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Feelings of powerlessness in relation to pain: Ascribed causes and reported strategies: A qualitative study among Dutch community nurses caring for cancer patients with pain

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ABSTRACT

This qualitative study focused on the causes for the feelings of powerlessness experienced by dutch community nurses in caring for cancer patients with pain. In addition, the study focused on the strategies community nurses employed to cope with feelings of powerlessness. Semistructured interviews revealed the following ascribed causes for feelings of powerlessness: problems in communication between community nurses and patients and between community nurses and personal physicians, dilemmas concerning physical care and opiates, and discrepancies between community nurses' pain management goals and what can realistically be achieved. The main strategies for reducing feelings of powerlessness were sharing feelings with the patient and colleagues, increasing knowledge and skills, and standing back from the situation.

Many patients suffer considerable pain in the preterminal and terminal phases of cancer^(1,2). Caring for patients with this type of pain can make nurses feel powerless. Fagerhaugh and Strauss⁽³⁾ described the reactions of nurses caring for patients with very severe pain. Feelings of powerlessness, despair and desperation appear to be widespread. Clements and Cummings⁽⁴⁾ similarly stated that personnel involved with patients suffering pain frequently experience a feeling of powerlessness and find it difficult to cope with the patient's situation.

Such feelings of powerlessness can be illustrated by a case described by one interviewee in the study presented:

Miss A. was a young, single woman who had had a mastectomy. Eventually secondary tumors were discovered. That was a terrible blow. Various drugs were used to try to get the pain under control but it continued to dominate her life. In the end, it got so bad that she couldn't bear to be touched anymore. The physician tried heavy doses of morphine but of course that made her unconscious and . . . she wanted to remain lucid. It was always an effort to go to see her, always seeing her suffer and not being able to offer any relief . . . that feeling of powerlessness.

Although the literature includes a number of references to feelings of powerlessness in relation to pain^(1,3,4), there was little insight in specific causes of and strategies to deal with the problem. This fact prompted the present study and the development of the following research questions:

1. What are the ascribed causes for feelings of powerlessness of Dutch community nurses in caring for cancer patients in pain?

2. What do Dutch community nurses do to reduce such feelings?

Based on descriptions of powerlessness^(5,6), the following definition was developed: "Feelings of powerlessness are negative sentiments connected with the idea of having no control over a particular situation, in this case the pain suffered by cancer patients or its management." The study presented is therefore concerned with the community nurse's subjective perception of having no control. No distinction is drawn between feelings of powerlessness in situations where some control is actually still possible and such feelings in situations where this is not the case.

The term "community nurse" used in this article means a certified nurse who delivers home care to cancer patients. In the Netherlands, community nurses have had either 4 years of higher vocational training, or 3.5 years of in-service training in a hospital plus another 2 years of intermediate vocational training. A study by Dorrepaal⁽⁷⁾ showed that 86% of cancer patients receiving care from Dutch community nurses suffer pain. Given that community nurses are so frequently confronted by pain symptoms, it is probable that they regularly experience feelings of powerlessness. This assumption is confirmed by the fact that all the community nurses interviewed in the course of the present study recognized such feelings from their personal experience. The "Results" section of this paper discusses the ascribed causes for feelings of powerlessness and the strategies that community nurses use to cope with these feelings. First, however, the following section describes the research methods used in this study.

METHODS

Qualitative research methods are appropriate to research in relatively new areas. Because only limited research had previously been conducted concerning nurses' feelings of powerlessness, no quantitative response formats existed that could be used in the study presented. In such cases, the use of qualitative methods to obtain valid descriptions seems the best alternative. In addition, qualitative research methods are appropriate to reveal personal perspectives and experiences. In exploring an issue as emotionally charged and as subjective as feelings of powerlessness, it is important to gain insight into the perceptions of the research subjects⁽⁸⁾. This consideration, together with the lack of previous research, led to the choice of qualitative research methods, and more specifically to the choice of qualitative interviews.

