SUPPORT FOR WOMEN WITH BREAST CANCER, AND FOR THE DISTRICT AND HOSPITAL NURSES INVOLVED
An intervention study

Maj-Britt Pålsson

Umeå 1995
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Maj-Britt Pålsson

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Support for women with breast cancer, and for the district and hospital nurses involved. An intervention study.

Maj-Britt Pålsson, Department of Advanced Nursing, Umeå University, Umeå, Sweden.

ABSTRACT

The purpose of this study was to investigate breast cancer patients' experiences of their illness and of traditional nursing care (TNC) or supportive nursing care (SNC) respectively, as well as nurses' experiences of support and of caring for cancer patients. An intervention including extended cooperation between the surgical ward and primary health care, shorter waiting times, and changed routines concerning the information about the diagnosis, as well as training and systematic clinical supervision for the nurses, was implemented. Newly diagnosed breast cancer patients (n=47) from two county councils in the south-east of Sweden were interviewed (IV, V). Thirty-four of them completed scales about well-being, burnout, hopelessness, anxiety and depression (VII). The women who had TNC reported lack of professional support during the initial phase of the disease and suggested changes in the care similar to those implemented in the SNC. In the SNC group the women expressed feelings of safety and security after the professional support and the organizational changes in the care. There were significantly more single women and women who had had breast conserving surgery in the SNC group than in the TNC (VII). The hopelessness scores in the SNC group were significantly higher than in the TNC group.

Thirty-nine district nurses (DNs) were interviewed at baseline (I), and thirty-three of them completed scales about burnout, empathy, and sense of coherence (SOC) before and after systematic clinical supervision (VI). Twenty-three of the 39 DNs, as well as 9 hospital nurses (HNs) who participated in the clinical supervision, were interviewed about their experiences of this intervention (III). Twenty-nine tape-recorded supervision sessions in three groups of DNs (n=23) were analysed (II). Baseline interviews and analyses of the content of the supervisory sessions strongly emphasized that DNs experienced problems in the home care of seriously ill cancer patients. Deep human contacts were a source of both strain and enrichment. The clinical supervision was said to provide relief from undesirable thoughts and feelings, confirmation of themselves both as individuals and in their professional role, a broader and deeper knowledge and increased self-confidence. There were no significant differences in the burnout, empathy, and SOC scores between the supervisory group (n=21) and a comparison group (n=12) at the first and second measures, nor over time within the groups. There were some correlations between these phenomena and the Karolinska scales of personality, as well as correlations between burnout, empathy and SOC.

The groups of women were not entirely similar as regards demographic and medical characteristics, and the sample size of patients and nurses was small. It is obvious that patients in the TNC missed those factors that were implemented in the SNC, at the same time the latter women expressed hopelessness more often than those who had received TNC. This result may be due to the fact that support from nurses had made the women more prepared to express their feelings, that support had not been provided to an adequate extent or in the right way, or that the applied scales were not appropriate. The finding that the nurses experienced the clinical supervision as very positive but that, despite this, there were no significant differences in attitudes measured by scales within or between the groups, can be interpreted in a similar way. Consequently, further research is needed to judge the effects of intervention. The study has, above all, produced qualitative descriptions of patients' experiences of the nursing care after discharge from hospital, and of DNs' experiences of the care of cancer patients in their homes, and of systematic clinical supervision.

Key words: Intervention, support, organizational changes of the care, systematic clinical supervision, breast cancer patients, district nurses, hospital nurses, experiences, well-being/ill-being, hopelessness, anxiety, depression, burnout, empathy, sense of coherence, the Karolinska scales of personality.
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Umeå 1995
To Olof
Joakim, Katarina and Martin
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ABBREVIATIONS

BCS = Breast Conserving Surgery
BM = Burnout Measure
DN = District Nurse = RN in Primary Health Care
ECRS = Empathy Construct Rating Scale
HAD = Hospital Anxiety and Depression Scale
HN = Hospital Nurse = RN in Hospital Care
HS = Hopelessness Scale
KSP = Karolinska Scales of Personality
MRM = Modified Radical Mastectomy
RN = Registered Nurse
RNT = Registered Nurse Teacher
SNC = Supportive Nursing Care
SOC = Sense of Coherence
TNC = Traditional Nursing Care
TNM = Tumour size, Nodal involvement, distant Metastasis
UICC = International Union Against Cancer
WM = Well-being Measure
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Key words: Intervention, support, organizational changes of the care, systematic clinical supervision, breast cancer patients, district nurses, hospital nurses, experiences, well-being/ill-being, hopelessness, anxiety, depression, burnout, empathy, sense of coherence, the Karolinska scales of personality.
This thesis is based on the following studies, which will be referred to in the text by their Roman numerals:


VI Pålsson M-B, Hallberg IR, Norberg A. & Björvell H. Burnout, empathy and sense of coherence in district nurses before and after systematic clinical supervision. Manuscript, submitted.

VII Pålsson M-B. & Hallberg IR. The degree of well-being, burnout, hopelessness, anxiety and depression in two groups of breast cancer patients cared for according to different care organizations. Manuscript.

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INTRODUCTION

Women with breast cancer

Breast cancer involves threats, not only to life and to physical well-being, but also to self-image, female identity, social functioning and emotional equilibrium. Existential questions seem to dominate the initial phase of the disease (Weisman & Worden 1976). Anxiety and uncertainty about the prognosis decrease the possibility of coping with the overwhelming situation. Women with breast cancer probably need help to deal with the experiences of the illness to be able to move towards a healthy outcome. Support from professionals may improve their ability to cope with the impact of the disease and medical treatment on 'daily living', which, in turn can improve well-being (cf. Carnevali & Reiner 1990, p. 15).

Breast cancer is the most common cancer diagnosis among women in Sweden, and there are more than 5 000 new cases every year (The Swedish Cancer Registry 1992). Mammographic screening has led to the detection of a greater number of smaller breast cancers (Cady 1990). The stage of cancer at the time of diagnosis, the degree of nodal involvement, and the occurrence of distant metastasis (the TNM classification, i.e., Tumour size, Nodal involvement, and distant Metastasis) (UICC 1978), as well as the medical treatment are important factors for the prognosis and quality of life (Boné et al. 1993; Gelber et al. 1991). The primary treatment consists of surgery, and is sometimes combined with adjuvant postoperative radiotherapy, chemotherapy, endocrine therapy or a combination of these treatment methods. By routine, patients with a well-defined tumour, < 20 mm, and no axillary metastases (stage I) are offered breast conserving surgery (BCS) with or without radiotherapy. Women with a stage II disease (tumour > 20 mm, with or without axillary metastases) are treated with a modified radical mastectomy (MRM), and if axillary lymph nodes are involved, postoperative radiotherapy is offered.

There is much factual knowledge of breast cancer, diagnostic proficiency, medical treatment, and of postoperative physical therapy (e.g., Adler & Helvie 1992; Cady 1990; Fisher et al. 1992; Gelber et al. 1991; Hassey 1985; Helzlsouer 1994; Overmoyer 1995; Rakowsky & Sulkes 1993; Wingate et al. 1989), as well as of treatment-related physical problems, e.g., lymphoedema (Swedborg et al. 1993), and skin erythema in response to radiation therapy (Russel et al. 1994). Research has also been carried out into psychological treatment-related problems, such as fear of cancer recurrence and grief at the loss of the breast, difficulties with female identity and acceptance of body configuration, sexual dysfunction, and anxiety in connection with surgical and adjuvant treatment (e.g., Boalt & Ålsäter 1987; Fallowfield et al. 1990; Ganz et al. 1992;
Gyllensköld 1976; Jones & Reznikoff 1989; Lasry & Margolese 1992; Maraste et al. 1992; Meyer & Aspegren 1989; Schag et al. 1993; Schain 1988). Cawly et al. (1990) reported that the greatest post-surgery concerns for women who had had breast conserving surgery (BCS) and primary radiation were the cancer diagnosis itself, fear that the cancer had already spread, and fear of dying. The diagnosis was perceived as most distressing among women who had already undergone modified radical mastectomy (MRM) and received adjuvant chemotherapy (Tish Knobf 1986). Thus, regardless of type of surgery and post-operative treatment, the primary concern was the implications of the cancer diagnosis itself.

There are only a few studies which focus on the experiences of threats to life (e.g., Drugge 1988, pp. 85-98; Gyllensköld 1976, pp. 141-162), and on the types of support which would help women with breast cancer to live through uncertainties about the future (Dunkel-Schetter 1984; Smith et al. 1986). During the initial phase women might be able to reduce the negative experiences of breast cancer, but are most likely to be filled with grief, anxiety, and sorrow. A Swedish retrospective study comparing long-term psychosocial adaptation following breast cancer showed that 17 of the women (n=58) had accentuated anxiety and/or mood impairment five years after the primary treatment compared to their state before surgery (Meyer & Aspegren 1989). Similar findings were reported in a study from the USA, where one third of the women (n=41) reported moderate to severe distress 18 months after breast cancer surgery, which was similar to levels reported at 3 and 30 days post-surgery (Northouse 1989 a). Fallowfield et al. (1990) reported that 68 women out of 248 with breast cancer were assessed as being anxious 12 months post-operatively (England). In a case-management study including increased information, Ganz et al. (1992) on the other hand found significant improvements in mood and adjustment among women with breast cancer (n=109) during the year after diagnosis (the USA).

Support
Social support is multi-dimensional (Bloom & Spiegel 1984), and involves emotional, informational, and tangible components. Emotional support involves closeness to others in an environment of acceptance, understanding and love (Dunkel-Schetter 1984; Northouse 1989 b; Schaefer et al. 1981), and opportunities to talk about feelings and experiences of illness with someone who listens and provides feedback (Smith et al. 1986; Zemore & Shepel 1989). Informational support includes giving information and advice which could help an individual solve problems, and providing feedback about how an individual is doing (Schaefer et al. 1981). Tangible support is task oriented and involves direct aid, e.g., help with housework (Smith et al. 1986).
There are phenomena (e.g., demands, constraints, interpersonal strife) that might dilute the positive effects of support (Schaefer et al. 1981). Social support may also have a negative impact on individuals and serve as a source of stress. For example, receiving support implies giving up some of one's autonomy, risking burdensome dependence on others, and risking the cost of rejection (Belle 1991, p. 259). The links between the social network and stress have been less fully developed than those between the social network and beneficial social support (Belle 1991, p. 259).

Studies examining social support received from family, friends and other significant individuals suggest that social support helps women with breast cancer cope with their illness (Northouse 1989b), and is associated with better psychosocial adjustment (e.g., Funch & Mettlin 1982; Jones & Reznikoff 1989; Northouse 1988; Zemore & Shepel 1989). According to Bloom (1982), social support affects adjustment through its effect on one's coping response. Support from primary network members also seems to be related to having a more positive self-concept (Bloom 1982), to affect the sense of well-being, to be positively related to one's outlook on life (Bloom & Spiegel 1984) and, it has been suggested, to be protective with respect to survival (Ell et al. 1992; Spiegel et al. 1989). The higher the level of social support, the less depressed the women's mood (Lewis et al. 1993). The most important source of support, according to a study from Australia, for married women with breast cancer was the husband (Neuling & Winefield 1988), and, for single women, according to a study from the USA, relatives and friends (Smith et al. 1986). The most beneficial type of support was direct expressions of love and concern (Dunkel-Schetter 1984), as well as listening to or talking about the illness (Smith et al. 1986). People, however, are not always prepared to discuss and ask questions about their disease (Lerman et al. 1993). Frequency of support from family members and close friends can decrease as the lapse of time from surgery increases (Neuling & Winefield 1988). A literature survey by Taylor et al. (1986) showed that, although most individuals reported high levels of social support following cancer, some of them experienced isolated instances of rejection or did not receive the type of support they wanted from family, friends, and professional carers. Bloom and Kessler (1994) found, however, that women with breast cancer experienced emotional support from family members during the three months following surgery. When support from the social network is not enough for individual needs, their ability to cope effectively with the disease will decrease (cf. Fleming et al. 1985, pp. 99-106). As might be expected, the outcomes of social support are dependent on the possibilities of family members to function supportively for the sick one, and on how support is given, e.g., if it maintains a sense of social integration.

A diagnosis of breast cancer is also an overwhelming threat to the family members (Hilton 1993; Issel et al. 1990; Lewis 1990; Northouse 1988, 1989a; Omne-
Pontén et al. 1993), which may, for instance, lead to communication problems within the family (Hilton 1994). Several studies in the USA and Sweden have shown that husbands of women treated for breast cancer expressed a generally high degree of emotional distress, similar to the degree of disturbances seen among breast cancer patients themselves (e.g., Northouse 1989 a; Omne-Pontén et al. 1993). These factors probably reduce the husbands' ability to act supportively for the sick one. Hilton (1993) found that women sometimes felt that their husbands were not as supportive as they wanted them to be, which may be due to the limited opportunities for the husbands to obtain support themselves. Northouse (1988) reported that some husbands of women with breast cancer had little contact with RNs and physicians. The husbands did not experience health professionals as sources of support (Northouse 1989 b). Even if the family comprises the most important part of an individual's support network (e.g., Neuling & Winefield 1988; Smith et al. 1986), the involvement of health professionals in the psychosocial rehabilitation of women with breast cancer may increase coping even more (Jones & Reznikoff 1989). Single people or those who feel they are receiving little support from family members may need substitutional support from health professionals.

