Components of courage in chronically ill adolescents: a phenomenological study

Although courage is an important variable when clients successfully deal with hospitalization and illness, the concept is contradictory and ill-defined in nursing and other literature. The phenomenological approach and research method has been suggested as one means of concept clarification and theory development. Using the phenomenological approach, this study asked: What is the essential structure of the lived experience of courage in chronically ill adolescents? Nine chronically ill adolescents participated in an open-ended, audiotape-recorded interview, describing their subjective experiences of courage. The descriptions were analyzed phenomenologically. Significant statements were extracted, meanings formulated, and themes identified. Thirty-one theme clusters in nine categories emerged from which an essential structure of courage in chronically ill adolescents was derived.

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THE CONCEPT of courage is not well defined in the literature of nursing or other fields, although it has been commonly identified as an important variable when patients successfully deal with hospitalization and illness. As far back as Socrates,[1] writers seem to have taken a pessimistic view of a human's ability to grasp the nature of courage or to provide clues to its origin or development. A recent development in nursing, which aids in defining and describing courage from the perspective of a person experiencing illness, is the recognition and acceptance of the qualitative, phenomenological method of research.[2-7] Using this approach, nurses are able to clarify concepts such as courage that are significant but have not been studied because of their abstract nature. By identifying the essential structure of courage, nurses may be able to diagnose the lack of courage and to identify mechanisms for encouragement.

Although courageous behavior is generally admired in anyone, it is especially

Adv Nurs Sci, 1987, 9(2), 64-80

intriguing and awesome when displayed by children. Courage is also an important concept when children experience a chronic illness. As chronically ill children develop during adolescence, health care professionals are often struck by the meaning and focus that some have derived for their lives—by the courage they display. Knowledge of the structure of courage could provide direction for encouragement of children who develop chronic illnesses.

Since courage is an elusive but significant concept when working with children and adolescents, the research question of this study was: What is the essential structure of the lived-experience of courage in chronically ill adolescents? Through identification of the common components of courage, the essential structure of courage experienced by chronically ill adolescents was derived. In phenomenological research, the essential structure is a synthesized, integrated description of an experience, including meanings for the individual. The common components are descriptions of moments or themes of a phenomenon expressed by a respondent that are similar to or compatible with other respondents' descriptions. The lived experience of courage was defined as the personal situations of courage described by the chronically ill adolescent participants. These are descriptions of everyday situations of courage that do not attempt to analyze the construct.

REVIEW OF LITERATURE

There has been little systematic study of courage, and that which has been written is often contradictory. Throughout history there have been numerous literary descriptions of heroism and bravery exemplified by such works as Homer's *Odyssey*.[8] These literary descriptions provide universal recognition of the concept under varying circumstances, but do not provide systematic study. Much of the literature on courage has been written by those who observe war or politics, and it focuses on courage as a moral choice or will power.[9-12] In writings by existential and humanist philosophers,[13-15] courage is described as essential to our being and as a product of creativity. From a psychological perspective, two primary studies have been done on courage. Rachman[16] utilized traditional scientific methods and viewed courage as a mirror image of fear. Asarian[17] used phenomenological methods to study well-adult experiences of courage. Asarian identified the interpersonal nature of courage as important to the experience.

The nursing literature on courage is limited. It is interesting to note that, although courage has been identified in the literature as one component of caring,[18] and caring was seen as an essential component of nursing,[19-21] courage has not been studied in any systematic fashion. Little and Carnevali[22] identified lack of courage as an often overlooked diagnosis and stated that courage is an area of nursing knowledge and skill that requires more research. Lanara,[23] in studying a related concept, heroism, found that heroism arouses caring in nurses.

