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# The Phenomenon of Powerlessness in the Elderly

Dana E. Dryer

COLLEGE OF NURSING AND HEALTH SCIENCES

*Nominated by Mary Graiver  
Associate Professor of Nursing*



Dana is currently in her fourth year here at Saginaw Valley and will be graduating from the College of Nursing in May 2007, at which time she hopes to find employment in a hospital's pediatric unit. When not working or attending class, she enjoys playing volleyball, attending SVSU football games, and spending time with her family and three dogs.

## Abstract

Powerlessness can be classified as both a subjective and objective feeling and is characterized by feelings of no control or a sense that one's actions will have no significant impact on an outcome. Feelings of powerlessness can be captured in an aesthetic experience, which can then be used to understand or visualize powerlessness. In the nursing profession, undiagnosed powerlessness in patients can be life-threatening; therefore, correct and immediate diagnosis along with appropriate nursing intervention is necessary. Powerlessness also has a large impact on the patient's feelings as a human, which can be improved by giving back some environmental control to the patient and encouraging positive self-esteem.

## Identifying and Defining Powerlessness

The phenomenon of powerlessness in the elderly is a very serious problem, yet one that is often ignored (Kubsch & Wichowski, 1997). Powerlessness, as defined by Wilkinson (2005), is "the perception that one's own action will not significantly affect an outcome; a perceived lack of control over a current situation or immediate happening" (p. 386). Therefore, powerlessness can be considered a subjective and/or an

objective feeling, because objective signs may be present while subjective feelings may or may not be expressed. The exact opposite phenomenon—power—can be defined to describe what powerlessness is not. Power is "the ability to influence people and events—the sense that one's opinion counts and will be heard" (Craven & Hirnle, 2003, p. 1255). A similar view is given in *Taber's Medical Dictionary* (2001), which defines empowerment as "participating actively and autonomously in policies or events that affect one's health or well-being" (p. 664). In summary, a patient who willingly makes his/her own decisions regarding environment, attitudes, and daily schedule is not one who is at high risk for developing the feeling of powerlessness.

When powerlessness occurs, what is life truly like for the person experiencing powerlessness, and how can others understand this phenomenon?

## Aesthetic Experience

As previously mentioned, patients experiencing powerlessness are known to lack all motivation to initiate improvement in their behaviors and tend to give up. Kubsch and Wichowski (1997) state that "the perception of powerlessness is a condition that can affect all humans at times throughout life" (p. 7) and that chronically ill patients are extremely vulnerable to

developing feelings of powerlessness “because of unrelenting exposure to intrusive procedures, side effects of drugs, and the continual downward disease trajectory” (p. 7). The use of aesthetic experiences, however, may be beneficial to such patients by increasing their awareness of feelings of powerlessness, viewing their feelings from a new perspective, and understanding that they are not alone. An aesthetic experience that captures the phenomenon of powerlessness is the poem “I Took My Power in my Hand,” by Emily Dickinson (1924):

*I took my Power in my Hand --  
And went against the World --  
'Twas not so much as David -- had --  
But I -- was twice as bold --*

*I aimed my Pebble -- but Myself  
Was all the one that fell --  
Was it Goliath -- was too large --  
Or was myself -- too small?*

The phenomenon of powerlessness is not well recognized as itself, but rather may be defined as anxiety, ineffective coping, or noncompliance (Kubsch & Wichowski, 1997). Emily Dickinson’s poem, “I Took My Power in my Hand,” enables the reader to truly understand what powerlessness feels like from the perspective of the patient or person experiencing the feelings. Dickinson’s words describe the pathway a patient travels, particularly the elderly patient, as feelings of powerlessness increase as health declines. In the analogy to the Biblical battle between David and Goliath, the patient is David, smaller and weaker than the powerful and controlling problem, or Goliath. The first two lines of the poem, “I took my Power in my Hand – And went against the World,” can be compared to the patient’s last bit of hope and strength that is being used to combat an actual or potential situation or medical problem that has the ability to take control over the patient. The patient longs for nothing more than to take back control over his/her body and environment, described by Dickinson in lines three and four. Ultimately, the patient views his/her fight as a failure. All hope is lost and feelings of powerlessness and hopelessness creep in. As the poem questions, in the lines “Was it Goliath – was too large – Or was myself, too small?” is it really the Goliath, or problem, in the patient’s life that was too powerful to defeat—or was it the amount of hope and fight left in the patient that caused him/her to give up the fight? The applications of this poem could be numerous, but Dickinson wishes the reader to understand that powerlessness feels like inadequacy, failure, and belittlement. The poem leads the reader through a battle with powerlessness and

