

CURRENT TRENDS & ISSUES IN NURSING IN NIGERIA



Edited by

PRISCA OLABISI ADEJUMO RN, Ph.D, FWACN

ADEBAYO OLAYIWOLA ADEJUMO RN, Ph.D, FWACN

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Summary

As the healthcare professionals involved in giving bedside care round-the-clock, professional nurses are in a unique position to promote state-of-the-art pain management practices for the health care consumer. Nurses make judgments regarding administration of ordered medications, timing of patient care activities, and also enable patients to make knowledgeable decisions regarding management of their pain. Historically, health care professionals maintained strict control over pain medications in order to protect patients/clients from deleterious effects of opioid medications, especially with concerns regarding addiction. However, as the health care consumers demanded a more active role in decision-making and as research has shown that fears of addiction were grossly exaggerated, pain rating and approaches to pain management are currently based on patients' self-reports and response to treatment. Potential deleterious effects of pain medications are now weighed against well researched negative effects of uncontrolled pain on patient's well-being, as well as patients' identified goals for pain relief. The impetus for this chapter, is to examine the issues on pain management from a contemporary perspective and its implication for nurses role.

Background information

Pain management is a dynamic clinical area and the specialty is gaining momentum throughout the world. An integrated approach

to pain management requires a broad understanding of both nociceptive mechanisms and relevant psychosocial factors that influence treatment outcomes. While basic research is generating new drugs and new technologies for their delivery, clinical research has demonstrated the important roles of psychological and environmental factors in the perception and management of pain (Loeser and Cousins, 1990). The recognition that the human brain plays a major role in pain perception and pain behaviours has led to the development of multidisciplinary approach to pain management in order to bring a diversity of diagnostic and therapeutic skills to clinical management. Nigerian health care system needs to respond to the new trends in pain management to enable the citizens of this country receive state-of-the-art care. Not only will this be more humane, but it will bring about a reduction in the cost of managing both acute and chronic pain. And nurses' role in contributing to this quest cannot be over-emphasized.

Nursing according to American Nurses Association (1980) is defined as, 'the diagnosis and treatment of human responses to actual or potential health problems of which pain is one. This implies that the focus of nursing care is the activities performed by nurses aimed at meeting the health needs of patients. Besides, among the health care professionals, nurses are the closest to their patients because of their continuous presence at all times; this gives them the unique opportunity to be central to the management of patients' pain. And pain is a complex, multidimensional phenomenon, the understanding of which becomes clearer as more studies are being conducted by scientists from many disciplines including nursing. Increase in knowledge will make nurses become aware of current trends and strategies for pain management. This will also enable them to collaborate with other members of the healthcare team in providing holistic assessment and management of patients' pain.

We all experience pain, but scientifically what is pain? Pain means several things to several people and its definitions are as diverse as the nature of man. Most of us think of pain as an unpleasant sensation that originates in traumatized tissues and warns of injury, but it also has emotional qualities. Ancient philosophers mostly considered pain as mostly an emotion. Aristotle for example, called it a passion of the soul (Aristotle 350 BC, cited in *The Health Authority*, 2005). Pain is defined as whatever the person experiencing the pain says it is, existing whenever the person says it does (McCaffery and Beebe, 1998).

This clinical definition recognizes pain as a personal, private experience. A standard definition for pain, as developed by the International Association for the Study of Pain (IASP) is as follows: "An unpleasant sensory and emotional experience normally associated with tissue damage or described in terms of such damage." Melzack (1999) defined pain as a subjective multi-dimensional construct that involves sensory, affective, cognitive, autonomic (physiological), and behavioural components. These are termed the ABCs of pain. The emotions related to pain (affective component), the behavioural responses to the pain (behavioural component), and the beliefs, attitudes, evaluations and goals about the pain and pain control (cognitive component) alter how pain is perceived (sensory component) by modifying the transmission of nociceptive stimuli to the brain (physiologic component). Each of these dimensions is important in the assessment and management of pain. While the North American Nursing Diagnoses Association (1994) in their classification of Nursing Diagnoses defined pain as a state in which severe discomfort or an unpleasant sensation is experienced and signaled by the following:

- i. Verbal and nonverbal communication including self-protective behaviour, narrowed attentional
- ii. focus evidenced by altered time perspective, social withdrawal or impaired thought processes;
- iii. Distraction behaviour such as moaning, crying, pacing restlessness;
- iv. A facial expression of pain characterized by dull and luster eyes, a beaten appearance and fixed or scattered facial movements or grimaces;
- v. Alteration of muscle tone ranging from listlessness to rigidity;
- vi. Autonomic responses such as increased blood pressure, pulse rate, pupil dilation and increased or decreased respiration rate.