METHODOLOGY

The study design was descriptive, using the phenomenological method of protocol analysis of transcribed, unstructured inter-

views with nine chronically ill adolescents. The researcher obtained spontaneous descriptions of the subjective experience of courage in specific situations through use of a data-generating question adapted from Stanley.[24]

Description of sample

The sample was purposive, based on potential participants' ability to identify and openly discuss a situation of courage they experienced. Nine 14- to 21-year-old adolescents, having a chronic illness as evidenced by their receiving health care at least three times for the same disease and having the condition for six months, were included in the study. One 21-year-old participant was included since he was especially identified as courageous by the nursing staff and had consistently been treated on the adolescent unit. An effort was made to include participants with life-threatening and non-life-threatening conditions. Twelve potential participants were approached for possible inclusion in the study. Three were eliminated at various stages of data collection and analysis because of their inability to identify a courageous experience, their attempts to analyze rather than describe a courageous experience, or technical difficulties.

The medical diagnoses of the nine remaining participants included leukemia, chronic renal failure, cystic fibrosis, recto-vaginal fistula, pulmonary stenosis, and scoliosis. The participants were hospitalized for a variety of treatments and procedures including surgery, chemotherapy, bone marrow transplant, and medical management of pneumonia. Participants who had surgery were well into the recovery period at the time of the interviews. Of the nine participants who completed the study, four were male and five were female; one was black and eight were white. All resided with one or both parents and none was married. One was engaged to be married and one had an infant less than one year old.

Data collection procedure

After obtaining institutional review board approval and participants' written consent to participate and be audiotape recorded, the investigator made appointments to conduct the interviews at a time and place convenient to the participants. They were asked to think about a situation of courage they experienced prior to the interview and were given a written copy of the data-generating question: "Describe a situation in which you were courageous. Describe your experience as you remember it, including your thoughts, feelings, and perceptions as you remember experiencing them. Continue to describe the experience until you feel it is fully described." The written copy included a detailed explanation of what was meant by each sentence in the question. Clarifying questions were asked at appropriate times during the course of the interview, but suggestive or leading questions were avoided.

DATA ANALYSIS

The following eight-step, analytical process, adapted from Colaizzi,[25] was used:

1. acquisition of a sense of each protocol's meaning through listening to and transcribing the tapes;
2. extraction of significant statements;

3. formulation of significant statements into a more general restatement;
4. formulation of a statement of meaning and validation of that meaning by judges;
5. organization of formulated meanings into themes, theme clusters, and theme categories;
6. integration of themes into an exhaustive description of phenomena of interest;
7. formulation of the statement of the essential structure; and
8. validation of the essential structure by study participants.

In the first step, the investigator acquired a feeling for and a familiarity with the descriptions (called protocols in phenomenological research) by listening to the audiotapes several times and personally transcribing them. All the participants chose to describe a situation that occurred over a period of several months or years that was related to their health-illness condition. Examples of the general focus of the situations were having open heart surgery, knowing about it and all that led up to it; gaining acceptance of having cystic fibrosis and assuming responsibility for care; and dealing with treatments for leukemia and the effects of the treatments.

In the second step, significant phrases and sentences that directly pertained to courage were extracted. Within the nine protocols, 889 significant statements were identified. The third step consisted of reformulating the significant statements into more general forms, a restatement, in order to transform the concrete language of the participant into the language of science. For example, the phrase "the scaredness went away" was restated as "fear dissipated," and "I stayed real calm" was changed to "remained very calm."

In the fourth step, significant statements and restatements were studied to derive and record a sense of their meaning, the formulated meaning. Each formulated meaning was developed with consideration of the statements preceding and following it so that the context was maintained. Concepts, labels, and processes were identified and clarified. For example, for the significant statement, "I stayed real calm," the formulated meaning was "feelings of nervousness, while present, were under control." The following are further examples of significant statements (SS), restatements (RS), and formulated meanings (FM):

SS: "My mom just held my hand and talked to me. That made it better."
RS: Mother holding hand and talking improved situation.
FM: Touch and verbal expressions of caring by mother decreased feelings of despair to a tolerable level.

SS: "I just talked myself out of it. Put my mind on something else and the scaredness went away."
RS: Talked to self of other things and feelings of fear dissipated.
FM: Conducted a self-dialogue about other things, which was effective in dissipating feelings of fear.

All participants chose to describe a situation that occurred over a period of several months or years that was related to their health-illness condition.

