

1-4-2012

Perioperative experience of adolescents

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PERIOPERATIVE EXPERIENCE OF ADOLESCENTS

by

JANEAN CARTER MONAHAN

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

2012

MAJOR: NURSING

Approved by:

Advisor

Date

DEDICATION

This dissertation is dedicated to my beloved nephew,

Army Captain Drew Russell.

KIA: October 8, 2011 Kandahar Province, Afghanistan.

**Drew was with me every step of my journey and his presence is still
felt during the final days of my dissertation.**



“Heroes Live Forever”

Drewbie, you will be forever in my heart.

ACKNOWLEDGEMENTS

One of the greatest personal gifts I have ever received was having someone believe in me until I could believe in myself. I will be forever grateful to Dr. Rosalind Peters, my chair, for her gift of devotion, commitment, and dedication. You are an amazing scholar, researcher, and mentor.

I wish to thank Dr. Jean Davis, Dr. Nancy George, and Dr. Karen Tonso, members of my committee, for their continued support throughout my trek.

Dr. Davis, words cannot express the debt of gratitude and respect I hold for you. Your undying support and loyalty facilitated my exploration.

Dr. George, thank you for your valuable and timely editorials, critiques, comments, and guidance. Knowing you were there for me helped in my journey.

Dr. Tonso, your knowledge of phenomenology strengthened this project in many ways. I will be eternally grateful for your continuous guidance and encouragement throughout my endeavor. Thank you for your support and shoulder, of which I leaned on daily.

I would like to thank Michael, my husband, for his never-ending support throughout this quest.

My children, Matthew, Erin, and Kerrie, for their encouragement, love and support. I have been gifted with perfect children and for that, I am eternally grateful.

My mother, Mary Jane for the hour-long phone calls that helped to keep me focused along the path.

My brothers and their beautiful wives, Jim and Patti, Joe and Ada, Bill and Adele, JJ and Sue, I appreciate all the calls, hugs, and encouragement.

I am eternally grateful to the Carter family, LeRoy and Joan, and their incredible children, Joanie, Maureen, Barbara, and Barry. You have always been there for me. Thank you for your love and support.

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CHAPTER 1

INTRODUCTION

In 2008, more than 25 million people in the United States had a surgical procedure, meaning that 1 in 12 Americans had an experience in a perioperative setting (Center for Disease Control and Prevention [CDC], 2010). In recent years, the number of inpatient surgeries has declined while the number of surgical procedures in ambulatory settings has increased. By 2015, it is anticipated that close to 90% of all surgeries in the United States will be performed on an ambulatory basis (Center for the Advancement of Perioperative Health, 2010: www.anesthesiologu.uci.edu). Although the trend to have a procedure performed on an ambulatory basis is continuing to rise, the goal to promote a successful perioperative experience has remained constant.

The term perioperative experience refers to all the events associated with an operative or invasive procedure and it includes the patient's perception of those events. Perioperative experiences have been associated with psychological distress. It is estimated that 80% of surgical patients develop significant stress and anxiety before surgery (Jlala, et al., 2010). Of even higher significance is the impact stress and anxiety have on postoperative recovery. Preoperative anxiety is associated with negative physiological and psychological postoperative outcomes in young children and adults. Bodner (2005) discovered that intense levels of preprocedure stress correlated with greater postoperative pain, compromised wound repair, and required more anesthesia in adult patients. In addition, young children and adults who experienced high levels of stress before the procedure had more postoperative

complications (Lago-Mendez, et al., 2006). Approximately 1.3 million patients experience postoperative complications annually, costing approximately \$25 billion for additional healthcare procedures (Bamgbade, Rutter, Nafiu, & Dorje, 2007). This raises questions about whether increased interventions to decrease preoperative anxiety could reduce expenses associated with postoperative complications.

As will become clearer in subsequent chapters, researchers have examined perioperative experiences of adults and young children (Costa, 2001; Dewar, et al., 2003; Gilmartin & Wright, 2008; Kain, Mayes, Wang, Caramico, & Hofstadter, 1998; Lithner & Zilling, 2000; Margolis, et al., 1998; Ng, Chau, & Leung, 2004; Semple & McGowan, 2002; Sjolting, Nordalh, Olofsson, & Asplund, 2003; Turker, Varol, Ogel, & Basa, 2008; Yount & Schoessler, 1999), but adolescents have received much less research attention. This has occurred despite the fact that children, adolescents, and adults perceive experiences differently because of different cognitive development and personal experiences (Nardini, Jones, Bedford, & Braddick, 2008). In recent years, there has been an increase in the number of investigations studying *children's perceptions* and coping with stressful medical events (Hinton, Watson, Chesson, & Hathers, 2002; LaMontagne, Hepworth, Cohen, & Salisbury, 2004; Smith & Callery, 2005); however, little research has been performed examining *adolescent's perceptions* of these events.

Statement of the Problem

Research has shown that preoperative stress is associated with poorer health outcomes in adults and young children, but there is little in the literature about the stress experienced by adolescents. Clinical experience, however, has shown that

adolescents behave differently in the perioperative experience than either adults or children. Adolescents often emerge from anesthesia thrashing, crying, and combative, posing a safety concern to themselves and to operating room staff. In addition, preoperatively, adolescents rarely ask questions (unlike adults and children), and when spoken to tend to provide short answers, avoid eye contact, and often have movements that are jittery.

These clinical observations suggest that the perioperative experience is different for adolescents than for adults or children, but why these differences exist is not known. There is a gap in the literature as there is little research that explores the perioperative experience for adolescents. Therefore, to promote adolescent health and to provide adolescents with appropriate interventions that will support a positive surgical outcome, research is needed to discover the perceptions and meanings adolescents attribute to their perioperative experience.

Purpose of the Study

The purpose of this phenomenological study is to describe and capture the essence of the perioperative experiences of persons in late adolescence in order to understand the meaning of their experiences. By uncovering the insider perspective of the perioperative experiences, findings will begin to provide information expected to help health professionals as they plan and implement interventions for adolescents who are undergoing operative or invasive procedures.

Justification for the Study

The outcomes of this study are important to the discipline of nursing, and specifically to nurses who specialize in providing perioperative care. Perioperative

nursing practice facilitates health and healing, so patients can achieve a level of wellness equal to or greater than that which they had before their operative procedures (Association of periOperative Registered Nurse [AORN], 2011). Perioperative nursing practice is supported by the best available research evidence, therefore, it is important for perioperative nurses to seek new knowledge that will continue to improve practice in this setting. Incorporating research findings into practice assists perioperative nurses to promote wellness, provide a safe environment for patients, and reduce the risk for postoperative complications.

Numerous studies examine adult and child perioperative experiences; however, there are limited studies examining adolescents' perioperative experiences and few that examined adolescents' perspectives of the experience. Without understanding perioperative experiences from adolescents' point of view, perioperative nurses have little basis for perioperative interventions specific to this age group. A phenomenological approach allows for discovery of adolescents' perceptions of the perioperative experience. It is imperative for nurses to promote a positive perioperative experience so the risk of postoperative complications is reduced and the patient returns to an appropriate level of well-being.

Specific Context of the Study

The phenomenon of interest for this study was perioperative experiences of adolescents. There are four specific contexts within which this phenomenon was studied: the phases of perioperative experience, surgical setting, type of surgery, and age of participants.

Perioperative phases. There are three phases within the perioperative experience: preoperative, intraoperative, and postoperative. The preoperative phase begins when the patient is first informed of the need for surgical intervention and includes all events up to the actual surgical procedure. These events can include phone contact for scheduling the procedure, preoperative interview, preoperative testing, and admittance into the preoperative room. The intraoperative phase consists of the surgical procedure and concludes once the procedure is completed. Finally, the postoperative phase begins in the recovery room and lasts until the patient returns to his or her usual roles and responsibilities (AORN, 2011).

Ambulatory surgery settings. An ambulatory surgery setting is defined by AORN (2011) as an area in which outpatient surgery or other invasive procedures are performed, including but not limited to freestanding surgery centers, hospital-based ambulatory surgery units, physician offices, cardiac catheterization suites, endoscopy units, and radiology departments. A further distinction is that ambulatory surgery does not require an overnight stay. For the purpose of this study, the setting was defined as an ambulatory surgery setting, specifically, the offices of a group of oral surgeons.

The setting for this study was significant as the trend in healthcare is an increased use of ambulatory settings for surgical procedures, especially nonemergent surgeries. The movement toward ambulatory surgery began in the 1970s and has been increasing every year; approximately 20 million ambulatory procedures were performed in 1996 and that number increased to an estimated 53.3 million procedures in 2006 (National Survey of Ambulatory Surgery, 2010). The ambulatory site

provides safe, convenient, and cost effective care for those patients who are otherwise healthy and present with few other conditions that may impede a successful recovery. In comparison to inpatient surgery, ambulatory surgery has multiple psychological and medical benefits for patients (Chahal, et al., 2008). One such medical benefit is the type of anesthesia that is administered to the patient who is undergoing an ambulatory procedure. Ambulatory surgery is usually done with new shorter-acting anesthetic agents that permit rapid recovery for patients, allowing them to be discharged on the same day (Chung, 1995; Rothrock, 2010). Additional benefits of an ambulatory experience include a shorter recovery period, a diminished risk of infection, a decrease in cost, and less risk of postoperative pain, nausea, and vomiting (Rhodes, Miles, & Pearson, 2006).

Ambulatory settings offer an excellent site for performing research with adolescents. Although adolescence is a time of rapid changes, adolescents are relatively healthy without coexisting health problems, making ambulatory sites safe and convenient for this population. In addition, the ambulatory setting seems appealing to adolescents, as there are few disruptions of normal daily activities and less time away from school or work (Rothrock, 2010).

Types of surgery. With enhanced minimally invasive techniques that allow for same day discharge, the types of surgeries that can be performed on an ambulatory basis have increased. The types of procedures that can be performed on an ambulatory basis include elective oral surgery, tonsillectomies, laparoscopic, arthroscopic, ophthalmic, otic, and cosmetic procedures. Criteria for appropriate patient selection are essential for safe ambulatory surgery. If a patient has coexisting

health problems, the surgeon must determine if ambulatory surgery is a safe choice. In addition, procedures requiring extended recovery are not recommended for an ambulatory surgical site.

Age of participants. This study was unique as the perioperative experiences of adolescents, ages 18 to 21 years, were explored. According to the American Academy of Pediatrics (AAP, 2010), adolescence is defined as the years from puberty to adulthood (American Academy of Pediatrics, [AAP], 2010), and is divided into three stages: early (12-13 years), middle (14-17 years), and late adolescence (18-21 years). However, Arnett (2010) has proposed that, due to a longer transition to adulthood, a new life stage called emerging adulthood should be applied to young people 18-25 years of age. The number of adolescents in the United States began to increase in the 1990s and is expected to continue to increase through the year 2050 (National Adolescent Health Information Center, 2002). In 2006, over 63 million residents of the United States were adolescents (National Adolescent Health Information Center, 2002).

With the increase in adolescent population, the need to perform healthcare research specific to this age group has been identified. Numerous national commissions and panels, which include the National Research Council, the National Association of State Boards of Education, and the American Medical Association, have emphasized a concern regarding adolescent health and the need for research to guide interventions for this age. In 1998, the National Institutes of Health called for an increase in research with children and adolescents (Mack, Giarelli, & Bernhardt, 2009). In the past, it was controversial to include adolescents and children in research,

as they are a vulnerable population (Broome & Richards, 2003). Thus, interventions for adolescents had been developed based on the results of adult research. In time, adolescents began to be included in healthcare research, which has produced important benefits for adolescents by providing significant insights about how adolescents differ from adults and children. For example, there has been a distinction found in therapeutic responses and drug elimination between adolescents, adults, and children (Lepouse, et al., 2006) which has significant implications for perioperative care. Even with this increase in adolescent health research, many of the studies performed on adolescents have neglected to examine the young person's perspective on healthcare concerns which may affect care provided to the adolescent. In other words, the research was *on* adolescents, not *with* adolescents. And, although the number of studies with adolescents has increased, limited research has focused on the perioperative experience.

Developmental aspects of adolescence. Adolescents were the focus of the research; therefore, a brief overview of developmental changes specific for this age group will be presented. Adolescence is unique as it is a time of change and challenges. Adolescents experience rapid growth and development that enhances physical, cognitive, and emotional maturation, and increases social and academic stresses (Busen, 2001). Adolescents' struggle with who they are, exploring their identity, and attempting to separate from their parents (Hockenberry & Wilson, 2009). Adolescence is characterized by the development of more complex thinking processes, which include formal operational thought, abstract thinking, and the ability to reason (Rothrock, 2010). Adolescents begin to think abstractly, reason logically,

and draw their own conclusions from information provided. Subsequently, knowledge obtained is used in specific situations encountered.

Problem-solving skills are developed by the use of trial and error strategies (Crandell, Crandell, & VanderZander, 2009). During this time, inductive and deductive reasoning emerge as adolescents develop hypotheses and deduce or conclude which is the best way to solve problems and make rational judgments. The ability to understand consequences of events and behaviors also develops. During adolescence, an understanding of logical proofs and values develop (Crandell, Crandell, & VanderZander, 2009). Adolescents also change in the way they view social matters. Adolescents have a heightened self-consciousness, which is reflected in personal uniqueness. In addition, invasion of privacy and loss of confidentiality, whether real or perceived, are of great concern to this age group, and interactions with adolescents require healthcare providers to take these concerns seriously (Rothrock, 2010).

Development is explained by the outcome of crises that occur during the life of a person. It must be remembered that there is overlap with each stage. According to Steinberg (1989) “each crisis is a challenge that the individual must resolve; these crises are normative as they are an inevitable part of being alive and growing older (p. 249).” Crisis refers to internal emotional conflict or struggle. Theorists define certain crises in which a person actively focuses on and questions aspects of their identity. One such theorist is Erik Erikson. According to Erikson’s theory (1982), individuals progress through eight stages of development. Erikson’s model focuses on the sequential meaning of eight character-forming issues or crisis stages and each stage

builds on skills learned in previous stages. Erikson was interested in personal development and fulfillment. According to Erikson (1982), individuals experience eight psychosocial crisis stages which significantly affect each person's development and personality. Erikson was the first theorist to develop the idea of identity and presented this stage as the fifth stage, identity versus role confusion, and includes the ages of 12-18. In this stage, the adolescent establishes a clear sense of who they are and how they fit into the world by reflecting on traits and abilities the adolescent possesses. The sense of identity is most prominent and crucial during adolescence, although development in childhood provides the basis for development in adolescence (Erikson, 1982). If the adolescent is unable to form a stable and secure identity, identity confusion occurs.

According to Erikson (1982), the key to resolving the crisis of identity versus role confusion lies in the adolescent's interaction with others. In it especially important for those healthcare providers who care for adolescents to understand this stage so that care can be focused on specific needs associated with this stage. Within the stories shared by the participants, all appeared to have an appropriate understanding of the role of patient which suggests an understanding of who they are. Throughout the stories told, a sense of respect toward staff as well as their mothers was gleaned. This was apparent as all participants were compliant with postoperative instructions and acknowledged the role their mothers took in providing care to the participant.

The sixth stage of Erikson's theory is intimacy versus isolation and encompasses the ages of 18 to 40 (Arnett, 2010; Crandell, Crandell, & VanderZander,

2009). Intimacy is the process of achieving relationships with family and significant others. This stage includes the capacity to give and receive love, connecting with others, and forming honest relationships and friendships. A sexual component of this stage includes sexual mutuality: giving and receiving of emotional and physical connection that includes a reciprocal aspect of support, love, trust, and comfort. It is during the intimacy versus isolation stage that an increased interest in romantic, sexual relationships, and genital sex behavior occurs (Santrock, 2001). The adolescent can develop strong emotional attachments to romantic partners and may express these feelings within sexual relationships. Most adolescents participate in sexual intercourse before the age of 20 (Advocates for Youth, 2010, www.advocatesforyouth.org). Erikson believed that a sense of personal identity, which should have occurred in the identity versus role confusion stage, is needed to develop intimate relationships. The second aspect of the sixth stage is isolation and occurs if an individual is unable to master the crises of this stage. If isolation occurs the individual tends to have less committed relationships and is more likely to suffer from loneliness, emotional isolation, and may experience feelings of alienation and estrangement.

A brief overview of Erikson's theory has been presented as it relates to the participants in the current study. Erikson's theory provided a guide to understand the developmental concerns of this age group and placed an emphasis on social and cultural influences. Erikson was influenced by Freud as Erikson studied under Anna Freud in Vienna following an appointment to teach at an experimental school for American children. Much like Freud, Erikson believed that childhood is important in

personality development (Erikson, 1982). However Erikson, unlike Freud, considered development to continue throughout the lifespan. Erikson's theory examines psychosocial development through eight stages while Freud focuses his theory on biological sexuality in five stages, which ends with the genital stage beginning at puberty and continuing through adulthood (Erikson, 1982). Erikson's stage of intimacy versus isolation (ages 19 to 40) is similar to Freud's genital stage, however, Erikson's theory addresses adulthood: generativity versus stagnation (40 to 65 years) and old age: integrity versus despair (65 years to death). Erikson's ethnographic approach was carried out among human societies which was different from Freud's work, which was founded from the newly emerging psychoanalytical perspective. This difference in approach is apparent as Erikson has incorporated cultural and social aspects into his theory versus Freud's biological and sexually oriented theory.

The researcher agrees with Erikson that development continues throughout life and found Erikson's theory helpful in understanding adolescent development. The researcher easily understood the stages within Erikson's theory, as it provided a logical and comprehensive overview of adolescent development. Although the researcher was comfortable in using Erikson's theory, the theory has received some criticisms and these will be presented next.

Critiques of Erikson. One criticism of Erikson's theory is that the theory focuses on male development more so than female development (Adams & Fitch, 1982; Archer, 1982; Gilligan, Ward, Taylor, & Bardige, 1988; Grotevant & Thorbecke, 1982; Lyons, 1982; Marcia, 1980). Erikson (1982) believed that there are sex differences with development based on biological differences. For example,

Erikson's belief was that females place intimacy as a higher priority than developing identity formation, while male's identity development tends to come before intimacy. From here, it has been suggested that developmental processes of forming an identity and establishing intimacy takes place simultaneously for females while males achieve identity before intimacy (Jordan, et al., 1991; Lytle, Bakken, & Romig, 1997). Another criticism of Erikson's theory is that the model is outdated and narrow (Cote, 2000; Schachter, 2005; van Hoof & Raaijmakers, 2003). However, it has been suggested that Erikson's theory reflected the social conditions of the time (Archer, 2002; Kroger, 2007). Interestingly, Erikson suggested back in the 1960's that it was taking young people in industrialized societies longer to achieve identity formation and referred to this as prolonged adolescence (1982). Erikson speculated that many adolescents in industrialized societies began to pursue secondary education around this time, which resulted in adolescents marrying later and becoming parents at a later age than previous generations.

Despite these criticisms, the researcher found Erikson's theory to be comprehensive as it assisted in an overall understanding of the stages of development for adolescents and allowed for an understanding of the specific tasks that participants were addressing. Although Erikson did not address or further develop his thoughts on prolonged adolescence, another theorist, Arnett, has developed a theory that provides more information and depth about the issues and concerns facing adolescents of recent years. The researcher found Arnett's theory to be helpful in understanding the developmental tasks of the participants as it provides a deeper explanation of these tasks. This concept is referred to as emerging adulthood and will be discussed next.

Emerging adulthood, as described by developmental psychologist Arnett (2010), encompasses individuals from 18 years to approximately 25 years of age. This theory was inspired by social change, which includes the increase of secondary school attendance in the United States and other western countries (Arnett, 2010). This theory does not apply to all cultures, only in cultures that allow young people to postpone entering adult roles, such as leaving the parental home, parenthood, or marriage, until late twenties; therefore emerging adulthood exists mainly in industrialized societies. The researcher found this theory especially helpful for this project as all participants had attended secondary schools or would be attending in the near future. Arnett's theory acknowledges the transition to adulthood is postponed for many adolescents until the mid-twenties.

The main features of emerging adulthood include identity exploration, instability, self-focus, feeling in-between, and age of possibilities. Identity exploration is considered the most central feature of emerging adulthood (Arnett, 2010), and is aligned with Erikson's theory and fifth and sixth stages of psychosocial development. Emerging adulthood is a time when the individual concentrates on life experiences and tries a variety of possibilities in work and love. This is when identity formation intensifies. The adolescent spends time exploring during this stage and may find decisions made previously are often changed; this leads to instability. Emerging adults develop many skills. These skills are for daily living and allow them to gain a better understanding of who they are and what they want from life. By being self-focused, the individual can begin to build a foundation for adult life. The emerging adult often has a feeling of in-between: not quite an independent adult and still

dependent on parents. This is due in part to being in transition, where people feel that they are neither an adolescent nor an adult. The last feature of this stage, age of possibilities, is where young people believe that no matter what life is like now, that they will achieve the adulthood that they envision. Arnett (2010) believes that these life stages are a continuation of what begins in earlier stages of adolescence but peak during this period of emerging adulthood.

Within Erikson and Arnett's theories, several similarities are noted. Both theories express the importance of identity exploration. Arnett describes emerging adulthood as an age of identity exploration, instability, self-focusing, feeling of in-between, and the age of possibilities. These concepts align with Erikson fifth stage of identity versus role confusion. Erikson places the 18 to 40 year old into the stage of intimacy versus isolation where individuals gain the capacity to give and receive love, connect with others, and form honest relationships and friendships. Even though the participants in this study are within the age group of Erikson's sixth stage, Arnett's description aligns better with the developmental concerns of the participant's specific to this study; the experience of identity exploration and feelings of in-between were gleaned from the stories the participants shared in the current study.

It was important to have an understanding of the developmental concerns of this age group so that expectations of the adolescent going through a perioperative experience will be recognized. For example, knowing that adolescents are developing a sense of identity is important so that appropriate behaviors, such as addressing questions to the adolescent instead of a parental figure during interviews, are practiced. Also, understanding adolescent development will allow perioperative

nurses to provide care that is appropriate, such as providing privacy, allowing the opportunity for the adolescent to ask questions, and offering reassurance to the adolescent. The researcher found that Erikson's theory provided a comprehensive overview of this age group in a logical manner, while Arnett's emerging adulthood provided more detail of the developmental milestones for this age group.