makes for an enhanced understanding of why patients experiencing loss of power tend to forfeit control to their illness.

## Client’s Experience

The phenomenon of powerlessness relates to a particular patient I cared for this semester at my clinical site. The first lengthy discussion occurred during the patient’s (W.G.) morning care. He was sharing stories with me about his life and family, along with his personal view of his medical diagnoses: “If I have to live like this, then there is no reason to live at all.” Upon hearing such a comment, I began looking for other signs of hopelessness and powerlessness. W.G. required constant supplemental oxygen and was unable to move his lower limbs due to prolonged bedrest and other medical conditions. W.G. also experienced tremors of the hands and was unable to feed himself, while renal failure left him incontinent and in need of catheter. In short, he was a total care patient and the sum of his medical conditions had left him powerless against them, with little control over his body and care. W.G.’s battle with Goliath had been fought numerous times in the past and had finally proved ineffective. He no longer possessed the appropriate coping mechanisms needed to deal with feelings of powerlessness and put up one last fight, winner taking the control. W.G. lacked the motivation to improve his behavior and had placed the blame for his condition solely upon the staff providing his care. Whether this was a sign of denial, lack of responsibility, or a personal coping mechanism, observations of this patient supported the presence of powerlessness.

### *Health History and Physical Examination*

W.G. is an 83 year-old Caucasian male born and raised in Michigan. He has been married and divorced six times and currently has a girlfriend of 15 years. W.G. shared with me that one of his ex-wives and his current girlfriend often visit him at the same time. He has two children from his first marriage: a daughter, who lives in the area, and a multimillionaire son, who is currently living in Australia and owns a large amount of open land. Previous to his hospitalization, W.G. lived alone in an apartment and was capable of caring for himself and his living quarters. At the present moment, his girlfriend is managing his finances and taking care of his apartment. Over the past few years, W.G.’s multiple medical problems have slowly taken control of his life and rendered him powerless against them.

W.G.’s extensive list of medical diagnoses is headed by diabetes mellitus type 2, which has been

difficult to control as of late. Combining forces with the diabetes mellitus type 2 is peripheral vascular disease (PVD), which is causing decreased circulation to the extremities. What started out as coronary atherosclerosis has further developed into congestive heart failure (CHF), and along with ischemic cardiomyopathy and hypertension, has left W.G. with a weak and poorly operating heart. Also affecting this patient and contributing to feelings of powerlessness over his own body is chronic renal failure, which has advanced so far as to require an indwelling catheter for urinary elimination. Degenerative arthritis has made ambulation painful and nearly impossible, predisposing him to further complications associated with prolonged bedrest. W.G. has a history of prostate cancer that was removed many years ago, a procedure that has the potential to be difficult for men to deal with. A history of depressive disorders (unspecified) could also be contributing to the patient's powerlessness. In short, the multiple heart conditions along with chronic renal failure, bedrest, and arthritis have led to decreased activity tolerance. Decreased activity and the patient's CHF have resulted in severe edema in the lower extremities. Tremors have taken away the patient's ability to feed himself and chronic renal failure has removed the privacy that typically accompanies elimination. The medical diagnoses W.G. is facing have compromised his independence and have only advanced his feelings of powerlessness.