In studies from Sweden (Carlson & Pålsson 1986; Ödling et al. 1995), Finland (Suominen 1992) and Australia (Neuling & Winefield 1988), breast cancer patients stated that they received insufficient professional support. In the study by Neuling and Winefield (1988), women's anxiety and depression levels were significantly related to satisfaction with support from surgeons 1 month post-operationally. In the Finnish study women expected to receive mental rehabilitation, encouragement, and help in achieving a positive attitude to the future (Suominen 1992). Most of the patients (n=69) in a study by Cawly et al. (1990) reported limited psychosocial support, lack of encouragement to address their fears and concerns, and the need for a more caring and concerned health care team. The reason patients felt professional support was insufficient may be that RNs' views of support for patients did not correspond to those of the patients. In Finnish studies RNs reported that patients were well supported in hospital by the staff (Suominen & Laippala 1993), while the patients reported insufficient support from RNs (Suominen 1992). Another possible explanation for patients' experiences of insufficient support may be that RNs want to give their patients more attention, but lack the time, since they have to perform other immediate tasks (cf. Åström et al. 1994). On the other hand, Northouse (1989 b) and Northouse and Swain (1987) reported in studies from the USA that breast cancer patients identified nurses and physicians as important supports while they were hospitalized.
Intervention to support cancer patients

Despite the high frequency of breast cancer and the complex medical treatment, there are few studies of interventions to support patients during the initial phase of the disease, when the consequences of surgery (MRM, BCS), uncertainty about survival and fear of recurrence are great concerns.

The intervention studies (Table 1) that have been conducted focused mainly on the effects of behaviourally-oriented interventions on cancer patients' emotional distress. Most of them involved short-term interventions with groups of patients rather than individuals, and some of them included small groups of patients, as well as cancer patients with varying cancer diagnoses.

The brief group programmes (Table 1) have generally produced statistically significant improvements, which may have been influenced by the fact that patients were highly motivated for the intervention. There are probably patients experiencing significant psychosocial difficulties following cancer who do not wish to deal with these experiences in a group situation. It is difficult to compare the results of the intervention studies presented, since these differ regarding types of intervention, and design (Table 1).

Some interventions for cancer patients have not been evaluated, for instance Berger (1985); Fawzy and Fawzy (1994); and Fredette (1990). Drop-in support groups to offer mutual support and enhance communication between patient and family, patient and doctor have been described (Berger 1985). Support groups for helping women deal with the physical and emotional consequences of breast cancer and resolve psychosocial problems have also been carried out, e.g., in Sweden (Boalt & Ålsäter 1987). Fawzy and Fawzy (1994) described an intervention for breast cancer patients, including health education, stress management, coping strategies and group support. Fredette's (1990) educational model entailed talking about the disease, correcting misinformation, introducing new ideas and options about disease and treatment, and discussing the new identity, sexuality, and fear of recurrence. Family-oriented interventions have been emphasized (Lewis 1990), and interventions of support for family members have been implemented (e.g., Häggmark 1989, pp. 111-139; Häggmark & Theorell 1988). These studies are not, however, presented in this dissertation.

An on-going series of crises for women with breast cancer (Gyllensköld 1976, p. 279) and an overwhelming situation for family members too (e.g., Hilton 1993; Northouse 1989 a, b; Omne-Pontén et al. 1993) make support from RNs central in the nursing care. Few intervention studies have had a nursing perspective, however, and no interventions with the focus on support for both patients and RNs have been described. It therefore seems important to implement a nursing intervention with the focus on support of both patients and RNs. Since most of the studies have used one single
Table 1. Intervention studies with the focus on support of cancer patients.

<table>
<thead>
<tr>
<th>Author/s, Diagnosis</th>
<th>Number of pat. E*</th>
<th>Method, intervention</th>
<th>Intervention, period</th>
<th>Intervention, team</th>
<th>Data collection</th>
<th>Method, evaluation</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hack et al. 1994, Canada Breast cancer</td>
<td>35**</td>
<td>A card sort technique to elicit patients’ preferences for control over treatment decision-making</td>
<td>45 min with each of the patients to complete cards and for interview</td>
<td>RNs and administrators</td>
<td>During the intervention</td>
<td>Semi-structured interviews</td>
<td>Patients who desired an active role in treatment decision making also desired detailed information about their diagnosis, treatment alternatives, and treatment procedures. This relationship was not as clear for passive patients.</td>
</tr>
<tr>
<td>Cimprich 1993, USA Breast cancer</td>
<td>16</td>
<td>Attention-restoring activities. Each patient should perform chosen activity 20-30 min, 3 times a week</td>
<td>The first 3 months after surgery</td>
<td>RNs</td>
<td>3, 18, 60, 90 days after surgery</td>
<td>Standardized tests Self-rating scales</td>
<td>Subjects in the intervention group showed significant improvement in attentional capacity over the four time points, while the non-intervention group showed a pattern of inconsistent performance over time. All subjects had decreased capacity for directed attention for an extended period following breast cancer.</td>
</tr>
<tr>
<td>Bridge et al. 1988, England Breast cancer</td>
<td>47 44</td>
<td>Group 1: relaxation Group 2: relaxation and imagery training. Each patient in both groups should practise 15 min a day</td>
<td>Half an hour once a week for 6 weeks after surgery</td>
<td>Research officers Senior lecturer Professor of Psychiatry</td>
<td>At baseline and at the end of the treatment</td>
<td>Self-rating scales</td>
<td>Relaxation treatments significantly improved the mood state of patients receiving a course of radiotherapy for early breast cancer. Relaxation plus imagery was the most effective treatment, and women aged 55 and over benefited most.</td>
</tr>
<tr>
<td>Arathuzik 1994, USA Breast cancer metastatic</td>
<td>8</td>
<td>Group 1: relaxation and visualization training Group 2: relaxation, visualization, and training in cognitive coping skills</td>
<td>Group 1: 75 min Group 2: 120 min</td>
<td>Assistant Professor of Nursing</td>
<td>Pre- and post-treatment test</td>
<td>Self-rating scales</td>
<td>Significant differences were found between the treatment groups and the control group in ability to reduce pain. There were no significant differences found in pain intensity or distress or mood.</td>
</tr>
<tr>
<td>Spiegel et al. 1989, USA Breast cancer metastatic</td>
<td>50 36</td>
<td>Psychosocial group therapy. The patients were encouraged to discuss how to cope with cancer, to express feelings and effects on their lives</td>
<td>Weekly meetings for 90 min during 1 year</td>
<td>Psychiatrist or social worker</td>
<td>At baseline and follow-up every 4 months for a year</td>
<td>Psychological tests</td>
<td>Patients in the intervention group had significantly increased survival time (36.6 months) compared with the patients in the control group (18.9 months), and the interval from first metastasis to death was significantly longer for the intervention group.</td>
</tr>
<tr>
<td>Study</td>
<td>Country</td>
<td>Cancer Type</td>
<td>Intervention Description</td>
<td>Time Points</td>
<td>Outcome Measures</td>
<td>Results</td>
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<tr>
<td>Edgar et al. 1992, Canada</td>
<td></td>
<td>Breast cancer</td>
<td>Coping skills-based psycho-social intervention 5 hours. Each patient met with a nurse for five 1-hour sessions</td>
<td>At baseline, 4, 8, and 12 months</td>
<td>Interviews, Self-rating scales</td>
<td>No significant differences were found between the groups, except at 8 months, when Group 2 (4 months delay) was significantly less depressed, anxious, and worried, and felt in more control than the participants in Group 1 (immediately after diagnosis).</td>
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<tr>
<td>Cain et al. 1986, USA</td>
<td></td>
<td>Gynecologic cancer</td>
<td>Thematic counseling focused on information about cancer and positive health strategies. 8 weekly sessions of 11/2 hours each within 1 month of diagnosis</td>
<td>At baseline, after intervention, 6 months later</td>
<td>Structured interviews, Self-rating scales</td>
<td>Women who participated in thematic counseling were significantly less depressed and less anxious and had more knowledge of their illness, better relationships with caregivers, fewer sexual difficulties, and more participation in leisure activities. The model was equally helpful for both intervention groups.</td>
<td></td>
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<tr>
<td>Greer et al. 1992, England</td>
<td></td>
<td>Varying forms of cancer</td>
<td>Adjuvant psychological therapy, a brief, problem-focused, cognitive-behavioural treatment programme 6 one-hour sessions</td>
<td>At baseline, 8 weeks, 4 months and 12 months</td>
<td>Self-rating scales</td>
<td>At eight weeks patients receiving therapy had significantly lower scores on helplessness, anxiety, psychological symptoms, and on orientation towards health care. At four months they had significantly lower scores than controls on anxiety, psychological symptoms, and psychological distress.</td>
<td></td>
</tr>
<tr>
<td>Cunningham &amp; Tocco 1989, Canada</td>
<td></td>
<td>Varying forms of cancer</td>
<td>A psychoeducational or coping skills training programme, which included supportive discussion 6 weekly, 2-hour sessions with groups of patients</td>
<td>At baseline, at the end of the last session, 2-3 weeks later</td>
<td>Self-rating scales, Symptom checklist</td>
<td>Both groups were associated with significant benefits, the psychoeducational groups had a greater effect than the control group who received supportive discussion only.</td>
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</table>

* E=Experimental group; C=Control group. **In all the studies, except in Hack et al. (1994), the patients were randomly assigned to either the intervention or control groups.
method for evaluating the effects of the intervention it seems important to investigate the effects using different methods to make it possible to view the intervention from a variety of perspectives.

**District and hospital nurses**
The nurse-patient relationship is believed to be central in nursing care (Benner 1984, pp. 47-75), and it seems crucial to find a balance between distancing and coming too close. Benner (1984, p. 164) suspected "that the distancing techniques dimly protect nurses from the pain in the situation, but they also prevent them from taking advantage of the resources and possibilities that come through engagement and participation in the patients' and families' meanings and ways of coping." Morse *et al.* (1992) stated that "the mechanism of detachment is probably a necessary process that enables nurses to overcome the stress caused by the patient's suffering..., and that caregiving would be impossible or disabling if the caregiver permitted him-/herself to imagine and, therefore, experience the patient's experience" (p. 817). It was found to be difficult for RNs in medical and oncological care in Norway to strike a balance between being open and being sheltered, being close to patients and being distanced from them (Lindseth *et al.* 1994). In a Swedish study, RNs described nurse-patient relations as ranging from deliberately avoiding close contact with the patient to developing a deep relationship, sometimes as far as forming a genuine friendship (Åström *et al.* 1993 b).

In primary health care, district nurses (DNs) are responsible for the nursing care of seriously ill cancer patients who are cared for at home. They often work alone and close to the patients and their families, which may lead to a deep interaction. No studies have been found highlighting DNs' experiences of caring for cancer patients, but there are studies dealing with similar problems. In a Swedish study of abuse of the elderly in their homes, Saveman *et al.* (1992) found that DNs reported considerable problems and could choose to leave the scene (distance themselves), and felt powerless when they came close to families with severe problems.

McElroy (1982) reviewed studies which found cancer nursing to be particularly stressful. It was suggested that oncology nurses were vulnerable to professional and emotional burnout (e.g., Bram & Katz 1989; Jenkins & Ostchega 1986). Oncology nurses who had higher burnout scores showed a higher level of environmental tension, and a greater degree of work dissatisfaction, but were not at any greater risk of burnout than other hospital-based nurses (Jenkins & Ostchega 1986). Since researchers emphasize RNs' vulnerability in the care of cancer patients in hospital (e.g., Lindseth *et al.* 1994; McElroy 1982; Åström 1995, pp. 27-31), it seems important to investigate DNs' experiences of caring for cancer patients in their homes.
Sources of difficulties and satisfaction

Providing nursing care to patients with cancer has been described as both stressful and satisfying. The causes of job-related stress seem to be difficulties in dealing with human suffering, e.g., during the long unpleasant treatments cancer patients receive, the provision of comfort when few or no remaining treatment options exist, witnessing what cancer does to people physically, and identifying with patients (Haberman et al. 1994; Hedly 1993, pp. 48-49; Steeves et al. 1994). Dealing with the grief of family members and feelings of being inadequately prepared to meet these demands (cf. Glaser & Strauss 1979, pp. 5-7; Harris et al. 1990) could be balanced by appreciation from patients/families, and ties of friendship developed in those relationships (Cohen et al. 1994 a; Hedly 1993, p. 54). A major source of satisfaction was found to be the possibility of seeing the patient as a whole person and not just an individual with cancer (Haberman et al. 1994), as well as "participating" in the personal experiences of their patients, which implies that patients become individuals with personalities, histories, goals, and unique lives (Steeves et al. 1994). Relationships with patients were found to be rewarding, but losing a patient with whom the nurse had had good relations was stressful and caused feelings similar to those invoked by losing a friend (Cohen et al. 1994 a; Haberman et al. 1994; Hedly 1993, p. 8). Other sources of difficulties were lack of competent managers, lack of support from colleagues, and lack of time for talking to patients and families (Cohen et al. 1994 a; Hedly 1993, p. 49). Hedly (1993, pp. 6-8) found that nursing staff did not know how to talk with patients or handle problematic situations, e.g., when severely ill and dying cancer patients were anxious and expressed their emotions, and when they wanted to discuss questions of death. Interviews with Swedish cancer nurses showed that it was especially difficult in care situations where the nurse knew what she wanted to do but felt unable to do it (Åström et al. 1993 a). Such difficult care episodes may lead to the avoidance of emotional involvement, for instance distancing manoeuvres (cf. Glaser & Strauss 1979, p. 226; Haberman et al. 1994; Lindseth et al. 1994), which implies the risk of decreasing the nurse's ability to provide high-quality nursing care.