Magnitude of the problem

Pain is one of the most common reasons for patients to enter health-care settings and most common reason given for self-medication (Von Korff, Dworkin, Le Resche and Kruger, 1988). A significant number of people with pain are disabled by their pain, giving rise to a serious economic implications as well as major health issues. For example, most workers may return to work

within three weeks following an injury but the pain may persist or lead to a prolonged work absences. Adding to the problems of patients with acute pain, such as cancer pain, is a tendency for health care providers to prescribe small, inadequate doses of pain killers to control the pain. Also, nurses often times tend to administer the smallest prescribed analgesic dose when a range of doses is prescribed (Maxam-Moore *et al*, 1994). Such practices can only provide little relief from unremitting pain and are not consistent with the current trends in pain management protocols (Agency for Health Care Policy and Research, 1994; American Pain Society, 1997; WHO, 1996)

Types of pain

(i) *Acute Pain*

Acute pain is severe and lasts a relatively short time, it is usually a signal that body tissue is being injured in some way, and the pain generally disappears when the injury heals. Acute pain, for the most part, results from: disease, injury to tissues and inflammation. The pain generally comes on suddenly, for example, after trauma or surgery, and may be accompanied by anxiety or emotional distress. The cause of acute pain can usually be diagnosed and treated, and the pain is self-limiting, that is, it is confined to a given period of time and severity. In some rare instances, it can become chronic.

(ii) *Chronic Pain*

Chronic pain on the other hand is widely believed to represent disease itself. Chronic pain persists over a longer period of time than acute pain and is resistant to most medical treatments. It can, and often does, cause severe problems for patients. Chronic pain can also interfere with rehabilitation, adjustment, and return to work (Dillingham and Delatair, 1995). Chronic pain can be difficult to treat, as it may not respond to pharmacological or physiotherapy management (Halbert, Crotty, & Cameron, 2002). In addition to experiencing pain, chronic pain patients who present for treatment are often disabled and report other associated problems, such as sleep difficulties and fatigue (Moldofsky and Lue, 1993). Over time they may have become interpersonally isolated and have developed unsatisfactory family roles and responsibilities (Kraaimaat, Bakker, Janssen and Bijlsma, 1996). The persistent attempts to react and adapt to pain and its

widespread destructive consequences often result in a range of emotional problems, such as depression and pain-related fear.

Interestingly, patients with chronic pain have an elevated presentation of other phobic responses, such as the fear of social interaction, leaving secure environments, blood, illness and death (Asmundson, Norton, and Jacobson, 1996). Chronic persistent pain, fear and depression inevitably have negative effects on other aspects of cognition. Patients commonly complain of poor concentration, poor memory and increased failure to complete cognitive tasks (Kewman, Vaishampayan, Zald, and Han, 1991). In some individuals, both pain conditions can become chronic and disabling, evolving into an entrenched and vicious cycle of psychological distress and suffering, physical de-conditioning, withdrawal from activities, behavioral dysfunction, as well as dependence on medication and health care services. However, it is widely accepted that there are considerable individual variations in pain experience, and that psychological, social, contextual, and biological factors contribute to these differences (Turk, & Gatchel 2002, Melzack, 1999). As a result, there is a current consensus that pain is best understood through a bio-psychosocial perspective.

Psychological factors in pain experience

A patient with chronic pain such as cancer pain faces many stressors during the course of the illness including dependency, disability and fear of painful death (Breitbart, 1993). Although such fears are universal, the level of psychological distress vary and is affected by medical factors; (such as the quality of care, caliber of health care providers, medical management and health facilities available); social support, coping capacities; and the individual's personality. Pain has profound effects on psychological distress in cancer patients, and psychological factors such as anxiety, depression, and the meaning of pain can intensify cancer pain experience (Breitbart, 1993). Daut and Cleeland (1982), showed that cancer patients who attribute a new pain to an unrelated cause report less interference with their activity and pleasure than cancer patients who believe their pain represents progression of disease. Spiegel and Bloom (1983), found that women with metastatic breast cancer experience more intense pain if they believe their pain represents spread of their cancer; and if they are depressed. They concluded that beliefs about the meaning of pain and the presence of a mood disturbance are better predictors of pain level than is the site of metastasis.