#### *How Powerlessness is Unique to This Client*

W.G. is a chronically ill patient who has fallen victim to powerlessness. He has lost all will to live because he feels that he can no longer control his health. Currently, medication (approximately 15 different medications) and other nursing interventions are being used to control the side effects of many of this patient's medical problems. Furosemide, a diuretic, is being administered to decrease the patient's edema due to CHF, PVD, and hypertension. Tylenol 3 (with codeine) is also being given on an "as needed" basis for pain relief. Combined, the two drugs just listed should provide for less painful ambulation. Atenolol is also being administered to control the side effects of W.G.'s hypertension and CHF, which should increase the amount of activity that he can endure (Deglin & Vallerand, 2005). However, no medication to improve his mood or counteract his developing depression has been ordered by the physician. As mentioned previously, continuous oxygen flow at three liters via nasal cannula is given to ease his breathing patterns and an indwelling catheter is aiding in urine excretion. In order to encourage W.G. to become more active, physical therapy is being offered, yet he oftentimes

refuses to go, stating that the pain throughout his body is too severe. As it seems, the medications have more control over W.G.'s health than he does himself and when he has the opportunity to take some control, he refuses or is hesitant to do so.

Ultimately, I am quite positive that W.G. would like to take back control of his health and his life. However, I conclude that he has given up that fight and my conclusions are supported by his everyday actions and choices, or lack thereof. If given the choice, W.G. would choose death over life at this current moment, if it meant he would no longer live with the pain and suffering that accompany his medical problems. He once stated "I wish I could end it all right now." This was a desperate cry for help, comfort, and assurance. If W.G. felt as if he maintained some power over his life, his self-esteem and general mood would be greatly improved. In a general sense, W.G. has become depressed, withdrawn, inactive, and refrains from telling the nurse about pain or changing conditions due to his feelings of powerlessness.

### **Powerlessness and its Relationship to Human and the Environment**

Powerlessness can affect any human. According to Saginaw Valley State University's nursing program, a human is "an entity who participates in a family unit . . . exercises freedom of choice in pursuit of self-actualization, and has ultimate accountability for decisions and behavior" (Philosophy & Organizing Framework, 2005). Humans also have physiologic or psychological needs that are necessary for a healthy existence (Craven & Hirnle, 2003). Abraham Maslow, a humanistic theorist who created Maslow's hierarchy of human needs, has organized these needs into five categories in order of necessity: physiologic needs (air, nutrition, water, elimination, rest/sleep, thermo-regulation, and sex), safety needs, love needs, esteem needs, and self-actualization needs (Craven & Hirnle, 2003). Powerlessness affects the metaconcept of human by compromising such needs – the more human needs that are compromised, the more aspects of human are affected.

Specifically to W.G., powerlessness has affected all of his human needs in one way or another. His medical problems have affected most of his physiological needs by compromising air inspiration, altering nutrition, retaining fluids, preventing conscious urine elimination, and limiting the amount of sleep he receives at night. Safety needs have been affected by powerlessness due to W.G.'s inability to control his leg muscles. W.G.'s relationship with his girlfriend has

been compromised due to his current conditions and he often feels like he does not belong here on earth anymore. The fourth tier of Maslow's hierarchy includes esteem needs, which is supported by four fundamental criteria, one being power. When a patient loses power and no longer feels that his/her opinion is of any worth, then self-esteem is lowered (Craven & Hirnle, 2003). Finally, the fifth tier, self-actualization needs, has been affected by the patient's powerlessness because he no longer lives his life to its full potential.

Furthermore, a 1997 study, *Restoring Power Through Nursing Intervention*, by Sylvia Kubsch and Harriet Conley Wichowski, showed that environmental factors also affect feelings of powerlessness in patients. Nursing theorist Virginia Henderson has defined environment and the nursing role in terms that are very appropriate in W.G.'s case. While the nursing role will be discussed later, Henderson views environment as "all external conditions and influences that affect life and development" (as cited in Craven & Hirnle, 2003, p. 58). Therefore, loss of control of environmental temperature, lighting, noise level, cleanliness, and/or placement of objects within the environment can result in the patient feeling powerless over his/her environment.