SS: "You start thinking. You start thinking a lot, wondering how it would affect everybody, how it would affect your parents if you were to die."
RS: When thinking about surgery, thinks about the effects of own death on others, especially parents.
FM: Thoughts about the scheduled surgery include scenarios of the possible effects of own death on others.

To ensure that the formulated meanings did not sever the connection with the original protocols while moving beyond the protocol statements, the restatements and formulated meanings were validated by two doctorally prepared judges with experience in qualitative research. They read both the restatements and the formulated meanings and compared them with the original protocols. The formulated meanings were validated with a minimum of changes. The changes resulting from the validation process were made to increase precision or to include relevant concepts. For example, "decision to follow intuition" was expanded to "decision to trust and follow intuition."

In the fifth step of data analysis, themes were identified from the formulated meanings. The themes were organized into clusters and categories to allow for the emergence of themes common to all participant protocols. Discrepancies that seemed present in the themes were not eliminated since they could be "logically inexplicable but existentially real and valid."[25(p61)] Data that did not seem to fit were not ignored nor were hypotheses prematurely generated that would eliminate the discordance. The 31 theme clusters that emerged fell into nine categories. As an example, from the category "Coping Themes," one theme cluster, "Coping Directly with the Situation," was derived from the following specific themes: "attempt to live as well as possible"; "learn to perform own medical care"; "identify alternative goals and priorities"; "attitudes of acceptance, patience, and resolve." The appendix lists the nine categories, the theme clusters, and the specific themes.

The themes and their relationship to each protocol were validated by the same judges who validated the formulated meanings. These two individuals were asked to decide whether there were any themes suggested by the original significant statements that were not accounted for and whether the themes incorporated anything not implied in the original protocols. The accuracy of all the themes was validated.

In the sixth step of analysis, an exhaustive description of courage was derived, which is a narrative integration of all the themes, theme clusters, and categories of themes. The exhaustive description was developed to gain insights into the structure of the lived experiences. From the exhaustive description, the seventh step of data analysis, the essential structure, was derived. The essential structure of courage is an integration and synthesis of the common components of courage identified in the exhaustive description. It includes a description of the processes and meanings derived through the previous steps of analysis.

In the final step of data analysis, three participants, selected because of their accessibility by phone, were asked to confirm that the essential structure of courage was the same as they had experienced. The essential structure was read to the partici-

pants with clarification when complicated terminology was used. The reading was stopped frequently to ask specifically whether each element was experienced by the participant. All three concurred that their experiences were the same as described in the essential structure.

RESULTS

As a result of the eight-step process of analysis, the essential structure of courage in chronically ill adolescents was identified. This structure may be described as follows:

The lived experience of courage in chronically ill adolescents is an interpersonally assigned attribute that occurs as the result of a gradual process of living in a specific manner through the experience of having a health-related condition. The initial phase of the lived experience involves a struggle to gain personal awareness of the nature and impact of the health-related situation of courage. Awareness and resolution of the experience as one of courage are obtained through daily encounters with the many "minisituations" of courage: the procedures and treatments, the physical changes, and the alterations in interpersonal relations that result from having the health-related condition. As the nature of the situation is revealed, it is viewed as difficult, but not impossible. Coping strategies are identified or developed to deal actively with the situation, but also to avoid dealing exclusively with it. Other aspects of life are actively pursued. Behavioral responses to the situation of courage are experienced. A variety of positive and negative responses are also experienced.

The situation of courage evolves in a spiraling, regressive-progressive manner toward the realization that the lived experience is, indeed, one of courage. The progress toward awareness and resolution of the experience as one of courage is aided by the supportive relationships of health care personnel, family, and others who have experienced similar situations. It is also aided by the transcendence themes of hope and faith. Through the many daily experiences of dealing with aspects of the situation of courage, resolution occurs: a sense of mastery, accomplishment, and competence develops. There is a feeling of growth having taken place. The adolescent is motivated to continue to maintain and improve the situation and to help and inspire others. A feeling of acceptance occurs where the individual acknowledges that the lived experience of courage has contributed to who and what he or she is.

DISCUSSION AND IMPLICATIONS

The primary conceptualizations of courage found in the literature are discussed in light of the essential structure of courage identified in this study, as is the relationship of courage to several additional concepts of interest. Furthermore, the implications for nursing are included.