Late adolescence (18 – 21 years) can be a time of turmoil because of physical, emotional, social, and cognitive changes the young person is experiencing. Given the developmental tasks of this age group, surgical experiences can pose significant concerns and challenges that are unique to this age group. For the purpose of this project, adolescent will refer to individuals between the ages of 18 and 21.

Four specific contexts within the phenomenon of concern were defined for this research. These included phases of the perioperative experience, ambulatory surgery settings, types of surgical procedures, and the adolescent population. The perioperative context included the pre-, intra-, and postoperative phases. The setting for the research was an ambulatory site where elective surgery was performed. This research examined adolescents between the ages of 18 and 21 years. It was important to have an understanding of the specific contexts within which this phenomenological study was conducted so that the focus and aim remained clear (Munhall, 2012; van Manen, 1990).

Assumptions Underlying the Study

In addition to the four contexts within which the phenomenon was explored, it was important to describe assumptions underlying the development of this study. van Manen (1990) states all phenomenological investigation begins with the real life

experiences of the investigator. Therefore, a brief description of the researcher's perioperative practice and philosophy of nursing will be presented as these have led to the researcher's beliefs and assumptions regarding perioperative experiences. It was from clinical experience that the perioperative experience of adolescents was identified as being a concern. It was important to make assumptions explicit so that biases in material collection and analysis could be kept in abeyance.

Perioperative experience. The researcher has practiced perioperative nursing for 30 years and has functioned in many roles. These roles have included scrub nurse, circulating nurse, educator, and manager in inpatient institutions and ambulatory facilities of which care was provided to all age groups. Although the researcher specialized in caring for patients undergoing neurosurgery and cosmetic surgery, care was provided in all procedures with the exception of open-heart surgeries. When providing care to adolescents, the researcher found behaviors that were somewhat different than adults and children. Adolescent patients would seldom ask questions, rarely maintained eye contact, and often emerged from anesthesia in a combative way: thrashing, kicking and uncooperative.

Assumptions of the researcher based on previous experience.

1. Behaviors noted in adults and children are different than adolescents. For example, adults and children verbalize fears, ask questions throughout the perioperative experience. Adolescents rarely verbalize fear or ask questions throughout the perioperative experience.
2. Common behaviors of adolescents emerging from general anesthesia include combativeness, thrashing, and crying. These behaviors are

uncommon in adults and young children demonstrating another way in which the perioperative experience is different for adolescents.

3. Adolescent behaviors suggest that there may be developmental issues that affect how adolescents perceive a surgical experience, for example not asking questions and lacking eye contact may be related to autonomy and need for privacy.

Philosophy of nursing. Nursing philosophy should address, at a minimum, the nature of human beings and the focus of nursing (Salsberry, 1994). From here, beliefs and ideals become the foundation for nursing practice. The researcher's philosophy of nursing provided a frame of reference that guided thinking, observations, interpretations, and practice.

The researcher views patients as holistic and in constant interaction with their environment. When providing nursing care to patients, there is concern with reducing potential, perceived, or actual stressors that may arise from the person's environment. By addressing stressors throughout the patient's perioperative experience, an attempt is made to facilitate a successful outcome. A successful outcome includes an uneventful surgical experience that allows the patient to return to a level of well-being equal to or greater than that which they had prior to the operative procedure.

Within the researcher's philosophy, the patient and nurse are viewed as forming an interacting open system. This system is complex and organized with continuous interaction between the patient and nurse. It is through a process of input, output, and feedback that the relationship between patient and nurse is maintained allowing the nurse to assist the patient to the highest level of health. In addition, there

is a relationship between the person and environment that affects health. The researchers' philosophy of nursing is further described below. It addresses the metaparadigm concepts of human beings, health, environment, and nursing (Fawcett, 2005) and reflects the values, logic, morals, and ethics held by the researcher.

Beliefs about humans and adolescent development. Adolescence can be a fascinating time; however, it can also be a time of turmoil. The adolescent struggles to belong and yearns to be accepted. The adolescent attempts to make independent decisions and begins to accept responsibility. Some adolescents are struggling as they attempt to become an autonomous individual, although many are still dependent on others financially, socially, and emotionally. Many adolescents become fearful about situations that they are unsure how to handle and may feel uncomfortable or awkward to ask for assistance, or do not know how to ask for help. Peers are extremely important to adolescents and with the need of adolescents to “fit in”; many behave differently when with friends and family versus when they are alone. Although behaviors within this age group are somewhat alike, the researcher understands and accepts the uniqueness within each adolescent.

In the perioperative setting, the researcher views each patient as a unique individual. This perception is based on the specific characteristics and needs that make the patient distinct from other patients. One of these characteristics is the developmental stage the individual is experiencing and the needs associated with the stage. For example, an infant is at risk for hypothermia. Because of this risk, care must be directed to protect the infant by assuring the patient is kept warm. For adolescents, care is provided that recognizes the uniqueness and considers

developmental aspect of this age group. When providing care to an adolescent, additional privacy is provided, especially when asking questions that may cause unease. For example, questions regarding medication, previous surgical history, sexual activity, drug use, and if the patient has body piercings are done in private so responses are not overheard by parents or parental figures. In addition, when interviewing adolescents, eye contact is maintained.

Beliefs about the environment. The environment encircles the person and includes external, internal, or created forces and is in constant interaction with the client. The external environment is outside a person, correlates with interpersonal and extrapersonal stressors, and includes physical surroundings and social interactions. The internal environment is contained within the person and is associated with intrapersonal stressors. The created forces or created environment is expressed as the subconscious or conscious reality perceived by the person. These created forces are correlated with intra-, inter-, and extrapersonal stressors (Neuman & Fawcett, 2011). The created environment has a protective effect that allows the person to respond to environmental stressors or perceived stressors. The researcher believes that understanding how the person creates their environment is important as this knowledge can guide nursing care that will promote, preserve, and enhance wellness.

Beliefs about the environment and adolescent development. The adolescent years are trying times. The adolescent is taking on new roles as new responsibilities are created and many are put in a situation or environment that may lead to an uncomfortable or uneasy feeling. For example, many adolescents begin secondary education, which takes them from home, while many adolescent begin to work.

Confusion may occur as the adolescent is not certain of the expectations of these new roles; this may lead to role confusion and feelings of uncertainty. Within their external environment, adolescents need to feel comfortable and seek out environments that offer comfort and familiarity. Socially, peer relationships are important and the adolescent begins to broaden these relationships. During adolescence, the adolescent prefers to be with friends and begins to spend time away from home.

The researcher believes that the environment plays an important and significant role to the well-being of an individual. If the adolescent perceives a situation as being stressful, and is experiencing uncertainty, confusion, or turmoil, this will affect how they feel about themselves and those individuals near them. This stress will affect their well-being, which often will result in behavioral changes. For example, the adolescent may become withdrawn, aggressive, or introverted during a time of stress. When an adolescent is placed in an unfamiliar environment, such as a perioperative setting, negative behavioral changes may occur. The researcher is aware that some of these negative behaviors may not be typical for that adolescent, however, may be in response to a perceived stressor in the environment.

It is important for the adolescent patient to feel comfortable within the environment. Providing reassurance to the adolescent as well as answering all questions may provide comfort to the adolescent. Adolescents should be treated with respect and acknowledged throughout the perioperative experience so that they may find comfort in the unfamiliar surroundings.

In the perioperative experience, the researcher's definition of environment consists of the preoperative, intraoperative, and postoperative settings in which the experiences occurred. The external environment consists of all equipment and instrumentation that is used throughout the perioperative phase. The internal environment represents the disease process that brought the patient to the perioperative setting and all factors associated with the procedure. The created environment includes the patient's perception of the procedure and outcomes.

Beliefs about health. The researcher defines health as a state of well-being that is on a continuum, with wellness and illness at opposite ends. In order for the patient to experience health, it is necessary for the psychological, physiological, social, spiritual, and developmental components to be in harmony. Health is associated with optimal system stability, achievement of a positive outcome, and wellness. There is continuous energy that flows between the environment and the patient that affects health. When there is more energy generated than what is used, the patient moves toward health and wellness; when more energy is required than what is generated, movement is toward illness.

Beliefs about health and adolescents. It is the researchers belief that many adolescents feel that health is a "given" and are not aware that certain behaviors may have a negative impact on health long-term. For the most part, adolescence is a healthy time and few adolescents present with life-altering disease processes. Many adolescents may not have the cognitive ability to look into the future and see how bad behaviors during this time can affect their future health. For example, smoking, excessive drinking, using illicit drugs, driving while impaired, and practicing unsafe

sexual practices may, at present, appear not to have long term consequences for the adolescent, and the adolescent may have the attitude of “it can’t happen to me”. The researcher is aware that many adolescents participate in activities and may demonstrate behaviors that are not healthy and illegal. It is imperative that the adolescent understands that this behavior and activity is not judged. In addition, the researcher is aware that many adolescents would allow the opportunity to receive education on these topics, but may not know how to ask for help.

It is important for the perioperative nurse to provide the adolescent with the knowledge that will promote a positive surgical outcome, thus leading the adolescent back to health. Education about the surgery and postoperative events may help and encourage the adolescent to return to a state of well-being. The perioperative nurse must assess the adolescent patient so that the needs of the patient are identified so that appropriate nursing care can be provided.

In the perioperative setting, health is defined as a positive outcome for the patient, which is different from a successful surgical procedure. A positive experience includes the patient achieving a level of wellness equal to or greater than that which they had before the procedure. The researcher’s definition is holistic as it includes a positive psychological, developmental, cultural, and spiritual outcome, with minimal stress on physiological functioning.

Beliefs about nursing. Nursing is defined as activities and behaviors that are used to address the issues and concerns of patients. These activities and behaviors provide complex care for patients in a high-dependency situation and include providing education, attending to physical needs, and being a patient advocate. The

overall goal of nursing care is to promote the well-being of patients. This goal is accomplished by identifying unique characteristics of the patient, providing a safe environment, protecting the patient from adverse reactions, and safeguarding the patient's integrity by acting as an advocate throughout the perioperative experience.

Beliefs about nursing and adolescents. It is the researcher's belief that adolescents view nursing as a caring profession. As one participant stated "nurses take care of sick people". Most adolescents understand the role of nurse, however, in the perioperative setting the role of the perioperative nurse is confusing. The researcher often has received a less than welcoming greeting by an adolescent prior to a surgical procedure. Once the researcher explains the role of the perioperative nurse most adolescents respond politely, however, few ask questions. The researcher is aware of the uncertainty the perioperative setting presents, thus an effort is made to make all patients comfortable, this is especially true for adolescents who have unique concerns related to developmental tasks, for example privacy concerns and dependency issues. When caring for adolescents, an ample amount of time is spent with the adolescents in an effort to help them feel comfortable and to ask any questions they may have. If appropriate, adolescents are encouraged to make choices, for example walking to the operating room or riding on a stretcher. Also, the adolescent patient receives an introduction to all members of the perioperative team as well as information as to the role that person is to take in the care provided. In addition, patient safety is a concern and is addressed throughout the perioperative experience.

By providing patients with appropriate care, the nurse views them as a whole person, not as a diagnosis such as septic gallbladder or a fractured hip. When providing nursing care in the perioperative setting, preparation for the procedure is performed by identifying specific needs for the patient. By looking at the patient's age, one can reasonably determine the size of instrumentation needed for the procedure. By reviewing a patient's history, one can determine if there are physiological needs that must be addressed, for example, any known allergies. During the interview process, an assessment of the patient's demeanor can identify behaviors that may indicate anxiety. In addition, spiritual and cultural needs can be determined through interviewing, observation, and reviewing the patient's history.

Nursing care that is focused on the external environment consists of actions that protect a patient from physical harm, for example, ensuring all equipment is working properly and maintaining a sterile field. Another example of nursing care for the external environment includes providing the appropriate positioning devices for surgical procedures.

Interventions that are geared toward the internal environment include providing a proper diet and appropriate medication. In the perioperative setting, providing a warming blanket to patients to address the issue of hypothermia or applying sequential compression device for circulation are examples of providing interventions for the internal environment.

The created environment is where a response to a threatening or stressful situation is perceived; therefore, nursing care that addresses behaviors and that is emotionally supportive is provided. When providing care targeted for the created

environment, patients are assessed by looking for behaviors that may suggest anxiety or stress. If the nurse perceives the patient is experiencing anxiety or is stressed, then nursing care is guided to address these behaviors. Behaviors that occur in the perioperative setting may be dependent on the patient's previous experiences, developmental stage, and coping strategies.

Nursing in the perioperative setting includes actions performed that promote well-being for the patients. The researcher's goal of nursing care in the perioperative setting is to ensure positive perioperative outcomes, with interventions that are focused on providing perioperative care that attempts to eliminate or lessen the stress or reduce stressor reaction.

The philosophical beliefs the researcher holds are aligned with the Neuman Systems Model (NSM), (Neuman & Fawcett, 2011). The focus of the NSM is the wellness of the patient, or client, in relation to environmental stress and reactions to stress. Due to the wellness perspective of the model, NSM used the term client instead of patient. The client is viewed as an open system in constant interaction with the environment. The environment consists of internal, external, and created environments. Included within the client's environment are intrapersonal, interpersonal, and extrapersonal stressors, which can have a positive outcome with the potential for a beneficial system change for the client (Neuman & Fawcett, 2011). Nursing is defined as "actions which assist individuals to maintain a maximum level of wellness through actions that are initiated to retain, attain, and maintain optimal client health or wellness" (Neuman & Fawcett, 2011, p. 25). The primary aim for nursing is the stability of the client system through nursing interventions, which

consists of primary, secondary, and tertiary interventions, to reduce stressors. Health is a condition in which all parts are in harmony within the client. The NSM examines stress and the client's reaction to stress.

The researcher's view of the world aligns with philosophical assumptions of moderate realism. Moderate realism reflects on common sense knowledge and reasoning (Kikucki & Simmons, 1999) as it recognizes sense knowledge and intellectual conceptual knowledge. This philosophy focuses on probable truth rather than absolute truth. It is based on a belief that an objective reality exists independent of the mind. However, context becomes critical as humans are situated in a set of circumstances that influences their perceptions of this reality. It is through examination of multiple contextually based conceptions that probable truths can be known. The researcher's worldviews are aligned with moderate realism; therefore, phenomenology provided an excellent approach to explore an individual's perception of reality.

Based on this philosophy, the patient's perception of his or her perioperative experience needed to be understood so that meaning could be placed on what patients find to be stress-inducing in the perioperative setting. By using a phenomenological method of inquiry, an increased understanding of what it meant to be an adolescent patient in a perioperative setting was acquired, thus increasing nursing knowledge for this age group.

Method Used

To explore the perceptions and meanings adolescents ascribe to the perioperative experience, a qualitative design was suggested. A qualitative approach

looks for deeper truth, derives insider meaning, and may be exploratory (Creswell, 2003). Research methods using qualitative data are interactive and humanistic, allow for gaining insight through discovering meaning given to phenomena, and identify the essence of human experiences (Creswell, 2003). Qualitative research encompasses a wide range of research that produces findings not arrived at by means of statistical procedures or other means of quantification (Strauss & Corbin, 1990). As this researcher was interested in knowing the meaning of the perioperative experience of adolescents, a phenomenological approach was needed. The foundational characteristics of phenomenology are the nature of the phenomena, reality, subjectivity, and truth (Sokolowski, 2000). By investigating and describing the perioperative experience of adolescents, one can interpret the essence of their experiences.

Aim of the Study

The aim of this study was to understand the meaning of the perioperative experience of persons in late adolescence. By understanding the meanings of perioperative experience of this age group, it was hoped that this information would increase sensitivity of the perioperative nurse to the surgical experience of this age group.

Research Question

To achieve the overall study aim, one key research question was addressed: “What is the meaning of the perioperative experience to adolescents?”

Significance to Practice

Standards of perioperative nursing require the use of the best available research evidence to guide practice (AORN, 2010). Unfortunately, there is a gap in the literature related to the needs of adolescents undergoing a surgical experience. This study begins to fill that gap by generating beginning knowledge of adolescents' perspectives of their needs while undergoing a surgical procedure. Findings from this study provided important new information and insights regarding the type of information adolescents wanted throughout the perioperative experience. This information suggests possible areas of interventions with adolescents and may guide future perioperative research that is specific for adolescents. Results from studies involving children and adults found the surgical environment provokes feelings of stress, anxiety, loss of control, and fearfulness, especially fear of the unknown (Bodner, 2005; Fortier, et al., 2009; Maliglig, 1994; Stewart, Algren, & Arnold, 1994; Visintainer & Wolfer, 1975). The results of the current study aligned with previous studies involving children and adults. However, the results of the current study indicated feelings of apprehension and concerns of the adolescents changed from the preoperative experience to the postoperative experience. This study provided preliminary results and provided insight into how the adolescent perceives the preoperative and postoperative experience differently.

Summary

Previous research has examined perioperative experience of adults and children; however, there is limited research that examines adolescent experiences. It is known that a surgical experience can be stressful for adults and children, but there

is little in the literature about the stress experienced by adolescents. Clinical experience has shown that adolescent behavior is different than adults and children in the perioperative setting (e.g., adolescents rarely ask questions, neglect to maintain eye contact, are restless, and often display combative behavior emerging from anesthesia). What is not known is why adolescents' behavior is different than adults and children. Therefore, to promote adolescent health it is important to understand how adolescents perceive their perioperative experience so that nurses can provide age-specific nursing care that promotes a positive outcome for the adolescent.

CHAPTER 2

EVOLUTION OF STUDY

The prospect of surgery can be stressful, and it is known to provoke feelings of fearfulness. (Maligalig, 1994; Stewart, Algren, & Arnold, 1994; Visintainer & Wolfer, 1975). These fears include fear of the unknown, loss of control, and ineffective pain control (Bailey, 2010). As a result, these fears result in stress and anxiety for the patient (Bodner, 2005; Fortier, et al., 2009; Maligalig, 1994; Stewart, Algren, & Arnold, 1994; Visintainer & Wolfer, 1975).

Stress is defined as “a relationship between the person and environment that is appraised by the person as taxing or exceeding his or her resources and endangering well-being” (Lazarus & Folkman, 1984, p. 21). When an individual is in a situation that is perceived as stressful, the cause of the stress is known as a stressor. A stressor can be a physical or psychological force that puts demands on the body, emotions, spirit, or mind of the individual. Stressors can be real or perceived and are always stimuli that produce tension, and may have either a positive or negative outcome effect (Neuman & Fawcett, 2011). Stress manifests itself in the way a person relates to a certain situation, not necessarily because of the situation itself (Lazarus & Folkman, 1984). Environmental events or stimuli may have a negative or positive effect on the person. What determines if a stress reaction will occur is the way in which the stimulus is perceived. If the stimulus is interpreted in a negative way, as a stressor, then physiological and psychological reactions can occur, and anxiety is increased.

Due to limited life experiences, adolescents may not have adequate coping strategies to negotiate the effects of stressors. Common reactions to stressors include psychological detachment, anger, and restlessness (LaMontagne, Hepworth, Cohen, & Salisbury, 2004). In addition, surgical patients may react to stress with an increased heart rate, increased respiratory rate, sweating, vasoconstriction, and a compromised immune system. Depending on the severity of the reaction, multiple responses to the perceived stressors may occur. If surgical patients experience these reactions during the perioperative phase, the responses may result in a poor perioperative experience.

Due to patients' stress responses, their anxiety and behaviors may hinder the surgery, thus prolonging surgical time (Lago-Mendez, et al., 2006). Surgical time may be increased by the need for a longer induction or prolonged anesthetic affect. In addition, anxiety can be harmful to the recovery of the surgical patient, resulting in prolonged hospitalization and an increase in postoperative complications (Brumfield, Kee, & Johnson, 1996).

The prospect of surgery can be stressful. The response to this stress can result in a less than optimal perioperative experience for patients. What is not known is what adolescents perceive as stressful in the perioperative experience due to the lack of research in this area. Understanding how adolescent patients perceive perioperative experiences may guide nursing practice in ways that promote positive perioperative experiences for adolescents.

Rationale for the Study

This phenomenological study explored ambulatory perioperative experiences of adolescents. Findings from this study generated beginning information that offers

suggestions and provides insight for clinical practice to promote a positive surgical outcome for adolescents. The rationale for this study arose from both an experiential and historical context, which are described hereafter.

Experiential Context

van Manen (1990) states that all phenomenological inquiry begins with the real life experiences of the investigator. The researcher's interest in the phenomenon stemmed from experience as a perioperative nurse. Throughout 30 years in perioperative nursing practice, the role of the researcher's primary commitment was to the patient. In the role of patient advocate, the nurse ensures a safe environment by preventing injury, and speaking for the patients while they are in a compromised state. Because most adult and children ask numerous questions and verbalize feelings of fear and anxiety, it is known that the perioperative experience can be stressful and anxiety provoking. In an attempt to reduce a stressor reaction in patients, support is offered and questions are answered. Interestingly, the researcher found that adolescents rarely asked questions and because of this, it was difficult to know what they found to be stressful within the perioperative experience. However, the behavior exhibited by adolescents is different from adults and children. When asked questions preoperatively, adolescents often provide short answers and rarely maintain eye contact. In addition, preoperative behaviors exhibited by adolescents include irritability, jittery movements, and restlessness. Upon emerging from anesthesia adolescents often display combative behavior by thrashing, crying, and are uncooperative. This phenomenon has been called emergence delirium.

Based on the researchers' experience and observation of adolescents in the perioperative setting, a literature review was conducted in an attempt to understand why this age groups behavior was different than adults and children. In reviewing the literature, the researcher found little research that explored the perioperative experiences of the adolescent. Therefore, it was important to discover the meaning of a perioperative experience from the adolescents' perspective. Results from this study can be used to help guide future clinical interventions and research for adolescents in the perioperative setting as well as begin to fill a gap in the literature.

Historical Context

Although numerous studies examine stress and anxiety in adult and child perioperative experiences, only limited studies examine adolescent experiences in the perioperative setting. Therefore, a review of adult and children's experiences is included in the discussion of the historical evolution of this study.

To determine what was known about perioperative experiences, the terms ambulatory surgery, perioperative, adolescents, adults, and children were inputted into two main search engines: PubMed and Cumulative Index to Nursing and Allied Health Literature (CINAHL). The search resulted in numerous articles on adults' and children's perioperative experiences, but only limited articles on adolescents' perioperative experiences. This review is divided into three sections: adults' perioperative experiences, children's perioperative experience, and adolescents' perioperative experiences.