The study involved a total of 13 individual and 3 group interviews (the latter involving two or three nurses simultaneously). Recruitment and sample characteristics are now described.

Sample

A letter was sent to 24 community nurses working in Amsterdam, Rotterdam, and The Hague inviting them to participate in the study. A criterion for inclusion in the study was that

the community nurses were caring for, or had recently cared for, cancer patients with pain. Of the 24 nurses 3 were not able to participate for various practical reasons. Eventually 21 subjects were interviewed (20 women and 1 man). This sample, and the total of 16 interviews conducted, proved sufficient for reaching "theoretical saturation"⁽⁸⁾.

Data Collection

The interviews were semistructured by an interview schedule. This schedule included questions about the common nursing care of cancer patients, about how nurses relieve pain, and about the successes and problems they experience in relieving pain. The interviewer asked no leading questions about powerlessness. To do so would have influenced the interviewees and risked creating a situation in which feelings of powerlessness would be discussed in too narrow a context. In addition to the interview schedule, cases selected by the nurses themselves provided an important basis for the interviews. The community nurses each had been asked to recall one of his or her own cases in which pain control was not successful.

Each interview lasted on average 65 minutes and was audiotaped.

Analysis of the Interviews

As usual in qualitative research, each interview was transcribed and analyzed before going on to the next⁽⁸⁾. The first step in the analysis was to search for indicators of feelings of powerlessness in the transcribed interview text. Feelings of anger, irritation, or sadness are cited in the literature^(6,4) as indicators of feelings of powerlessness. Such feelings were expressed in the interviews through phrases and metaphors such as "not knowing what to say," "having nothing to offer," "just not being able to cope with it any more," and "having to face that pain again time after time." Often, the community nurses also referred explicitly to feeling powerless: "I felt so powerless in this case." The verbal expression of feelings of powerlessness was often accompanied during the interview by nonverbal signs such as gestures of despair, sighing and, silences.

Fragments relating to "feelings of powerlessness" were marked in the text and were assigned content-related codes or category names⁽⁸⁾. In qualitative research, codes and categories are developed inductively and are directly derived from the data (in this case transcripts of interviews). Important codes relating to the reported causes of feelings of powerlessness were, for example, "not daring to talk" and "reticence." These codes were classified in the category problems in communication. In addition, codes like "nursing interventions or not" and "morphine or not" formed the basis for a second category called dilemmas. Furthermore, "wanting to but not being able to" and "implied and achieved objectives" belonged to a third category called discrepancies.

Codes relating to strategies for reducing feelings of powerlessness included these for instance: sharing, learning, and looking back. These codes were accommodated in the following categories: sharing with others, increasing knowledge and skills, and standing back. How these categories relate to feelings of powerlessness is shown in ^{Figure 1} and discussed later in the "Results" section.

[FIGURE 1]

Reliability and Validity

Important strategies used to ensure internal validity were combining group and individual interviews and obtaining feedback on the researcher's analyses from supervisors and members of a working party of qualitative researchers.

Reliability, in the sense of controllability, was ensured by transcribing the interviews verbatim and, wherever possible, quoting nurses directly in reports. Reliability, in the sense of consistency between different researchers, was checked by comparing the analyses of the main researcher with those of two independent researchers. Mutual analyses were found to

be parallel to a large extent. However, when interpretations did not completely parallel, they were discussed, giving rise to further development and adjustment of analyses.

RESULTS

This section presents the results of the study: first the three reported causes of feelings of powerlessness and then the three strategies for reducing them.

First Ascribed Cause: Problems in Communication

The person in pain is the only authority on the existence and severity of that pain⁽⁸⁾. For this reason, it is important to nurses that patients should be able to talk about their illnesses and pain. Unfortunately, there may be problems in communication. One barrier to communication between nurses and patients is patients' reticence. Some patients find it difficult to talk about their pain. Certain stages in the progress of the disease may be marked by denial or repression⁽¹⁰⁾. This lack of openness on the part of the patient can lead to feelings of powerlessness expressed thus: "He was a difficult man and so withdrawn. You just couldn't get through to him and you don't know why not. Cases like that make me feel so uncertain, I start to doubt myself."