Heroism and courage

Courage may more closely resemble a gradual development of attitudes and coping methods than it does the literary descriptions of "born heroes." In this study, the adolescents emerged from their experiences with a sense of growth and increased competence through a process.

The development of attitudes and coping methods occurred over time, through practice, in a progressive-regressive manner. Thus, the question may be raised whether the often-heard admonitions to "be brave" are ineffective and possibly harmful if variables such as previous experience or supportive relationships are not present.

Fear and courage

Courage seems to be a bridge between fear and action as asserted by Tillich,[15] rather than the mirror image of fear as asserted by Rachman.[16] The adolescents did not describe actually gaining freedom from fear. Instead, they described an increased ability to effectively cope with their fears. In discussing their experience, the participants cited some examples of encouragement, such as clarification by others, which may be a means of identifying actions to increase effective coping with fears.

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Creativity and courage

In this study, creativity was closely connected to courage, as has been asserted by May.[14] In addition to demonstrating May's four categories of courage (physical, moral, social, and creative), the adolescents experienced a creation of a new "self," one who has mastered a difficult situation. Such creativity did not occur in a vacuum, however. The interpersonal assignment of courage that occurred indicated that social supports and other resources are necessary for creativity, awareness of the situation as one of courage, and resolution to occur. Supports include opportunities for clarification, discussion of possible coping strategies, and opportunities to have the presence of and to interact with others who are significant or who have similar conditions. The relationship between creativity and courage in development of a new "self" may be significant for studying self-concept.

Will and courage

Courage in chronically ill adolescents does not appear to be only will power as asserted by many observers of war and politics.[11,26] There were many times when the participants had no desire or will to have anything to do with the situation in which they found themselves, but no alternatives were available to them. A view of courage as a product of cultivated attitudes, habits, and relationships, rather than as a choice to be made,[12] seems to more accurately describe the adolescents' experiences. The minisituations of courage provided the adolescents with opportunities to cultivate attitudes of ability. Effective habits were developed to either avoid or deal directly with the situation. Meaningful, important relationships were developed to gain support. Since adolescents dealing with situations of courage avoid focusing exclusively on the situation, daily participation in and opportunities for routine activities, such as interaction with peers and school, need to be maintained.

Courage within a stress-coping model

A comparison of the findings of this study with the Stress-Coping Model of Scott, Oberst, and Dropkin[27] indicates that courage is closely related to the challenge decision within the model. Similar to the experience of the adolescents, the challenge decision described by the model occurs when a stressful situation is viewed as an opportunity for growth, mastery, or gain, assuming that the situation is difficult, but not impossible, using existing or acquirable resources. The results of this study regarding the progressive-regressive nature of courage and the frequent decision to use avoidance as a coping mechanism indicate that adolescents occasionally choose to view a minisituation as a potential loss or harm, or as a threat as described by the model. In addition, when adolescents approach each minisituation as a challenge, there is a possibility that the barrages of procedures may deplete resources to effectively deal with the situation. Assistance by health care personnel in the evaluation and decision-making process may be helpful.

Essential structure of courage

As in Asarian's[17] study, meanings for the adolescents were established within the network of significant others including health care personnel, family, friends, and others with similar experiences. This finding has implications regarding the social support afforded hospitalized adolescents. The interpersonally assigned attribute also holds implications for nurses to communicate their own perceptions of a patient's behavior and to provide opportunities for patients to relate their perceptions of situations they experience.

Time and consciousness

This study revealed alterations in consciousness, especially a struggle with time perceptions. The initial sense of unreality emerged into a gradual personal awareness of the situation as one of courage. During that process, the perceptions of time were often incongruent with clock time. The adolescents struggled to gain accurate time perceptions. Because of the progressive-regressive nature of courage identified in this study, the alterations of time perceptions seem significant. Waiting times were especially difficult. Insufficient data were obtained to draw conclusions of what may be helpful in assisting the adolescent to gain a comfortable perception of time, but a sensitivity to the adolescent's needs regarding altered time perceptions seems necessary.