Adults' perioperative experiences. Previous research examining perioperative experiences of adults found the experience provoked feelings of

anxiety, loss of control, and fear of the unknown (Kain, Mayes, Caldwell-Andrews, Karas, & McClain, 2006; Li, 2007; Maligalig, 1994). Jjala and colleagues (2010) reported that up to 80% of adults scheduled for surgery experienced a high level of anxiety. The specific source of the anxiety varied with each patient and depended on an individual's life experiences. Examples of life experiences that may influence a surgical experience include previous surgeries and illnesses, or witnessing those experiences in loved ones and family members. But, consistently, well-informed patients were less anxious than patients who did not receive preoperative information (Chahal et al., 2008).

Of seven studies addressing adults undergoing surgery, six focused on preoperative educational programs and their relationship to anxiety. Preoperative information provided to patients in preparation for surgery consisted of explanations about the routine during the perioperative experience (Gilmartin & Wright, 2008), wound care, postoperative pain management (Dewar, et al., 2003; Lithner & Zilling, 2000; Ng, Chau, & Leung, 2004; Semple & McGowan, 2002), and postoperative care (Sjoling, Nordalh, Olofsson, & Asplund, 2003).

The Ng, Chau, and Leung (2004) study included 192 participants who were scheduled for an outpatient procedure. This study evaluated the effectiveness of preoperative information that was focused on anxiety reduction by providing basic information with details of the operative procedure, basic information with details of expected recovery, and basic information with details of the operative procedure and recovery. The results indicated preoperative information led to a significant reduction in self-reported anxiety.

Informational needs of surgical patients were examined in a quantitative study (Lithner & Zilling, 2000). Prior to an inpatient surgical procedure, 50 patients completed a questionnaire that asked the type of preoperative information that was important to them. The results indicated information related to anxiety-creating factors, such as pain management, was requested most.

Consistent in these studies was that the information, both verbal and written, was provided to the patients on average one week before the surgery. The results of these studies indicated educational information was beneficial. These benefits included lessened anxiety and positive surgical outcomes. Positive surgical outcomes included a decrease in postoperative infections, early ambulation, effective pain management, and improved patient satisfaction (Dewar, et al., 2003; Gilmartin & Wright, 2008; Lithner & Zilling, 2000; Ng, Chau, & Leung, 2004; Semple & McGowan, 2002; Sjoling, Nordahl, Olofsson, & Asplund, 2003). Although the results suggested preoperative education was successful in decreasing anxiety and promoting positive surgical outcomes in adult patients, the preoperative information provided was based on what the healthcare provider thought the patients should know, not what the patients wanted to know. Therefore, it is not known if anxiety could be further reduced if it is known what information surgical patients would like to receive.

The remaining study used a hermeneutic phenomenological approach to explore the perioperative experience of patients in an ambulatory setting (Costa, 2001). This study interviewed 16 patients one week after undergoing abdominal surgery in an ambulatory setting and explored adult perceptions of their perioperative experience. Three themes emerged from the experiences of adults: fear, knowing, and

presence. Fears about anesthesia, death, and loss of control were the most common concerns. In addition, patients requested receiving more information about the procedure to satisfy the concept of knowing. An interesting finding of this study was the concept of presence. Patients identified the value of the presence of family members and the nurse. The researcher interviewed the participants once and did not have follow-up phone contact. The length of the interview is unknown. Procedures to address trustworthiness were not presented; therefore, it is not known if the results accurately demonstrated the participants' experiences. Another concern with this study is the project was performed in 2000. In recent years, technologies in ambulatory surgery centers have continued to improve, which may address some of the concerns and findings from this study. Families are often allowed to stay longer with patients, and in some settings, patients are allowed to wear their clothing into the operating room. These practices may address the fear of loss of control these participants perceived. Although this study provided excellent information, it is not known if the results are consistent with adolescents' perioperative experiences.

Children's perioperative experiences. Most research conducted on young children did not address personal experiences or insider perspectives of perioperative experiences. One study questioned children about their need for preoperative information and the way they would like to receive the information. Using a qualitative design, Smith and Callery (2005) explored the informational needs of nine children, ages 7 to 11 years, who were to be admitted to the hospital for surgery. Children asked for information regarding anesthesia and the surgical procedure, and they requested a description of the operating room (Smith & Callery, 2005).

Hinton, Watson, Chesson, and Hathers (2002) addressed informational needs of children aged 5 to 15 years, who had been diagnosed with a chronic illness. Even though the setting for this project was not perioperative, the results did provide important information as to how children preferred to receive information regarding their illness. Researchers provided information to the participants via brochures, booklets, video, and oral presentations. The results of this study indicated participants preferred information via booklets and brochures. In addition, the participants suggested the material had to be “appealing.” The authors did not explain how this could be accomplished. Although this study did not address perioperative settings, it highlights the importance of including children in producing educational information. However, this study only addressed the delivery of the information, not the information the participants wanted to receive.

Much like adults, research has indicated that children benefit from preoperative educational programs. Two quantitative studies focused on preoperative education programs and their relationship to a positive surgical outcome and anxiety. (Kain, et al., 2006; Li, 2007). Kain, et al. (2006) conducted a controlled cohort study that included 241 children, aged 5 to 12 years, whereas the Li (2007) study included 203 children 7 to 12 years of age. The participants in Kain, et al. (2006) were scheduled for the elective ambulatory procedure of tonsillectomy and adenoidectomy. The participants in Li’s study were scheduled for elective day surgery (type of procedure was unknown). Participants in both studies were randomly assigned to an experimental group receiving educational information specific to their procedure to the control group receiving routine information. The results of these studies indicated

preoperative educational programs were beneficial in reducing anxiety, thus promoting a positive surgical outcome. These benefits included a shortened anesthesia induction time, better pain management, and reduced postoperative complications.

In a study by Margolis, et al. (1998), children who received preoperative information and additional educational material regarding their surgical procedure demonstrated a decrease in aggressive behaviors postoperatively. This randomized clinical trial involved 102 children, ages 2 to 6 years, who were scheduled for an elective ambulatory surgical procedure. The participants were randomized into a control group who received routine preoperative education or an intervention group that received an interactive education book. The purpose of this study was to decrease perioperative stress through an educational intervention. The global mood score (GMS), a tool that assesses mood, measured the participants' anxiety. The measurements were taken throughout the perioperative setting. The results indicated that as all children progressed throughout the perioperative setting, anxiety increased and participants in the control group experienced a higher level of anxiety. Interestingly, children in the control group demonstrated an increase in aggressive behavior during the postoperative period when compared to those in the intervention group.

These studies indicated that children who receive preoperative information experience less anxiety and better surgical outcomes than children who do not receive preoperative information. Although preoperative information provided important benefits to some study participants, none of the studies described the perioperative

experience from the patient's perspective. Instead, studies focused on the benefits of preoperative information, without substantive information about whether the educational content was relevant to the needs of patients or presented from patients' perspectives.

Adolescent's perioperative experiences. Despite limited research examining adolescent perioperative experiences, one study examined postoperative pain and perioperative anxiety in adolescent patients (LaMontagne, Hepworth, & Salisbury, 2001). This descriptive study included 74 participants, ages 11 to 18 years, who were scheduled for inpatient orthopedic procedures. The study examined the relationship between the participant and his or her parent's preoperative and postoperative anxiety with the participant's reported postoperative pain. Results of the study indicated adolescents who verbalized high levels of anxiety preoperatively reported high levels of postoperative pain. Interestingly, participants reported high levels of pain postoperatively when their parents reported high level of preoperative anxiety, regardless of the patient's own level of anxiety.

Similar to studies with adults and young children, adolescents who received preoperative educational information were better prepared for ambulatory surgery and reported less anxiety than did those adolescents who did not receive preoperative information (Chahal, et al., 2008; LaMontagne, Hepworth, & Salisbury, 2001). The results of these studies were consistent with inpatient surgical procedures. Adolescents scheduled for cardiac surgery experienced a quicker recovery, fewer complications, and had better pain control than those adolescents who did not receive perioperative information (Sutherland, 2003).

It has been observed that adolescents emerge from anesthesia differently than adults and children. The adolescent often kicks, thrashes, and is uncooperative. This phenomenon is known as emergence delirium and is described as a “disturbance in awareness of and attention to the environment with disorientation and perceptual alterations including hypersensitivity to stimuli and hyperactive motor behavior in the immediate postoperative period” (Sikich & Lerman 2004, p. 1138). Masin (2004) defines emergence delirium as a “dissociated state of consciousness, in which the patient is inconsolable, irritable, uncompromising or uncooperative, and typically thrashing, crying, moaning, or incoherent” (p. 1). Even though this phenomenon is usually temporary and occurs within 30 minutes of anesthesia emergence (Malarbi, Stargatt, Howeward, & Davidson, 2011), it can be severe and may result in physical harm to the patient, site of the surgery, and staff members taking care of the patient. While it is not certain what provokes emergence delirium, several thoughts have been presented. Bastran and Moyers (1967), attribute the problem to misperception of environmental stimulus or a psychomotor response, while Masin (2004) believes that it may be due to the adolescent not recognizing or being able to identify familiar people while emerging from anesthesia. In addition, many believe it may be related to anesthetic agents that the patients have received (Duffen & Williams, 2011; Mountain, Smithson, Cramolini, Wyatt, & Newman, 2011; Vyckemans, 2001). Upon a literature search, no studies were found that examined this phenomenon qualitatively. By exploring emergence delirium from a qualitative perspective, an understanding of what the perioperative experience means to the adolescent may shed

light on what may contribute to emergence delirium, for example, stressors within the perioperative environment.

In recent years there has been an increase in the number of adolescents undergoing cosmetic (de Andrade, 2010; Maltby & Day, 2011; Markey & Markey, 2009; Zuckerman & Abraham, 2008), and bariatric surgery (Bondada, Jen, & Deugarte, 2011; Jarvholm, et al., 2011; Keider, Hecht, & Weiss, 2011; Ratcliff, Reiter-Purtill, Inge, & Zeller, 2011; Widhalm, et al., 2011) which has led to a plethora of studies in these areas. However, what is lacking in these and other studies is the discovery of the adolescent's perspective and what is important throughout the perioperative experience. Limited studies have been found that examine the perioperative experience through the adolescent voice; therefore, research is needed to discover the meaning of the adolescent perioperative experience.

In reviewing the literature related to the surgical experiences of adults, children, and adolescents it is evident that the focus has been on the nature and outcomes of educational interventions, or on the body image issues that relate to cosmetic and bariatric surgeries. Only one study specifically examined adult surgical experiences from the patient's perspective. Studies examining the needs of adolescents undergoing surgery are especially lacking. To improve the care of adolescents undergoing surgery, it is imperative that nurses and other healthcare professionals have a better understanding of the perioperative experiences from the perspective of adolescents.

Summary

The researcher has extensive experience in the perioperative setting and has noted that adolescents behave differently than adults and children. In an effort to understand why behaviors are different, a literature search was done. From the results of the literature search, it became clear research is needed to understand the perioperative experience of this age group. With the need to understand the perioperative experience of the adolescent identified, an approach to uncover the meaning of the experience will be presented in the next chapter.

CHAPTER 3

METHOD OF INQUIRY: OVERVIEW

A qualitative research approach is indicated in areas of healthcare where little is known about a phenomenon (Marshall & Rossman, 1989). Qualitative approaches look for deeper truth, derive insider meaning, and are exploratory (Creswell, 2003). Research methods using qualitative data tend to be interactive and humanistic to allow for gaining insight through discovering meaning given to phenomenon and to identify the essence of human experiences (Creswell, 2003). Qualitative research encompasses a wide range of research that produces findings not arrived at by means of statistical procedures or other means of quantification (Strauss & Corbin, 1990). With little extant research on the adolescent ambulatory perioperative experience a phenomenological design was used for this project.

Phenomenology focuses on an individual's subjective experience and interpretations of the world. Implicit in phenomenology is the need to discover the significance of a phenomenon experienced and described by the participant (Parson, 2010). Although phenomenology does not solve problems, it does provide an understanding that could significantly contribute to the promotion of well-being. A phenomenological design strives to describe lived experience (Creswell, 2003). Lived experience is the way a person experiences and understands the world as meaningful and real (van Manen, 1990). A phenomenological approach to qualitative research places value on participants' points of view and gains insight into the perceived reality of the individuals who are experiencing, or have experienced, the phenomenon of interest, in this case, adolescents' ambulatory perioperative experiences.

Patients' perceptions of perioperative experiences need to be understood so that meaning can be placed on what patients find as stressful in the perioperative setting. By using a phenomenological method of inquiry, an increased understanding of what it means to be an adolescent patient in a perioperative setting was acquired, thus increasing nursing knowledge regarding this age group. By using a phenomenological method, a description, or text, of an ambulatory perioperative experience was constructed. Max van Manen's phenomenological approach especially guided uncovering the descriptions of the meanings provided by the participants and is discussed in detail later in this chapter. The decision to use this method was based on the assumptions and philosophy of phenomenology.

Assumptions and Philosophy of Phenomenology

Assumptions are basic principles that are accepted as being true based on logic or reason, without proof or verification (Polit & Hungler, 1997). It is important to have an understanding of the philosophical assumptions central to hermeneutic phenomenological research. Phenomenology is the study of phenomena or the appearance of objects or aspects of reality as we experience them (Rodgers, 2005). Key assumptions underlying phenomenology include the concepts of experience, consciousness, intentionality, and first-person perspective.

The philosophy of phenomenology focuses on the lived experiences of people. The emphasis is on the relationship between objects and perceptions. With phenomenology, individuals need to be understood in their entirety within a situational context, not separated from the environment. The world is a function of

personal interaction and perception. Beliefs rather than facts form the basis of perception.

The other central notions in phenomenology link consciousness and intentionality. Consciousness is a mental phenomenon that allows one to perceive that they are having a particular experience, whereas intentionality is the belief that every mental act is directed toward something (Sokolowski, 2000). Intentionality suggests that whenever there is consciousness, consciousness is always conscious of something (Cohen, Kahn, & Steeves, 2000; Creswell, 2007; Munhall, 2012; Sokolowski, 2000). In other words, consciousness is always directed toward something and is a way we perceive things to be; it is the internal experience of being aware of something.

Phenomenological inquiry seeks to determine the essential elements of the structures of consciousness and conscious experiences. Phenomenology does not produce new information but interprets a meaning already implicit to lived experiences as its truth (Burch, 1989). According to van Manen (1990), phenomenology attempts to provide an understanding of the “internal meaning, or essence, of a person’s experience in the lived world by careful description of that experience and strives to understand the experience rather than provide a causal explanation of that experience” (p. 212). Therefore, the final assumption of phenomenology is that the first-person perspective must be obtained to gain an understanding of the meaning of experiences (van Manen, 1990).

Phenomenology began in the philosophical reflection of Husserl in Germany in the mid-1890s as “an alternative to the empirically based positivist paradigm”

(McConnell-Henry, Chapman, & Francis, 2009 p. 7). Phenomenology grew out of an understanding grounded in humanism with the general philosophical stance that there is an essential structure to human experience (Thorne, Kirkum, & MacDonald-Emes, 1997). Within 50 years, phenomenology spread throughout the world and was used within music, religion, education, and literature. By the 1990s phenomenology was being used in nursing and medicine (McConnell-Henry, Chapman, & Francis, 2009).

Hermeneutic phenomenology is concerned with human experience as it is lived and includes the interpretive element to explicate meaning (van Manen, 1990). A hermeneutic approach enables a researcher to have a stronger awareness of a participant's perception and allows for a deeper appreciation of human experiences through the meaning of the written word of inquiry that focuses on interpreting a text. Hermeneutic phenomenology focuses on language and communication and suggests a way of looking at data sets or texts. The interpretive element refers to the meaning of an experience as opposed to predicting an experience. The tenets of hermeneutic phenomenology stress the importance of interpretation of the human existence with a focus on the lived experience rather than the person or phenomena. A philosophical aim of hermeneutic phenomenology is to clarify the subjective, humanistic meaning of an experience through interpretation (McConnell-Henry, Chapman, & Francis, 2009). In summary, phenomenology describes how one orients to a lived experience, and hermeneutics describes how one interprets the lived experience.

Max van Manen

Max van Manen's (1990) phenomenological approach was used to guide all aspects of the current study. Phenomenology studies "the lifeworld and the lived

experience to explicate the meanings as we live them in everyday existence” (van Manen, 1990, p. 9). The lifeworld is a person’s daily life experiences as they actually occur prior to reflection, conceptualizing, or categorizing. The lifeworld contains existentials, which form an intricate unity, creating the basic structure of the lifeworld as experienced in everyday situations and relations. van Manen (1990) describes four existentials including: spatiality (lived space), corporeality (lived body), temporality (lived time), and relationality (lived relation). These existentials provide a lens to facilitate interpretation of a lived experience, as meanings are found within stories told.

van Manen’s conception of phenomenological research is based on hermeneutic phenomenology. The distinction between phenomenology and hermeneutics is that “phenomenology is pure description of lived experience, while hermeneutics is an interpretation of experience via some text or symbolic form” (van Manen, 1990, p.25). van Manen’s position (1990) is a method for human science that involves description and interpretation of the experience by means of text or a symbolic form and by self-reflection. Human science focuses on an individual and the meaning experiences may have for that individual, and it reflects the recognition that these experiences are uniquely interpreted. All human science research efforts share a common feature: the desire to explore and become more familiar with the human experience. van Manen (1990) describes human science as studying persons or beings that have consciousness and who act purposefully by creating meanings that are expressions of how human beings exist in the world. The significance of phenomenological knowledge is formative in nature as it enhances our understanding.

van Manen considers phenomenology to be an applied philosophy that focuses on practical concerns and gives greater attention to context and complex situations. As such, van Manen (1990) views phenomenology as a philosophy of practice as well as a philosophy of being.

van Manen's methodology. van Manen distinguishes between a research methodology and a research method. Methodology is defined as the philosophic framework, whereas method is defined as a set of investigative procedures that one can master relatively quickly (van Manen, 1990).

The first feature of phenomenological methodology is the *reductio*: bracketing or suspension of everyday experience or previous knowledge (Sokolowski, 2000). Bracketing, also called phenomenological reduction or *epoche*, is a process of suspending beliefs and prior assumptions about a phenomenon. Bracketing is accomplished by setting aside judgments of the natural interpretation of an experience so that one can concentrate on the basic nature of the experience. The second feature of phenomenological methodology is achieved through the researcher's writing: the *vocatio*. The *vocatio* recognizes that a text can tell us things through the relationship between the semantics and uniqueness of that text. Texts are generated from interviews, provide the basic source for interpretations, and make the phenomenon being studied visible. Knowledge and meaning comes through language, interpretation, and understanding of text. Because meaning can be embedded within a text, it is important to reread the text numerous times so that the meaning of the experience can be derived. By reading, reflecting, writing, and rewriting, the lived

experience can be transformed into a textual expression of its meaning (van Manen, 1990).

van Manen's method. van Manen (1990) describes the investigative procedures of his method as both descriptive and interpretative. Descriptive refers to providing an explanation of an event; interpretive refers to describing the meaning of the event. The research process is insightful, thoughtful, sensitive to language, and constantly open to experience (van Manen, 1990). The aim of van Manen's method is to produce insights into human experience by focusing on the phenomenon and transforming the lived experience into a textual expression of its essence (van Manen, 1990). The meaning of human phenomenon will be explicated by writing, which will help understand the lived structure of meaning. Although there are several phenomenological methods to inquiry, they all have the underlying similarity of describing the essence of the phenomenon. van Manen (1990) describes essence as the core meaning of the phenomenon that makes it what it is. van Manen (1990) does not propose a specific fixed method of phenomenological inquiry, but he does suggest six steps that provide a guide for researchers to follow during the research process (Table 3.1) These steps are aligned with his phenomenological worldview and philosophy.

Table 3.1

Steps in van Manen's Method

1. Nature of Lived Experience
 - An interest in the phenomenon
 - A question to discover the meaning
 - Assumption and preunderstandings about the phenomenon
2. Investigating the Lived Experience
3. Reflection

4. Phenomenological Writing
 5. Maintaining a Strong and Oriented Relation
 6. Balancing the Research
 - Context by considering parts and whole
-

The first step is the nature of the lived experience. Within this step are three substeps: an interest in the phenomenon, a question to discover the meaning of the experience, and assumptions and preunderstandings about the phenomenon. Every phenomenological study begins with an interest of the researcher and a concern. The researcher attempts to make sense of a certain aspect of the human experience (van Manen, 1990). van Manen (1990) states all phenomenological investigation begins with the real-life experiences of the investigator, which includes assumptions, preunderstandings, and biases. An important part of this step is the process of bracketing. It is important for the researcher to bracket out preconceived ideas and prejudices to understand meanings. The same is true for those describing the experience. The intention of bracketing is to allow the researcher to describe the encounter precisely as it is perceived. The researcher achieves bracketing by writing beliefs and prior assumptions in a diary or journal. In addition to prestudy bracketing, it is suggested that the researcher make notations prior to each interview (Munhall, 2012). This process is known as decentering or unknowing. Decentering attempts to achieve the state of mind of unknowing, which is a condition of openness. Unknowing is a process that allows an individual to separate, or decenter, from presuppositions, beliefs, values, knowledge, thoughts, and ideas about the phenomenon of interest. Decentering, or unknowing, is important because many people have hidden beliefs and may try to find ways to document those beliefs

throughout their studies (Munhall, 2012). Unknowing is necessary to the understanding of inter-subjectivity and perspectivity. Inter-subjectivity is defined as verbal and nonverbal interaction between two individuals in which one person's subjectivity intersects with another's subjectivity. Perspectivity is defined as the unique perspective each participant has as a result of his or her experiences and a unique perspective of who he or she is as individuals in the world (Munhall, 2012).

The second step in van Manen's approach is investigating the lived experience. The researcher must actively explore the phenomenon of interest. This can be accomplished by interviewing the participants and taking notes of nonverbal behaviors during interactions with the participants. The purpose of interviewing is to explore and gather narratives, or stories, of the experiences from participants in their own words. The interview allows the researcher to discover what is on the participants' minds and their perceptions of the lived experience. In addition, interviews allow for development of a conversational relationship between the researcher and participant. Texts generated from the interview provide material for interpretation of the experience.