Measures of emotional disturbance have been reported to be predictors of pain in late stages of cancer, and cancer patients with less anxiety and depression are less likely to report pain. These findings reveal that pain in cancer patients had both clinical and psychological causes (McKegney, Bailey and Yates, 1981). Therefore, the treatment of cancer patients experiencing pain requires both clinical and psychosocial interventions. Too frequently, however, psychological variables are underplayed or outrightly ignored, especially in settings in developing countries such as Nigeria, where there is paucity of skilled manpower in this speciality (Onibokun, 1998; 1999; 2000)

Pain Assessment

The goals of pain assessment are to: identify the etiology of the pain, understand the patient's sensory, affective, behavioral, and cognitive pain experience for the purposes of implementing pain management techniques and identify the patient's goal for treatment and resources for self-management of the pain. In some health facilities, it is usually the nurse who is responsible for gathering and documenting members of the pain management team.

Pain Management

Pain management is the control of acute or chronic pain or discomfort. Pain medications may be underused due to misconceptions about tolerance, dependence and addiction. Other techniques include cryotherapy (cold therapy), cognitive behavioral therapy, electrical therapy, immobilization therapy (e.g., casts, braces), injection therapy and nerve blocks.

What is Pain Management?

The most important issue in pain management is a focus on managing pain symptoms as opposed to looking for a quick fix. Pain management generally encompasses a variety of techniques to be used in combination over time. This multi-modal approach generally includes pharmacological interventions and lifestyle changes (e.g. diet, exercise, stress management) for optimal management of symptoms. To manage your condition, it is useful to think of chronic pain as a chronic disease. Much like heart disease or diabetes, chronic pain may require a long-term treatment approach encompassing medication use in conjunction with behavioral changes to keep your pain symptoms in check.

Pain Management Techniques

We can classify the most widely used techniques in terms of the degree of intervention they involve:

- Noninvasive non-drug pain management
- Non-invasive pharmacologic pain management
- Invasive pain management

Noninvasive non-drug pain management

There is an immense variety of noninvasive non-drug pain management techniques available for treating back pain and neck pain. A few of the most widely accepted in comprehensive pain management programmes are the following:

- *Exercise*—physical exertion with the aim of training or improvement. Includes the McKenzie method, water therapy, flexion exercises, aerobic routines, and many others. They may involve active, passive, and resistive elements. Exercise is necessary for proper cardiovascular health, disc nutrition, and musculoskeletal health.
- *Manual techniques*—manipulation of affected areas by means of chiropractic adjustments, osteopathy, massage therapy and other techniques. Some evidence for the effectiveness of certain techniques is available.
- *Behavioral modification*—use of behavioral methods to optimize patient responses to pain and painful stimuli. Cognitive therapy involves teaching the patient to alleviate pain by means of relaxation techniques, coping techniques, and other methods. Biofeedback involves the gradual alteration of neuromuscular signals for symptomatic improvement.
- *Cutaneous stimulation*—superficial heating or cooling of skin. These pain management methods include cold packs and hot packs, and should be used in conjunction with exercise.
- *Electrotherapy*—the most commonly known form of electrotherapy is transcutaneous electrical nerve stimulation (TENS). TENS therapy attempts to reduce back pain by means of a low-voltage electric stimulation that interacts with the sensory nervous system. Randomized controlled trials have yielded either positive

or neutral results regarding the efficacy of TENS as a treatment for back pain.

Noninvasive pharmacologic pain management

Although a physician or an advanced nurse practitioner prescribes the drugs, it is usually the nurse's responsibility to evaluate the effectiveness and side effects of prescribed medications. It is also the responsibility of the nurse to communicate the efficacy of the medication to the prescriber and suggest changes when appropriate. As the nurse implements these roles, he or she applies knowledge and skill related to several pharmacologic concepts: calculating equianalgesic doses, scheduling analgesic doses, titrating opioids, and selecting from the prescribed analgesic drugs.

Pain relievers and related drugs are used at every stage of the medical treatment of back pain for example, from the initial onset of acute pain to facilitation of rehabilitation, treatment of chronic back pain and alleviation of pain in cases of failed back surgery. The most common noninvasive pharmacologic treatments for chronic back pain are:

- *Analgesics*—includes acetaminophen. Long-term use involves risk of renal damage.
- *Nonsteroidal anti-inflammatory agents (NSAIDs)*—includes aspirin, ibuprofen, naproxen, and the new COX-2 inhibitors.
- *Muscle relaxants*—used to treat muscle spasms due to pain and protective mechanisms.
- *Narcotic medications*—most appropriate for acute or post-operative pain. Since use of narcotics entails risk of habituation or addiction if not properly supervised, they are not often used for chronic conditions.
- *Antidepressants and anticonvulsants*—used to treat neuropathic ("nerve") pain.