## Nursing Interventions for Powerlessness

Nursing theorist Henderson has defined the nursing role as "assisting and supporting the individual in life activities and the attainment of independence" (as cited in Craven & Hirnle, 2003, p. 58). One of the most important and effective nursing interventions that relates to powerlessness is *self-esteem enhancement*, defined as "assisting a patient to increase his/her personal judgment of self-worth" (Dochterman & Bulechek, 2004, p. 633). An activity that pertains to self-esteem enhancement includes monitoring W.G.'s statements of self-worth because of previous statements of worthlessness and hopelessness. Other activities that are pertinent to W.G.'s situation include assisting him to set realistic goals to achieve higher self-esteem and to accept dependence on others, as appropriate. Under the circumstances, W.G. is not expected to be completely independent and he must learn to accept the fact that he requires assistance from other people and devices. Facilitating an environment and activities that will increase self-esteem is also important in order to prevent further depression and inactivity. Self-esteem levels should be monitored on a daily basis.

*Self-responsibility facilitation*, defined as "encouraging a patient to assume more responsibility for own behavior" (Dochterman & Bulechek, 2004, p. 637), is also a commonly used intervention with

powerlessness. Activities specific to W.G.'s needs include holding him responsible for his own behaviors, encouraging independence but assisting him when unable to perform, and encouraging him to take as much responsibility for his self-care as possible. In order for W.G. to regain some control in his life, he must take responsibility for and perform tasks that he is capable of doing independently.

*Mutual goal setting*, an additional intervention, is defined by Dochterman and Bulechek (2004) as "collaborating with a patient to identify and prioritize care goals, then developing a plan for achieving those goals" (p. 506). Activities specific to mutual goal setting include assisting W.G. to identify realistic, attainable goals, assisting him to set realistic time limits, focusing on the expected rather than desired outcomes, and encouraging the acceptance of partial goal satisfaction. By setting realistic goals that can be attained within a realistic time limit, disappointment, failure, and ultimately feelings of powerlessness can be avoided. Positive reinforcement is also necessary for W.G. because he has little confidence in the benefits of activities and has a depressed outlook on his life.

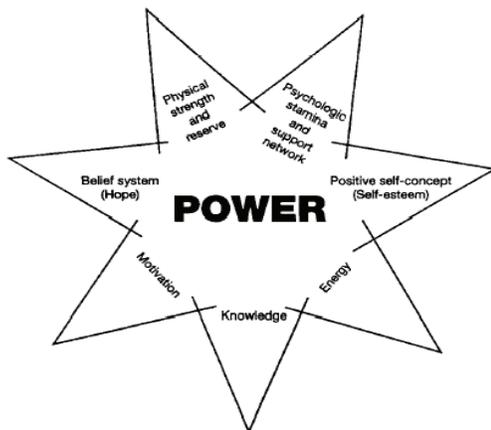
*Decision-making support*, defined as "providing information and support for a patient who is making a decision regarding health care" (Dochterman & Bulechek, 2004, p. 273), is also a very important intervention used with a patient who feels like he/she has lost control over his/her health and care. Specific activities include facilitating W.G.'s articulation of goals for care, providing the information requested by the patient and respecting his right to either receive or not receive the information, and serving as a liaison among the patient, family, and other health care providers. Through these decision-making activities, trust can be built among the nurse, patient, and family, miscommunication can be avoided, and the patient's wishes remain important and can be respected. Therefore, feelings of powerlessness can be decreased by allowing the patient to retain his decisional-making power.