Reflection is the third step to this research method. van Manen (1990) describes reflection as the thoughtful and reflective grasping of what it is that makes this particular experience significant. Reflection is regarded as an ongoing analytic process and begins with gathering lived experience material. Reflection is the primary means of discovering the essence of the experience and allows researchers to obtain a deeper meaning of the experience by identifying commonalities through interviews and accounts of experiences as well as finding out what is essential in order for the

phenomenon to exist. Reflection is part of phenomenological analysis that includes reading, rereading, writing, and rewriting. There are three types of reflective methods that are presented: hermeneutic, existential, and thematic.

A hermeneutic interview reflection is a conversation where both individuals reflectively orient themselves to the interpersonal ground that brings the significance of the phenomenological question into view (van Manen, 1990).

The second type of reflective method is existential. Existential reflection focuses on the four existentials of the lifeworld. These are spatiality (lived world), corporeality (lived body), temporality (lived time), and relationality (lived human relation). All humans have experiences that can be explored through these four existentials regardless of their historical, social, or cultural experiences (van Manen, 1990). In phenomenological literature, these four existentials belong to the basic structure of the lifeworld. These existentials provide a guide in which the researcher can process questioning, reflecting, and writing.

Thematic reflection refers to an interpretive process in which data are systematically searched for patterns that provide a description of the phenomenon. This process results in the development of meaningful themes that are embodied within the text (van Manen, 1990). Themes are structures of experience that provide order and a sense of organization to research and writing. In other words, themes provide the researcher with a means to get to the phenomenon of interest. There are three approaches a researcher can take to uncover a theme: the holistic or sententious approach, the selective or highlighted approach, and the detailed or line-by-line approach. For the holistic or sententious approach, the text is read as a whole and

phrases that may capture the fundamental meaning of the text are identified. This approach is more global and seeks the overall meaning of the text. In the selective or highlighted approach, the researcher reads the text several times. From here, statements or phrases that appear to be essential or revealing about the phenomena are highlighted or selected. In the last approach, the detailed or line-by-line approach, each sentence is read carefully and closely examined so meaning can be taken from it. The structuring of meaning with themes sets the stage for a process of bringing speech to something, by writing, and rewriting (van Manen, 1990). Because the aim of hermeneutic phenomenology is to produce rich textual descriptions of a lived experience, deeper understanding of the meaning of the experience is sought. This understanding is accomplished by deeper and layered reflection of the text.

The fourth step is phenomenological writing. This step is linked with reflection and describes the richness of the phenomena within the lived experience. The role of phenomenological writing is to convey meaning and descriptions of phenomena, with the goal of discovering the essence of the experience. van Manen (1990) states that the art of writing and rewriting brings meaning, which can be hidden, to the surface and forces an individual into a reflective attitude. Writing is fixing thoughts about the participant's experience on paper; it externalizes what in some sense is internal and involves more than communication of information. According to van Manen (1990), the form of writing cannot be separated from the content of the text. The purpose of phenomenological writing is to penetrate the layers of meaning so that an understanding of the phenomena occurs by reflection and

refocusing on the phenomena. In other words, phenomenological writing assists the reader in gleaning an interpretation of the experience.

Writing is a process and product of phenomenological inquiry and allows the writer to shape his or her thoughts. Writing distances the researcher from a lived experience, but it also allows discovery of the structures of the experience as well as a textual reflection. Once the lived experience is brought to consciousness through thought and on paper, the discovery of meaning of the lived experience can occur.

The fifth step involves maintaining a strong and oriented relation to the project. The researcher must aim for the strongest possible interpretation of the phenomenon through awareness of the lived experience. When using van Manen's method, a rich and deep text is hoped for; this is accomplished through writing and rewriting, which leads to externalizing the lived experience. This means the researcher must constantly remind himself or herself of the focus of the research. A researcher may lose sight of the end goal of the research. It is necessary for the researcher to step back and look at the total and the contextual givens. According to van Manen (1990), the researcher must remain strong in orientation to the basic questions of the research. Because phenomenological research is demanding, a researcher may be tempted to get sidetracked and wander from the aim of the research.

The final step is balancing the research context by considering the parts and the whole. For example, the researcher may become immersed in the participant's experience (parts) such that the focus (whole) becomes distracted. van Manen (1990) advises researchers to step back several times throughout the study to look at the

whole. From here, each part needs to be examined in relation to and in its contribution to the total. This process should be ongoing and requires the researcher to be attentive to the aims and focus of the study. van Manen (1990) suggests this can be accomplished by having a well-defined and well-focused research project.

Summary

The interest of this study was the meaning of perioperative experiences to adolescents; therefore, a hermeneutic phenomenological approach was needed. Hermeneutic phenomenology allows an emphasis on the human response to health and illness as it refocuses our attention on the concerns of the patient. In order to implement van Manen's method, an understanding of assumptions and philosophy was needed. van Manen's (1990) phenomenological approach guided discovery and the interpretation of the lived experience of the adolescents during the perioperative experience. By implementing van Manen's six steps to phenomenology inquiry, the meaning of adolescent's perioperative experiences was discovered.

CHAPTER 4

METHOD OF INQUIRY: APPLIED

van Manen (1990) provides a method of phenomenological inquiry that guided this research in discovering the meaning of perioperative experiences for adolescents. Although van Manen (1990) states his guide implies a certain order, it does not mean the researcher must fully complete one step before proceeding to the next step, as much of phenomenological research is iterative in nature. By using van Manen's six steps, the researcher was guided to answer the research question, which asked about the meaning of perioperative experiences to adolescents.

Exploration of Phenomenon

The first step was to begin to explore the nature of the perioperative experience phenomenon. van Manen (1990) discusses the need to bracket one's biases, assumptions, and previous experiences of the phenomenon. This is why the researcher took time to openly address her assumptions, her philosophy of nursing, and her clinical experiences with patients undergoing surgery. A journal was kept that allowed the researcher to document beliefs and assumptions regarding the perioperative experience. In addition to prestudy bracketing, the researcher also used this journal to make notations prior to each interview to decenter and come to "unknow," and used it to note researcher biases and assumptions as they arose.

Gathering Lived Experience Material

The second step in van Manen's method of phenomenological inquiry focuses on investigating the lived experience with individuals who have experienced the

phenomenon. Gathering lived experience material involves selecting an appropriate sample, appropriate setting, and an appropriate inquiry method.

Sampling plan. With phenomenological studies, the principle of gaining rich and in-depth information guides the sampling strategies; therefore, purposive sampling was used in the current study (Patton, 1990). Purposive sampling is a form of nonprobability sampling. This type of sampling allows for selection of participants known to have experience with the phenomenon of interest (Patton, 1990), which in this case is adolescent perioperative experiences. For qualitative research, events and experiences are the objects of purposeful sampling, not the participants per se. Participants enter into qualitative studies by virtue of having personal knowledge about an experience (Sandelowski, 1995) and being willing to share their stories.

Inclusion and exclusion criteria. The sample for this project included adolescents who were scheduled to have a surgical procedure performed at one of five ambulatory surgery sites in Metropolitan Detroit. Criteria for inclusion in the study included adolescents between the ages of 18 and 21 years, and who were scheduled for an elective procedure. In addition, the adolescents needed to be willing to tell their story and were required to speak and read English. Exclusion criteria included participants who had attended the same high school as the researcher's children to reduce the likelihood of the researcher knowing participants. Adolescents who had previous surgery, either inpatient or ambulatory, were also excluded. The reason for this is the literature demonstrates that previous surgical experience may affect perceptions about subsequent surgeries (Melamed, Dearborn, & Hermez, 1983). Participants scheduled for emergent or cosmetic procedures were also

excluded. This decision was based on the researcher's clinical expertise that individuals needing emergency surgery or desiring cosmetic surgery differ in substantive ways from those advised to have surgery. Women who were pregnant were also excluded, as inclusion criteria included that the surgery was elective and nonemergent. For safety reasons, pregnant women should not undergo an elective surgical procedure.

Plan for determining sample size. The sample size was not determined a priori, but planned to end once saturation was achieved (e.g., when no new information emerged). In recent years, data saturation has become the gold standard to determine sample sizes (Holloway and Wheeler, 2002), but it is difficult to determine when saturation has occurred as there are no clear guidelines or descriptions of how saturation might be determined. However, it has been suggested that saturation usually occurs in phenomenological studies with as few as five or six participants (Creswell, 1998; Morse, 1994). The researcher planned to interview until redundancy occurred within the stories provided by the adolescents. In other words, no new information emerged. Because data analysis in phenomenology is iterative, the researcher constantly reviewed texts and hoped saturation would be easily identified once redundancy was recognized within the stories. Upon reviewing and rereading the text from the stories, an understanding that the experience was stressful for all participants emerged. Because of this redundancy, the researcher thought saturation was achieved, however during an audit of the data collection process, it was discovered that data collection may have ended prematurely.

Recruitment strategy. When an English-speaking adolescent between the ages of 18 and 21 years was scheduled for an elective, noncosmetic procedure, the clinic staff informed the patient of the study and inquired if he or she would be interested in learning more about the study. If the adolescent agreed, the staff asked questions to determine if the potential participant met the inclusion criteria. Questions asked included:

Have you had any other surgical procedure?

Are you available for a second interview, approximately one week after your surgery?

What high school did you attend?

Can I give the nurse researcher your contact information?

After obtaining the participants' permission, the staff provided the researcher with the names and contact numbers of patients expressing interest in the study. The potential participants were then contacted via a telephone call by the nurse researcher. An explanation of the project, complete with goals, aims, and possible risks was given to the potential participants (Appendix A). In addition, potential participants were informed of the time commitment expected for the study, which was two interviews lasting approximately 60 minutes each, with the first occurring immediately prior to the surgery and a second interview approximately one week following the procedure. Participants also were informed that they would receive \$25 at the completion of each interview. If the patient was still interested, he or she was asked to arrive to the clinic one hour prior to the scheduled surgical procedure time.

Setting. The setting selected for this study encompassed the ambulatory surgery clinics of a large surgical practice located in Metropolitan Detroit. Six board certified oral and maxillofacial surgeons operated out of five sites located in Clarkston, Clinton Township, Grosse Pointe Woods, Rochester Hills, and Warren. Each of the five sites earned accreditation from the Accreditation Association for Ambulatory Health Care (AAAHC). To become accredited, the sites passed a stringent review that demonstrated a commitment to providing high quality care by complying with the AAAHC nationally recognized standards of patient care. The number of procedures performed weekly varied; with the average surgical schedule involving 30 patients per week, as each surgeon performed approximately five procedures. However, as recruitment progressed, referrals were found to come primarily from one surgeon at one site, with two referrals from another surgeon located at the same site. Follow-up contact was made with the other surgeons and each clinic site in an attempt to increase recruitment.

Sample characteristics. The sample for this project included ten participants; all were female. Although males were approached to participate, no males met the inclusion criteria during the recruitment period. One participant was later excused from the study as unbeknown to her, she had had a previous surgical experience. This participant interviewed once, preoperatively, but during her recovery a relative informed her that she had a previous surgery at four years of age. The participant informed the researcher immediately and it was decided that as she did not meet inclusion criteria, her interview could not be used for data analysis. Therefore, the final analytic sample consisted of nine female participants.

Upon arrival to the ambulatory surgery clinic, the potential participants were brought into a private office. The research details were again presented, which included an overview of the project, review of the aims and goals, possible risks, compensation, and time commitment. The consent was reviewed with the potential participant and prior to obtaining written consent, the participant was informed that participation was voluntary and at any time she could withdraw from the study. It was further explained she may not benefit directly from participating in the research; however, the information obtained from participating could assist in increasing nurses' and surgeons' knowledge of perioperative experiences from an adolescent's perspective. It was also discussed with the potential participants the likelihood of publications resulting from the findings of this study. From here, the need for assigning a pseudonym to the participants to maintain confidentiality for future publications and throughout the dissemination of the findings was discussed. After signing the consent (Appendix B), a pseudonym was assigned to the participant.

A master list that linked the participant's name, telephone number, and the study pseudonym was not kept in printed form. The list was kept electronically on a password-protected computer in the researcher's home and was deleted once the information for each participant was linked following the second interview. Consents were kept in a safe, located in a storage room belonging to the researcher. The remaining data, containing only pseudonyms, were locked in a file cabinet in the home office of the researcher who had the only key. The audio tapes were not reused and were destroyed after the completion of the project. Following the final defense of

the research, all other material related to the study will be kept in a safe and destroyed within five years.

The researcher was a Registered Nurse with experience in a surgical setting but was not affiliated with Summit Oral & Maxillofacial Surgery, where the research occurred. Other professional caregivers were available on site.

Lived Experience Material

According to van Manen (1990), the point of phenomenological research is to “borrow” other people’s experiences in order to understand the deeper meaning of human experience. van Manen (1990) further explains that we gather other people’s experiences because they allow us to become more experienced ourselves. For the purpose of this project, participant’s experiences were borrowed by interviewing participants.

Interviews. The interviews for this study were conducted in a private office in one of the five ambulatory surgical sites. Interviews took place immediately prior to the surgical event on the day of the scheduled surgery and then again on the day of the scheduled postoperative appointment prior to the appointment, about one week after the procedure. The preoperative interview allowed the adolescent to tell her story regarding the impending surgery. The purpose of the postoperative interview was to gather each participant’s sense of perioperative experiences. In addition, a second interview allowed for the discovery of any new perceptions or meanings about the perioperative experience. The preoperative interviews lasted approximately 35 minutes, whereas the postoperative interviews lasted an average of 45 minutes.

All interviews were one-on-one and were conducted by the researcher. The interviews were audiotaped. To protect the confidentiality of the participants, pseudonyms were used during the taping and in all data records and they will be used for any dissemination of findings. The audiotapes were transcribed verbatim within two days of the interview. It was important to have tapes transcribed in a timely manner as sampling, information collection, and analysis were an iterative process, and preliminary findings may have shaped subsequent sampling choices and questions to be asked. Each transcription was reviewed by the researcher while listening to the audiotape to verify the accuracy of the transcription.

Interview questions. An interview guide (Appendix C) with open-ended questions regarding the perioperative experience was used to guide each interview. Open-ended questions support the exploratory and descriptive nature of qualitative studies (LeCompte & Schensel, 1999). The intent of the interview was to discover the participant's perceptions and to probe thoughts on the perioperative experience and what it meant to her. As such, the interviews were guided by broad, grand tour inquiry to help extract how the adolescent perceived the perioperative experience. From here, the direction of the interview was determined by the responses provided by the participant.

The first interview took place preoperatively, immediately before the procedure. The grand tour question that was asked during the first interview was, "Tell me about your surgery."

The second interview took place at the postoperative visit, approximately one week following the procedure. The researcher met with the participants prior to

meeting the surgeon. The grand tour question that was asked for the second interview was, “What has this surgical experience been like for you?”

A final question at the end of each interview was asked to ensure the participants had sufficient opportunity to tell their stories. This question was, “Is there anything else you would like to tell me about your experience?”

During the audit, it became apparent that some questions became clinically focused instead of qualitatively focused, especially during the second interview. Although clarifying questions are needed within qualitative research (Cohen, Kahn, & Steeves, 2000), a number of these clarifying questions became closed-ended which reflected a clinical perspective rather than a researcher perspective. For instance, although probing questions were asked, a deeper understanding may have been obtained had the probing questions not focused on the clinical aspects of the experience. Questions such as “can you tell me more about...”, “can you describe (that) further”, and “can you explain (that) in more detail” may have provided an opportunity for the adolescent to describe their surgical experience in more detail.

Interview notes. Notes were taken after each interview. The purpose of the interview notes was to provide a condensed version of what occurred. Spradley (1980) suggests including phrases and single words describing what happened during the interview. Interview notes were made immediately following the interview and provided detailed information about the interaction. These notes provided a narrative of what happened during the interview. The interview notes provided another layer of text that allowed the researcher to confirm consistency between the notes and transcribed text. The researcher found the data from the interview notes to overlap

with the transcribed text from the interviews, therefore little new information was gleaned from the interview notes.

Researcher journal. van Manen (1990) suggests the researcher use a journal throughout the project to allow for reflection. According to Spradley (1980), making an introspective record enables a person to take into account personal biases and feelings, while Lincoln and Guba (1985) state maintaining a journal is beneficial for reducing potential for researcher bias. Entries were made for each contact describing the interactions with participants following each interview. The entries included the researcher's personal thoughts, feelings, and responses to the participants, which allowed for identifying any potential issues with participants. By documenting personal reactions to the interviews and participants, a record of perceptions, emerging findings, and assumptions allowed for reflection, in other words, provided a way for the researcher to decenter and come to unknow (Munhall, 2012). It is important for a researcher to decenter, as it is a condition of openness, which allows one to separate personal beliefs, values, thoughts, and ideas about the phenomenon of interest, here the perioperative experience. It is through unknowing that the researcher should be able to bring forward personal beliefs and ideas which can help in understanding the participant's story without bias. However, the researcher found it difficult to decenter, which may have introduced researcher bias and affected the manner in which the interviews took place. Though journaling allowed the researcher to be attentive to the aim and focus of the study throughout the data collection, due to the researcher's experience in the perioperative setting, the researcher looked

primarily for commonalities, and once identified incorrectly assumed saturation and prematurely ended data collection.

Demographics data. During the first interview, demographics were obtained from the participant (Appendix D) to determine if the participant met the inclusion criteria for the study. Demographic information that was obtained included date of birth, gender, and academic history. In addition, the type of surgery the participant was scheduled for was documented.

Reflection

The third step in van Manen's research method is reflection. Although van Manen (1990) describes three types of analytic reflection, the focus for this study was thematic analysis of the lived experience material. Thematic analysis is an interpretive process in which data are thoroughly reviewed to identify recurring and significant themes or recurrent patterns and assists in organizing data. Themes capture something important about the data in relation to the research question and identify some level of patterned response and meaning within the data set (Braun & Clarke, 2006). van Manen (1990) defines themes as tools for capturing the phenomenon of interest that are the structures of experience, the building blocks upon which the understanding of the phenomenon is built. As such, reflection is regarded as an ongoing analytic process that starts with gathering lived experience material and continues throughout thematic analysis.

Thematic analysis. Thematic analysis assists researchers in analysis as it moves analysis from a broad overview reading of the data toward developing themes by discovering pattern. Thematic analysis consists of three approaches: holistic

(sententious), selective (highlighting), and detailed (line by line). Holistic approach involved reading the text as a whole to discover the fundamental meaning or significance of the text. The selective approach is achieved by rereading the text several times to discover what statements or phrases appear to be essential about the experience. Finally, in the detailed approach each sentence is read to discover what is revealed about the phenomenon. Thematic analysis guided reflection.

Reflecting. The process of reflection began with the collected data of interview text. Texts were constructed following the interviews. Each interview was transcribed verbatim within 48 hours, which allowed for accurate recall of words not clearly picked up on the audio-recording. The texts were read numerous times so that preliminary essential themes were identified. To allow the researcher to be immersed in the material, the transcripts were read and reread using the holistic reading approach (van Manen, 1990); this allowed for the capturing of the fundamental meaning of the interview as a whole.

Once the text was read several times, the selective approach was utilized. Rereading of the text allowed for discovery of phrases that captured the initial response. The phrases were created so that the foundational meaning of the perioperative experience was understood. These phrases were written in the margins of the texts. From here, a sense of the experience and understanding of the uniqueness of the descriptions of the adolescent's perioperative lived experience was captured. With a clearer understanding of the whole, a deeper analysis of the parts allowed for a more thorough understanding of the whole. Thematic analysis continued with rereading of the text which allowed for identifying statements and phrases that

appeared to be essential or revealing about the perioperative experience; this is the detailed approach. These statements and phrases were highlighted and written on a note card for each participant. From here, a master list of all statements and phrases was created. The transcripts were then reread, which assisted the researcher in reorienting to the research question. Finally, each sentence of the narrative was read, line-by-line, and commonalities identified were noted on note cards. The note cards were then compared to the master list of all statements and phrases. This detailed step completed the thematic analysis.

Themes were reviewed and consensually validated by a committee member. Through a peer debriefing process, interpretations were clarified. By rereading through the text numerous times and submitting themes to peer review, a constant reworking of the interpretations allowed for the meaning of the adolescent's perioperative experience to be discovered. The process of thematic analysis was assisted by the guidance of the hermeneutic circle and will be discussed next.

Hermeneutic circle. The hermeneutic circle is essential to interpretive phenomenological methods and is used throughout thematic analysis. The hermeneutic interpretation is a dynamic process that allows for the understanding and interpretation of the text (Standing, 2009). The concept behind the hermeneutic circle is that an individual understands the text as a whole, which is based on the understanding of the individual parts, which in turn, is based on an understanding of the text as a whole. Utilizing the circle meant that understanding and interpretation was an ongoing iterative process. This process allowed themes to evolve and assisted in the formulation of an understanding of the feelings that were created by the

perioperative experience. By understanding the parts in terms of the whole, and understanding the whole in terms of its parts, the hermeneutic circle was defined and served to place participants' experiences in the perioperative setting and other events that comprised the context of the perioperative experiences in the participants' life. By reading and rereading each text in its entirety, the stories of the adolescents' overall experiences were acquired before breaking them into the parts. For example, after discovering commonalities within the experience (feelings of apprehension and concerns) the texts were reread. From here, the essence of the perioperative experience began to emerge (a stressful experience), which prompted a rereading of the text, which discovered further commonalities within the perioperative experience (developmental and life concerns of the participants). In other words, the process of the hermeneutic circle was circular and increased the depth of engagement and the understanding of texts.

Reflection allows for an essential meaning or understanding of something. The utilization of thematic analysis, through activities of immersion, reflection, and rereading of the narratives, allowed for an understanding of the perioperative experience. The act of immersion allowed for the interpretation of the material, which drove the thematic analysis. Reflection allowed for a deeper meaning of the perioperative experience by recognizing commonalities within stories shared. Rereading is a way of moving to a deepening of understanding as it gives the reader a holistic view and a control of the text that is not possible in a first reading (Hunsberger, 1985).

After the researcher felt certain all themes were identified, all data collected from interviews and texts were reviewed again. From here, reflection encouraged the next step, which involved writing.

Phenomenological Writing

The fourth step in van Manen's method is phenomenological writing. van Manen (1990) states writing is fixing our thoughts on paper; it externalizes what is internal. The aim of phenomenological writing is to explain the structural features of a phenomenon to help visualize the essence of the phenomenon (van Manen, 1990). Essence is defined as the essential meaning of something before social and cultural meanings are attached to it; the true being of something (van Manen, 1990).