Invasive pain management techniques

Invasive techniques in pain management involve invasion of instruments and devices into the body. However, pain management should be distinguished from surgery, which involves a greater degree of surgical insult and permanent alteration of tissue than other invasive pain management techniques.

A multitude of invasive pain management therapies have been used to treat neck and back pain for example. Some of the most popular include:

- *Injections*—direct delivery of steroids or anesthetic to nerve, joint or epidural space. Injections into the facet, peripheral nerve, "trigger point" and other locations are also known as "blocks". These may provide relief of pain (often temporary) and can be used to confirm diagnosis. Epidural injections provide temporary relief for severe back pain.
- *Prolotherapy*—injection of solution to stimulate blood circulation and ligament repair at affected site. The effectiveness of this technique is not known.
- *Surgically implanted electrotherapy devices*—implantable spinal cord stimulators (SCS) and implantable peripheral nerve stimulators. Clinical data offers inconclusive findings on the effectiveness of SCS.
- *Implantable opioid infusion pumps*—surgically implanted pumps that deliver opioid agents directly to affected nerve. The appropriateness and effectiveness of these devices for treating chronic back pain is controversial.
- *Radiofrequency radioablation*—deadening of painful nerve via heat produced by a specialized device. The efficacy of this treatment is mixed.

Other pain-management techniques

- | | |
|--------------------------------|---|
| • Acupressure | • Manipulation Therapy |
| • Biofeedback | • Occupational Therapy |
| • Cognitive Behavioral Therapy | • Physical Therapy |
| • Cryotherapy | • Posture & Ergonomics |
| • Electrical Therapy | • Thermotherapy |
| • Exercise Therapy | • Transcutaneous Electrical Nerve Stimulation |
| • Hydrotherapy | • Ultrasound Therapy |
| • Injection Therapy | |

New pain-management techniques

At the University of Michigan Medical Center, physicians and nurses are taking the approach that "pain is an emergency" and that no pain is untreatable. Two of the latest pain-management techniques being offered at the medical center represent opposite

ends of the treatment spectrum, from high-tech brain surgery performed while the patient is awake to low-tech cognitive-behavioral therapy, a literally "hands-off" approach that helps break the cycle of chronic pain.

1. Deep-brain stimulation. Conditions such as paralysis, ruptured discs and reflex sympathetic dystrophy syndrome can cause chronic nerve pain that even morphine cannot touch. For those who have tried and failed such standard first-line treatments as oral opioids, nerve blocks and corrective surgery, neurosurgeons offer a sophisticated weapon called deep-brain stimulation. During this procedure, electrodes are implanted into the thalamus, the sensation control center of the brain. Once stimulated, these electrodes send signals down the neuropathways, blocking the pain with vibrations - a sort of scratch-for-an-itch approach that distracts patients from their pain.

With the patient awake, neurosurgeon bores a dime-sized hole into the skull and probes down toward the thalamus with a tiny electrode. Once the destination is reached, he stimulates the electrode, asking the patient where he or she feels a vibrating sensation. The surgeon hits the bull's eye when the patient feels vibrations in the body part that is most affected by pain. Once the brain electrode is in place, a small pulse generator the size of a woman's powder compact is implanted below the collarbone; the patient then only needs to wave a magnet over the generator to turn the pulse on and off at will to receive the stimulation that gives relief. While a patient's pain may not disappear entirely, it can, in many cases, be reduced by at least 50 percent. "We turn things around for them so if they have the motivation, they can change their life," Taren says.

2. Eye-movement desensitization. For patients whose chronic pain is associated with post-traumatic stress disorder resulting from an accident or abuse, cognitive-behavioral therapy may be essential to long-term recovery. The pain may be closely associated with the event, flaring up years later in the same area as the original injury, triggered by a memory or suggestion of the traumatic incident. Typical cases involve those who have suffered work injuries, sexual abuse or car accidents. At the Multidisciplinary Pain Center, these patients often are treated by psychologists, who have been using a new technique called eye-movement desensitization (EMD) to break the cycle of pain.

In weekly 90-minute sessions, patients are asked to close their eyes and recreate the initial traumatic experience. Once they are in

the midst of the moment, surrendering to the memory of the pain and voicing their feelings, they are asked to open their eyes. The therapist moves his hand back and forth across their plane of vision, forcing them to make rapid eye movements. Then they are instructed to close their eyes and let go of whatever is in their mind, take a deep breath and report what they are experiencing. "For many people, the pain surfaces during the memories and becomes very real again," according to Bachman, who is among the first in Michigan to use this technique for chronic pain. "For some reasons, over time, EMD disrupts the memories and breaks the connection with the pain. How it works exactly or why it works is yet to be discovered, but it does."