When nurses cannot discuss the pain with the patient, they sometimes try to obtain information via the family. This can lead to chats over the kitchen sink or on the doorstep, which may provide the necessary information but leave the nurse with the unhappy feeling of having gone behind the patient's back to get it.

Barriers to open communication may be exacerbated by community nurses' own reluctance to broach the subject of pain. Some are afraid of intruding on patients' privacy or creating a situation they cannot handle; as one nurse reflected: "I find it hard to talk about pain. I think it's the fear of stirring something up. I just don't dare. It scares me. If you're really going to talk about pain, you have to have to be able to handle things properly."

Barriers to communication are therefore both nurses' own reluctance and the reticence of patients.

Community nurses and personal physicians must be able to communicate in order to develop policies on pharmacological pain management. Yet most of those interviewed report communication problems with certain physicians. For instance, nurses do not always agree with the treatment prescribed as shown by this statement: "Prescribing on an 'as needed basis' is not a good thing. I could see that with this patient too. She was always unsure, wondering whether or not it was the right time to take the medicine. I don't know why they do it that way. Perhaps doctors themselves are a bit uncertain about dosages."

In many cases, community nurses' ideas about the right pain medication fail to produce a dialogue with the personal physician. Nurses are often afraid of encroaching on the professional territory of the doctor. The nurse says nothing but still feels that the pain treatment being provided is far from ideal. A feeling of powerlessness results.

Second Ascribed Cause: Dilemmas

In dealing with patients who are entirely dependent physically and in considerable pain, caregivers may face difficult decisions between various options, all of which are felt to be in some way undesirable or unpleasant⁽¹¹⁾. In nursing care, for example, the choice of whether to continue giving bed baths, dressing wounds, or turning the patient, or whether at least to cut down on such procedures can create a dilemma.

For as long as possible, the community nurse must continue to involve the patient in choosing between different options, all of which have clear advantages and disadvantages. Carrying out procedures means that patients will be clean, but also that they will suffer extra pain as a result of being turned or having clothing removed. As one nurse protested: "I want to do the best I can and cause the patient the least possible pain, but pain is unavoidable, and that makes me feel so powerless, knowing I can do nothing to change the situation."

Abandoning such procedures has the advantage of sparing the patient periods of extra pain, but the clear disadvantage is that painful bed sores, for example, will generally be aggravated in the longer run. This kind of dilemma makes nurses feel powerless because they realize that either decision will inevitably produce pain.

There are also dilemmas relating to opiates and spinal anesthesia. One task of the community nurse is to monitor the effectiveness of pain control and to inform the personal physician. Unfortunately, this role also involves dilemmas. For example, regular high doses of a morphine preparation will usually relieve pain (an advantage for both patient and nurse), but community nurses may ask themselves whether that advantage really outweighs the accompanying disadvantages. Chief among the disadvantages is the increasing drowsiness of the patient and the accompanying problems of communication reflected by this observation: "If you inject enough morphine it will relieve the pain for a while, but you will never really be able to communicate with the patient again. I don't know if that's such a good thing. It gets rid of the pain all right, but you can't talk to the patient anymore."

The inability of the community nurse to discuss the details of treatment with drowsy patients is a problem, but a still greater disadvantage is that patients have more difficulty communicating with their nearest and dearest during the last few precious days of life. One nurse was left thinking, "Immediately after the first injection the patient became subcomatose, so that communication with her was impossible. Her husband found that very hard to cope with. He really felt he would rather it hadn't happened that way. He was sorry he wasn't able to talk to her again."

Dilemmas like this can also inspire feelings of powerlessness; after all, nurses feel that, whatever choice they make, it is impossible to give the patient the best possible treatment from every point of view. Also, many community nurses find it difficult to accept the occasional lack of any clear policy on the prescribing of morphine. Imperfect knowledge on the part of personal physicians seems to be one reason for hesitancy and delay in prescribing morphine. Some nurses report that they are also not entirely certain about effects and side effects.