Humor and courage

The use of humor was mentioned frequently by the participants. These findings support Mishinsky's[28] study of humor as a courage mechanism rather than as a defense mechanism. This conscious use of humor is supported by the study findings.

Transcendence themes

In the adolescents' descriptions, transcendence themes of faith and hope were an integral part of the lived experience of courage. Opportunities to express those themes helped the participants gain awareness and resolution of the situation, although this study did not identify the

ways in which such spiritual care for adolescents was offered.

RECOMMENDATIONS FOR STUDY

Identification of the essential structure of courage provides direction for future studies, such as the development of courage in the context of the caring relationship and the meanings of interactions with family, health care personnel, and peers. Studies of the experience of waiting and altered perceptions of time surrounding procedures and surgery may yield further information on the significance of time in the development of courage. Studies of the choices and patterns of coping used to develop the sense of growth, creativity, and mastery that are the resolution of a situation of courage would be useful. Finally, phenomenological studies of the many pleasant and unpleasant responses to the situation such as comfort, humor, relief, and pain are also needed.

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Appendix

Theme categories derived from theme clusters and specific themes

Category	Theme cluster	Themes
1. Characteristics of the situation	Gaining awareness of the situation	Event or series of events precipitates courage; initial difficulty perceiving and comprehending the situation as real; no prior major physical symptoms; procedures done to verify and evaluate situation; alternatives evaluated and plans made for treatment; situation evolves slowly, unexpectedly, and progresses in severity
	Physical changes	More concern than actual disease; a concern when interacting with others; unwanted; a source of self-consciousness; effect on activities of daily living and quality of life
	Time perceptions of the situation	Waiting periods were time of uncertainty, evaluated as being long or short and related to length of hospitalization; situations and reactions to it dynamic; identification of when situation changes; time perceptions significant to progress of situation; effective coping perceived as developing over time

Category	Theme cluster	Themes
2. Evaluation of the situation	Evaluation process	Inability to identify satisfactory alternatives to choices; inability to identify alternative coping strategies; evaluation of the chances of improvement based on scientific progress in treatment; evaluation based on comparison of own situation and that of others; evaluation of the effects of different possible outcomes on self and others; decision making related to goal identification; change in perception of ability to tolerate situation when situation itself changes
3. Coping themes	Coping through thought processes	Attention is focused on positive aspects of the situation, unrelated or pleasant past events, pleasant or future outcome, nonlife-threatening aspects, technical aspects of treatments and procedures
	Coping through avoidance	Attempts to avoid unpleasant or disturbing thoughts; avoidance not always effective; inner dialogue conducted or effort exerted to consciously avoid thought about the disease and procedures; avoidance through involvement in distracting, enjoyable, and fun activities, sleep or rest, interaction with family, friends, or health care personnel

Category	Theme cluster	Themes
	Coping directly with the situation	Attempts to live as well as possible; learn to perform own medical care; identification of alternative goals and priorities; attitudes of acceptance, patience, and resolve
	Coping through clarification of the situation	Learning about the situation; learning through reading, through technical information; clarification through discussions with others
	Factors affecting coping	Faith; presence of others; amount of physical discomfort; mastery of previous difficult experiences; time factors affecting coping including having a respite between procedures, perceived level of maturity, whether or not events expected
4. Responses to the situation	Behavioral responses	Inability to sleep, trembling, vomiting, tenseness, coldness, inability to control behavioral responses
	Unpleasant emotional responses	Fear, loss, anger, shock, sadness, and depression; powerlessness; helplessness; lack of control of situation; embarrassment; disappointment; aloneness; annoyance; irritability; mood swings; regret
	Pleasant emotional responses	Gratitude, relief, happiness, excitement, comfort, being special and unique