Cancer nurses seem to have to be protected when in deep relationships (Åström et al. 1995), as well as to maintain a balance between their personal and professional lives (Cohen et al. 1994 a). Personal and professional balance may be achieved by establishing supportive networks of occupational relationships. A study in the USA showed that emotional support (admiration, respect, liking) from unit managers, and tangible aid (services, information, or materials) from co-workers were linked to a lower perception of work-related stress among RNs in a variety of clinical specialities (Morano 1993). Similar findings were reported by researchers in the USA who found that the perception of less support in the workplace was significantly related to higher
burnout scores among oncology nurses (Bram & Katz 1989; Jenkins & Ostchega, 1986). In a study in the USA, oncology nurses stated that talking about their experiences in caring for people with cancer helped them to see their work in new ways, and to implement necessary changes within their workplaces so that patients could receive the high-quality care that the nurses wanted to provide for them (Cohen et al. 1994 b). Swedish cancer nurses revealed that supportive relationships with their co-workers were important for their possibilities to act according to their ethical reasoning and feelings (Åström et al. 1993 a). The nursing staff in Hedly's study (1993, p. 7) wanted psychological support when they experienced problems in the terminal care of cancer patients in hospital.

It seems logical to assume that DNs caring for cancer patients also need support, since the job-related risk factors mentioned above could also be encountered in primary health care. Since DNs often work alone, they cannot easily get together with colleagues and talk about problems in the workplace and express feelings related to errors and demanding events.

**Intervention to support nurses**

Regular systematic clinical supervision has proved to be effective in supporting nursing staff in hospital, in decreasing job-related stress and increasing job satisfaction (Berg et al. 1994; Hallberg 1994; Hallberg & Norberg 1993; Hallberg et al. 1994; Jansson et al. 1993) (Table 2).

The systematic clinical supervision in the studies (Table 2) was based on narrations and aimed at facilitating the participants' reflections on lived experiences in the provision of care. It is assumed that people give meaning to or find meaning in lived experiences when they put them within the narrative structure of a story (cf. MacIntyre 1985, pp. 204-225; Sarbin 1986, pp. 3-21). Experiences of meaningfulness are deepened by reflecting on the story told and the possibility of viewing it from a theoretical perspective.

The clinical supervision of Hallberg and coworkers (Table 2, Nos. 3-5) differed from that of Jansson et al. (1993). For example, the composition of the groups differed, and the sessions in the former study focused a particular patient's life story and present situation, while, in the latter study, each member of the group brought a story from his/her clinical work, a problem, an event or episode, which could be either positive or negative, and which they wanted to share and reflect upon in the group sessions.
Table 2. The designs and the methods used for evaluating the effects of systematic clinical supervision in Swedish studies.

<table>
<thead>
<tr>
<th>Author/s Design</th>
<th>Number of nurses</th>
<th>Participants in the supervisory group</th>
<th>Clinic</th>
<th>Data collection</th>
<th>Method evaluation</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Jansson et al. 1993 Descriptive</td>
<td>EW* 15</td>
<td>RNs from various wards</td>
<td>Psychogeriatric</td>
<td>After supervision</td>
<td>Interviews</td>
<td>Increased understanding of themselves and others, as well as new ideas about how to manage the nursing care</td>
</tr>
<tr>
<td>2. Hallberg 1994 Pretest-post-test</td>
<td>CW* 11</td>
<td>All nursing staff on one ward</td>
<td>Child psychiatric</td>
<td>At baseline, and at 6 and 12 months after the start of the intervention</td>
<td>Interviews Self-rating scales Questionnaire</td>
<td>Improved co-operation and self-confidence and a broadened and changed knowledge was found. The degree of tedium decreased significantly regarding mental exhaustion, and the staffs’ satisfaction increased significantly regarding nursing care, and co-operation and comfort in the work group.</td>
</tr>
<tr>
<td>3. Hallberg &amp; Norberg 1993**, Quasi-experimental</td>
<td>EW* 19</td>
<td>All nursing staff on one ward</td>
<td>Psychogeriatric</td>
<td>At baseline, and at 6 and 12 months after the start of the intervention</td>
<td>Self-rating scales</td>
<td>Supervision proved to have a positive effect on nurses’ views of demented patients. Nurses saw the patients as significantly more responsive, to a lesser degree as victims of nihilation, patients’ willfulness and emptiness were significantly easier to handle. No changes were found on the control ward.</td>
</tr>
<tr>
<td>4. Hallberg et al. 1994**, Quasi-experimental</td>
<td>CW* 19</td>
<td>All nursing staff on one ward</td>
<td>Psychogeriatric</td>
<td>At baseline, and at 6 and 12 months after the start of the intervention</td>
<td>Questionnaire</td>
<td>Nurses’ experiences of praise, professional growth, autonomy, and quality of care, as well as their feeling of co-operation with colleagues and comfort improved significantly, while no changes occurred on the control ward.</td>
</tr>
<tr>
<td>5. Berg et al. 1994**, Quasi-experimental</td>
<td>EW* 19</td>
<td>All nursing staff on one ward</td>
<td>Psychogeriatric</td>
<td>At baseline, and at 6 and 12 months after the start of the intervention</td>
<td>Self-rating scales</td>
<td>Creativity and innovative climate improved significantly among the EW nurses in eight out of ten factors: ideasupport, dynamism, conflicts, risk-taking, idea-time, freedom, trust and playfulness. Also tedium and burnout decreased significantly during the year of intervention, while there was no change on the control ward.</td>
</tr>
</tbody>
</table>

* EW=Experimental Ward, CW=Control Ward; ** Refers to the same study (Nos. 3-5).
It is difficult to discover the separate effects of the supervision in Hallberg's and coworkers' study (Table 2, Nos. 3-5), since the clinical supervision was combined with directly supervised implementation of individualized care. Logically, an intervention including two support strategies in combination would make it easier to obtain improvements in a positive direction. In the study by Hallberg (1994) (Table 2, No. 2), however, only clinical supervision was implemented and the evaluation revealed a significantly decreased degree of mental exhaustion, and an increased satisfaction regarding responsibility, organization, quality of care, co-operation, and comfort in the work group.

Systematic clinical supervision seems to be a valuable supportive strategy for developing and enhancing the quality of the working life of carers. It seems logical to assume that clinical supervision also supports DNs and HNs in cancer care, as well as that other phenomena than empathy, creativity, job satisfaction and burnout may be affected. For instance, it may be valuable to examine RNs' sense of coherence (SOC) related to their personality, since the type of personality is an important factor in successful coping in a stressful environment (cf. Hagberg et al. 1991, pp. 8, 9). It is suggested that a high SOC, i.e., an experience of a high comprehensibility, manageability and meaningfulness means that the individual has a good ability to cope (Antonovsky 1987, pp. 24-28).

More attention ought to be paid to the RN's supportive role in the meeting with women with breast cancer and their families. Reasonably, to be able to be involved emotionally and support cancer patients, RNs' own needs for support must be met. No intervention studies have been found dealing with systematic clinical supervision for hospital nurses (HNs) or DNs caring for cancer patients. Therefore, there is a need to develop and implement support for DNs and HNs in cancer care.

**THE AIMS OF THE STUDY**

An intervention with the focus on support for women with breast cancer, as well as for DNs and HNs was implemented. The intervention included organizational changes in the care and professional support, as well as training and systematic clinical supervision for DNs and HNs.

The aim of the study was to investigate the experiences of breast cancer women of their illness and of traditional nursing care (TNC) and supportive nursing care (SNC) (IV, V), as well as to describe the level of well-being/ill-being, burnout, hopelessness, anxiety, and depression in the two groups of women with breast cancer (VII). A further aim was to describe DNs' experiences of difficult care situations (I, II), and to investigate DNs' and HNs' experiences of systematic clinical supervision and their
handling of demanding care situations (III), as well as the effects of the intervention on burnout, empathy, and SOC among DNs (VI).

MATERIAL AND METHODS

The Swedish context for nursing care of cancer patients

Intervention studies to support cancer patients have mostly been carried out in countries that differ from Sweden regarding, for example, the organization of care (Table 1). Cancer care in Sweden is organized around six Oncology Centres located at the regional hospitals. These centres provide specialized services, co-ordinate the available clinical resources, and work with the development of medical treatment programmes and psychosocial issues. For further information about the regional organization of cancer care in Sweden, see Tishelman (1993, pp. 14-17).

The surgical departments of general hospitals are responsible for diagnosis, surgical treatment, chemotherapy and endocrine therapy of breast cancer patients. When radiotherapy is prescribed, the patients are referred to the regional hospital. In general, the surgical department is responsible for follow-up examinations after primary and postoperative medical treatment.

Primary health care in Sweden is organized around the primary health care centres, which offer and co-ordinate primary care within a region. The centre serves the population during normal working hours. In the evening and at night, patients are obliged to visit the nearest hospital. There are similarities as well as differences between these centres (Johansson 1994, pp. 37-38), as there probably are between the co-operation between primary health care and the general hospital within the regions regarding cancer care.

The framing of the training of nurses is important for the nursing care of cancer patients. Both HNs and DNs receive a basic training of 2 to 3 years and DNs are subsequently given postgraduate training for one year, which is focused on general nursing and primary health care. Earlier, the training of nurses in Sweden focused on medical aspects. A "paradigm shift" took place in 1982, from which date the training has been focused on nursing (Askling, 1987, pp. 144-159). For a description of nursing education in Sweden, see Hjelm-Karlsson (1988) and Mogensen (1994, pp. 13-29, 124-181).

The background to the supportive nursing care

The SNC was developed on the basis of a literature review and a previous investigation of breast cancer patients' experiences of nursing care in connection with diagnosis, surgery, and post-surgical treatment (Carlson & Pålsson 1986). The investigation was
carried out in a county council area in the south-east of Sweden. The women in that study stated that the time from their own discovery of breast symptoms to surgery, including the wait in between for the result of the diagnostic examinations, was a strain. Getting information about the diagnosis by telephone or letter was trying and, usually, the women felt they had no opportunity to discuss their experiences with the personnel. Most of them felt safe and relieved during their stay in hospital in connection with the surgery, since competent personnel were at hand to be asked questions. The home­coming, however, was trying, especially for the women who only had a small social network to help them in everyday life and to give them support. It was concluded that women with breast cancer needed professional support before and after surgery.

The intervention
The supportive nursing care, theoretical framework
A combination of a nursing model (Carnevali & Reiner 1990), crisis theory (Lindemann 1944; Sund 1976), and a salutogenic perspective (Antonovsky 1987) based on humanism was used as a theoretical framework when developing the SNC. Humanistic nursing implies that the patient's individuality and dignity and the equal and unconditional value of all people are stressed (e.g., Norberg et al. 1994, p. 23).

The nursing model formulated by Carnevali (Carnevali & Reiner 1990, pp. 4-15) is focused on health problems associated with the impact of disease and medical treatment on the individual's everyday activities and experiences. Nursing interventions are needed when the individual's internal and external resources are not sufficient to create a balance between requirements and resources. Internal resources, for instance, are needed to be able to accept a changed body, and external resources, e.g., family members and health care professionals are needed to help and support the sick one. The interaction between RN and patient is crucial for a vulnerable cancer patient, and is related to the RN's supporting role (cf. Norberg et al. 1992, p. 77).

The crisis theory elucidates why there is a decrease in well-being in cancer patients during the acute phase of their illness. Lindemann's (1944) crisis theory focuses on symptomatology and management of acute grief. Sund (1976) described how to provide crisis intervention during the acute phase of a traumatic crisis. This is a crisis that can be precipitated by events, which the individual cannot handle by employing his/her usual problem solving powers. He accentuated the importance of helping the individual to express feelings and thoughts about the crisis-initiating event and its consequences, and of assessing the individual's own resources and possibilities.