Community nurses experience the dilemmas but have little influence on the decisions taken. The ultimate decisions on the administration of opiates are made by the physician. Most community nurses report a feeling of powerlessness in this respect.

In caring for patients in the home, spinal administration of opiates has a number of consequences. For example, it takes up more of the community nurse's time. Family members might help, but there are objections to this. Not only do most family members lack the necessary professional expertise, but involving them means imposing a still greater practical and emotional burden on them.

Moreover, although Dutch law has recently been changed to allow community nurses to carry out medical procedures of this kind, they are often not yet competent to do so. To refuse is the safest option for community nurses themselves, but they are generally unhappy about doing this. It may mean that an effective form of pain control is denied to the patient, or that he has to go to hospital specially to receive this treatment.

Third Ascribed Cause: Discrepancy Between Goals and Feasibility

The remarks made by community nurses suggest that many of them feel a dying patient should really be completely free of pain. Others feel that where it is impossible to achieve this, it is important to teach the patient to cope with the pain so as to make it at least endurable. But these goals cannot always be achieved, and this discrepancy between ideals and practical feasibility frequently produces feelings of powerlessness as expressed by a community nurse: "I run myself into the ground trying to do my best and patients are still in pain and I can't get any further. That's what makes me feel so powerless."

The realization that the desired goal is not going to be achieved brings community nurses face to face with their own limitations and that is not always easy. Goals are not always modified. Freeing the patient from pain is not, for example, replaced by reducing pain to an

acceptable level. This means that nurses continue to receive frequent and painful reminders that it is not within their power to achieve what they so much want to do. One nurse struggled with thoughts such as these: "You're constantly being reminded that you can do nothing to change the situation. You can't take pain away. You are all the time being asked to do something, and you have no solution to offer."

The literature⁽⁹⁾ identifies the potential of massage, relaxation, and distraction techniques to enhance the effect of pain medication. Such techniques might help community nurses to achieve their pain relief goals and thus alleviate their feelings of powerlessness. But the necessary knowledge and skills are sometimes lacking.

Even when community nurses do go further than simply providing good physical care and pain medication, their efforts sometimes fail to achieve the desired effect (e.g., in cases of patients with bone metastases). There remains a discrepancy between their wishes and goals on the one hand and what is practically feasible on the other. Even when nurses know that they have done all they possibly can, they may still be left with a nagging dissatisfaction, a feeling of powerlessness, and misgivings such as these: "We did a lot. I think it was all we could do, and yet I still feel very powerless when I think about all she went through. . . . It was so hard to watch her getting thinner and thinner and being in such pain."

In such cases, nurses may find it hard to face the task of caring for the patient, and visits may become a burden.

STRATEGIES FOR REDUCING FEELINGS OF POWERLESSNESS

In general, the community nurses interviewed are keen to continue working with cancer patients. The work is described as intensive and demanding, but also as interesting and satisfying. To keep on doing it, nurses have to be able to cope with their own feelings of powerlessness. The strategies they develop (consciously or otherwise) to reduce such feelings may be termed powerlessness strategies. Two kinds of powerlessness strategies can be distilled from the interviews: (a) effective strategies that alleviate feelings of powerlessness and may directly or indirectly benefit the patient and (b) ineffective strategies that may well help the community nurse in the short term but are extremely unlikely to do anything to benefit the patient. Examples of the latter are erecting psychological barriers and physical avoidance of the patient⁽³⁾. In this article we consider only the effective strategies.

First Strategy: Sharing Feelings

One important and effective strategy is to share feelings of powerlessness with the patient. Nurses and patients who discuss their feelings often find that they share the same emotions, and this produces a sense of solidarity⁽¹⁰⁾. This can strengthen the relationship and at the same time help to reduce the feelings of powerlessness. As one nurse said, "You can just say to each other how you're feeling, and that immediately relieves the tension. I felt that with her too and said, 'I do really so much want to help you, but I just can't. She replied, 'No. I know you can't. It's something I have to manage for myself.' And then it's all right because you've gotten it off your chest."

