherapy has proven effective as a non-pharmacological method for symptom relief, particularly for pain. Although mentioned by interviewees, they did not delve into the specific benefits of aromatherapy in palliative care.

Another subcategory noted by interviewees is meditation, which may be individualized or involve guided imagery. This technique can be classified as directed distraction and relaxation, which Correia et al. (2021) describe as potentially effective in symptom relief.

Thermotherapy was mentioned by two interviewees, who explicitly referred to the application of heat or cold on inflamed or painful areas, providing beneficial effects for patients. Theoretical support for this comes from Correia et al. (2021), who highlighted the importance of additional methods, such as heat or cold application, in pain management.

Regarding complementary therapies, diet was mentioned by only one interviewee, who noted that a customized diet could alleviate symptoms like nausea. Silva et al. (2023) report that herbal supplements are often used to mitigate symptoms in patients, but such interventions typically require knowledge of the medicinal effects of these plants.

Environmental management was another category emphasized by nurses, mentioned by four participants. Fall prevention, creating a calm atmosphere with ideal temperature and lighting, emerged as factors in environmental management that can alleviate symptoms and foster a positive connection between patient and family, as noted by Souza et al. (2021). Family involvement in the care process, although highlighted by only one nurse, is supported in the literature by Souza et al. (2021).

Positioning/alternation of positions, categorized through content analysis, was noted by four nurses. This procedure is relevant for alleviating symptoms such as dyspnea, pain, and patient comfort. According to Souza et al. (2021), seemingly simple non-

pharmacological interventions can significantly impact patient comfort.

The category of knowledge of the patient emerged from the interviewees' responses as a valuable factor in tailoring non-therapeutic measures to each patient's preferences and needs, enhancing their positive effects on symptom relief. Strengthening the use of non-pharmacological measures to improve palliative care processes is emphasized, encompassing physical, psychological, social, and spiritual dimensions to empower professionals in holistic patient care (Souza et al., 2021).

The results suggest that these findings offer valuable insights for clinical practice. They imply improved applicability in consideration of patient comfort and well-being, thus enhancing health care and advancing nursing practices. Continuous and specialized training in non-pharmacological measures is recommended for nursing practice.

Studies like this one enrich the field of palliative care, as Silva et al. (2023) note that scientific evidence remains limited due to the small number of studies on non-pharmacological measures.

However, it is essential to note that the study's limitations include a small sample of only 10 participants with limited experience in palliative care and its confinement to a single Palliative Care Unit, which could introduce bias to the study's findings.

CONCLUSION

The increase in average life expectancy requires healthcare professionals to develop new caregiving skills, making it essential to manage symptoms in Palliative Care through both pharmacological and non-pharmacological measures, thereby helping to minimize suffering and preserve dignity.

This study found that non-pharmacological measures are frequently used in symptom management within Palliative Care, either in combination with pharmacological measures or as standalone strategies.

Communication emerged as one of the most commonly applied measures, associated with active listening, anxiety control, therapeutic touch, posture, tone of voice, and eye contact.

Complementary therapies were also prominently highlighted, encompassing approaches such as oriental medicine, music therapy, therapeutic massage, aromatherapy, meditation, thermotherapy, and diet.

Environmental management, family involvement in the care process, patient positioning/alternation, and understanding the patient were also identified by interviewees as important measures to consider.

In summary, symptom management, supported by the nurse's skills and competencies, involves recognizing, assessing, treating, monitoring, and paying attention to detail while anticipating outcomes. Thus, symptoms are addressed as a multidimensional concept.

Communication and complementary therapies are fundamental components of non-pharmacological measures, forming a critical foundation in the relationship between healthcare professionals, patients, and their families.

This study highlights the importance of clinical practice research to ensure healthcare based on scientific evidence, which increases the healthcare

professional's confidence and, consequently, the quality of care.

Continuous and specialized training in non-pharmacological measures should be part of nursing practice.

One limitation of this study is that the nurses had limited experience in palliative care, with little specialized training, and the study was confined to a single Palliative Care Unit. However, as this is a qualitative study, the results cannot be generalized.

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