The final nursing intervention I found to be important when addressing powerlessness is *spiritual growth facilitation*, defined as the "facilitation of growth in the patient's capacity to identify, connect with, and call upon the source of meaning, purpose, comfort, strength, and hope in his/her life" (Dochterman & Bulechek, 2004, p. 663). According to a 1991 study done by Stein (as cited in Kubsch and Wichowski, 1997), results suggest that powerlessness is related to spiritual health. Therefore, performing activities such as offering W.G. individual and/or group prayer support, encouraging him to examine his spiritual commitment based on his beliefs and values, and referring him to

support groups may help boost his self-esteem and acceptance of his situation.

I had the opportunity to work with this patient on three separate occasions, so the only two nursing interventions I was able to use were self-esteem enhancement and self-responsibility facilitation. If given more time with W.G., I would have liked to incorporate all the above listed nursing interventions into my care, in addition to others mentioned within studies, to facilitate the best possible outcomes. Efraimsson, Rasmussen, Gilje, and Sandman (2003) suggest that reflection on behalf of the patient and nurse or other caregiver may help the patient feel more in control when making the most beneficial decisions regarding his/her care. Johnson (1998) supports the use of self-esteem enhancement and presence as nursing interventions when caring for a patient experiencing powerlessness due to restraint use. However, Kubsch's and Wichowski's study (1997) reveals the most valuable therapeutic nursing interventions when dealing with powerlessness: meditation, exercise, reminiscence, therapeutic touch, contracting, and sensation information. Also stressed by Kubsch and Wichowski (1997) is the use of the Holistic Power Model (see Figure 1), which defines patient power resources, as well as the Powerlessness Assessment Tool for evaluating a patient's level of powerlessness. I would undoubtedly use this model and evaluation tool when assessing my patient for baseline measurements and improvements.

Figure 1. Patient Power Resources



Source: Miller, 1992, p. 8

## My Personal Learning about Powerlessness

Previous to researching for this paper, I thought I had a solid understanding of what powerlessness was. I viewed powerlessness in its physical aspect, as more closely related to fatigue, lack of energy, or low endurance. However, I soon learned that powerlessness is much more. As stated earlier, powerlessness, as defined by Wilkinson (2005), is "the perception that one's own action will not significantly affect an outcome; a perceived lack of control over a current situation or immediate happening" (p. 386). Powerlessness is a feeling, and I was aware that this feeling could be felt by anyone. However, Kubsch's and Wichowski's article really allowed me to understand specifically who was at greater risk for developing feelings of powerlessness and why. Unfortunately, I never took the time before writing this paper to think about all the aspects of one's life that can be affected by powerlessness, including health, socialization, mobility, and cognitive functions. It was also interesting to research this phenomenon from perspectives other than nursing. This allows for an enhanced understanding of what happens when feelings of powerlessness take over one's life.

I was also very interested in the multiple and varying types of nursing interventions that have been deemed effective with patients experiencing the phenomenon of powerlessness. I now have a better understanding of the typically used interventions, self-esteem enhancement and self-responsibility facilitation, but I truly enjoyed learning about alternative therapeutic interventions, such as meditation, exercise, reminiscence, therapeutic touch, contracting, and sensation information. One day I hope to apply these interventions to my care plan with someone experiencing powerlessness and monitor their effectiveness for my own knowledge. It amazes me that such simple activities as meditation and exercise could facilitate the growth of power within a person.

Caring for W.G. has taught me a lot about powerlessness. I witnessed first-hand how it affects different aspects of your life and what possible conditions could be the root cause of developing feelings of powerlessness. Observing such things has allowed me to mentally understand how and why the chosen interventions can be effective in a care plan for such a patient. I believe all this information will help me to become a better nurse, especially when caring for a patient who finds himself or herself under similar circumstances. I am now more competent in identifying powerlessness in a patient and choosing the most

beneficial nursing interventions specific to that client. The most important lesson of all is that powerlessness affects who the person is as a human, an aspect which is also influenced by the patient's environment. David beat Goliath out of sheer courage, strength, and determination. This type of defeat may not occur often, but maybe another "David" can defeat another "Goliath" if we, as nurses, start implementing nursing interventions before "Goliath" takes control.

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