Writing and rewriting created a textual reflection that developed insight and connected the "what and how" of the surgical experience; this allowed for a sense of the perioperative experience for the adolescents to be revealed. By transforming the spoken word into writing, a summary of the major interpretations and themes found in the participants' narratives was generated, which created a textual interpretive statement and allowed for a true description of the perioperative experience of the adolescents.

Maintaining a Strong and Oriented Relation

The fifth step involved maintaining a strong and oriented relation to the study. According to van Manen (1990), texts must be oriented, deep, and rich; therefore, the researcher must remain strong in orientation to the fundamental questions or notion of the research. The data was reviewed numerous times throughout the study, which kept the purpose of the study close to mind. Notes were made immediately after each

interaction in the researcher journal, which included observations, perceptions of the interview, and descriptions of the setting. The purpose of these notes was for personal researcher reflection and was not used for analysis. During analysis, text obtained from the interview that was not related to the perioperative experience was extracted so that data relevant to the perioperative experience was the focus. This allowed the researcher to maintain a commitment to the research question.

Balancing the Research

The final step of van Manen's method is balancing the research context by considering the parts and the whole. For this project, the researcher constantly reviewed the study and looked for the significance that each part brought to the whole. van Manen (1990) states this can be accomplished by having a well-defined and well-focused research project.

This study was well defined as it examined a specific group: adolescents between the ages of 18 and 21 years. The study was well focused as it examined adolescents who had a perioperative experience. To further ensure this study was well defined and well focused, it was evaluated for trustworthiness.

Trustworthiness

In order to establish that findings of a qualitative project are noteworthy, trustworthiness must be ensured. Following the definition of trustworthiness, application of trustworthiness criteria to this project is discussed. Holloway and Wheeler (2002) define trustworthiness as methodological soundness and adequacy. Trustworthiness must be established to render the results of a study valid. The goal of trustworthiness encompasses sufficient thoroughness in performing the study so that

the presentation accurately represents participant experiences and promotes confidence in the findings of the study. Trustworthiness can be established by documenting data gathering and analysis decisions (Sandelowski, 1995; van Manen, 1990). Lincoln and Guba (1985) discussed four criteria for evaluation of trustworthiness in qualitative research: credibility, transferability, dependability, and confirmability.

Credibility

The credibility criterion addresses the truth-value of the study and the confidence one has that results are an account of the phenomenon, in other words, valid. According to Lincoln and Guba (1985), several techniques make the research more likely to have credible findings. These include member checking and peer debriefing.

Member checking is often viewed as an integral part of the phenomenological analysis process (Lincoln & Guba, 1985). However, there are drawbacks to member checking of interpretive themes (McConnell-Henry, Chapman, & Francis, 2011; Sandelowski, 2000). Therefore, establishing credibility centered on the researcher's triangulation of finding across participants, prolonged engagement with the subject matter, hermeneutic reflection on participant data, and a peer debriefing process (Lincoln & Guba, 1985).

Peer debriefing enhances credibility by helping to identify investigator biases that may have influenced the data collection and analysis process. Two members of the committee, each of whom had experience with qualitative research and no perioperative experience, performed a critical review of all texts and data analysis.

Transferability

The second criterion is transferability. Rich, descriptive accounts of the settings allow others to judge whether findings can be applied in other contexts. By providing sufficient detail about the research, readers can form their own opinions about whether the research environment is similar to their situation and whether these findings can be applied there. Transferability is important as phenomenological research does not produce generalizations that apply to all related situations, but it provides meaning and knowledge from a particular phenomenon that can be inferred to similar experiences (Lincoln & Guba, 1985). Strategies that improved transferability included a purposive sampling method and ensuring the sample was representative of a particular clinical population (e.g., female adolescents between the ages of 18 and 21), and using a relatively common surgical procedure. At the time of recruitment, no males met inclusion criteria.

Dependability

Dependability is the third criterion to evaluate trustworthiness in qualitative research. This criterion addresses the consistency and accuracy of the study. The researcher needs to address if the findings can be repeated with same or similar participants. An audit trail is necessary to achieve some measure of dependability (Holloway & Wheeler, 2002). An audit trail contains information that provides details linking data sources to analysis worksheets for findings, marking the steps taken from the beginning of a project to the development and reporting of findings. Categories for developing an audit trail include raw material, reduction and analysis summaries, and theme development (Akkerman, Admiraal, Brekelmans, & Oost, 2008). The audit

trail allows an auditor to trace the textual sources back to the interpretations (Creswell & Miller, 2000).

An audit trail was created for this study by carefully documenting all components of the study. The audit trail consisted of chronological narrative entries of research activities, audiotapes of the interviews, and transcriptions. In addition, various drafts of interpretations that cited data sources, data type, and date were included for the audit trail.

Confirmability

The last criterion that needs to be addressed is confirmability, which refers to the degree to which others could confirm the results. At the completion of the analysis, a member of the committee conducted an audit. The purpose of the audit was to have a member examine the material collection and analysis procedures and make judgments about the potential for distortion or bias. An audit was important because qualitative research acknowledges that biases and assumptions of the researcher could influence the interpretations and conclusions made by the researcher. It was through an audit that a bias was identified, partly due to the researcher's extensive experience in the perioperative setting. While the results of this inquiry produced interesting findings, richer and deeper understandings of the perioperative experiences seem likely to have been elicited by utilizing more probing questioning during the interviews. As it is imperative that findings of any study are trustworthy, trustworthiness was addressed in this study through credibility, transferability, dependability, and confirmability.

Human Participant Considerations

Prior to initiation of any research activities, approval for the study was obtained from the Internal Review Board (IRB) at Wayne State University. As there was no more than minimal risk to participants, the review was expedited. There was a possible psychological risk if answering questions about the surgery caused anxiety. However, material collection was done exclusively by the researcher, who as a master's prepared nurse, was able to offer reassurance and referral if necessary. However, no participants voiced concerns that required referral for further follow-up. There was no physical harm involved in participating in this study as the data collection was gathered by interviewing the participants. Permission to proceed at the ambulatory surgery site was obtained from the governing board of the practice as well as practicing surgeons. A meeting was held at the ambulatory site prior to the interview process. The purpose of this meeting was to introduce the study, to present the aim and purpose of the study, and to review the recruitment process and script with clinic staff. The meeting lasted approximately one hour and was attended by five staff members and one surgeon.

At the end of the interviews for the day, all material was transported to the home of the researcher in two briefcases: one for the consent forms and master list, the second brief case for all other material collected for the day. All information remained in the researcher's home office, locked in a file cabinet within a locked office, and will be destroyed within five years after completion of the study. The audiotapes were used once and were destroyed at the end of the project.

Summary

This chapter described application of van Manen's phenomenological method to adolescents' lived perioperative experiences. Guided by the six steps in van Manen's method, the meaning of perioperative experiences was elicited. Nine adolescents were interviewed twice: once before their surgery while the second interview took place about one week after the surgery. Interviews were analyzed using a thematic approach and guided by the hermeneutic circle. Five themes emerged: two preoperative and three during the postoperative experience. The preoperative themes are "I know that..." and Feelings of apprehension. Postoperative themes are "not as bad as I thought", Concern, and "I needed my mom". These themes will be addressed in the next chapter.

CHAPTER 5:

FINDINGS OF THE INQUIRY

“I made it through, so death is not a worry anymore.”

This statement illustrates one participant’s understanding of wisdom tooth extraction – a death-defying event. Fortunately, this was a minority view, yet worry was a common expression voiced by many participants. In addition to worry, this chapter unpacks other meanings associated with the perioperative experience from the perspective of a group of adolescents.

The purpose of this hermeneutic phenomenological study was to describe and capture the meaning of perioperative experiences of adolescents’. In order to understand the meaning of the experience, two interviews took place. The first interview was done prior to the procedure on the day of surgery. Participants were encouraged to “Tell me about your surgery.” For the second interview, held appropriately one week after the procedure, the participants were asked, “What has this surgical experience been like for you?”

Following thematic reflection, five themes emerged. Two themes were identified from the preoperative experience and three themes were identified from the postoperative experience. The identified themes in the preoperative experience were “I know that...” and Feelings of apprehension. From the postoperative experiences, the following themes were identified: “Not as bad as I thought,” Concern, and “I needed my mom.” These themes united the stories of the perioperative experience for the participants. Following the description of the participants, preoperative themes will be discussed followed by the postoperative themes.

Description of Participants.

Purposive sampling was used to allow for selection of participants known to have a perioperative experience. Sampling was done in the summer. Nine adolescents participated in the study, all female. Four were 18 years of age, four were 19, and one was 20 years of age. All were high school graduates, four currently enrolled in college, with four to start college in the near future. One participant worked full time in retail after attending college for one year. All participants were scheduled for an elective ambulatory surgical experience, specifically wisdom tooth extraction.

The Preoperative Experience

Preoperative interviews found two common themes within the stories told by participants, “I know that...” and feelings of apprehension. The preoperative interviews indicated that participants had an understanding about the procedure; family and friends primarily provided this information. In addition, participants were knowledgeable about the medicines they were to take after the procedure. Participants also described feelings of apprehension, which was the second theme gleaned from the stories. Participants shared their apprehensive thoughts related to anesthesia and after affects. A description of these themes will be presented.

“I Know That...”

All participants presented with an understanding of the procedure and medicines. Information was given to them by the office staff; however, most participants stated family and friends provided the most information.

The procedure. In discussing the surgery, many participants provided a succinct description of what they expected to happen during the preoperative events

of their surgery. Participant F told about expecting an IV: “I know that I’ll be given an IV, so I’m not supposed to really remember any of it” (int 1, 374¹), while participant I stated, “Well, I’ll be put to sleep and my teeth will be gone when I wake up” (int 1, 595). Participant A stated, “I’m being put to sleep and they are going to remove all four [wisdom teeth]” (int 1, 671). In addition to knowing about the procedure, several participants shared what they knew about the medications that were prescribed to take after the procedure.

Medicines. A few of the participants were knowledgeable about the medications that were to be taken after the procedure. One participant comments, “They gave me penicillin and one more antibiotic that I’m supposed to be taking as soon as I get out of surgery” (Participant D, int 1, 140). Another participant discussed her prescriptions, stating, “Apparently, they are giving me three different pills, an antibiotic, pain pill - Vicodin, I think - and something to reduce the swelling” (Participant F, int 1, 386). Participant H noted, “They gave me two more prescriptions, penicillin, and one more antibiotic” (int 1, 501). Another participant discussed her medications saying, “I think there is a couple [of] other; I don’t know exactly the other medicine. I think there is three other medicines that I’ll have to be taking for the next couple of weeks after the surgery” (Participant I, int 1, 599-601).

Thus, participant statements demonstrate a vague awareness of the upcoming surgical procedure and what would be needed afterwards; however, what is interesting is who provided the information.

¹ Citations to data sources follow the convention of participant name, which interview, and line number in the interview transcripts

Family and friends. Although all participants received information from the clinic staff prior to arriving for the surgery, participants spoke more about the information they received from family and friends. Thus, a large amount of information about the surgery came from people participants knew who had had the same procedure performed. Participant C said, “A lot of my friends have gotten them [their wisdom teeth] out. It’s been different with every person I’ve talked to, but some people have been bad for the whole week, very dependent on each person” (Int 1, 16). Participants D and F also told stories about getting information from friends: “I have a few friends that had dry sockets and I don’t want to get one; they told me all about it.” (Participant D, int 1, 129), and “I heard a couple things from friends. I know some of my friends said they were able to eat that same day and others took like two or three days” (Participant F, int 1, 382). A few participants received information from siblings. Participant D said that her sister had the procedure two years ago, and “she told me everything about it and I remember she was groggy for a few days” (int 1, 158). While Participant I’s siblings “have all gotten through it, so it’s kind of like it’s going to be fine” (int 1, 575) One participant received information from her mother and explained “...and then my mom told me what to expect, since she had her wisdom teeth removed” (Participant B, int 1, 841). Only one participant discussed receiving written and verbal information from the clinic staff, saying “I’ve read the most; they haven’t told me as much as I’ve read in the sheet. I’ve heard more from people that I’ve talked to outside of here” (Participant G, int 1, 875). Participant G described receiving the written information from the office staff as “a little comforting, it was pretty comforting” and continued to explain that:

It was nice that me and my mom both knew what we needed to do so that, in case for some reason I can't complete something, she can do it. Or if she doesn't know, we have those [sheets] to refer back to at home (int 1, 899).

Thus, participants who spoke about the surgical procedure expressed the importance of their family and friends as the source of information.

Despite their ability to verbalize what they knew was to happen during and after the surgery, participants voiced a range of feelings about the upcoming procedure: four felt uneasy, two had mixed feelings, three were more seemingly nonchalant, and some described being worried about what was to happen. Thus, the participants described feelings of apprehension about the surgery.

Feelings of Apprehension

The theme of feelings of apprehension was apparent in the description the participants shared about their upcoming surgery. Four participants described an uneasy feeling in anticipating the procedure, and three had mixed feelings, while three participants did not. A few participants made it clear they were nervous by stating "I'm really nervous, what if I throw up" (Participant D, int 1, 147), and Participant H began by saying "I'm kind of nervous, I mean, I've never had anything done surgically, so that's like a major thing" (Participant H, int 1, 488). Then, Participant H said, "I don't think I am too worried about the whole procedure in general" (int 1, 489), she also stated "I don't like my face touched" (int 1, 488), and later said: "I'm really nervous" (Participant H, int 1, 505). A second participant had mixed feelings, similar to Participant H as Participant I voiced conflicting feelings.

On one hand she asserted, “It is going to be fine; it’s just little nerves, not too bad” (int 1, 581), but then went on to say she thought the experience was “nerve-wracking” (Participant I, int 1, 575). Plus these two participants vacillated between being uneasy and being nonchalant about the procedure. Participant E also thought the procedure was “very nerve-wracking” (int 1, 270). One participant further described being nervous by stating, “...I don’t know. I have no idea why. I just have this feeling, like I’m really nervous for some reason” (Participant D, int 1, 147). Participant B deepened the level of feeling by saying, “So I am pretty scared, [because I am] sure it is going to hurt” (int 1, 804), while two other participants linked their worry to particular post-operative issues: “I’m worried about the pain...and I’m also worried about doing daily things. I’m just worried about being affected” (Participant G, int 1, 882-883). Another stated, “I have a few friends that had dry sockets and I don’t want to get one, so I am kind of nervous about that” (Participant D, int 1, 129). And, in an extreme case, one participant’s apprehension rose to the level being afraid she would die, saying, “Maybe too much anesthetic or I will die so, I really want to avoid that” (Participant E, int 1, 260-263). Thus, for these six participants presurgery thoughts expressed considerably more apprehension for the upcoming surgical procedure than for the other participants.

The stories shared by these six participants described an uneasy feeling about the surgery. In contrast, a few other participants stated that they were “not too worried,” “not so much concerned,” and “hoping for the best” from their procedure (Participant C int 1, 13). Likewise, Participant F was “not too worried about it” (int 1, 375). Participant A emphatically exclaimed, “I’m going to be fine, I know this isn’t

that bad, but I mean I'm really not that nervous about it all" (int 1, 617), and although these three participants voiced few feelings about the procedure in general, each of them went on to express apprehension in relation to specific after effects of the procedure. Thus, although some of participants' feelings were vague, many participants discussed specific feelings that involved anesthesia, after affects of the procedure, and pain and hurt.

Anesthesia. During the preoperative interview, several participants described being apprehensive about the anesthetic they would be receiving. These feelings about anesthesia included not being anesthetized, feeling pain during the procedure, and being under anesthesia too deeply. As Participant E put it:

...there might be complications during the procedure with the anesthetic; maybe too much anesthetic or I will die or they will not put me under. I have seen a couple of scary movies where people are still awake, but they are actually still asleep so they feel all the pain... (int 1, 260-262).

Another participant was apprehensive about anesthesia being "unnatural," saying, "Just kind of the idea of being put to sleep kind of involuntary is a weird concept in my mind" (Participant I, int 1, 580). Participant D discussed an experience her sister had with anesthesia "I decided not to do the anesthetic because my sister had it done about two years ago. She was groggy for a few days and was in a ton of pain (int 1, 157)."

Another participant said, "Well, I'll be put to sleep. Um, and I've never really had any surgery done. So, this is my first big thing" (Participant I, int 1, 575). Two

participants expressed apprehension about saying things under anesthesia that would distress their mothers. Participant G (int 2, 938) shared her worry about worrying about her mom, while Participant E hoped she did not disappoint her mother (int 1, 266). Participant D discussed her anesthesia choice by stating, “I’m just getting a local anesthetic, I decided not to do the anesthetic so I think if you don’t have to go under I don’t think I really should” (int 1, 157-159). Participant B provided more detail by stating:

I have the option to be put to sleep or get just the injection, the needle into my gums. I know that they will have to cut open my gums to take out my tooth...so, you know I will get the needle injection to my gums” (int 1, 795-804).

Thus, participants were apprehensive about anesthesia, which encompassed worries of not being anesthetized and feeling the pain, of being under too deeply and having difficulties postoperatively, and of saying “disappointing” things that their mothers might hear. Although participants shared their apprehension about the anesthesia, they also anticipated after effects from the surgery.

After effects. In addition to feeling apprehensive about the anesthesia, several participants stated they were worried about after effects they may experience following the surgery. These after effects included pain and hurt, dry sockets, swelling, eating, and disruption of activities.

Pain and hurt. From the stories shared by the participants, the most troublesome after effect was pain and hurt as most participants discussed these feelings. Although one participant reported being told it was not going to hurt, she

cast doubt on the information, saying, “Ok, so they said it is not going to hurt, but there is a good chance, you know, that it is going to hurt” (Participant B, int 1, 807). She was not alone in this opinion. Other participants also expressed apprehension with pain: “I don’t think I am too worried about the whole procedure in general, just the pain” (Participant C, int 1, 28). Others corroborated these feelings saying, “...and so I am pretty scared it is going to hurt...” (Participant B, int 1, 805); “I’m worried about the pain” (Participant G, int 1, 883); “I know it’s going to hurt afterwards” (Participant A, int 1,686); and “I heard it can be unbelievably painful...” (Participant E, int 1, 263). On the other hand, another participant displayed optimism by saying, “It’s going to be a little bit painful, I’ve been told...I’m hoping for the best” (Participant C, int 1, 13).

Expecting pain, some participants discussed their plans to address pain, especially discussing the medications prescribed to them for pain management. According to participant I:

They already gave me prescriptions to be filled. I think I’ll take Vicodin to ease the pain because there’s so many [teeth being removed]; all four of them are going to be taken out. I think I take it for a couple of weeks (int 1, 598).

Participant D said: “I have a prescription for Vicodin. I’m supposed to take it every six hours” (int 1, 137), and echoing this participant, Participant H stated how she will take her Vicodin: “Yeah, I’m just going to take Vicodin every six hours” (int 1, 499). Participant A shares her thoughts, “I know it’s going to hurt afterwards; they already gave us prescriptions and we had it filled yesterday” (int 1, 686/694). But,

Participant C shared apprehensions about taking Vicodin: “I don’t know if I’ll be able to, like my stomach will be able to handle it. But, I guess we’ll see. I’m hoping I won’t need to use that very often” (int 1, 31). Even though some participants thought about pain management as a routine part of wisdom tooth extraction, many participants still worried over pain and hurting after the procedure.

Dry sockets. The potential for having dry sockets, a complication associated with disrupting wound healing after a tooth extraction, permeated participants’ talk. For instance, Participant D said, “I have a few friends that had dry sockets and I don’t want to get one, so I am kind of nervous about that. They [clinic staff] like hype up the dry socket thing” (int 1, 131). When prompted to expand on her nervousness about developing dry sockets, she stated, “It’s just, like, horrible pain since the wounds aren’t healing the way they should. Yeah, I don’t want to be having to take a whole bunch of pills for like two weeks because I’m in pain” (int 1, 129-135). Participant E shared her nervousness with developing dry socket by stating, “... so I will have to be careful not to have dry sockets and infect the area” (int 1, 254). This participant continued, “... and I have heard that dry sockets can be unbelievably painful, so I really want to avoid that” (int 1, 263). Lastly, Participant H described her fear of dry sockets, “They tell you about dry sockets. They are like, ‘oh you might get dry socket.’ Basically, your wounds aren’t healing and it’s like intense pain for quite a few days. That freaks me out” (int 1, 491-494). Here, the possibility of dry sockets created apprehension for participants, and were connected to nervousness about being in pain and having to take medications for pain. But, surprisingly few participants expressed being apprehensive about swelling.

Swelling. Only two participants discussed swelling when discussing feelings they had regarding their impending surgery. As Participant C put it, “I’m more concerned about the after effects such as swelling” (int 1, 27), while Participant F mentioned having “something [a prescription medication] to reduce the swelling” (int 1, 387). By contrast, to the few participants expecting swelling as an after effect, eating received more comment.

Eating. Some participants discussed their apprehension regarding eating. For instance, Participant C said, “I’m more concerned about the after effects, such as not being able to eat” (int 1, 27), while Participant D shared her apprehension about eating by stating, “So I won’t be able to have solid food for quite a few days, but I should be, like, normal by 3 to 8 days” (int 1, 122). Another participant (F) shared how she expected to deal with eating, saying, “So, [I plan to] eat soft foods, ice cream, applesauce, all that” (int 1, 377), and continued with what advice from her friends saying, “I know some of my friends said they were able to eat that same day and others that took like two to three days” (int 1, 382-382). Finally, Participant A said, “Don’t eat food for the first day, or eat very soft food” (int 1, 650). Thus, some participants understood they would modify their eating postoperatively, just as they expected to limit activities.

Disruption of activities. Because several of the participants were active in sports, these participants’ expressed being apprehensive with limiting their activities following surgery. Participant D stated, “...so I will be back on the [soccer] field hopefully in a week. I don’t want to be out for like two weeks” (int 1, 169). One participant was scheduled to participate in a golf tournament the weekend following

her surgery. When she asked the surgeon if she could participate, she shared this response, “He said that it’s tentative, so you can plan on it because it will be the fourth day, but be prepared to maybe have to cancel if you’re not up to it because everyone is different with their recovery period” (Participant F, int 1, 398). Thus, for those participants active in team sports limiting activities became a source of apprehension among after effects.