Implications and limitations of CBT in pain management

Psychological techniques need to be tailored to the individual patient and not offered piecemeal. Cognitive therapy is perhaps something that any good clinician will do in explaining to the patient the cause of the pain. Knowledge of the natural history of conditions is essential. False promises lead to confusion and long-term disillusionment. Behavioral techniques are something adopted by any good therapist with rewards being given for re-establishment of function rather than expressions of pain and misery.

One limitation with using imagery in pain control is that some individuals are less apt in imagining scenes than others (Melzack & Wall, 1982). Not every patient finds these techniques acceptable, and the therapist must try out a number of approaches to determine which are consistent with the patient's style. On the whole, patients with severe pain can expect limited benefit from psychological interventions unless somatic therapies can lower the level of pain to some degree. Confusional states interfere dramatically with a patient's ability to focus attention and so limit the usefulness of these techniques. It is pertinent therefore to mention some of the cross/cultural differences in the use of mental imagery in Nigeria. For instance, the use of beach environment with an average Nigerian is alien; or the use of such words as "skiing", "boating", going to the "movies" are examples of activities they cannot easily relate with.

Nurses and other carers need to know that the images used with patients have to be adapted, and culturally accepted by the subjects themselves. They should be images they feel comfortable with and can easily relate with. For example, images suggested, formed

and used by patients at the Lola Marinho Cancer Counselling Clinic at the University College Hospital (UCH) Ibadan, Nigeria are: "light of God radiating round you, and penetrating into your body through your head", "visualising holy oil pouring into your head and penetrating down. As it moves along, cleansing all the cancerous cells in your body", and "imagining holy ghost fire burning all the cancerous cells in your body, and replacing them with brand new healthy cells". It is quite clear that many patients improve a great deal on a multi-disciplinary pain management programme, with some getting a reduction in pain and others improving greatly on parameters of reduced distress and reduced disability. Nurses are at the fore front of these interventions.

Nursing issues in pain management

The pain expert: the person with the pain and not the health professionals, is the expert about the pattern, intensity, and nature of the pain, as well as the degree of the relief obtained from pain medication. Patients often do not recognize that health professionals cannot tell how much pain they experience. The nurse must therefore assist the patient to recognize his or her expertise about the pain and when this expertise is shared with the health care professionals, better pain management can be obtained. Empowering the patient to be an active partner in reporting information about his or her pain is an important nursing activity which is of paramount importance to every other therapy. This includes assessing the pain intensity and efficiency of pain killer with the patient.

Besides, nurses are responsible for assessing, treating, and monitoring pain (referred to as the fifth vital sign); educating patients about their pain medications; ensuring safety during pain medication administration; and advocating for patients with unrelieved pain. Nurses therefore need to be knowledgeable and be current with contemporary pain management guidelines.

Documentation of pain is another vital issue: Pain assessment should be documented in the patient's medical records that is easy to assess by all health care providers, such as the patient's pain chart, vital signs form and nursing notes. Without documentation, even the best pain measurement or assessment conducted by one nurse has no value if the information obtained is not shared with other nurses and health care professionals responsible for the care of the patient with pain.

In addition, the nurse has the responsibility to network with pain management team to advance and promote optimal management for persons with acute pain, chronic pain, cancer pain and palliative care end-of-life pain.

There are many implications of psychological and social factors in the experience and management of pain for nursing practice. Although nurses are mainly concerned with clinical treatment, attitude and behavior of health professionals can also influence patients' perceptions and expressions of pain. The interaction between nurses and their patients affects the psychological aspects of a patient's condition and may affect pain perception, expression and ultimately response to treatment.

The knowledge of psychological approaches can therefore ensure that nurses help patients reduce their pain and maximize their response to treatment. Psychological approaches to augment clinical care, such as explanation, education, attention refocusing, reassurance and good communication skills as well as introducing a feeling of control may all assist in reducing the experience of pain.

Conclusion

In summary, as the healthcare professionals involved in round-the-clock care of patients, professional nurses are in a unique position to promote pain relief. Through knowledge of medications and principles of pain management, as well as knowing the patients' and their underlying conditions, professional nurses have the ability to make appropriate judgments to control pain, promote comfort and well being.

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