Nurses indicate that to share such feelings there must already be a good relationship with the patient. Community nurses must also see that there is some point in sharing. They must have the idea that talking about feelings would have an effect on the patient. The idea that a patient would be burdened by such an admission can also be an obstacle. Nurses may think that the situation is already harder for them than for the patient.

Probably the most common strategy is to share feelings with close colleagues. As the following statement illustrates, community nurses can use their colleagues as a "safety valve": "I get a lot of support from the team here. They give me the feedback I need and I can have a good moan."

Just telling someone is not always enough, however: A response is required. But this means that the other person has to be familiar with the situation, as revealed by the this statement: "You can tell them all about it but they don't actually go there. They don't know the patient and that's what you miss."

To reduce the feeling of isolation, patient care is sometimes shared between two community nurses. Being able to discuss treatment makes the nurse feel more confident. Having a close colleague recognize the difficulties sometimes prevents or reduces feelings of powerlessness.

By contrast, such feelings are seldom discussed in team meetings, though nurses do recognize that it may be important to do so and have expressed it thus: "I think you can reduce powerlessness by tackling the issue together. Either with your team or with the personal physician. You should talk about it every week and try to make people take the problem seriously."

Seminars that give community nurses the chance to discuss powerlessness, emotions, and their own limitations also seem to be fairly unusual. One community nurse does, however, report once having organized a seminar of this kind and having been helped by it to accept her own limitations. She has since found it easier to cope with her feelings of powerlessness because sharing them with others has given her a better understanding of potential solutions.

Second Strategy: Increasing Knowledge and Skills

Training provides an opportunity not only to discuss feelings of powerlessness, but also to extend knowledge and skills. It can offer nurses new ways to take action to relieve pain, and this can prevent or reduce feelings of powerlessness. One nurse observed: "I can do a lot more things now-relaxation exercises, distraction methods and so on-but you really need time to do that sort of thing, and to teach other people. I am involved in in-service training myself at the moment. I notice that other people also have the same feelings of powerlessness that I have experienced. Nobody likes to see people suffer and you want something to be done about it. Everyone is very interested."

Third Strategy: Standing Back

Standing back means "calling up feelings and experiences in order to reflect on them and then put them away from you." This kind of detachment and involvement go hand in hand⁽¹¹⁾. Community nurses themselves report that it is important for them to stand back from the situation in order to be able to renew their commitment to the patient. By doing so, they can gain a clearer perspective on a situation that has become clouded by their emotional involvement. Standing back from the situation takes time, and this can be granted community nurses if their colleagues avoid giving them any more cancer patients to look after for a while. As they have said: "Sometimes we say we can't manage it just now and then someone else takes over. It works fine."

The interview data indicate that where nurses find it very difficult to make themselves stand back from the situation, they may eventually be forced to do so permanently (because of severe stress symptoms). Some home care agencies then allow community nurses to specialize in a field other than oncology.

CONCLUSIONS AND INTEGRATION WITH THE LITERATURE

Problems in communication concerning pain and pain control, either with the patient or with the personal physician, often underlie the feelings of powerlessness experienced by community nurses. Ferrell et al.^(12,13), Ullrich and Fitzgerald⁽¹⁴⁾, and Johnston Taylor⁽¹⁵⁾ described similar problems in communication. A bonus of our research is that it has provided insights into the link between these problems and feelings of powerlessness on the part of community nurses.

Dilemmas prove to be another major ascribed cause. Various other authors have also referred to the difficult choices surrounding morphine^(9,16,13). Fagerhaugh and Strauss⁽³⁾, for example, described how the nurse, the patient, and the doctor each assesses the advantages and disadvantages of such pharmacological interventions from his or her own point of view. The dilemma that we outline concerning the issue of whether or not to administer morphine is an example of this.