Summary of the Preoperative Experience

The first interview was conducted on the day of surgery. The participants were encouraged to reflect about their upcoming procedure. From the stories they shared, two themes emerged, “I know that...” and Feelings of apprehension. All participants received information regarding the surgery and presented with awareness about the procedure. However, even with this knowledge, the participants shared numerous feelings of apprehension, which included anesthesia and after effects. All participants knew anesthesia was a routine part of wisdom tooth extraction, but several verbalized feelings over receiving anesthesia. The information participants received preoperatively also indicated what was to be expected after the surgery. Despite, or perhaps because of this information, many participants verbalized apprehension about what would happen following the surgery. Specifically they shared feelings about pain, dry sockets, swelling, eating, and disrupting their usual activities. Since it is not known if the perception of a surgical experience changes preoperatively to postoperatively, a second interview was conducted one week postoperatively. Next, a narrative of the postoperative experience will be presented to discover if perceptions changed, and if so, how.

The Postoperative Experience

Postoperative interviews, conducted about seven days after the surgery, found three themes within participants' stories. Participants shared how the experience was "not as bad as I thought," discussed concerns regarding their surgery, and shared how they "needed mom."

"...not as bad as I thought"

Most participants calmly described their procedure even though many had a range of concerns and expressed apprehension before the procedure. For instance in describing her surgery, Participant H stated the procedure "was ok, it went pretty good. Everything went great" (int 2, 521-522) although before the procedure she shared how nervous she was about the surgery. This participant simply stated, "I guess I was nervous for nothing" (int 2, 521), and when asked what made her nervous, she replied, "I'm really not sure. It's not that I had surgery before and that scared me. I'm not too sure" (int 2, 541-542). This participant then added, "It would have helped if I knew what was going on" (int 2, 562). When participant H was asked about her presurgery concern regarding developing a dry socket, she replied, "[I am] glad that never happened, I never thought about it" (int 2, 543).

When asked about their surgery, one participant exclaimed "The procedure was not as bad as I thought it would be, I am glad it is over with" (Participant E, int 2, 321/ 325) and Participant I shared the same thoughts by stating, "It was an okay experience and [I'm] happy I got it over with and done" (int 2, 653). Interestingly, both of these participants described themselves as being nervous before the procedure. However, Participant I reflected on her pre-surgical apprehension by

stating, “I think it was just the fact that I was being put under for the surgery. I definitely would not want to be awake during that (int 2, 657-658). Similarly Participant D described her experience as “it went pretty good” (int 2, 194), despite sharing how she was “really nervous” (int 2, 198) before the procedure. When asked why she may have felt this way, she put it this way:

I can't really say because I am not sure. Maybe it was because I didn't know what to expect. My sister told me how much it hurt when she had her teeth out, but now I know she lied. And I never felt like I was going to throw up. I don't know why I thought I would, [and] I didn't want to miss too many softball games (int 2, 222-225).

When asked about her presurgery apprehension, she added that her feelings came into being because “just that I worried for nothing, I think not knowing scared me” (int 2, 230-232). Participant C stated: “I mean the surgery went well. Everything was fine” (int 2, 80), and continued saying, “the surgery was routine and normal” (int 2, 87-88). Likewise, Participant B reported, “It wasn't as bad as I thought. I didn't feel anything. Like, you know I thought I would feel everything, but I didn't feel anything and it was really quick and it didn't hurt” (int 2, 820-823). Much like other participants, Participant A remembered her procedure, saying, “The procedure went well” (int 2, 726). A final participant expressed her relief, stating, “I came out of it alive and I survived. I mean, I made it through, so death is not a worry anymore” (Participant E, int 2, 281-282; 329). Thus, participants' reflections regarding their presurgery feelings suggested that they now thought those feelings had been groundless. However, despite this positive reflection on their preoperative feelings, participants

described a number of new concerns. These concerns involved the operating room, as well as issues that arose in the immediate recovery phase, and while at home recovering.

Concern

The stories participants shared about their surgical experience came with a multitude of concerns. While not all participants discussed the same concerns, many shared concerns that were specific to the operating room, recovery room, and the first day after surgery. In addition, many discussed their experience of pain following the surgery and what they did not know about the experience.

“In the room...” Most of the participants recalled concerns they experienced upon arriving into the operating room. As Participant D explains,

I didn't know what was going on. After talking to you, they called me back. I went into the room and they put a mask on me. It smelled. I could hear them talking to each other, but no one was talking to me. It was as though I wasn't there. Dr. H. came in and asked how I was doing. I couldn't say anything because of that mask on my face (int 2, 196-201).

Participant E willingly shared her recollection of her surgical experience, by sharing her concerns when she was in the operating room:

I could say that I was very nervous beforehand and when I went in of course, a million things went through my mind. When it started, I felt as though they were connecting me to 15 different things. And I like had a gas mask on and couldn't ask any questions and they weren't explaining things to me and it made my mind race and I remember

hearing this thing beeping, it wasn't very steady, it was like all over the place and I kept thinking, "Is that my heartbeat? Is that my heart beat?" And like something must not be right. So, I went under... (int 2, 280-303).

Participant E continued her story by expressing a desire to have had information about the operating room by explaining why the information would have helped her "probably just to know what to expect because I just went in there and they started hooking me up to all this stuff" (int 2, 337). She explained further:

[It] would have helped, like, if they would have explained what they were doing, like this is to monitor your heart, this is for anesthesia, this tool we will use to cut you, and yeah, I wish they would have explained it more so that I would have a clear mind that ok, they knew what they were doing; it was like I wasn't reassured they knew what they were doing. (int 2, 345-347).

Participant A shared the little she remembers about the operating room saying, "I don't remember much about the actual surgery. I remember walking into the room and sitting in the chair. They told me they were going to start an IV..." (int 2, 726). While Participant E explained, "I just went in there and they started hooking me up to all this stuff up to me and then I woke up and was all sore" (int 2, 339-340).

A few participants had limited recall of the events in the operating room. As Participant I stated, "I remember being put out..." (int 2, 614); while Participant C shares her experience of the operating room "I remember them being like, oh, "this will make you sleepy, and then I was passed out" (Participant C, int 2, 90). For these

participants the unfamiliarity of the operating room environment and routine caused concern for them. Once in the recovery room, several participants shared stories that described what caused them concern. In particular, participants wondered how they got to the recovery room.

“How did I get here...” Postoperatively, participants recalled entering the surgical room under their own power, but rather mysteriously being in another place afterwards and having no idea how they came to be there, thereby causing concern. Some recalled waking up in the recovery room and having a loved one sitting next to them. Participant C stated:

I remember laying down sideways in a different room than I was in [for the surgery] and my mom was there and she was trying to wake me up. I was just like how did I get to this room. But I couldn't understand why I'd feel like that (int 2, 93).

Participant A remembered her experience, saying:

...and the next thing I remember is my mom sitting next to me. It was weird because I don't remember walking to the room, but I guess I walked on my own. (int 2, 726-731).

While Participant D remembered, “Next thing I knew, my mom and dad were sitting next to me. I went home soon after that” (int 2, 201-202), and Participant H recalled “the next thing I knew, my mom was sitting next to me asking me how I felt. My mom helped me get up and walk to the car” (int 2, 524-525). Participant I shared that she “didn't really know what was going on, I was kind of freaking out. I kept asking my mom questions and I just didn't know what was going on” (int 2, 619). Participant

F stated, “I don’t remember much about the surgery itself. I remember waking up and my mom sitting next to me” (int 2, 414-415). Another participant recalled waking up in the recovery room, as Participant I remembers, “...and then just all of a sudden waking up all loopy” (int 2, 614). One participant continued sharing her operating room concern as she told the story of her recovery room stay:

I can’t remember anything [in the operating room], until I started waking up and I remember my mom and sister in the room and they were just like laughing at me for gosh, I can’t even remember how long. Eventually they told me all about it. All I kept saying was: Is that my heartbeat? Is that my heartbeat?... and I kept hearing that beep when I woke up and no one ever answered me and I still don’t know if that was my heartbeat. It didn’t seem very regular though so I honestly worried that I have an irregular heart beat so it was the only noise that would make sense to be a monitoring thing or like a gas or anesthesia or something. I pretty much focused on that noise, but I did hear a lot of talking and I was worried they would be laughing about my teeth while I was [still] under or talking about me while I was under, but I honestly just focused on that heartbeat” (Participant E, int 2, 280-303).

Here the participant is describing an irregular heartbeat, which is a common side effect of anesthesia. But, this auditory experience was of concern for her because her hearing came back prior to her other capabilities, such as speech. As such, the participant could hear the irregularity, but could not communicate her concern and distress.

Thus, several participants had a sense of mystery about how they moved from the surgery room back to recovery, and this seemed disconcerting to them. In addition, many participants found the time immediately after the surgery perplexing, as they could not make sense out of some events that occurred during this time. Once discharged home, several shared new concerns they had and described the difficulties they faced the first day after discharge.

“The first day was pretty tough...” The first day after the procedure was a “lost” day as expressed by several participants. In their story about the first day after surgery, many shared how much they slept and how little they ate. For instance, Participant F described her first night, “...I went to sleep as soon as I got home and stayed in bed. I couldn’t do anything that night, (int 2, 417-418), and sums up her first night as being “pretty tough” (int 2, 407). Participant D shares what she did after returning home “I slept for like 6 hours. It was past dinner and I was starved. My mom brought in some chicken soup. I ate it... and fell back to sleep until the next morning” (int 2, 203-205). This participant explained that even the next day was lost to her. She states, “I took a pain pill and went back to bed. All I remember is that I slept a lot, or at least tried” (int 2, 214-216). When asked what she meant by tried, she tells the story of her mother, “My mom kept checking on me. She is so weird, asking me if I was sleeping and if I was ok” (int 2, 217). Yet another participant explained her first night after the surgery, “I just wanted to go to sleep pretty much. I didn’t really want to do anything, eat anything. I just wanted to sleep it off” (Participant I, int 2, 634-635) and Participant E shares “I just went home and slept” (int 2, 311). Participant H shares her story:

I don't remember much about that night. I didn't get up until the next morning. I slept for about 15 hours. I pretty much slept all day; my friends were texting me, but I ignored them. As soon as I got up, my mouth started to throb. I looked in the mirror and my cheeks were swollen up (int 2, 527-529).

Thus, while some concerns varied among participants, those who commented on sleep told very similar stories of sleeping more than usual and trying to stay asleep.

Other participants told stories about recovering at home. While one participant stated "My face didn't get swollen. I was able to eat a lot of foods that I thought I couldn't" (Participant C, int 2, 57), Participant E described her day after leaving the clinic, saying: "I really wasn't up to eating anything. We stopped for a milkshake on the way home and that was painful...I was very sore" (int 2, 310-313) and continued with the day after surgery, "I had a little puffy cheeks, I was just sore". (int 2, 312-313).

According to participant C, the day after surgery she found "I couldn't keep a lot of things down. I threw up twice, so I couldn't eat a lot of foods" but continued by saying "I have not been nauseated for the past couple of days and I've been eating fine and yesterday I ate fine" (int 2, 59-60). Another participant's postoperative eating story connected her to her sister's experiences and her sister's support, "I came home and my sister bought me a bunch of baby food so I didn't have to chew, but I really wasn't up to eating anything" (Participant E, int 2, 308-310). She continued, "I couldn't eat much I felt sick" (int 2, 312). One participant described her first breakfast after the surgery, "I ate pudding for breakfast, but it was hurting too much"

(Participant H, int 2, 533). Participant F's experience lacked the negative side others reported: "The first night I don't remember eating a lot. The next day I had applesauce, pudding, and mac and cheese. The mac and cheese tasted good" (int 2, 433-434). In recalling her second postoperative day, she continued, "I pretty much ate everything. I still haven't eaten hard things, like nuts or apples, but I am pretty much eating what I want" (int 2, 435), and added "I didn't feel nauseated at all when I ate" (int 2, 439). Thus, participants' descriptions of their experiences with eating were quite varied, from being nauseous enough to not be hungry or able to eat, to eating particular sorts of soft food, to eating almost everything, except "hard" foods. Here, participants spent the first day after surgery eating little and attempting to sleep, which was facilitated by their pain medications.

Hurting. Almost all participants described the experience of general pain and hurting. One participant described her experience stating, "My mouth started to throb and it was hurting too much. As soon as I got home, I took a pain pill. I don't remember much about that night" (Participant H, int 2, 527-529). While another participant explained, "I was in a lot of pain even though I took my pills like I was supposed to" (Participant F, int 2, 417). While Participant E described her mouth and pain in this way, "I had a little puffy cheeks, I was just sore. Oh man, I was hurting" (int 2, 314-315). Participant I explained her first night after the surgery "I was just feeling a lot of pain from my mouth" (int 2, 634- 635). In explaining how her experience of pain had changed, participant A said: "The pain wasn't bad and each day it is getting less painful. It still hurts when I talk a lot and when I eat, it hurts to yawn" (int 2, 738). Another participant, B, stated, "Afterwards, it was painful to chew

or open my jaw” (int 2, 824). “I took a pain pill and went back to bed” (Participant D, int 2, 214-216). Participant A took almost the same tack: “I took a pain pill every 6 hours; I even woke up during the night to take them” (int 2, 737-739).

Several participants stated they were in pain or experienced feelings of “hurt” or “hurting.” For example, Participant G said “it hurt really bad” (int 2, 912); another participant, H, emphatically declared “it was hurting too much” (int 2, 533). In addition, Participant D recalls that when she got home “... I started to hurt, and took a pain pill” (int 2, 203/208). One participant referred to a feeling of being sore: “I was just sore” (Participant E, int 2, 315/340). One participant described her pain as “It’s probably a 5, I feel it, I know where it is, but I don’t feel a lot of pain” (Participant C, int 2, 76). Thus, these participants acknowledged experiencing pain, however, addressed the concern by taking the pain medication that was prescribed to them. The experience of hurting and pain for these participants was different for two participants who developed dry sockets.

Participant G tells of her experience of pain by saying: “A few days after my surgery, my mouth started to throb and hurt really bad. I have a dry socket and am in a lot of pain” (int 2, 911-912). She continued with “... and I know it hurts” (int 2, 913). A second participant, C, shared her experience with a dry socket: “I had dry sockets...I got a dry socket on Friday”...and explained her treatment by saying, “they put gauze in and they removed blood clots and that helped. With the dry socket and pain I’ve been in, I haven’t been feeling up to working out” (int 2, 51-53; 66-67). Thus, only two participants developed dry sockets, although most participants were well informed about this complication as it was discussed during the first interview.

Unfortunately, several participants wished they were as knowledgeable about other after effects of the surgery as they were with dry sockets.

“I didn’t know that…” Following the procedure, many participants expressed concern that they had not gotten sufficient information to help them fully understand the procedure and what would happen to them afterwards. They described not knowing enough about the anesthesia used during the surgery or about the medicines prescribed for after the procedure. In addition, participants indicated that they did not know enough about how to care for themselves while at home.

When sharing concerns about anesthesia, a few participants indicated they wished they had more information about sedation and the effect it would have on them. Participant C described her concern, saying, “I guess I wasn’t used to, like, the effects of the sedation that put me under, I wasn’t used to what the medication would do to me”, and continued sharing her thoughts on the sedation by stating “but I couldn’t understand why I would feel like that” (int 2, 95). Participant C simply described that after the surgery she felt “out of it” (int 2, 97). Participant I shared her story by stating, “I remember being put out and then just all of a sudden waking up all loopy” (int 2, 614). When asked to describe loopy further, she continued:

I didn’t really know what was going on, I was kind of freaking out. I kept asking my mom questions and I just didn’t know what was going on. I just didn’t know where I was. I was confused about what happened. (int 2, 623-625)

Here, confusion about the effects of the sedatives used during the surgery was unsettling to the participants, much like the medications that were prescribed to be taken after the procedure.

When talking about their experience, some participants shared concerns about their medications. While one participant acknowledged her medicines came with instructions on the bottle, she stated, “It would have been nice to know more about the medications...but I still needed to know more about it, like how long I should take them” (Participant F, int 2, 463-465). Participant G stated in a matter of fact way, “I was confused about my medications” (int 2, 938).

Participant C discussed her concern stating she wished she knew about the side effects of her medications, “I felt really nauseous after taking the Vicodin. The codeine didn’t do well with my stomach, so I wasn’t able to take that. But all the other medications were fine” (int 2, 86). One participant experienced nausea after taking her medication, hesitant as what to do, she asked her mother for direction, “my mom told me I should stop taking the Vicodin and Motrin” (Participant F, int 2, 415-417). When asked why she thought her mother wanted to stop the medications, she responded, “The Vicodin was hard on my stomach, it made me nauseated, so now I am taking just Tylenol a few times a day” (Participant D, int 1, 429). When encouraged to discuss other medications she was prescribed she added, “I am still taking my antibiotics. I will finish them later this week. I think I have to be on them for a week. I took the pills to help with the swelling, but that was for a couple of days” (int 2, 429-431). One participant described how she took her medication, “Yeah, I took my pain pills like I thought I should” (Participant G, int 2, 917). Many

participants found the medication made them nauseous. One participant stated, “it [Vicodin] made me nauseated (Participant F, int 2, 430), and further elaborated, “I didn’t feel nauseated at all when I ate, just after the pain pills” (int 2, 439). And another participant “threw up twice” (Participant C, int 2, 59).

Thus, although participants reported following the instructions for taking their medications, some experienced nausea and other distress they associated with the pain medications. These participants indicated that had they known more about the medications that were prescribed they would have had fewer concerns and a less stressful recovery period.

A few participants provided suggestions as to what they would liked to have known to help them better understand the procedure. For example, one participant noted her concern by stating, “I was worried something was wrong with me since I was numb most of the night. I guess if they gave me a timeline of what to expect the first night, it would have helped” (Participant A, int 2, 777-778). Another participant who experienced a dry socket wished she knew what to do to prevent dry sockets, “... like the rinsing with salt water. I didn’t know to do that which probably caused my dry sockets” (Participant C, int 2, 103). One participant who experienced swelling was not sure what to do, so she listened to her mother and stated, “I kept the ice packs on me to keep the swelling down... and I felt really embarrassed” (Participant E, int 2, 315), and offered this suggestion:

If they would have explained what they were doing, like this is to monitor your heart, this is for anesthesia, this tool we will used to cut you, and yeah, I wish they would have explained it more so that I

would have a clear mind that they knew what they were doing...(int 2, 343-348).

Another participant identified a daily behavior that proved to be troublesome after her surgery, the proper way to brush her teeth, as she shares her concern:

I didn't know how to brush my teeth. They might have told me how, but I can't remember. I brush the front teeth like I always do, but I just rinse with mouthwash in the back. I am not sure if I am supposed to do that or not. It seems like it is ok, but I don't know (Participant G, int 2, 938).

Several participants suggested information that would have been helpful to have prior to the procedure. One participant explained, "I would have liked for someone to tell me the procedures to do after the surgery more. I think they might have told my mom, but I would like to know myself" (Participant C, int 2, 100). Participant E said: "I wish I could have sat down and talked to a couple of people who had the same procedure done" (int 2, 335). She thought this information would have been helpful and shared "probably just to know what to expect because I just went in there and they started hooking me up to all this stuff" (int 2, 337). She explained further:

[It] would have helped, like, if they would have explained what they were doing, like this is to monitor your heart, this is for anesthesia, this tool we will use to cut you, and yeah, I wish they would have explained it more so that I would have a clear mind that ok, they knew

what they were doing; it was like I wasn't reassured they knew what they were doing. (int 2, 345-347).

One participant expressed uncertainty about what information she would have liked stating, "I don't know...maybe if I knew everything that was going on, it would have helped." (Participant H, int 2, 559). Finally, one participant stated, "I acted like I knew what I was supposed to do so she [mom] wouldn't worry about me" (Participant G, int 2, 938-940).

Thus, some participants shared what caused them concern after the procedure, some they anticipated, and others that seemed more troublesome than expected. While a few of the participants had suggestions about information that may have alleviated some of their concerns, others recognized that they had received some information but sought additional advice about their procedure and its after effects. The stories of the adolescents provided an insight into what was important to them to understand the procedure, however, one continuous feature within all the stories was their mother and the role she took during the surgical experience.

"I needed my mom"

In telling their stories, all participants shared how their mother provided support throughout the surgical experience. Although mothers filled different roles during the experience, it became apparent when listening to the stories how important mothers were to the participants.

Immediately after surgery, several participants remembered having their mother present. Participant F stated, "I remember waking up and my mom sitting next to me" (Participant F, int 2, 415). Participant C remembered, "...and my mom was

there and she was trying to wake me up, I needed her..." (int 2, 93). One participant recalled her mother sitting next to her and "asking me how I felt. My mom helped me get up and walk to the car" (Participant H, int 2, 524-525), which was something also recalled by Participant A (int 2, 767) and F (int 2, 417). One participant had both parents present, saying, "Next thing I knew, my mom and dad were sitting next to me. I went home soon after that" (Participant D, int 2, 200-201). After arriving at home, the participant continued telling her story of how her mom continued providing care by sharing, "My mom brought in some chicken soup, (Participant D, int 2, 203), and "I think it was oatmeal my mom made me" (Participant D, int 2, 210). Plus, "my mom kept checking on me. She is so weird, asking me if I was sleeping and if I was ok" (Participant D, int 2, 218-219). Another participant described mom preparing food, "My mom made me soup and pudding" (Participant A, int 2, 760). A few participants appeared to be grateful their mothers were taking care of them. "My mom was very good in taking care of me, she knew what to do, and my sister helped out too" (Participant E, int 2, 324), while Participant A remarked, "Luckily, my mom was there" (int 2, 768). Participant I explained, "I kept asking my mom questions and I just didn't know what was going on" (int 2, 619). Mothers also provided advice to the participants, "My mom told me I should stop taking the Vicodin and Motrin [because of stomach distress]" (Participant E, int 2, 426-427), while Participant B explained that her mother "told me what to expect since she had hers removed" (int 2, 841). Finally, one participant, knowing that her mother would be caring for her, expressed concern for her mother saying, "I'm mostly just concerned about worrying my mom" (Participant G, int 1, 881). All participants spoke of their mothers playing a

significant role throughout their experience, providing a postoperative support network.

Summary of the Postoperative Experience

The second interview was conducted about seven days after the surgical procedure. The participants were asked to reflect about the procedure. From the stories they shared, three themes emerged, "...not as bad as I thought," concerns, and "I needed my mom." Many participants reflected on the procedure and stated, "It was not as bad as I thought." Thus, many participants spoke of their presurgery feelings of apprehension as being unjustified; however, several participants did share concerns they had about the procedure. These included uncertainty about the activities in the operating and recovery rooms. Many discussed concerns about the first day after surgery and spoke of time lost during recovery at home. In addition, concerns about after care were discussed. Several participants wished they had received more information about the procedure as many talked about "things I did not know." All participants shared stories about their mothers and the roles they played in their care.