Antonovsky's (1987, pp. 15-32; 1993) salutogenic model of health was used as this model is related to the positive or healthy in patients, not only to the curing of the disease, and explains how people manage to stay well despite omnipresent stressors.
The salutogenic model takes the individual's social, historical and cultural context into account in explaining his/her movements on the ease/dis-ease continuum. An orientation which views activities as meaningful and perceives life events as comprehensible and manageable is called a "sense of coherence" (SOC) (Antonovsky 1987, pp. 15-32). According to Antonovsky, the stronger the SOC, the more likely the individual is to cope successfully with stressful life situations, which, in turn, leads to better health. In this perspective health is regarded as something more than absence of disease, and includes an objective as well as a subjective dimension.

A life-threatening disease like breast cancer, requiring complex medical treatment and extensive ongoing medical follow-up examinations, implies a crisis reaction (Gyllensköld 1976, p. 346) and an impact on the individual's everyday life. According to the crisis theory, a negative situation disturbs the normal balance between problem perception and the problem-solving capacity. Nursing care including professional support (Carnevali & Reiner 1990; Sund 1976) may improve breast cancer patients' ability to use their resources, and increase their problem-solving capacity, which, in turn, may lead to experiencing the exacting event as comprehensible and manageable (SOC) (Antonovsky 1987). Thus, a new balance may be found. Antonovsky's focus on health agrees with Carnevali's nursing model which suggests there should be a balance between requirements and resources so as to make it possible to find health. Effective management of daily living issues and personal responses to the cancer experience can have important consequences for well-being (Carnevali & Reiner 1990, p. 15).

The supportive nursing care, content and organization
The SNC was implemented in the same county council area as the previous study of breast cancer patients' experiences of their illness and the care received (Carlson & Pålsson 1986). The SNC meant that women with breast cancer were offered support from RNs in connection with diagnosis, hospital care and after the discharge from hospital. It included talking about illness-related thoughts and reactions with an HN or DN, and expressing and verbalizing anxiety, fear and agony, as well as being made aware of the connection between physical and mental symptoms and the crisis-initiating event (cf. Sund 1976). The most important tasks for the RNs in this situation were to listen, console, accentuate the importance of showing feelings and talking about the situation, to answer questions and explain misunderstandings (cf. Pålsson 1989).

The organizational changes in the provision of care meant that the women were offered a supportive conversation with an HN or a DN immediately after the diagnosis was given by the physician. They also included extended co-operation between surgical care and primary health care, which implied that a DN came to the hospital in connec-
tion with the patient's discharge. The woman, the HN and DN discussed the surgery, the woman's need for support, and whether she wanted to meet the DN at home or in the health care centre. In order to achieve continuity, one HN had special responsibility for the nursing care during the hospital stay, and the same DN was in regular contact with the woman after the hospital care (Table 3, p. 26). The medical follow-up examinations were, as before, carried out at the hospital by specialist physicians.

Training of district and hospital nurses
To facilitate DNs' and HNs' provision of SNC they participated in a training programme (40 hours) that concerned: the SNC intervention, medical care and treatment in connection with breast cancer, psychological reactions, the impact of breast cancer on everyday life and crisis intervention as presented by Sund (1976).

Clinical supervision of district and hospital nurses
The majority of the DNs and all the HNs were given regular systematic clinical supervision after the training (April 1991 - May 1992). The overall purpose of the supervision was to support the nurses, and to enhance their possibilities of supporting and helping patients with their health problems. The narrative framework for clinical supervision previously implemented by, e.g., Hallberg (1994) and Jansson et al. (1993, pp. 118-120) (Table 2) was chosen, since reflecting on the stories narrated offers insight into demanding events in the nursing care of cancer patients and deepens RNs' understanding of their patients and of their own actions (cf. Schön 1983, pp. 62-63; cf. Jansson et al. 1993, p. 122). Within narrative theory, stories are seen as disclosing the complex interplay between cognitive, emotional and conative phenomena in relation to actions performed (Sarbin 1986, pp. 3-21; Tappan 1990).

Two supervisors were involved in the supervision. They were RNTs with several years' experience of training RNs in clinical work and had had theoretical training in supervision. Each group session started with an RN talking about a problem she had had in her work situation or in a relationship with a patient or with a patient's family, how she had handled the situation, and what feelings the contact with that particular patient had evoked. The others in the group gave their reflections, either in relation to the narration in question, or by talking about a comparable patient or situation. The discussion concentrated on reflections on and interpretations of the narrations, and possible solutions were developed and presented by the participants. The supervisors led the group members to enter more deeply into their accounts by asking questions about their experiences. They also integrated theoretical nursing into the discussions by talking about nursing research results related to the topic.
The DNs and HNs were supervised in four different groups, and the sessions were provided at intervals of two to four weeks. Each session lasted between 1.5 and 2 hours and was held in a room separate from other activities (III, Table 3). The supervisory groups were closed, i.e. no new members were admitted during the period in question.

The DNs in the comparison group (training participants) and those who did not participate in the training also worked in line with the intentions of the SNC. All DNs/HNs and physicians received written and oral information about the SNC before the intervention started. The DNs in the comparison group and non-participants in the training had regular contact with the author during the intervention to discuss their work with breast cancer patients, and to get support and feedback. The author was not directly involved in the implementation of the SNC, but only supported the DNs and HNs who implemented it.

The design of the study
Since it was important to gain a deep understanding of breast cancer patients' experiences of their illness and the care received, as well as of DNs' experiences of the nursing care of cancer patients, a qualitative approach was chosen (cf. Polit & Hungler 1989, pp. 312-315; Taylor & Bogdan 1984, pp. 1-8). The understanding of the individual perspective is important when the research is intended to guide nursing action and interventions. A qualitative approach was also used to investigate the experiences of women and RNs of the intervention, and to compare women's experiences of TNC and SNC respectively.

Methods making it possible to quantify were used to examine the effects of the SNC and the systematic clinical supervision. The choice of a variety of methods makes it possible to obtain complementary findings and view the intervention from various perspectives and gain a deeper understanding of the phenomena being studied (cf. Polit & Hungler 1989, pp. 249-250; Taylor & Bogdan 1984, p. 68).

The quantitative approach allowed a comparison to be made between the group that had had an intervention and the group that had not (static group comparison) (Roe 1994, p. 7). In the study of DNs, the data were measured before and after the intervention (pretest - post-test design), while in the study of patients there was only one data collection about six months after the primary treatment (one shot case study) (cf. Roe 1994). The RNs were arbitrarily assigned to the intervention or the comparison groups.

The training of DNs and HNs was given before the intervention started, and the SNC was implemented simultaneously with the systematic clinical supervision (Figure 1).
Women with breast cancer

The sample consisted of women with breast cancer in two county council areas in the south-east of Sweden, diagnosed during a period of one year and cared for according to TNC (IV), and SNC (V) (Table 3).

Table 3. Characteristics of supportive nursing care (SNC) and traditional nursing care (TNC). (The Table is presented in Paper IV).

<table>
<thead>
<tr>
<th>ORGANIZATION OF THE CARE</th>
<th>SNC</th>
<th>TNC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended co-operation between surgical ward and primary health care</td>
<td>x</td>
<td>-</td>
</tr>
<tr>
<td>Information about the diagnosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- on the same day as mammography and cytology have been done</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>- about one week after the examination</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>A follow-up talk with a nurse after being informed about the diagnosis</td>
<td>x</td>
<td>-</td>
</tr>
<tr>
<td>Meeting a district nurse in the surgical ward before discharge</td>
<td>x</td>
<td>-</td>
</tr>
<tr>
<td>Personnel continuity during the hospital stay*</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Regular contact with a district nurse after the hospital stay</td>
<td>x</td>
<td>-</td>
</tr>
</tbody>
</table>

x=implemented; - = not implemented; * according to information from the nurse director in the TNC.

The criteria for inclusion in the study were similar for women with breast cancer in both the TNC and the SNC: diagnosis according to the TNM classification (UICC 1978) as stage I or II, adjuvant or no postoperative medical treatment, no previous history of breast cancer and 35-69 years of age.
Sixty-six women with breast cancer (TNC, SNC) met the sample criteria, four women could not be reached, and 15 did not want to participate. Thus, forty-seven (71\%) agreed to participate in the interview study (43 face-to-face interviews, 4 telephone interviews). The reasons for not participating given by the women in the TNC were frequently a wish to forget the disease, and low energy (IV). In the SNC (V) the women who did not participate stated that the hospital care and the contact with the DN were positive, and that they had nothing else to say. Demographic and medical data for the participants and the non-participants, collected from the surgical records, are presented in Table 4.

Table 4. Demographic and medical data for the participants and the non-participants in the traditional nursing care (TNC) (IV) and the supportive nursing care (SNC) (V).

<table>
<thead>
<tr>
<th></th>
<th>TNC (Paper IV)</th>
<th></th>
<th>SNC (Paper V)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>participants</td>
<td>non-participants</td>
<td>participants</td>
<td>non-participants</td>
</tr>
<tr>
<td>n=21</td>
<td>n = 8</td>
<td></td>
<td>n=26</td>
<td>n = 11</td>
</tr>
<tr>
<td>Mean age in years (SD)</td>
<td>56.1 (9.8)</td>
<td>54.9 (4.9)</td>
<td>53.7 (7.1)</td>
<td>57.6 (9.3)</td>
</tr>
<tr>
<td>Marital status:*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>single</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>married**</td>
<td>17</td>
<td>5</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>Type of surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>breast conserving surgery</td>
<td>6</td>
<td>2</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>mastectomy</td>
<td>15</td>
<td>6</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Post-operative treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>radiotherapy</td>
<td>11</td>
<td>4</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>chemotherapy</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>endocrine therapy</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

♦two missing values (participants, Paper IV); ** married = women who were married or living as if married.

The Mann-Whitney U-test was used to examine differences between the groups (TNC, SNC), between participants and non-participants in each group, as well as between all participants and non-participants in the studies (IV, V) regarding demographic and medical characteristics. There were more single women among the participants in the SNC than in the TNC (p<0.05). Paper VII describes 34 out of the 43 women with breast cancer interviewed face-to-face. Seventeen in each group (SNC = 71\%, TNC = 90\%) responded to a set of standardized scales anonymously after the interviews. No significant differences were found between the responders to the scales (79\%) and the non-responders (21\%) regarding demographic and medical aspects (The Mann-Whitney U-test) (VII).
District and hospital nurses

The DNs and HNs worked in the county council area where the SNC took place. Participating and non-participating nurses in the training and in the systematic clinical supervision (I-III, V) are shown in Figure 2.

<table>
<thead>
<tr>
<th>Participants in training and clinical supervision</th>
<th>DNs</th>
<th>HNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offered training</td>
<td>62</td>
<td>10</td>
</tr>
<tr>
<td>The training programme</td>
<td>39</td>
<td>23</td>
</tr>
<tr>
<td>The clinical supervision</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>9*</td>
<td></td>
</tr>
</tbody>
</table>

* There was a drop-out of one DN and one HN before the clinical supervision started.

Figure 2. Participating and non-participating nurses in the training and in the clinical supervision.

Thirty-nine DNs (I), out of a possible 62, and all the HNs (n = 10) participated in the training programme (p. 24). The 23 non-participating DNs declined to take part in the training because of the work load current at the time of the study. The participants (DNs) (Table 5) had spent significantly more years in the profession than the non-participants (I). Twenty-three DNs, (II, III), and nine HNs (III) (Table 5) participated in the systematic clinical supervision. These nurses were assigned arbitrarily by the author to the supervisory group, and the remaining 15 DNs were assigned to a comparison group (Figure 2). The criteria for assignment to the groups were: (a) all the DNs in a health care centre formed either a supervisory or a comparison group to avoid participants and non-participants influencing each other; (b) country as well as urban areas were to be represented in both groups (only DNs). Thirty-three (21 in the supervisory and 12 in the comparison groups) (Table 5) out of the 39 DNs completed a set of standardized scales before and after the intervention (VI). There were no significant differences between responders to the scales and non-responders regarding age and years in the profession (VI).

The number of subjects, methods of data collection, main content in the studies, and types of analyses of the various parts of the study are presented in Table 6. The DNs in Paper I are also described in Papers II, III and VI, and the women with breast cancer described in Papers IV and V are also described in Paper VII.
### Table 5. Characteristics of the district nurses (DNs) described in Papers I to III, and VI, and of the hospital nurses (HNs) described in Paper III.