Discrepancy between pain relief goals on the one hand and practical feasibility on the other is another possible cause of feelings of powerlessness. The failure to achieve pain relief goals sometimes seems due in part to imperfect knowledge and skills and negative attitudes regarding pain medication and certain types of nonpharmacological interventions^(9,12,17). Our study showed that such failures can have painful consequences not only for patients, but also for their nurses.

Sharing feelings of powerlessness with the patient or with colleagues was identified as an effective strategy for coping with them. Here again, we find references in other publications. With regard to sharing with the patient, Blockmans⁽¹⁰⁾ mentioned a "listening presence" and "revealing one's own sadness and emotions," whereas the use of colleagues as a safety valve is termed "blowing off steam"⁽¹⁸⁾.

Increasing knowledge and skills is nowhere in the literature explicitly described as a strategy for relieving feelings of powerlessness. The results of this research show, however, that this can be an effective way for some community nurses to achieve better control over their patients' pain and thereby also over their own feelings.

Standing back was found to be another way of coping. In this context, Blockmans⁽¹⁰⁾ spoke of "time out" and "drawing breath." Sometimes community nurses need an opportunity to distance themselves from a situation in order to be able to renew their commitment to the patient.

PRACTICAL RECOMMENDATIONS

The feelings of powerlessness experienced by community nurses caring for cancer patients with pain can be relieved either by eliminating the causes of such feelings or by use of effective strategies for dealing with them. In the next sections we discuss how causes can be eliminated and which strategies are effective. These discussions are based partly on relevant literature and partly on solutions suggested by the community nurses themselves.

Eliminating the Causes

Barriers to communication with patients might be alleviated by training in ways of communicating with reticent patients. In addition, the use of pain assessments⁽⁹⁾ might help nurses and patients to communicate more openly about pain. Another important approach may be training on how to differentiate between the nurse's goal and the patient's goal, and on how to support the patient.

Problems in communication with the physician could perhaps be reduced by setting up a home care team, within which the partners take joint decisions on a multidisciplinary treatment policy and regularly discuss the case under the leadership of a coordinator. Of the community nurses interviewed, the only one who had experienced this approach was extremely positive about it. It would seem useful in any case for home care agencies to draw more attention to the specific contribution that community nurses can make to effective pain relief (both separately from and working with personal physicians).

To reduce the dilemmas concerning opiates, it is important that nurses and other caregivers should be given extra pharmacological training. It should, for example, be more widely known that side-effects such as drowsiness generally become less severe after a few days^(9,2). It is sensible to monitor and record the extent of the drowsiness, for instance, by using a "pain flow sheet"⁽⁹⁾.

With regard to spinal analgesia, the home care agencies have the responsibility for providing care for patients receiving spinal analgesia and for ensuring that community nurses possess the necessary skills. Therefore, community nurses must be trained in the care for these patients.

Discrepancy between pain management goals and practical feasibility can be reduced if all pain relief measures are fully employed. Nonpharmacological interventions can also help^(9,19). In addition, better pharmacological pain management could reduce the discrepancies between goals and achievements and thereby reduce the feelings of powerlessness.

Use of Effective Strategies

In general, the community nurses who were aware of their own feelings of powerlessness and were seeking ways to deal with them seemed well able to cope with the burden of caring for patients in pain. Those community nurses who dared to acknowledge to themselves that they felt powerless seemed to be using the effective strategies. Although sharing with the patient seems to be effective, it would appear that it is not always easy to put into practice. Nurses must overcome the fear of revealing their emotions⁽²⁰⁾ and abandon the idea that by sharing their feelings, they will necessarily burden their patients.

There needs to be greater acceptance of the view that feelings of powerlessness are inherent to the experience of confronting severe pain. Community nurses should dare to admit such feelings and talk openly about them, and those in charge of home care agencies should create opportunities for this to happen. Finally, community nurses could themselves, for example, set up working groups to give each other mutual advice and support.

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FIGURES