Summary of Findings

The themes for the perioperative experience of adolescents' were 'I knew that...' and feelings of apprehension for the preoperative experience. Following the surgical procedure, themes gleaned from the postoperative stories were "not as bad as I thought", concern, and "I needed my mom".

During the first interview, immediately prior to the surgical procedure, participants presented with an awareness of the procedure and what was to come.

Even with prior knowledge, numerous feelings of apprehension were described by the participants, especially with anesthesia and after effects.

When the participants were interviewed the second time following the procedure, participants shared how the surgery was “not as bad as I thought,” even though the participants identified many concerns. These concerns involved events in the operating and recovery rooms. Upon returning home, several participants described concerns about after affects. These concerns included hurting, what they wanted to know about after surgery, and how to take care of themselves. This last concern was addressed as all participants shared how their mother played a prominent role in their care.

Interestingly, during the postoperative interview, many of the preoperative feelings were not discussed; however, the adolescents described postoperative concerns that were different from feelings that were shared during the preoperative interviews. For example, many participants discussed dry sockets in the first interview and shared feelings regarding the pain this may cause. However, during the postoperative interview, those who did not experience a dry socket neglected to mention it.

Phenomenology is the study of phenomena or the appearance of objects or aspects of reality as we experience them (Rodgers, 2005), and is concerned with the study of the individual’s lifeworld, as experienced rather than conceptualized (van Manen, 2002). The stories shared by the adolescents provided the true meaning, or essence, of their perioperative experience. What the stories told was that much like adults and children, this overall perioperative experience was difficult for and rose to

the level of being stressful for almost all participants. However, the developmental concerns unique to adolescents added another layer to the meaning of this experience. Specifically, issues with autonomy and loss of control were gleaned from the stories the adolescents shared about their perioperative experience. Stress is defined as the relationship between a person and the environment that is appraised as taxing or surpassing available resources and threatening one's well-being (Lazarus & Folkman, 1994). When an individual has feelings of apprehension or concerns, they experience feelings of stress (Steinberg & Morris, 2001). Stress will be further discussed in the following chapter.

Throughout the perioperative experience, participants shared their feelings of apprehension and concerns. By presenting with a range of concerns (from very little to mixed to scared, nervous, and worried) the participants responded to an anticipated threat. Postoperatively, the participants had a grasp on the current situation and had the opportunity to do something about it, thereby addressing concerns they had. During the preoperative interview, participants shared what they knew, while during the second interview, many discussed what they wished they knew. Here, all participants wanted to know what was to come, obtained information, but wanted to know more. All participants were taken care of by their mothers, and many implied it was comforting she was there and found this reassuring.

This chapter presented the stories of a surgical experience as perceived by nine female adolescents. What is needed next is to interpret these experiences so that an understanding of the perioperative experience will be known. According to van Manen (1990), all human experiences can be explored through the four existentials

that comprise the lifeworld, regardless of their historical, social, or cultural experiences. In phenomenological literature, these existentials are considered as belonging to the basic structure of the lifeworld as experienced in everyday situation and relations. By exploring the experience through the existentials, the perioperative experience of adolescent will be understood.

CHAPTER 6

REFLECTION on the FINDINGS

The aim of this study was to understand the meaning of the perioperative experience of adolescents. This study articulated voices of nine adolescents undergoing an ambulatory surgical experience. The method used to investigate this phenomenon was based on the phenomenological method of Max van Manen. This chapter will reflect on the findings and review extant literature related to perioperative experiences. Much like adults and children, the overall essence or meaning of the perioperative experience was that it was stressful to the adolescent. Stress will be defined and how it relates to the perioperative experience will be discussed. Developmental and life concerns unique to this age group will also be presented as these stages contributed to the perception of the experience. A discussion on the contributions to the discipline of nursing will then be presented, specifically how the results of this study can inform nursing theory, practice, and implications for future perioperative research. Finally, limitations of the current study will be discussed.

Exploration and interpretation of individual meanings led to five themes. Two themes, “I know that...”, and feelings of apprehension were gleaned from preoperative experiences of the participants. For the postoperative experience, three themes were identified. These themes are “not as bad as I thought”, concerns, and “I needed my mom”.

Preoperatively, all participants appeared to have an understanding of what the procedure would entail. Most participants verbalized an understanding of what was to

come, in other words, a theme of “I know that...” was gleaned from the interviews. Many participants described varying degrees of nervousness, unease, and worry providing a theme of feelings of apprehension.

During the postoperative interviews, many participants shared similar stories of their experience. For example, when referring to the procedure comments such as “it went pretty good”, “everything was great”, and “I guess I was nervous for nothing” were common, thus indicating the procedure was “not as bad as I thought.” Many participants talked about uncertainty and unease regarding the surgery and recovery, hurting, and not knowing enough about the experience, thereby signifying a theme of concern. In sharing stories about their day of surgery and subsequent days of recovery, all participants included their mother in the stories. One participant was thankful her mother was there, several shared how their mothers took care of them, indicating that they needed their mother, providing the theme “I needed my mom.”

Through the analysis of participants’ descriptions of their perioperative experiences, five themes, as described above, emerged. Reflection is the primary means of discovering the essence of the experience and allows researchers to obtain a deeper meaning of the experience by identifying and interpreting commonalities that are essential for the phenomenon to exist. The concept of lifeworld provided a phenomenological framework for interpretation of the perioperative experience; the lifeworld that guided reflection are lived body (corporeality), lived space (spatiality), lived relation (relationality), and lived time (temporality).

Lifeworld

Lifeworld is defined as the “common sense interpretive frames and logics by which individuals pre-reflectively and conceptually organize their perceptions of everyday life” (Fincher, 2011). The lifeworld can be thought of as the horizon of all experiences, the background on which all things appear to each person, and thus refers to the world of lived experience. According to Munhall (2012), the lifeworld is a dimension from which we can process phenomenological material to give meaning to an experience. van Manen (1990) believes that the existentials of lived body, lived space, lived time, and lived relation pervade the lifeworld of all people regardless of their historical, social, or cultural experiences. As such, all humans have experiences that can be explored through the existentials of their lifeworld. In phenomenological literature, these existentials are considered as forming an intricate unity, creating the basic structure of the lifeworld as experienced in everyday situations and relations. By examining the perioperative experience of adolescents through the four existentials, a deeper understanding of the experience may be obtained.

Lived body. Corporeality, or lived body, is the experience of the body in the world. The experience of corporeality involves appraisal and ascribes the meaning the individual places to the physical and emotional body. Adolescence is a time of marked changes in physical appearance and requires adaptation on the part of the adolescent. The adolescent searches for self-awareness and self-identify as one tries to understand and discover who they are as an individual. Emotional development is an essential component of an individual’s sense of self-awareness (Crandell, Crandell, & VanderZander (2009). Erikson best describes how the adolescent searches for

identity: ...a feeling at home in one's body (Erikson, 1982). Lived body was well represented in the stories participants told.

Preoperatively, almost all participants talked about developing dry sockets, a complication associated with wound healing, and one participant stated she did not like her face being touched. Two participants described how the surgery was done by stating, "they cut open my gums", while another described it as "being cut". Two participants talked about having a mask put on their faces, while several shared how an IV was started. One participant spoke of the activities in the operating room by sharing how they connected her [body] to "15 things", which made her "mind race". Upon waking up in the recovery room, several participants spoke of hearing noises, such as a heartbeat, while one participant shared how she heard "things going on around me". It is common for the sense of hearing to return before other senses begin to function after receiving sedation.

Several participants described how the sedation and medication made them feel "funny" and "not like myself." One participant stated she did not know she would feel "funny" and further described her experience as "a weird feeling" throughout her body. Another participant described waking up as "I was out of it, it was as if I wasn't there."

After discharge, one participant needed her mother's assistance in walking to the car, as she stated "my mom helped me [walk] to the car", suggesting the participant needed physical assistance in getting to the car. After returning home, several participants experienced nausea and described being sick. Referring to pain medications one participant stated, "they were hard on my stomach," while one

shared that she could not take Vicodin as it “didn’t do well with my stomach”. One participant had problems with the antibiotic, described how she felt sick, and vomited twice after taking the medication.

The days after surgery presented with several challenges as one participant did not know how to brush her teeth, or if she should rinse her mouth in trying to alleviate the pain she was experiencing. Several participants described pain and hurting after the surgery. One shared how her mouth throbbed, another was in “a lot of pain [in my mouth],” while one shared how talking hurt her mouth. One participant best described her experience with pain, as “oh man, I was hurting.” Two participants developed dry sockets and shared how painful the experience was. One described the treatment for dry sockets as sharing “they removed all the blood clots from my mouth and packed it”.

Throughout the stories shared, the participants showed how they were developing emotionally as they presented with a sense of self-awareness, which includes self-esteem, self-worth, and self-image. Appearance is important to adolescents (Santrock, 2001; Steinberg, 1989), especially females (Steinberg & Morris, 2001), thus many participants had concerns about facial features after the procedure. Several participants had concerns about their appearance; this concern was apparent as participants shared their feelings by stating, “I looked horrible”; “I looked like a chipmunk”, “my face was swollen”, and one went as far to say she was “embarrassed” by the way she looked.

Many participants described a sense of unease throughout the experience which may be due to the loss of control throughout the perioperative events. Several

participants shared “I didn’t understand”, “It would have helped if I knew what was going on”, and “I don’t remember anything”. These feelings of unease may be due to the effects of the anesthesia and sedation, which placed the adolescents in a compromised state.

Lived space. Lived space, or spatiality, is space that is felt; it is the space people feel that they need around themselves to feel comfortable” (van Manen, 1990, p. 103). Because lived space, or spatiality, is pre-verbal, most individuals do not reflect upon it. van Manen suggests that “we become the space we are in” (1990, p. 102); it is the experience of a person when they become aware of their environment before language is used to identify what is felt or seen (van Manen, 1990, p. 102).

Spatiality was represented in this study in numerous ways. Several participants in this study were keenly aware of their environment throughout the surgical experience. In the operating room, one participant shared, “I remember walking into the [operating] room, sitting in the chair.” While another participant tells of her experience in the operating room, “I could hear them talking, but no one was talking to me. It was as though I wasn’t there.” Once in the operating room, one participant became curious about the noises she heard and instrumentation that was in the room. A few participants remember the recovery room experience by feeling confused at where they were. One participant stated, “I was not sure how I got here. I was just like how did I get to this room.” While one remembers waking up and “being in a different room.” Several participants shared a different experience in the recovery room, by remembering they woke up in the recovery room with their mothers sitting next to them. After discharge, several participants shared how they spent time in bed,

especially the first day after the surgery. Many participants stated they stayed at home for a “few days” before venturing out.

The stories shared by the participants suggested the experience affected their autonomy. The stories indicated a sense of unease and dependence on others in the participants’ environment. For example, one participant stated “I don’t like my face being touched”, while another felt as though she was ignored and could not ask questions. Another participant shared how she could not talk while another participant wished she “knew about the tools they were going to use.” Within the stories, a sense of uncertainty and being uncomfortable in the environment was gleaned. These feelings of unease, uncertainty, and being uncomfortable may be due to the participants not having control of the environment as the adolescent had to surrender control to others throughout the perioperative experience.

Lived relationality. van Manen (1990) defines relationality as the “lived relation we maintain with others in the interpersonal space that we share with them” (p. 104). Adolescents experience a change within the family relationship as there is a need to form close and caring relationships with people outside of the family unit. There is also an increased need for privacy with adolescents. The analysis of the narrative data regarding lived relation offered insight into the relationships the participants experienced throughout the perioperative experience.

When the adolescent made it known they were scheduled for a procedure, family and friends willingly shared stories about their surgery. Numerous participants described what they expected to occur during the procedure by repeating what they heard from family and friends. Despite the fact that all participants received

information from clinic staff, they talked most about what they had heard from family and friends. In the operating room, a few participants remembered the staff being present, “I went into the room and they put a mask on me...I could hear them talking”, and “I felt as though they were connecting me to 15 different things”, “I remember walking into the room, sitting in the chair.” An interesting comment made by one participant questioned the competency of the staff “...so that I would have a clear mind that ok, they knew what they were doing, it was like I wasn’t reassured they knew what they were doing.” And one participant’s interaction with the staff in the operating room felt as though “I wasn’t there”, so the participant felt as though she was non-existent to the staff.

From the narratives of the interviews, the participants clearly suggested the closeness of the relationship between themselves and their mothers. As one participant stated, “Luckily, my mom was there.” Many other participants echoed this statement by describing how their mothers took care of them throughout the recovery phase. Interestingly, one participant was concerned about saying something that might disappoint her mother, while another participant had concerns about worrying her mother. Many participants discussed the role their mother played, “I woke up and she was there asking me how I was doing”, while another recalls, “my mom kept checking on me.” Another participant remembers that while waking up her mother and sister were sitting next to her “laughing at me.” Overall, all participants shared stories about their mothers and several stated how important it was to have their mothers present, while one participant remembers her mother and sister being present but was unsure why there were laughing.

From the stories shared by the participants, many developmental aspects of adolescence were present. For example, peer relationships were important as many participants shared with friends they were scheduled for surgery and obtained information from peers about the procedure. Autonomy was affected as all participants shared how they relied on and were dependent on their mothers for care throughout the perioperative experience. Egocentrism was also found within the stories from the participants. Adolescents believe that everyone in the local environment is concerned with the appearance and behavior of the adolescent (Crandell, Crandell, & VanderZanden, 2009), in other words, the adolescent is center of attention. While it is true that within the surgical experience the patient is the center of attention, from the stories shared by the participants it was more pronounced with the participants in this study. Several participants expressed feelings of being ignored once in the operating room while one participant felt her mother and sister were laughing at her. Interestingly, one participant was apprehensive that she may say something to disappoint her mother.

Lived time. van Manen (1990) defines temporality as subjective time, not objective time and “includes dimensions of past, present, and future; lived time is our temporal way of being in the world” (p. 104). It is linked to the individuals’ perception of time and is dependent on the person’s awareness of their life experiences. In this study, lived time presented as an interesting existential. A limited number of participants could recall the time spent in the operating room, and only a few remembered the immediate postoperative experience. Participants stated, “I don’t remember much about the actual surgery; “It was weird because I don’t remember”;

“I can’t remember anything that happened.” Adolescents are developing complex thinking processes; however, this loss of time may prove to be unsettling to them as they try to make sense of what happened to them during the surgical procedure.

Following discharge, several participants shared how much they slept. For many it was a “lost” day as explained by several participants, “I slept for about 15 hours”, “I went to sleep as soon as I got home and stayed in bed.” While one participant tells how she spent her time at home recovering, “All I remember is that I slept a lot, or at least tried.” Most of the participants told their stories based on subjective time, not objective time.

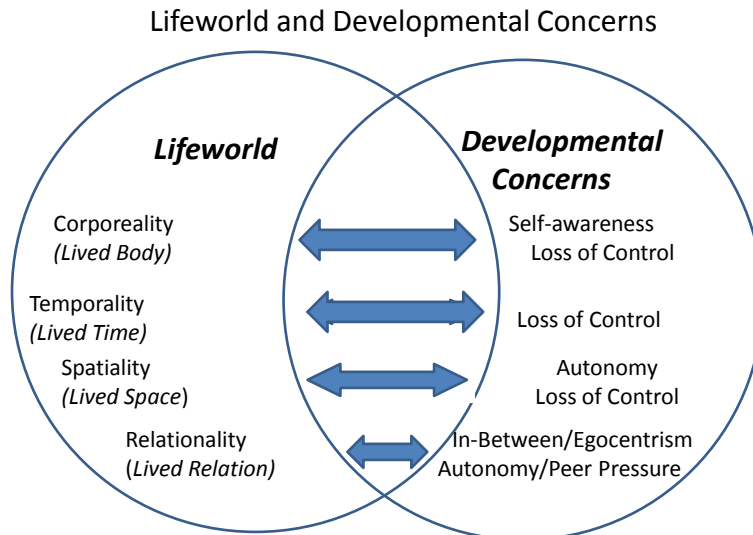
Many participants acknowledged they would return to their usual activities soon following the procedure. Several participants were active in sports and suggested that resting and “taking it easy” would allow them to return to their usual activities sooner. One participant shared a specific time line on her recovery by sharing “So, I will be back on the field hopefully in a week; while another stated: “I don’t want to be out for 2 weeks.” This logic may be due to the ability of adolescents to engage in hypothetical thinking. Hypothetical thinking helps in formulating a solution and changing behaviors by thinking ahead; this type of cognition plays an important role in decision-making (Steinberg, 1989). Here, deciding to rest and “take it easy” may allow them to return to their activities sooner.

From the stories shared by the participants temporality was well represented. For the adolescent, the perioperative experience included lost time. The experience of lost time may have caused apprehension for the adolescent as a loss of control of

events occurred throughout the perioperative event and the postoperative phase of the experience.

The current study found the existentials of corporeality, spatiality, relationality, and temporality well represented within the perioperative experience. It is through these elements of the lifeworld and developmental concerns that the adolescents' experience was perceived and gave meaning to the perioperative experience. The developmental concerns that were reflected within the stories include self-awareness, loss of control, autonomy, in-between, peer presence, and egocentrism (Figure 6.1).

Figure 6.1 Lifeworld and Developmental Concerns



The lifeworld provided a phenomenological framework for interpretation of the perioperative experience as perceived by the participants as well as providing organization to help make sense of the experience. Humans have the ability to

perceive an immediate awareness of a lived experience and to understand it through self-awareness within the body. Phenomenology is a way of thinking that allowed the researcher to reveal the perioperative experience as it was lived by adolescents through the lifeworld. To further understand the experience, the Neuman Systems Model (NSM) can be used as it utilizes a holistic approach to nursing and allows a connection between lifeworld and the affect on health.

Neuman Systems Model

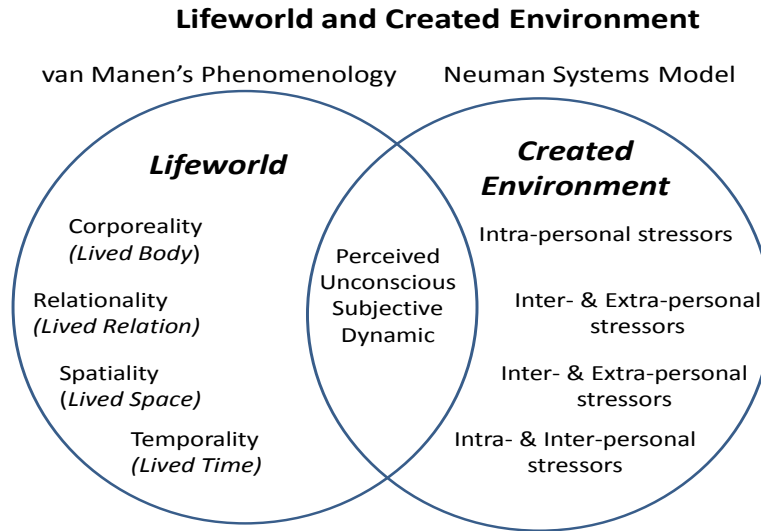
The Neuman Systems Model (NSM) is a nursing conceptual framework that has as its focus the wellness of the client related to environmental stress and reaction to stress (Neuman & Fawcett, 2011). The client is viewed as an open system in constant interaction with the environment. The environment consists of internal, external, and created environments. Included within the client's environment are intrapersonal, interpersonal, and extrapersonal stressors. Nursing is defined as "actions which assist individuals to maintain a maximum level of wellness through actions that are initiated to retain, attain, and maintain optimal client health or wellness" (Neuman & Fawcett, 2011, p. 25) and includes implementation of interventions to reduce stressors or stressor reaction. Health is a condition in which all parts are in harmony within the client. The NSM examines stress and the client's reaction to stress.

The researcher believes that understanding how the individual creates their environment is important in providing nursing care. The needs of an individual are created by the meanings that are attributed to the experience. By understanding the adolescent's perioperative experience, nursing care can be provided that addresses

what the adolescent has identified as stressful throughout the perioperative event. As the environment plays a significant role in the perception of the perioperative experience, environment will be discussed.

The environment encircles the individual, includes external, internal, and created environment, and is in constant interaction with the client. External environment is outside of the client and consists of influences existing outside the client systems and includes inter- and extrapersonal stressors. The internal environment is contained within the person, consists of influences contained exclusively within the boundaries of the client, and correlates to intrapersonal stressors. The created environment is developed unconsciously and shapes the lives and perceptions of the person, in other words this is where the person creates their reality. The created environment “supersedes the internal and external environments, encompassing both” (Neuman & Fawcett, 2011, p. 21). An important objective of the created environment is to stimulate health as the created environment has an insulating affect that allows the person to respond to environmental stressors or perceived stressors.

Individuals construct reality through the created environment, which is formed through perception of an experience. It is through the lifeworld of lived body, lived space, lived time, and lived relation, that this reality is organized and perceived, thus providing the lived experience. Both the lifeworld and created environment are dynamic, subjective, and perceived unconsciously (Figure 6.2). Although the lifeworld provided a way to interpret the perioperative experience, the NSM allowed for further exploration of the surgical experience.

Figure 6.2 Lifeworld and Created Environment

The NSM provided a guiding framework for understanding the adolescents' surgical experience from a nursing perspective. The NSM describes a multi-dimensional client system that is constantly exposed to environmental stressors. These stressors can be real or perceived and may have either a positive or negative outcome effect. Well-being, or system stability, can be disrupted when stressors break through the protective layers causing depletion of client energy with maladaptive responses to stress. It is important to understand how the adolescent perceived the perioperative experience so that possible intervention measures can be identified to address what was perceived as stressful throughout the perioperative experience, thus promoting a positive outcome effect.

Stress

Adolescents in the current study voiced feelings of apprehension and concern throughout the perioperative experience. When an individual has feelings of

apprehension or concerns, they experience feelings of stress (Steinberg & Morris, 2001). Though there are many theories that focus on the specific relationship between stressors and stress, two will briefly be described: one that examines systemic stress and one that has a transactional perspective. The content of the NSM was drawn from these theories (Neuman & Fawcett, 2011).