<table>
<thead>
<tr>
<th>Paper</th>
<th>Nurses:</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DNs</td>
<td>DNs</td>
<td>DNs</td>
<td>HNs</td>
<td>DNs</td>
</tr>
<tr>
<td></td>
<td>n=39</td>
<td>n=23</td>
<td>n=23</td>
<td>n=9</td>
<td>n=33</td>
</tr>
<tr>
<td>Mean age in yrs (SD)</td>
<td>45.9 (7.9)</td>
<td>48.6 (7.2)</td>
<td>48.6 (7.2)</td>
<td>40.6 (11.7)</td>
<td>48.0 (7.6)</td>
</tr>
<tr>
<td>Mean number of yrs (SD)</td>
<td>21.5 (7.9)</td>
<td>23.8 (8.0)</td>
<td>23.8 (8.0)</td>
<td>13.2 (7.8)</td>
<td>23.2 (7.7)</td>
</tr>
<tr>
<td>in nursing care</td>
<td>13.0 (6.9)</td>
<td>16.0 (6.9)</td>
<td>16.0 (6.9)</td>
<td>0.0</td>
<td>15.4 (6.8)</td>
</tr>
<tr>
<td>as a district nurse</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

### Table 6. The number of subjects, methods of data collection, main content, and types of analyses.

<table>
<thead>
<tr>
<th>Paper</th>
<th>Number of subjects*</th>
<th>Methods of data collection</th>
<th>Main content of the studies</th>
<th>Types of analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>39 DNs</td>
<td>Narrative interviews</td>
<td>DNs' experiences of the meeting with cancer patients</td>
<td>Content analysis inspired by grounded theory</td>
</tr>
<tr>
<td>II</td>
<td>23 DNs</td>
<td>Narrations in supervision sessions</td>
<td>DNs' narratives about demanding care situations</td>
<td>Phenomenological-hermeneutics</td>
</tr>
<tr>
<td>III</td>
<td>23 DNs, 9 HNs</td>
<td>Narrative interviews</td>
<td>DNs'/HNs' own view of the effects of clinical supervision</td>
<td>Phenomenological-hermeneutics</td>
</tr>
<tr>
<td>IV</td>
<td>21 women</td>
<td>Semi-structured interviews with open-ended questions</td>
<td>Breast cancer patients' experiences of TNC**</td>
<td>Content analysis inspired by grounded theory</td>
</tr>
<tr>
<td>V</td>
<td>26 women</td>
<td>Semi-structured interviews with open-ended questions</td>
<td>Breast cancer patients' experiences of SNC**</td>
<td>Content analysis inspired by grounded theory</td>
</tr>
<tr>
<td>VI</td>
<td>21 DNs, 12 DNs</td>
<td>Scales for*** BM, ECRS SOC, KSP</td>
<td>The degree of burnout, empathy, and SOC in two groups of DNs (S, C)****, and the relation between these phenomena and personality traits (KSP) in DNs</td>
<td>Descriptive statistics. Nonparametric tests for differences and correlations</td>
</tr>
<tr>
<td>VII</td>
<td>17 women, 17 women</td>
<td>Scales for*** WM, BM, HS, HAD,</td>
<td>The degree of well-being, burnout, hopelessness, anxiety, and depression in two groups of breast cancer patients (TNC, SNC)</td>
<td>Descriptive statistics. Nonparametric tests for differences and correlations. Discriminant function analysis</td>
</tr>
</tbody>
</table>

* Women = Breast cancer patients, DNs = District nurses, HNs = Hospital nurses. ** TNC = Traditional Nursing Care, SNC = Supportive Nursing Care. *** BM = Burnout Measure, ECRS = Empathy Construct Rating Scale, SOC = Sense of Coherence Scale, KSP = Karolinska Scales of Personality, WM = Well-being Measure, HS = Hopelessness Scale, HAD = Hospital Anxiety and Depression Scale. **** S = Supervisory group, C = Comparison group.
The procedure of the intervention
Written information about the professional support in the SNC was given to all women with breast cancer in connection with diagnosis during the intervention period, and it was repeated by an RN during the hospital stay. Women meeting the inclusion criteria for participation in the study received a letter with information about its purpose and procedure. The interviewees were asked to give their informed consent by telephone.

Information about the intervention concerned: health care professionals, trade unions, officials, and politicians. The organization of the SNC was worked out in discussions with DNs/HNs and physicians in hospital care and primary health care. Written information about the SNC was distributed to the RNs and physicians concerned. After being informed about the intervention, DNs/HNs and physicians worked in line with the SNC. After being informed about the study (training participants) and giving informed consent, DNs and HNs participated in the interviews and responded to the instruments.

Permission to carry out the study was granted by the chief physicians of the various hospitals. The study was approved by the Medical Ethical Research Committee of the University of Lund, and the Computer Inspection Board.

The methods
Interviews
Women with breast cancer
Semi-structured interviews with open-ended questions were conducted during the same period about six months after the primary treatment with 21 (IV) and 26 women with breast cancer (V). This time-frame was selected to allow the respondents sufficient time for physical and mental recovery from the initial traumatic crisis reaction. Each interview started with a social conversation aimed at establishing a relationship of trust with the interviewee. The formal interviews lasted between 45 and 90 minutes, and concerned the women's reported experiences: of getting the diagnosis, of primary and adjuvant medical treatment, of the contact with health care professionals and social network, of concerns about the future, of what changes in the care were important for meeting their psychosocial needs. The woman was encouraged to ask questions at the end of the interview. The majority of the interviews was tape-recorded (n=42), four women were interviewed on the telephone, and one woman did not consent to tape-recording. The interviews took place either in the clinic (IV) or in the author's workplace (V). The interviews were transcribed verbatim except in the five cases mentioned above, where key words were noted during the interviews, which were then written out afterwards.
The women were asked to complete instruments after the interview and were instructed how to do so.

**Nurses**

Narrative interviews with 39 DN's were conducted after the training programme was completed, and before the systematic clinical supervision started (I). The interviewees' narrated experiences from the care of cancer patients. The tape-recorded interviews (n=32) lasted from 30 to 90 min and were transcribed verbatim, except in seven cases where there was a technical failure (n=3), or where the interviewees did not allow tape-recording (n=4). In these cases key-words were noted during the interviews.

Paper III describes 23 DN's and nine HN's experiences of support in immediate connection with demanding care situations and of the clinical supervision. The interviews lasted from 30 to 60 min and were tape-recorded, except in three cases, where key-words were taken down during the interviews and typed immediately afterwards. This was done because the interviewees did not consent to tape-recording.

The interviews took place at the DN's (I, III) and HN's places of work (III).

**Tape-recorded supervision sessions**

Data were collected by means of tape-recordings of supervision sessions. Narrations about demanding situations in DN's meetings with patients and their families were focused on. Of the 50 group-sessions 29 were tape-recorded and transcribed verbatim (nine in group 1, 14 in group 2, six in group 3). Twenty-one sessions were not tape-recorded due to technical failure (n=6), because the participants did not allow tape-recording (n=9), or because only the SNC was brought up in them (n=6). The last-mentioned sessions were not used in the analysis (II).

**Instruments**

Women with breast cancer

The following scales were used to investigate the degree of well-being and ill-being, burnout, hopelessness, anxiety and depression (TNC and SNC groups): the well-being and ill-being measure (WM) (modified version of Lundman et al. 1988), the burnout measure (BM) (Pines & Aronson 1988), the hopelessness scale (HS) (Beck et al. 1974) and the hospital anxiety and depression scale (HAD) (Zigmond & Snaith 1983) (VII).

Nurses

A questionnaire and scales were distributed to the DN's to investigate their degree of burnout, empathy, and sense of coherence (before and after the intervention), as well as their personality traits (before the intervention). These comprised a self-report questionnaire about demographic details, the burnout measure (BM) (Pines & Aronson
analyses of data

The analyses of the interview texts, inspired by grounded theory (Corbin 1986, pp. 91-102; Glaser 1978, pp. 55-61) started with a reading of the interviews to gain a sense of the whole of each interview and the entire material. Open coding was carried out by each research participant individually (two researchers in study I, and three in studies IV and V), and sentences, word-pairs and expressions were marked. The coding allowed the understanding of the material to develop, and ideas about categories to emerge. The contents of the interviews, the codes and the suggestions for categories were discussed, compared and contrasted in the research team. The next steps consisted of grouping the codes into categories, and grouping the categories into themes. Lastly, all the interviews were read again in order to validate the structure of themes and categories against the interviews (I, IV, V).

To facilitate the comparison of similarities and differences concerning the women's experiences of the care received (TNC, SNC), a second coding of the material in study IV was made to investigate whether the categories and themes in study V could be used.

Phenomenological-hermeneutic analyses inspired by Ricoeur (1976), were performed in a series of steps (II, III). This analysis method was developed by Norberg and Lindseth and previously used by e.g., Lindseth et al. (1994), Söderberg and Norberg (1993), Udén et al. (1992), and Åström et al. (1993 a, b). To understand a text is to follow its movements from sense to reference (Ricoeur 1976, p. 87). A text has various possible meanings regarding both what the speaker intends to say (utterer's meaning) and what the sentence means (utterance meaning) (Ricoeur 1976, p. 12). In the present study (II, III), the utterance meaning was in focus. Firstly, a naive reading of each interview (III) or story (II) was made to obtain a sense of the text as a whole, and to get ideas for further analyses. Secondly, a structural analysis was performed in several steps, which aimed to explain the text (II, III). The first structural analysis was performed on the 147 stories narrated, using narrative categories (Sarbin 1986): story, main actor, co-actors, and intrigue (II, Table 2), by analogy with Söderberg and Norberg (1993). The second structural analysis focused on illuminating how the narrators labelled themselves: as One, I, or We (cf. Åström et al. 1993 a). This analysis also focused on whether the DNs narrated the care episodes as 'overwhelming' or as 'possible to grasp' (II, Tables 3, 4), by analogy with the work by Åström et al. (1993 a). The results were then grouped into themes (II, Table 5). Lastly, the texts were seen as a
whole again, taking the naive reading, the structural analysis, and the authors' pre-understanding into account (II).

*The statistical analyses* were performed using a set of non-parametric distribution-free methods to analyse data based on ordinal scales. This choice of statistical techniques is useful when the data set is small and not assumed to follow a specific probability distribution function (VI, VII) (*cf.* Polit & Hungler 1989, p. 308). The Mann-Whitney U-test was used for independent samples, the Wilcoxon signed rank test for related sample, and the Spearman rank correlation coefficient for calculating the strength of the relationships between the variables. A discriminant analysis (a parametric method) with stepwise variable selection was used with the groups (TNC, SNC) as grouping variable and background data (age, marital status, type of surgery), WM, BM, HS, and HAD scales as independents (Polit & Hungler 1989, pp. 295, 394). The Cronbach's Alpha (Cronbach 1951) was used to assess the internal consistency of the scales (VI, VII). The chosen level of significance was 0.05. The statistical analyses were performed by means of the Statistical Package for Social Sciences (SPSS 9.0, Nie *et al.* 1975).

**Ethical considerations**

Interviews with breast cancer patients about their experiences in the initial phase of the disease, six months after primary treatment, might create emotional discomfort for the interviewees. The investigator had a background of 27 years in nursing care and as a nurse teacher and felt reasonably qualified to intervene if problems arose. The women who felt that they required help and support were also offered contact with an almoner. The voluntary aspect was stressed, and confidentiality guaranteed. The patients were assured that their decision would not interfere with their treatment. There were prospects of benefits for the surgical departments in both hospitals, and for breast cancer patients in the future (IV, V). After the analyses of the interviews, the chief physicians (IV, V) and the RNs (V) were informed about the findings.

From the viewpoint of research it is desirable to have groups of patients who are treated differently, but from an ethical perspective all patients should be offered nursing care that meets their psychosocial needs. However, it was difficult to know whether the SNC would facilitate women's everyday lives or worsen their situation (V). The comparison group (IV) was given nursing care in accordance with current care principles in Sweden. These women were chosen from a hospital in another county council area, since it would have been difficult for professional carers not to give the same type of nursing care to all women with breast cancer in connection with diagnosis, surgery, and rehabilitation at home (V).

It was expected that the SNC would make increased demands on DN's and HN's, since they were emotionally involved and engaged in the patient and the family. The
clinical supervision was given during the period with the SNC to investigate whether this could support DNs and HNs in their relationships with cancer patients (III, VI). The DNs who did not participate in the clinical supervision (the comparison group and those who did not participate in the training) had regular contact with the author during the intervention.

FINDINGS (I - VII)

The experiences of district nurses in meetings with cancer patients (I)
The DNs' mainly reported dissatisfaction and feelings of mental strain, but also some satisfaction in their contacts with cancer patients. The following themes were found: dressing of ulcerous cancer wounds (not showing any reaction in the presence of the patient on witnessing the physical destruction of the patient's body); managing physical pain (not being able to relieve patients in intolerable pain, difficulties in balancing therapeutic relief against toxicants, lack of time to stay with the patient, and lack of competence for providing individual pain relief); being too close to the patient (identifying themselves with patients); not being allowed to communicate openly (walking a tightrope when "playing the game" with denying patients and their families, not knowing what information the patient had been given and how the patient had reacted when given that information, the patient expressing anger and bitterness towards healthy people, trying to find scapegoats at the hospital, relatives forbidding the nurse to talk openly with the patient); not being allowed to help (feelings of being insufficient and abandoned while knowing that the patient had a great need for help and support); patient's trust in alternative medicine ('walking a fine line' with cancer patients wanting treatment with natural preparations, hoping for effects from the preparation that did not accord with the DNs' own experiences of the treatment); being accepted as a helper (being able to help physically and mentally, feeling appreciated, being met with gratitude and feed-back produced feelings of satisfaction). The overall emotional tone in the interviews was positive. It seemed as if the DNs did not want to be without the strain and enrichment that emanated from the deep contacts and relationships.