Category	Theme cluster	Themes
5. Relationships with others	Relationships with health care personnel	Health care personnel perceived as helpful, competent, caring, powerful; communication of health care personnel serves as a baromcter of the situation
	Relationships with family	Presence of family significant; family influences own feelings, provides a sense of closeness, is perceived as caring, helpful, concerned, willing to sacrifice, and provides physical care
	Influence of others	Beliefs of others increase own beliefs in outcomes; sharing provides closeness; satisfaction gained through demonstrating mastery of experience to others; more positive perspective gained through discussions with others
	Influence of others with the same or similar condition	Serve as role models; provide a sense of hope, closeness, inspiration; feelings of empathy for those who suffer; questioning whether comparison of self with others is right
	Informing others	Selective of who is informed of situation; desire family to know of developments; increased understanding when friends informed; stranger perceived as curious or confused; attempt to explain situation to strangers; emotional reaction when others learn of situation without consent, including self-consciousness, humiliation, embarrassment, annoyance, and irritation

Category	Theme cluster	Themes
6. Transcendence	Hopes are specific	Wellness or improvement in the situation; a resolution to the situation; going home; normality
	Sources of hope	Intuitive sense of well-being; faith in God; statements by significant others of a positive outcome; knowing of others who survived; progress in the discovery of treatment methods; meeting others who are coping well; hearing of the positive outcome of others; belief in a better life; previous improvement in condition; lack of further problems over a period of time; tentative nature of hope
	Faith in God	Prayer by self and others; well-being attributed to God; struggle to obtain and maintain faith
7. Dealing with procedures	Anticipation of procedure	Behavioral reactions; concern, uncertainty, fear while waiting for procedure to begin; transfer to location of procedure
	Fear	Time factors; focus of fear on being alone, changes in physical status, disease reoccurrence, pain, uncertainty of outcome, intrusiveness of procedure; fear reduced by discussions, medication, increased knowledge, sleep, trust in health care personnel, belief in power of prayer

Category	Theme cluster	Themes
	Medical technology	Observations of machines and procedures distressful, confusing, strange, intriguing, provide distraction; medications altered mood and level of consciousness; medications unpleasant but necessary; occurrence of a barrage of medical experiences to assess, monitor, or treat the situation
	Pain	Possible causes of pain identified; disease itself not as painful as procedure; intrusive procedures painful; relief from pain through distraction, sleep, medication, and conscious effort to control
	Positive reactions to procedures	Relief when less distressful than anticipated, when completed, when coping strategies found effective; happiness with evidence of progress or completion; comfort from realization that others experience similar feelings or from other's presence; pride for accomplishments; being cared for and supported through prayers and verbal comments; receiving tangible gifts, having visitors, physical touching

Category	Theme cluster	Themes
	Evaluation process for procedures	Viewed as more or less difficult based on effectiveness of coping; involves distinctions in sensations and identification of rationale for experiences; includes identification of reasons for differences in level of difficulty; evaluation affected by the repetitive nature of procedure; fantasies perceived as frequently worse than actual procedure; behavior of others used as clues to evaluate procedure; evaluation occurs in comparison with temporary or permanent nature of outcome, changes in physical ability or structure, other procedures, and reactions of others in similar situations
8. Perception of surgery	Prior to surgery	Surgery a new and unreal experience; preparation activities increase perceptions of the situation's realities; waiting periods difficult; waiting period used to evaluate possible outcomes; physical restraint significant; medications and anesthesia produce floating sensation; attempts to maintain, understand, and control under medication and anesthesia

Category	Theme cluster	Themes
	Immediately following surgery	Inability to recall surgery; fear of having wakened during surgery; time lapse during surgery perceived as short; altered sense of time; attempts to obtain personal awareness of surgical experience; cognitive awareness of surgery obtained from others; sense of well-being from hearing and seeing others; sense of well-being when aware of location; alternating levels of consciousness; pain expected; pain subordinate to feelings of relief for positive outcome; pain perceived as improving with time, hence tolerable
	Surgical recovery period	Sense of incredulity that situation mastered; well-being based on removal of apparatus, healing, ability to perform activities of daily living, alleviation of pain; impatience for recovery to be complete; desire to return home and resume desired life style
9. Resolution	Resolution	Sense of mastery, feeling of accomplishment and competence; feelings of having learned a lot; experience serves as a motivator to help others and improve or maintain own condition; feelings of acceptance of situation; outcome attributed to God's presence and control