District nurses' narrations of difficult care situations (II)
The home care of seriously ill patients, the contact with the loneliness of elderly people and people with severe social problems was demanding for DNs. Sometimes there was a balance between the negative and positive dimensions in these meetings. The following themes emerged in the analysis of the narrations: coming too close to the patient (difficulties in distancing themselves from the patient, making demands on the patient and leaving the responsibility for the patient to a colleague, feelings of being indispensible, identification with the patient, difficulties in drawing the line between the
professional and the private role, risking reduced quality in the contact with other patients); *keeping and restoring patients' hope* (not taking the patients' hope away but not raising unrealistic expectations, uncertainty about how well-informed the patient was, and relationships with cancer patients with negative frames of references); *conflicting opinions* (conflicts between personnel in primary health care and in hospital concerning terminal care, conflicts between DNs and physicians or patients and their families); *feeling powerless* (not knowing how to help elderly people to lead a meaningful life, elderly people longing for death, not knowing how to find a positive solution or how to act in the contact with people believed to be physically and/or mentally abused, wanting to help patients but being unable to or forbidden by the patient); *meeting unrealistic demands* (conflicts between patients' demands and DNs' possibilities to meet these demands, dividing time between help to people where the problem was loneliness, and others suffering from serious diseases, relatives' expectations that the DN should be able to stop the development of a cancer disease, being forbidden by family members to talk openly to the patient about the disease); *patients' trust in alternative medicine* (difficulties in keeping the truth from patients asking about the effects of natural preparations, satisfaction in the regular meeting with patients for whom there was no conventional treatment available); *feeling disgust, shame and guilt* (support to caregiver in the family who had feelings of disgust in the care of a family member with changed personality and behaviour, difficulties in the contacts with patients with necrotic cancer wounds); *relations to patients' families* (relatives showing aggression towards DN, accusing her of insufficient care, feelings of shame and guilt because of insufficient resources available to support the relatives, difficulties in handling the relationships with worried and emotionally affected family members); *communication gaps* (between patients and professionals at the hospital, between primary and hospital care, between the sick person and family members, feelings of uncertainty and fear in DNs, since they did not know what the physician had told the patient, feelings of dissatisfaction when DNs could not bring about open communication between the sick person and family members). A deep contact with seriously ill patients and their families was demanding, since the DNs' own existential anxiety could be evoked. Nevertheless, it was also an enriching experience, involving friendship, familiarity with other values, and learning from patients.

**The experiences of district and hospital nurses of demanding care situations and of systematic clinical supervision (III)**

The RNs (DNs, HNs) spoke about their need for immediate support when they had been in emotionally charged care situations. Support from colleagues could be blocked, *e.g.*, when colleagues themselves were emotionally involved in demanding care situ-
It emerged that the content of the supervision in groups 1 and 2 was focused on the patients' problems and the RNs' experiences in contact with the patients, while in the groups 3 and 4 it focused on the RNs' experiences.

The DNs' and HNs' descriptions of immediate social support and their experiences of the supervision were categorized as relief: immediate relief (unburdening oneself of emotionally stressful thoughts and feelings in their contacts with colleagues, family and friends); and relief in the supervision (verbalizing their own thoughts and feelings, listening to and discussing colleagues' experiences and points of view, being undisturbed when analysing what had happened); confirmation: confirmation of actions (immediately or getting feed-back in the supervision about how the actions and communication with the patient/family had been handled); confirmation of the nurse as a person (hearing that colleagues had felt and reacted similarly to oneself); confirmation of the professional role (understanding each other's work, being encouraged, supported, respected and understood in one's professional role); and development: getting a broader and deeper knowledge (awareness of the influence of illness and/or treatment on the individual's everyday life, and his/her need for emotional support during the various stages of an illness); self-confidence (increased courage, self-assurance, and mental strength); increased sense of well-being (making better use of one's own resources, coping with stress in the job more easily, being able to give more of oneself in the nursing care).

**Women's experiences of their illness and the traditional nursing care (IV)**

Women's narrations about the care received and their experiences of breast cancer could be understood in terms of the following themes: **the organization of the care:** the overall experiences of the organization (being kept waiting for information, shortcomings in the routines surrounding the care, want of help and support from health care professionals in connection with diagnosis and decision about the type of surgery, and post-surgery); **sense of control:** getting information (sufficient information about the disease and its treatment reduced anxiety, fostered hope and gave feelings of strength, insufficient or lack of information caused feelings of uncertainty, confusion and incompetence, feelings of guilt when a physician blamed a woman for not having discovered the tumour herself); **emotional contact** (insufficient support from health care professionals during the disease process, family members, above all their husbands, being supportive, as well as other women who had their own experiences of the illness, feelings of fear in non-supportive contacts, leading to increased isolation, loneliness, and possible mental breakdown); **confirming relationship** (when health care professionals...
showed understanding, were medically competent, took their time, and the woman dared to ask questions; *disconfirming relationship* (when professionals were only technically and medically interested, did not console and encourage, and were stressed or evasive); **the future**: *the value of the present and the near future* (changes in their view of life, appreciating things that were taken for granted earlier, increased openness and time spent on oneself); *the fear of the terrible future* (feelings of anxiety about cancer recurrence and death, fear of the consequences of surgery, and feelings of anxiety among the members of the family); **patients' suggestions for changes of the care**: (possibilities of getting support from an RN, trusting relationships between professionals and women and the families, a female RN present at the information session about the diagnosis, progressive information in stages about the disease and with the focus on hope, oral information combined with written, more information about what they could do to prevent a recurrence).

**Women's experiences of their illness and the supportive nursing care (V)**

The following themes were found when analysing the women's narrations: **the organization of care**: *overall experiences of care* (positive response to shorter waiting times in connection with information about the diagnosis, a follow-up talk with an RN immediately after the diagnosis, regular contact with the same DN after discharge from hospital, the same 'chemo nurse' at the hospital, and with the same doctor at the follow-up examinations); **sense of control**: *getting information* (feelings of safety and security in connection with sufficient information, and of uncertainty and fear when the information was insufficient, information about the nursing care was mostly sufficient, but about medical care was often insufficient or lacking); **emotional contact** (receiving support from DNs, *i.e.*, sharing illness-related problems, being listened to, being consoled, and being invited to further contacts was important, as well as receiving help with practical things in everyday life from family members and friends, negative feelings when interest from their social network declined and the "wrong" things were said, feelings of not being alone when they understood that other women with breast cancer had reacted in the same way as they themselves); **confirming relationships** (the relationships with health care professionals was mostly reported as 'confirming', feelings of satisfaction at being respected as a human being, being shown interest, understanding and consideration, and when the tone of the conversation was permissive); **disconfirming relationships** (feelings of disappointment at being treated as an object and at having no time for questions); **the future**: *the value of the present and the near future* (their everyday life had not been influenced so much, the present appeared more important than before the cancer disease, they focused more on themselves, the future looked hopeful and promising, and the family had been brought closer together); *fear of the*
terrible future (fear of recurrence and death, and that the loss of the breast would be visible in contact with other people, and focusing on physical symptoms); patients' suggestions for changes in care: (shorter waiting times for the result of metastasis examinations, invitation to foster breast cancer patients' involvement in treatment decisions, sufficient information about medical treatment, and support when radiation therapy was finished).

**Burnout, empathy and sense of coherence in district nurses (VI)**

No significant differences were found at baseline between the supervisory and the comparison groups concerning demographic aspects and personality traits (the KSP), except in the two subscales Detachment and Inhibition of Aggression, which showed significantly lower scores in the comparison group (VI, Table 3).

Data related to the level of BM, ECRS, and SOC are shown in Table 7. No significant differences were found with regard to these phenomena over time within the groups, nor between the groups at baseline or after the intervention. There were significant correlations between some of the personality traits (KSP) and BM, ECRS, and SOC (VI, Table 4), as well as a negative significant correlation between the scores in burnout and empathy ($r = -0.64$, $p < 0.001$) and between the burnout and the SOC scores ($r = -0.69$, $p < 0.001$). In addition, the empathy scores correlated significantly and positively with the SOC scores ($r = 0.76$, $p < 0.001$).

Table 7. The degree of burnout, empathy and sense of coherence in the supervisory (n=21) and the comparison groups (n=12) before and after the systematic clinical supervision (The Table is presented in Paper VI).

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td><strong>Supervisory group</strong></td>
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</tr>
<tr>
<td>Burnout</td>
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</tr>
<tr>
<td>Empathy*</td>
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<td>31.0</td>
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<tr>
<td>SOC</td>
<td>148</td>
<td>17.5</td>
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<tr>
<td><strong>Comparison group</strong></td>
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</tr>
<tr>
<td>Burnout#</td>
<td>02.3</td>
<td>00.7</td>
</tr>
<tr>
<td>Empathy0</td>
<td>435</td>
<td>35.0</td>
</tr>
<tr>
<td>SOC##</td>
<td>154</td>
<td>13.6</td>
</tr>
</tbody>
</table>

* One DN in the supervisory group was excluded from the description of empathy because there were several missing values on the empathy scale.

# = <3.0, >3.0 (scores of 3.0 or more indicate a risk of burnout); □ = 84-504 (the top score is interpreted as "well-developed empathy"); ## = 29-203 (the higher the score, the stronger the SOC).
Well-being and ill-being, burnout, hopelessness, anxiety and depression in women (VII)

There were significantly more married/cohabitant women in the TNC than in the SNC, and significantly fewer women had had BCS in the TNC than in the SNC (VII, Table 1).

Data related to the level of WM, BM, HS, anxiety and depression (HAD) are shown in Table 8. All median values to the WM (SNC, TNC) were located in the positive half of the scale (1-3) (VII, Figure 1). There were significantly higher hopelessness scores in the SNC group than in the TNC group (Table 8). A discriminant analysis with the background variables included and the degree of WM, BM, HS and HAD scales as independents showed that the degree of hopelessness was the first factor that distinguished women in the SNC from those in the TNC. Marital status and type of surgery also significantly distinguished (p<0.01) the groups (SNC, TNC).

The Spearman correlations between WM/ill-being, BM, HS, HAD were all significant (VII, Table 3).

Table 8. The degree of well-being, burnout, hopelessness, anxiety, and depression among the participants in the SNC (n=17) and the TNC (n=17).

<table>
<thead>
<tr>
<th>Groups</th>
<th>SNC Mean (SD)</th>
<th>TNC Mean (SD)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-being#</td>
<td>43.7 (20.35)</td>
<td>37.3 (11.35)</td>
<td>NS</td>
</tr>
<tr>
<td>Burnout0</td>
<td>2.7 (0.89)</td>
<td>2.5 (0.44)</td>
<td>NS</td>
</tr>
<tr>
<td>Hopelessness##</td>
<td>7.6 (5.06)</td>
<td>3.7 (2.14)</td>
<td>*</td>
</tr>
<tr>
<td>Anxiety (HAD)D</td>
<td>7.4 (3.91)</td>
<td>5.3 (2.26)</td>
<td>NS</td>
</tr>
<tr>
<td>Depression (HAD)+</td>
<td>3.7 (3.75)</td>
<td>2.2 (2.43)</td>
<td>NS</td>
</tr>
</tbody>
</table>

* p < 0.05
# = 0-119 (higher scores indicate greater perceptions of negative attitudes or feelings); 0 = < 3.0, > 3.0 (scores of 3.0 or more indicate a risk of burnout); ## = minimal (0-3), mild (4-8), moderate (9-14), severe (15-20); D = minimal (0-7), moderate (8-10), severe (11-20).

DISCUSSION

Methodological considerations

A qualitative approach - because it makes it possible to gain a deep understanding of social and psychological phenomena (Giorgi 1993, pp. 74-75; Taylor & Bogdan 1984, pp. 5-9) - was used to elucidate DNs' experiences of meeting cancer patients (I), their narrations concerning demanding care situations in the supervision sessions (II), and DNs'/ HNs' experiences of demanding care situations and of systematic clinical super-
vision (III). Such an approach was also used to elucidate the experiences of women with breast cancer of their illness and the TNC (IV) and the SNC (V). The quantitative approach was chosen so as to make it possible to measure the degree and extent of various phenomena in the samples (VI, VII). The combination of methods when examining the effects of the intervention makes it possible to view the intervention from a variety of perspectives (Taylor & Bogdan, 1984, p. 68).

The groups of women with breast cancer (TNC, SNC) were made as homogeneous as possible with regard to age, diagnosis and stage of disease (i.e., all women had early-stage breast cancer), in order to avoid findings related to specific age or disease-related factors (cf. Freidenbergs et al. 1981-82, p. 321). Studies have indicated that age is related to different psychological reactions. Among males and females with a variety of cancer types, Edlund and Sneed (1989), for instance, found that the oldest (>70 years of age) experienced significantly less psychological distress than the younger ones. The number of non-participants was rather high in both groups, in the TNC 38% and in the SNC 42%. There were, however, no significant differences between participants and non-participants in the groups regarding medical and demographic aspects.

There was a higher proportion of married women in the TNC group than in the SNC (81% vs 73%). Since it has been shown previously that the husband is an important source of support for women with breast cancer (Neuling & Winefield 1988), this difference may have had an impact on the result, i.e., fewer reports of distress in the TNC group.

The weakness of the research design is that neither the women with breast cancer nor the DNs and HNs were randomly assigned to the intervention or the comparison groups. The design of the quantitative parts of the study allowed the analysis of some of the potential threats to internal validity, i.e., if the groups were equivalent, or if there was a loss of subjects during the intervention (VI, VII) (Polit & Hungler 1989, pp. 135-137). For example there were more non-responders to the scales among women in the TNC than in the SNC, which could theoretically have biased the results. However, the groups (TNC, SNC) were comparable with respect to background variables such as age, marital status, and type of surgery (VII).

There were differences between the groups of women who responded to the scales concerning marital status and type of surgery (VII). These differences may have had an impact on the results, since it has been revealed that the risk of anxiety is especially great for mastectomized women in comparison with women treated with BCS (Maraste et al. 1992). There is a need for controlling this aspect in samples in future studies. The absence of a pre-surgical baseline assessment limits the study in determining whether factors that may have affected the subjects' experiences of well-being/ill-being were al-
ready evident prior to diagnosis and surgery (cf. Roe 1994). A healthy reference group could have been used.

Only DNs (n=39) and HNs (n=10) who chose to participate in the training programme were involved in those parts of the study that concerned DNs' narrations of demanding care situations (I) and the evaluation of the effects of the systematic clinical supervision (II-III, VI). The DNs who participated in the training (63%) (Figure 2) had spent significantly more years in the profession than the non-participants.

No significant differences between DNs who responded to the scales (85%) and the non-responders with regard to age and years in the profession were found (VI). Among the responders in the comparison group there were significantly lower scores in the two subscales - detachment and inhibition of aggression (KSP) than in the supervisory group (VI, Table 3). It is hard to know whether these differences had any impact on the results. Since there were no differences between the groups in the other 10 subscales, reasonably, the two groups did not differ at baseline (VI). Data were collected before and after the intervention (pretest - post-test) (cf. Roe 1994), which allowed a comparison of the findings before and after the clinical supervision within and between the groups. Personal sources of support in the DNs' social network and personal problems in their private lives were not examined. There may have been factors threatening the internal validity. However, these social and individual factors are likely to be evenly distributed between the RNs in the two groups. The staff drop-out was limited to one DN and one HN during the intervention period (Figure 2), and was thus no threat to the validity.

The fact that the interviews with all DNs in the three groups about their experiences of the clinical supervision were conducted by the supervisor of two groups may imply that they responded positively to please the supervisors. All the interviews with the women (TNC, SNC) were conducted by the author (IV, V). They did not know, however, that she was responsible for the intervention.

All DNs within the county council area where the SNC was implemented were supposed to work in accordance with the organization of the SNC. This implies that the women with breast cancer could have had contact with DNs who had had training and were getting supervision, with those who had had training, and with DNs who had neither had training nor supervision. Thus, the DNs had different prerequisites to give support and help to women with breast cancer. This might have decreased the application of the SNC, and therefore threatened the validity of the study. Apart from not participating in the training, those DNs (37%) may have been less interested in working in accordance with the intentions of the SNC than the participants. This implies that the women did not necessarily get the same kind of support from DNs. The DNs who did not participate in the supervision, as well as those who did not participate in the train-
ing, had regular contact with the author during the intervention. These meetings (n=4) concerned advice and feedback about the SNC. The regular contact may have decreased the threat to the validity concerning SNC. On the other hand, these regular contacts concerned DNs in the comparison group and may therefore have decreased the possibility of evaluating the effects of clinical supervision. This implies an increased threat to the validity in that study (VI).

The women in each group were interviewed under identical conditions and about the same topics. The same structure was used for the interpretation and presentation of the findings (IV, V). The author's earlier experience of interviewing women with breast cancer (Carlson & Pålsson 1986), can have made her more sensitive and open-minded about the problems of breast cancer and post-operative medical treatment. It could also have affected the interpretation of data negatively, as the pre-understanding might have made the author less sensitive and open-minded to learning something new during the interviews and the interpretations of the texts. However, because of the researchers' different pre-understandings they could see different things in the texts, and during the reflection and discussion the understanding of all parties could be deepened.

It was expected at the outset that the health care districts would be similar and that there would not be any changes in the environment during the year of clinical supervision. However, during that period a large organizational change in Swedish primary health care was implemented (the 'ÄDEL' reform, Alaby 1992, pp. 9-28), and a reform of the system to incorporate family doctors was prepared (SFS 1993:588). The new organization, which led to concrete changes in DNs' daily work, and the proposed family doctor reform made DNs worried and uncertain whether their independent jobs would still be there in the future. These reforms concerned both the supervisory and the comparison groups, so it seems unlikely that they should have influenced the groups differently (VI). As the comparison group also received training and was visited and given feedback during the study, the Hawthorne effect was probably equal for both groups (VI) (cf. Merton 1968, pp. 120-121).

Interpretations of the findings
The findings can be interpreted on the basis of Lazarus' theory of stress and coping (Lazarus 1992, 1993 a, b; Monat & Lazarus 1991, pp. 2-9). This theory is focused on psychological stress, human experiences and individual differences. The individual uses coping strategies when he/she is dealing with stress-evoking events. Lazarus (1993 b) views coping as a process of "ongoing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person " (p. 237). Coping can be emotion-focused and/or problem-focused (Lazarus 1992, 1993 a, b). Emotion-focused (or palliative) coping consists of
thoughts and actions whose goal is to relieve the emotional impact of stress. This makes the person feel better, but does not actually alter the threatening or damaging conditions (Lazarus 1992; Monat & Lazarus 1991, p. 6). Problem-focused coping includes attempts to change the circumstances, e.g., by changing the environment or oneself. Problem-focused coping strategies deal concretely with actions, such as seeking social support, seeking information, and planful problem-solving (Lazarus 1992; Monat & Lazarus 1991, p. 6). Both kinds of strategies are often used simultaneously. In general, a specific coping strategy is not good or bad, but its effectiveness is determined by the situation, time, and the individual who uses it (Lazarus 1992; Lazarus 1993 a, b). The relationship between coping and its outcome is complex and dependent on several factors. Lazarus (1992, p. 28) maintains that "each illness has its own unique source of psychological stress (threat, harm)", and that there are great differences between individuals in appraisals of the meaning of the illness, as well as within the same individual during the course of the illness. Thus, the coping strategies reasonably vary in type and quality from one individual to another, and therefore nursing care has to be given on an individualized basis.

The women with breast cancer suffer from a life-threatening disease, and need, e.g., the RN's specialist knowledge and friendship to recover or to find meaning in their illness (cf. Hobble & Lansinger 1986, pp. 196-200). District nurses and HNs are exposed to stress when judging the strains the patient is exposed to (cf. Morse et al. 1992). Coping strategies that reduce anxiety and increase control in emotionally demanding situations are important to both patients and RNs.

District nurses' narrations and experiences of difficult care situations
When interpreting the findings about DNs' experiences it must be borne in mind that their narrations in the supervision sessions were focused on demanding care situations (II), while the interviews concerned situations in their meetings with cancer patients (I).

District nurses faced problems in the home care of seriously ill cancer patients when confronted with the anxiety of patients and family members concerning death and separation (II). This may be related to the possibility that among other things they were reminded of their own mortality (cf. Homer 1984). Situations that made the care of people with cancer especially trying, highlighted in the interviews (I) as well as in the sessions (II), were connected with difficult issues, such as the dressing of ulcerous cancer wounds, coming too close to the patient, not being allowed to help, patients' trust in alternative medicine, and not being allowed to communicate openly.

Coming too close to patients seems to be a common problem in health care, and may be related to long-lasting relations with the patient and his/her family. It has previously been stressed that HNs balance between being too closely involved and becoming
too distanced (cf. Lindseth et al. 1994; cf. Åström et al. 1993 b). In the present study, being too close to the patients implied that it was difficult to draw the line between professional and private roles (II), that it was difficult to repress thoughts about the patients in off-duty hours (I), and that there was a risk of reduced quality in contact with other patients (II). Reasonably, it may be more demanding to care for seriously ill cancer patients in their homes than in hospital, since DNs meet patients in their social environment and perhaps experience the meaning of the physical and mental suffering in the family more intensely. District nurses described feelings of powerlessness when they could not relieve patients' intolerable pain, and when they did not have enough time to stay and support an anxious patient (I, II). They described the deep human contacts as a source of both strain and enrichment (I). This phenomenon implies that there is a balance in DNs' work, which, in turn, reduces experiences of stress. Similar phenomena of positive and negative aspects were also described in an interview study by Cohen et al. (1994 a).

The phenomenon of balance in the nursing care could also be identified in the themes not being allowed to help, patients' trust in alternative medicine, and not being allowed to communicate openly. In situations referred to the theme not being allowed to help, DNs had to balance between being intrusive and pursuing a wait-and-see policy. The DNs experienced a conflict when the patient did not allow them to do what they wanted to do. This dilemma led to feelings of uncertainty about how to handle the situation (I, II). Patients' trust in alternative medicine (I, II) was described as a source of both satisfaction and difficulty. In the contact with patients who wanted treatment with natural preparations, DNs had to balance between not taking away the patient's hope and giving too much hope. They felt dishonest and cowardly for not telling the patient the truth when he/she asked about their earlier experiences of the preparations (I, II). Saveman et al. (1992, 1993) described similar findings among DNs having contact with abusive families. The authors described DNs' balancing between active and passive strategies as 'walking a fine line'. In the present study, DNs' feelings of satisfaction were related to being able to support and help patients for whom there was no effective conventional treatment (II). These feelings resemble those described in the theme being accepted as a helper (I). Reasonably, being able and allowed by the patient to give support and help is positive, while failure to support and help may seriously threaten RNs' composure.

The theme not being allowed to communicate openly concerned DNs' balancing between talking with the patient about the disease and avoiding talking about it. This dilemma was related to the fact that DNs did not know whether a behaviour that seemed to be denial was due to the patient's psychological defence or to insufficient information about the disease (I, II). District nurses described their meetings with cancer
patients as walking a tightrope, and they felt uncertain about the correctness of "playing the game" with patients and/or relatives who avoided talking about the disease (I). It is an important prerequisite for the establishment of a long-term relationship between RNs and patients that there are no barriers to communication. Such barriers can, e.g., stem from the possibility that RNs do not know what information the woman has been given, and her reaction to the information. Thus, it seems important that physicians inform the involved personnel about what they have told the patients concerning the disease (cf. Feigenberg 1979, p. 52). This information must also be given to DNs. Denial has been found to be one of the most powerful mechanisms for coping with a cancer disease during active medical treatment (Baider & De-Nour 1989). Physicians and RNs may have inspired denial by averting anguish-creating questions (cf. Feigenberg 1979, p. 18). Thus, it is important that RNs are aware that the use of denial can increase the individual's ability to deal with overwhelming threats, and also that their own approach can increase the use of this behaviour.

Deepened discussions about the ethical aspects of these problems are necessary. Lindseth et al. (1994, p. 250) concluded "that it is highly probable that deep discussions between professions about their being in ethically difficult care situations will lead to interpersonal understanding, respect and consensus of opinion regarding how to act in concrete situations." Even if DNs' narrations about the deep human contacts were described as a source of both strain and enrichment, i.e., there seems to be a balance between negative and positive dimensions (I, II), the constant exposure to patients' suffering does not leave them unaffected.

District and hospital nurses' experiences of systematic clinical supervision and their handling of demanding care situations

The results concerning the effect of clinical supervision on RNs can be understood as partly emotion-focused and partly problem-solving. The problem-solving component concerned broader and deeper knowledge, and increased self-confidence (III). District nurses and HNs stated that the reflections on care situations had contributed to an increased awareness and a better understanding of the influence of a disease and its treatment on an individual's everyday life (III). Being given colleagues' views on the nursing care and how they had handled a difficult care situation, as well as the supervisor's outside view of the situation, may have increased their action repertoire. Findings concerning RNs' experiences of group supervision revealed that they developed new ideas about how to handle an event in their clinical work with demented people (Jansson et al. 1993). By analogy with Schön (1983), it can be suggested that individuals learn and grow by reflecting on their narrated lived experiences. Another possible effect of talking about and reflecting on difficulties in the sessions was profes-
sional development, which meant that they acquired a special professional skill, thereby being made to feel more important and competent (III). Schön (1983, p. 62) stated that reflection is central to the art through which practitioners sometimes cope with the troublesome "divergent" situations of practice (p. 62).

The emotion-focused component concerned 'confirmation' and 'relief'. It was important to have the possibility of unburdening and verbalizing own thoughts and feelings (immediate relief, relief in the supervision). It was also important to hear that the colleagues would have handled a certain difficult situation in the same way or would have made the same decisions (confirmation of actions), to hear that one's feelings and problems in the nursing care were not unique, and to get feedback from colleagues that it was not morally or professionally wrong to feel in a certain way about an event or a patient (confirmation of the nurse as a person). The importance of hearing that others also had the same feelings and problems in the nursing care is reported by other investigators (cf. Alexander 1993; cf. Chapman 1993; Harris et al. 1990; Jansson et al. 1993). Confirmation of the professional role implied that someone showed respect, interest and understanding for their work (cf. Gustafsson & Pörn 1992, 1994; Jansson et al. 1993). According to Buber (1965, pp. 96-117, 1990, pp. 153-173, ), confirmation means to identify with another person, to engage and "make present". The wish to be confirmed and the content of the confirmation in a relationship are similar to the findings in other supervision studies (Hallberg 1994; Jansson et al. 1993).

To be confirmed in a relationship and the possibilities of unburdening thoughts and feelings seem important for DN's and HN's sense of well-being. They stated that they used their resources in a better way and could give more of themselves in the nursing care. Thus, systematic clinical supervision seems to be a way of providing relief, confirmation, and professional development. Supervision probably also enables the participants to gain a deeper understanding of their own and other individuals' feelings, which probably has positive consequences for the nursing care (cf. Hallberg 1994; Jansson et al. 1993).

**Burnout, empathy, and sense of coherence in district nurses**

There were no significant changes found in the degree of burnout, empathy and SOC within or between the supervisory and the comparison groups, which implies that the intervention had no effect on these phenomena (VI). The fact that interview data indicated that the participants experienced the systematic clinical supervision as positive (III) does not mean that either or both kinds of data are invalid. More likely, it may be a result of measuring different aspects. The fact that the supervision failed to show improvement measured by scales can be interpreted in various ways. There may have been shortcomings in the way the intervention was carried out. For instance, the clini-
cal supervision might have been insufficient to change these phenomena. Clinical supervision combined with supervised individualized care has resulted in significantly improved empathy (Hallberg 1995), decreased burnout among nursing staff and improved creativity (Berg et al. 1994), improved job-satisfaction (Hallberg et al. 1994), and changed perception of patients (Hallberg & Norberg 1993). A factor of importance for positive effects of clinical supervision may be the structure of the supervisory group, i.e., that all nursing staff from the same ward participate in the sessions (e.g., Berg et al. 1994; Hallberg 1994), which was not the case in the present study. The small sample also influences the possibility of achieving statistical significance (Siegel 1956, p. 202-213). In the present study, DNs' degree of burnout turned out to be low at baseline, and the degree of empathy and SOC high (Table 7). Thus, a large decrease and increase respectively could not be expected. A further explanation for the SOC not changing as an effect of the intervention may be that this phenomenon is fairly stable over time, with only minor fluctuations (Langius et al. 1992). With a more intensive and extensive intervention, there might be an effect on burnout, as has been found in previous research (Berg et al. 1994). There is a need for replication of this study, and further exploration of this topic, as well as for larger samples, and for comparing the effects of composing supervisory groups in different ways (see p. 19). An evaluation of the long-term effects of clinical supervision on nursing care and professional carers is also of importance.

Breast cancer women's experiences of their illness and the care received

The women's overall positive statements about the organization of the care indicated that the changes in the SNC are important means of decreasing the strain of breast cancer in the initial phase of the disease (V). Women in the TNC reported feelings of uncertainty and anxiety during the waiting periods between examination and being informed of the results, since they felt they had no personnel to discuss their thoughts and questions with (IV).

Important aspects of the results concerning women's experiences of having breast cancer could be understood as having, or not having, emotional contact involving 'confirming' and 'disconfirming' relationships, and receiving or not receiving information. Emotional contact is possible to understand within the framework of support (IV, V). Verbalizing feelings and sharing illness-related problems with DNs/HNs who listened and gave feedback meant help with clarifying feelings and forming a clearer view of the situation (V). This support was viewed as a way of reducing anxiety and led to feelings of security (V). Women in the TNC experienced support from health care professionals as insufficient, and they suggested an RN to talk with during the initial phase of the disease. The finding that women experienced insufficient support from
health care professionals is congruent with those of Neuling and Winefield (1988), Suominen (1992) and Ödling et al. (1995). Reasonably, support is important during this period, when women feel anxiety about the possible spread of the cancer, uncertainty about the future, fear of recurrence and death, and fear of the consequences of the surgery (IV, V). Although previous studies have revealed that family and friends are the most important sources of support (for references see introduction), this study, in keeping with other studies (Hilton 1993; Lewis 1990; Northouse 1989 b; Omne-Pontén et al. 1993), indicated that family members worried about the consequences for the woman's health.

An important aspect of having emotional contact was the confirming relationship. According to Watzlawick et al. (1967), confirmation is the greatest single factor ensuring mental development, which implies that a confirming relationship gives rise to feelings of increased self-esteem. This seems important to women with breast cancer, who sometimes experience themselves as worthless and unfeminine. Disconfirming relationships led to feelings of being abandoned (IV) and of being treated as an object (V). To a vulnerable woman with breast cancer, a confirming relationship seems to be an important basic support, and may mean that they experience the medical care as helpful (cf. Gustafsson et al. 1992). Support has previously been defined as involving emotional, informational, and tangible components (Dunkel-Schetter 1984; Schaefer et al. 1981). 'Confirmation' may be seen as a dimension of support. A confirming relationship is seemingly an essential part of support.

Getting information seemed to be another important factor for increasing wellbeing. Women in the SNC referred to information given by the RNs, which was often experienced as sufficient and gave feelings of confidence and security (V). Information from physicians about medical aspects was often experienced as insufficient by women in both groups (TNC, SNC) and led to feelings of uncertainty (IV, V), confusion, and incompetence (IV). Women's experiences of insufficient information from physicians may be due to the possibility that the frightening and shocking nature of the information leads to a crisis reaction with difficulties in remembering and understanding what the physician has told them. For instance, women in the SNC said that they had felt shocked on learning the diagnosis and had trouble taking in the physician's information (V). This finding has similarities with that of Lerman et al. (1993) who reported that among the most common problems for women with breast cancer were difficulties in understanding physicians and asking them questions.

One aspect of information is the participation in decision-making, for instance about the type of surgery. Women talked about insufficient knowledge of the treatment alternatives (IV), and about having to make the decision when they had just received the diagnosis (V). To participate was important to some of the women, while others
preferred the physician to make the decision (V). Support to women and their significant others through the decision-making process seems important. This has also been emphasized by other researchers (e.g., Hack et al. 1994; Pierce 1993). Apart from support, women with breast cancer seem to need time enough after the diagnosis to prepare themselves mentally for participating in the decision (cf. Pierce 1993). They also need more information as to why one treatment is recommended rather than another.

Problems in communication with health care professionals have proved to be associated with increased anxiety, depression, anger and confusion in women with breast cancer (Lerman et al. 1993). Thus, it seems important to improve the information process, e.g., how the diagnosis is presented and how the physician can form a safe relationship with the patient. Women in the TNC suggested information about the available treatment options given stepwise, and without taking hope away from the patient (IV). Physicians in the SNC wanted to be alone with the patient when they communicated the diagnosis. However, immediately after receiving this information, patients were offered a follow-up talk with an HN, who answered questions and made sure that the diagnosis was clear to the patient (V). A question of importance is whether an RN or the physician should conduct the follow-up talk after the diagnosis. Reasonably, this contact is a matter of, above all, emotional support. Therefore, an RN may complement, or perhaps replace the physician on such occasions. Nurses' possibilities of following up the information improve if they are present while it is being received. This organization in connection with the diagnosis should reduce the gap in communication between RNs and physicians, and may make RNs more confident in their contact with cancer patients. However, a third party present at the diagnosis may also disturb relations between physician and patient.

The women's experiences related to emotional contact, involving confirming relationships and support (from family members, other women with breast cancer, and professionals), and getting information about the disease and its treatment can be interpreted as dimensions of great importance for their ability to experience a sense of control during the overwhelming initial phase of the disease. These dimensions also seemed related to their chances of experiencing the care as helpful and giving hope for the future. A sense of control is probably important for women's ability to cope with the diagnosis in a healthy and positive way, and can mean an improved level of well-being.

Well-being and ill-being in women with breast cancer
The highly significant correlations between the WM, BM, HS, and HAD scales (VII, Table 3) indicate that these measures cover almost the same phenomena. The mean scores of those aspects were quite low, which is in line with other studies (Brandt 1987). Women in the SNC more often expressed hopelessness than those who received
TNC (VII), which can either be interpreted as the intervention not having had any effect, or that it had had a negative or a positive effect. A possible explanation of missing effects measured by scales may be that the support had not been provided at the right time. Edgar et al. (1992) found little benefit from early psychosocial intervention (immediately after surgery) among women with breast cancer, whereas a late intervention (4 months delay) reduced distress in every dimension at 8-month follow-up (Table 1). Another explanation may be that support had not been provided to an adequate extent or in the right way, i.e., that the DNs involved were not interested or prepared enough to provide crisis intervention. This may depend on the possibility that the training and the clinical supervision were not enough, and/or were not given to all DNs concerned. The reasons for possible effects of the intervention, not revealed in the measurements, might be that the groups differed concerning important aspects, e.g., marital status and type of surgery. It may also be due to the possibility that support from RNs had made the women more aware of their feelings and more prepared to express them. For instance, Watson et al. (1984) reported that women with breast cancer who used denial experienced significantly less mood disturbance during their hospital stay for mastectomy than patients who accepted the diagnosis of cancer more realistically. Among patients awaiting surgery for breast cancer, Jelicic et al. (1993) found that many patients had anxiety scores within the normal range. The authors concluded that these patients were probably using denial as a defence against stress. Finally, it may be unrealistic to expect effects of support in terms of well-being, burnout, hopelessness, anxiety and depression six months after the diagnosis, since many women are still in a crisis phase. Three months after surgery Maguire et al. (1980) found no differences compared to a control group in the degree of depression and anxiety as a result of individual counselling by a specialist nurse. However, at 12 to 18 months after surgery the intervention group showed much less anxiety.

Women's experiences of the SNC showed that there were dimensions in the care that were insufficient to enable them to feel a sense of control. However, women in the TNC described similar experiences concerning information and confirming relationships. Therefore, reasonably, the SNC has had benefits for the women concerned, i.e., effects in reducing psychological ill-being in the long run.

Several studies have reported significant effects in mood states after interventions (Bergkvist et al. 1994; Cain et al. 1986; Spiegel et al. 1989), while others have failed to show this reaction (Baider & De-Nour 1989; Jacobs et al. 1983), or have shown that both kinds of groups were associated with significant changes in affective state (Cunningham & Tocco 1989). These differences may be related to the duration of the intervention, the frequency of the contacts, whether the groups were randomly assigned or not, whether they were similar concerning demographic aspects and type of
intervention. The basic difference between the present intervention and others (e.g., Cain et al. 1986; Cunningham & Tocco 1989; Grahn 1993; Spiegel et al. 1989) is that this intervention was focused on both patients' and nurses' need of support, and included both content and organizational changes of the care. The intention of the individualized approach of the intervention was that the RN should be able to tailor the number and length of the meetings to an individual woman's need and thereby offer a more flexible service. More research is needed to investigate the relationship between professional support initially and psychological distress on the one hand, and the effects of support in the long run on the other, as well as to examine whether the same pattern as in this study will occur (VII).

**Summary of the findings**
The main findings in the study were:

* concerning job satisfaction, district nurses experienced a balance between positive and negative dimensions related to deep human contacts

* district nurses experienced difficulties in striking a balance between:
  - coming too close and becoming too distanced,
  - not being allowed to help and being allowed to help,
  - not taking away the patient's hope and not arousing unrealistic expectations,
  - not being allowed to communicate openly and talking with the patient about the disease

* systematic clinical supervision was experienced by DNs and HNs as providing broader and deeper knowledge and increased self-confidence, as well as relief from thoughts and feelings, and confirmation of actions, of the nurse both as a person and as a professional. The latter components were related to their sense of well-being

* no significant differences were found in burnout, empathy and SOC within or between the supervisory and comparison groups, indicating that there was no effect on these phenomena

* women with breast cancer highlighted two aspects as important for their ability to experience a sense of control: emotional contact comprising confirming relationships (being respected as a human being, *i.e.*, being shown interest, understanding and consideration) and support (being listened to, being consoled, and being invited to further contacts with an RN), and receiving information about the disease and its treatment
women in the SNC group experienced the organizational changes of the care and the support from RNs as positive; women in the TNC group experienced support from professional carers as insufficient, and perceived shortcomings in the organization of care; women in both groups experienced the information about the disease and its treatment as insufficient

the degree of hopelessness was higher among women in the SNC than in the TNC group six months post-surgery. This was probably related to differences between the groups in marital status and type of surgery.

CONCLUSIONS

• Women with breast cancer in TNC express a need for support similar to that which women in the SNC received.

• Supportive nursing care (SNC) is based on organizational co-operation between hospital and primary health care.

• District nurses express difficulties in balancing between closeness and distance, between active and passive strategies, and between taking away the patient's hope and giving too much hope. They state that systematic clinical supervision provides support in these respects.

• Thus it is important to examine and evaluate:
	1. forms for co-operation between hospital and primary health care and support for DNs
	2. emotional and informational support for women with breast cancer.
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