The theory by Selye is based in physiology and psychobiology. According to Selye (1974), stress is “the nonspecific response of the body to any demand made upon it” (p. 14). Selye termed the reaction to stress as the General Adaptation Syndrome (GAS), which consists of three phases: alarm reaction, stage of resistance, and exhaustion. This general reaction to stress is viewed as a set of reactions that mobilize the organism's resources to deal with an impending threat (Krohne, 2002).

The next theory emphasizes the relationship between the individual and environment. According to Lazarus and Folkman (1984) psychological stress is transactional. Specifically, they define stress as “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, 1984, p. 19). From this perspective, stressors can be viewed as demands made by the internal or external environment that affects physical and psychological well-being. This model of stress is an appraisal theory that allows the individual to appraise the situation and determine whether or not the situation is benign, irrelevant, or stressful. If deemed stressful, then the person must determine if he or she has the appropriate resources to manage the stressor.

Building on the work of Lazarus and Folkman, the Neuman Systems Model (NSM) addresses stress, stressors, client reactions to the perceived stressors, and the effect that these stress-related concepts have on a person's health (Neuman & Fawcett, 2011). The NSM will be utilized to further examine the perceptions of the adolescent during the perioperative experience; a review of the NSM and how it was applied will follow.

The focus of the NSM is the “wellness of the client in relation to actual or potential environmental stressors and reactions to stress” (Neuman & Fawcett, 2011, p. 12). There are several key concepts important to understanding the NSM including client system, stressors, environment, nursing as prevention as intervention, and health. These concepts are described briefly below.

Client System

Within the NSM, human beings are viewed as open systems in constant interaction with both internal and external environmental forces or stressors (Neuman & Fawcett, 2002). Humans are a composite of five interacting variables. The five variables are physiological, psychological, sociocultural, developmental, and spiritual. These five variables have common characteristics and interact with, and influence all functions of the client system.

Variables. The five variables are physiological, psychological, sociocultural, developmental, and spiritual. Each will be discussed below in relation to how the variable was represented in the data from the current study.

Due to the similarities within the psychological and developmental variables, they will be discussed together, while physiological, sociocultural, and spiritual

variables will be discussed separately. However, it must be remembered that some overlap may occur due to common characteristics of these variables. Following definitions of each variable, a brief review of adolescent development specific to the variable will be presented.

Physiological variable. The physiological variable refers to internal function and bodily structure (Neuman & Fawcett, 2002). After experiencing rapid growth and development, the 18 to 21 year old reaches physical maturity and reproductive growth begins to level off, and is a time of maximum physiologic development and health (Santrock, 2001). Wisdom teeth, often referred to as third molars, usually appear between the age of 17 and 25. It is common for wisdom teeth to become impacted or erupt at an angle that can cause chronic pain for the patient. Interestingly, approximately 35% of the population does not develop wisdom teeth (American Association of Oral and Maxillofacial Surgeons, 2011).

In this study, participants experienced impaction of their wisdom teeth, therefore, excision was recommended. Participant data regarding the surgery and its after affects, including the effect of the medicines and sedation represent the physiological variable. All participants received information prior to the procedure and were able to describe what the surgery entailed, some sharing how they were going to be cut, and what after affects to expect. Following the procedure, many participants discussed how the medicine and sedation affected them. For example, stating they felt nauseated and “loopy.” Two participants described their experience with dry sockets and many shared how their cheeks were swollen. Thus, the physiological variable was affected in a number of ways.

Psychological and developmental variables. Psychological and developmental variables refer to mental and developmental processes as well as age-related activities and interactive environmental effects (Neuman & Fawcett, 2011). Cognition is developing as adolescents begin to think abstractly, reason logically, and draw their own conclusions from information provided (Rothrock, 2010). Subsequently, knowledge obtained is used in specific situations encountered. According to Piagetian theory of cognitive development (Steinberg, 1989) cognitive development of formal operations is developed during adolescence. It is during adolescence that deductive, reflective, and hypothetical reasoning is possible and egocentrism return and imaginary audiences are common (Steinberg, 1989). Imaginary audiences “involves having such a heightened sense of self-consciousness that the adolescent imagines that his or her behaviors is the focus of everyone else’s concern and attention” (Steinberg, 1989, p. 64). During this time, adolescents develop hypotheses and deduce or conclude which is the best way to solve problems and make rational judgments. It is through hypothetical-deductive reasoning that the adolescent systematically test possible solutions to a problem and arrives at an answer that can be defended and explained (Arnett, 2010). Problem-solving skills are developed by the use of trial and error strategies (Crandell, Crandell, & VanderZander, 2009). The ability to understand consequences of events and behaviors also develops (Crandell, Crandell, & VanderZander, 2009). Many decisions made by the participants during their surgical experience, such as taking medications and limiting social activities, represent the cognitive and problem-solving skills that adolescents are developing.

Preoperatively, all participants received information regarding the procedure. Due to the cognitive skills the adolescent is developing, an appraisal of the experience was apparent as the adolescents had an understanding of what was to come during the surgery and recovery. Many of the participants shared feelings of apprehension regarding the surgical procedure. These feelings focused on pain, eating, anesthesia, medication, and dry sockets. Postoperatively, the focus of many of these feelings had changed. For example, in discussing pain many participants during the preoperative interview stated pain was a worry, while postoperatively one participant stated "...it wasn't bad." Additionally, the participants continued with an explanation of how they took pain medication. These adolescents formed representation of their surgical procedure, and implemented coping strategies, here taking medication prescribed for pain. An appraisal of the pain occurred; this is evident by the participant stating the pain "wasn't bad." Many implied the experience was "not that bad," and stated they were nervous for nothing. It was apparent many adolescents were able to "think through" and reason what had happened to them. While a few stated they were confused after receiving sedation, an element of cognitive appraisal was obvious with many participants as they described how they reacted to the sedation and medication. All participants discussed what they expected during their recovery. While many understood the medicines that were prescribed, many stated they wished they had received more information. Several of the participants were involved in team sports and activities. There was concern with some of the participants that they may not be able to return to their activities soon after the procedure. One participant stated she was going to take "it easy" for a few days, while another was hoping to rest so she

could return to her team. From a cognitive perspective, preoperatively participants were able to describe what they expected to happen. However, despite having received information from clinic staff, family, and friends, adolescents were still apprehensive about what was to happen. According to Muris, Merckelbach, Meesters, and vandenBrand (2002), feelings of apprehension are common among children and adolescents and these feelings may function to motivate action to cope with a threat that is causing apprehension (Davey, 1993). In addition, a study by Salmon (1993) suggested that moderate levels of preoperative worry could help patients to prepare for surgery and reduce the stress of a procedure. The feelings of apprehension that adolescents discussed are representative of normal development.

Participants in the current study provided information that addressed intimacy versus isolation. Intimacy was evident in the theme “I needed my mom”. Data within this theme suggested that all participants have an important relationship with their mothers. From the stories shared, all spoke of the care their mothers provided and how much their mothers were appreciated, which suggested that the participants had a close relationship with their mother. A study by Wagner, Cohen, and Brock (1996) that examined coping in adolescents, found that adolescents coped better to everyday stressors when they had a close relationship with their mothers. Everyday stressors were defined as academic and social situations that the adolescent regularly experienced.

In addition, almost all participants talked about peers and siblings. According to Seiffge-Krenke (1995), support systems are often needed to buffer stress. These support systems are often found in close relationship with others, especially family

and friends. Many participants stated they received information from friends and peers while others discussed team activities in which they participated. Although participants did not discuss romantic relationships, their statements indicated that all participants had relationships based on friendship, respect, and connections with others.

In the stories shared, many participants struggled with autonomy, being self-sufficient and self-focused. Issues with autonomy were noted when participants discussed surrendering control throughout the perioperative experience: to the surgeon, staff, and mothers. This loss of control was unsettling to many as the adolescent is attempting to become autonomous: struggling with independence, while being dependent on many for care. Issues with independence and self-sufficiency were noted as participants relied primarily on information from friends, while depending on their mothers to provide care after the procedure. Many participants shared how they were unable to make sense of the experience, especially immediately after the surgical procedure and wished they knew more about the procedure. Self-focusing was evident as participants described decisions made following the surgery. For example, several participants discussed returning to team activities soon after surgery and many talked about hurting and eating and how these concerns were addressed.

Within the NSM, the psychological and developmental variables have provided a unique perspective for understanding the perioperative experience for the adolescent as it was discovered the experience affected autonomy. In addition, the stories told how the participants experienced a lack of control over events of the

experience, thus creating apprehension and concern for the adolescents throughout the perioperative experience. To further understand the perioperative experience, sociocultural influences will be discussed.

Sociocultural variable. The sociocultural variable within NSM refers to “combined effects of social cultural conditions, and influences” (Neuman & Fawcett, 2011, p. 16). Families are an important aspect of social support; however, peers play a prominent role in adolescents’ lives (Santrock, 2001). The role of peers is important and necessary in fostering healthy development (Steinberg, 1989) as friendships for adolescents are based on loyalty and trust. Social relationships, especially those with parents and peers, are important to positive development that begins during adolescence and continues throughout adulthood (O’Connor, et al., 2011). According to van Wel (2002), parental bonding is as important for well-being during adolescence as peer relationships.

Throughout the preoperative interview, all participants shared that they had received information about their procedure. Most participants obtained information from their peers. Interestingly, few participants spoke of peers during the postoperative interview and one stated she received text messages from friends, but chose not to respond because she was feeling so poorly. All participants shared stories about their mothers. Specifically, participants told of how their mothers took care of them throughout the surgical experience, as they were present throughout the perioperative experience. Thus, participants described aspects of the sociocultural variable.

Spiritual variable. Spiritual variable refers to spiritual beliefs, influences and encompasses the search for the meaning of life; this may or may not include religious beliefs (Neuman & Fawcett, 2011). To further explain, spirituality it is how an individual makes sense out of life situations, values, and beliefs. Often adolescents temporarily abandon traditional religious practices, and “reexamine and reevaluate many of the beliefs and values they grew up with” (Steinberg, 1989, p. 299). In this study, spirituality was not evident in the descriptions participants gave about their surgical experience.

In summary, of the five client variables, all but the spiritual variable was represented in the current study. Participants provided data that indicated that the perioperative experience reflected physiological, psychological, developmental, and sociocultural aspects of their lives. The inter-relationship among these variables determines the amount of resistance the client has to any internal or external environmental stressors (Neuman & Fawcett, 2011).

The ability of a client to resist stressor penetration is important for protecting the client’s basic structure, which consists of basic survival factors (e.g., energy reserves) (Neuman & Fawcett, 2011). In order to preserve the client’s system integrity, the basic structure is protected by the flexible line of defense, normal line of defense, and lines of resistance.

Flexible line of defense/normal line of defense/lines of resistance. The flexible line of defense (FLOD) is the protective buffer system for client stability as it functions to prevent stressor invasion into the client system. If successful, the FLOD prevents any stressor reaction or symptomatology (Neuman & Fawcett, 2011). The

FLOD functions to protect the normal line of defense (LOD). The LOD represents the usual wellness level of the participant, which has evolved as a normal range of responses to the environment (Neuman & Fawcett, 2011). For this study, there is no information on the FLOD, but the LOD is evident in that participants are all healthy young women. However, the LOD will be invaded by the surgery, thus causing a stressor reaction. This stressor reaction will vary based on the participant's five variables. This will be discussed further in the next section. Once the LOD has been penetrated, then the lines of resistance (LOR) are activated. The LOR are internal resistance factors, which function to stabilize and realign the client to the usual wellness state, or system stability. The LOR must function successfully to allow the system to reverse the reaction to the stressor (Neuman & Fawcett, 2011). If the LOR is successful, reconstitution occurs, which is the return of system stability. If the LOR is unsuccessful, the basic structure is affected, energy is depleted and if not restored, then death may occur. The lines of defense and resistance are in place to protect the core from stressor penetration. The adolescent becomes vulnerable when external stressors are able to penetrate through all lines of defense and resistance leaving the adolescent unprotected. These stressors have the potential to affect system stability.

Environment

Stressors are defined as environmental factors that have a potential of disrupting the well-being and system stability of a client. (Neuman & Fawcett, 2011). Stressors arise from the internal or external environment of the client. In addition, the NSM also identifies a created environment.

The internal environment is defined by Neuman & Fawcett (2011) as “consisting of all forces or interactive influences internal to or contained within the boundaries of the defined client system” (p. 20). Internal environment aligns with the lifeworld, lived body as it refers to the experience of the body in the world. For this study, the internal environment consisted of the participants’ third molars, sutures at the incision site, physiologic reactions to the anesthesia and medications, as well as the psychological responses to the surgical experience and can be linked with lived body within the lifeworld. The external environment consists of all forces or influences existing outside of the client. Much like the lifeworld lived relation, the external environment includes relationships we have with others. The external environment also aligns with the lifeworld lived space, as it is the experience of a person when they become aware of their environment. Examples of the external environment in the current study included all aspects of the surgical suite (i.e., preoperative holding area, operating room, recovery room) as well as the patient’s home environment. The created environment includes the external and internal environments, encompassing both, and is the client’s unconscious mobilization of all system variables, and functions to offer a protective coping shield (Neuman & Fawcett, 2011, p. 20). The created environment reflects beliefs and energy that functions dynamically to protect the client in order to regain and maintain system stability. According to NSM, the “insulating effect of the created environment changes the response or possible response of the client to environmental stressors” (Neuman & Fawcett, 2011, p. 21). An example of the created environment was the feelings of apprehension as apprehension is linked with cognition and anticipatory process that can be triggered by thoughts related to realistic events. In

addition, many participants shared “it’s [the surgery is] going to be fine”; and “it wasn’t as bad as I thought,” which may indicate a successful coping response.

Stressors

Within the NSM, stressors are tension producing stimuli occurring within the internal and external environments of the client (Neuman & Fawcett, 2011), and have the potential for a reaction with the client. Stressors can have either a negative or positive outcome effect which is dependent on the clients’ perception and ability to negotiate the effects of the perceived or actual stressor (Neuman & Fawcett, 2011). There are three types of environmental stressors: intrapersonal, interpersonal, and extrapersonal, which will be explained next.

Intrapersonal stressors. Intrapersonal stressors are internal and occur within the boundary of the client system (Neuman & Fawcett, 2011). In this study feelings of apprehension, concern, pain, and inability to eat are examples of intrapersonal stressors experienced by the participants. During the preoperative interview, intrapersonal stressors identified by the participants included different feelings, such as worry, nervousness, and uneasy about anesthesia and after effects of the procedure, which included pain, dry socket, eating and swelling. Participants described intrapersonal stressors in the operating room as feelings of being ignored and not knowing what was going on, and one participant described how she would felt unsure of the skill level of her surgical team by stating “it was like I wasn’t reassured they knew what they were doing”. Once in the recovery room, many participants experienced additional intrapersonal stressors. Several participants shared not knowing where they were which was distressing to them. Once at home, several

participants described other forms of intrapersonal stressors. They expressed concerns about pain and hurting, effects of the anesthesia, and described being “out of it.”

Interpersonal stressors. Interpersonal stressors occur outside the boundaries of the client system, but at a proximal range (Neuman & Fawcett, 2011). Examples of interpersonal stressors during the preoperative experience include taking the role of a patient. During the intraoperative experience interpersonal stressors experienced by participants included being “hooked up to 15 things” and not being able to communicate with the staff when asked questions. In addition, one participant wished she had knowledge about the instrumentation that was to be used during the procedure. During the recovery experience, a couple of participants described concerns about what they might have said under anesthesia and one participant remembers hearing her mother and sister laughing, assuming they were laughing at her. Once at home, a few participants discussed not being able to resume normal activities and one shared how because she felt so poorly she did not respond to text messages from friends.

Extrapersonal stressors. Extrapersonal stressors are external environmental forces that occur outside the boundaries of the client system at the distal range, and include financial concerns (Neuman & Fawcett, 2011, p. 22). This stressor was not well represented. No participants discussed financial concerns or immediate plans for work or school following the procedure.

Stressors have the potential to disrupt system stability; therefore, it is important to recognize environmental factors that may pose a potential threat to the client’s level of wellness. In this study, intrapersonal and interpersonal stressors were

identified as occurring throughout the entire perioperative experience (i.e., in the preoperative, intraoperative, and recovery experiences). Extrapersonal stressors were not discussed. If potential or an actual stressor penetration occurs, it is through nursing actions and interventions that the client is returned to an optimal wellness level.

Nursing

Within the NSM, nursing is defined as “actions which assist individuals to maintain a maximum level of wellness through actions that are initiated to retain, attain, and maintain optimal client health or wellness, using the three preventions-as-interventions to keep the system stable” (Neuman & Fawcett, 2011, p. 25). The goal for nursing within the NSM is “to reduce stressor impact, whether actual or potential, and to increase client resistance” (Neuman & Fawcett, 2011, p. 29). The primary aim for nursing is the stability of the client system through nursing interventions. Within the NSM, there are three prevention intervention levels: primary, secondary, and tertiary. The prevention interventions overall goal is to retain, attain, and maintain well-being.

Primary interventions. Primary intervention strategies are used to protect the clients’ usual wellness state. Primary interventions are done to identify and reduce risk factors associated with environmental stressors in order to prevent a possible stress reaction. Primary prevention interventions protect the client’s FLOD and LOD. An example of a primary intervention is health promotion. For this perioperative experience, a primary intervention was the clinic staff providing education and information to the participants before their procedure. Education and information

included explaining the procedure, providing details of what was to come, and providing prescriptions. Providing prescriptions are considered a primary intervention because it is before a stressor reaction occurs; the act of taking the prescription is a secondary intervention as the medication is taken after the surgery. Other primary interventions include prepping the incision site prior to the procedure, placing monitoring devices on the participants, and sterilizing instruments for the surgery. Maintaining a sterile field was also a primary intervention that was implemented during the procedure. If the primary intervention is not successful and a reaction occurs, secondary interventions are implemented.

Secondary interventions. Secondary interventions relate to interventions provided after symptoms appear and are needed when there has been some level of stressor penetration of the LOD. The goal for secondary interventions is to provide treatment of symptoms to attain well-being and energy conservation (Neuman & Fawcett, 2011), which can be accomplished by strengthening the internal lines of resistance. Secondary interventions focus on treating the symptoms, reducing harmful effects, and returning the client to wellness (Neuman & Fawcett, 2011). For this perioperative experience, secondary interventions included cauterization to control bleeding and participants taking medications as prescribed. These medications were for pain, infection, and swelling. Sleeping, eating liquid or soft food, and rinsing the mouth are other examples of secondary interventions needed by these participants.

Tertiary interventions. The goal of tertiary interventions is “to maintain an optimal wellness level by supporting existing strengths and conserving client system energy” (Neuman & Fawcett, 2011, p. 29). Tertiary interventions are used to return the

client to wellness and facilitate reconstitution. Reconstitution is “the state of adaptation to stressors in the internal and external environment; it is the person’s progress to a return to stability and wellness after a stressor has created a variance from wellness” (Neuman & Fawcett, 2011, p. 90). Reconstitution also may be viewed as “feedback from the input and output of secondary intervention” (Neuman & Fawcett, 2011, p. 29). Tertiary interventions can begin at any time in client reconstitution following treatment when some degree of system stability has occurred (Neuman & Fawcett, 2011). Examples of tertiary interventions for participants of this study were postoperative discharge instructions and treatment of dry sockets. Two participants developed dry sockets and were treated immediately by the clinic staff.

The nursing component of the NSM is concerned with keeping the client system stable and assisting client adjustment that is needed for optimal wellness and system stability after reaction to stressors. It is through nursing actions that nurses assist clients to maintain optimal health.

Health

The NSM equates health with optimal system stability, that is, the best possible wellness state at any given time (Neuman & Fawcett, 2011). Health is further defined as a condition in which all parts and subparts are in harmony with the whole of the client and ranges on a continuum from illness to wellness (Neuman & Fawcett, 2011).

The NSM provided guidance for further interpretation of the adolescent perioperative experience following the discovery of meaning through the lifeworld. By utilizing a holistic approach guided by the NSM, a deeper understanding of the

perioperative experience was gleaned from the adolescents' stories. The utilization of the lifeworld and NSM allowed for an understanding of the experience as both acknowledges the importance of perception and subjectivity, and are dynamic in understanding an experience.

Phenomenology and the NSM recognize experience as the ultimate basis of knowledge, and philosophically encompass wholism and perception (Cohen, Kahn, & Steeves, 2000; Fawcett, 2005; Neuman & Fawcett, 2010; Sokolowski, 2000; van Manen, 1990). The NSM represents a reciprocal interaction world view (Fawcett, 2005). van Manen and NSM view perception to be significant in understanding the meaning of an experience therefore, the lifeworld and NSM provided a unique way to understand what the perioperative experience meant to the adolescents.

It is important to know if the themes identified from this study, by interpretation through the lifeworld and NSM, are consistent with previous studies that examined perioperative experiences. Previous research that examined perioperative experiences will be presented next.

Previous Studies

A review of previous literature examining perioperative experiences was conducted. Several studies were found that examined surgical experiences of adolescents, however, few of these were phenomenological studies. This literature search did return numerous studies that examined cosmetic and bariatric surgeries in adolescents and will be presented next. Due to the limited number of studies found that examined adolescent perioperative experiences, studies that included adolescents

as participants will be presented. Lastly, studies that included adults and children will be presented.

Studies: Adolescent

In recent years there has been an increase in the number of adolescents undergoing cosmetic (de Andrade, 2010; Maltby & Day, 2011; Markey & Markey, 2009; Zuckerman & Abraham, 2008), and bariatric surgery (Bondada, Jen, & Deugarte, 2011; Jarvholm, et al. 2011; Keider, Hecht, & Weiss, 2011; Ratcliff, Reiter-Purtill, Inge, & Zeller, 2011; Widhalm, et al., 2011) which has lead to a plethora of studies in these areas. Many studied the preoperative experience exclusively, and many examined only the postoperative experience. However, few examined both preoperative and postoperative experiences.

A number of studies examined cosmetic surgery and body image in adolescents. Several studies examined factors that predict consideration of having cosmetic surgery (Callaghan, Lopez, Wong, Northcross, & Anderson, 2011; Maltby & Day, 2011; Markey & Markey, 2009), and one study examined patient reported outcomes of a plastic surgery procedure, specifically rhinoplasty (Cingi, Songu, & Bal, 2011). Many of these studies concentrated on the postoperative experience as it examined patient satisfaction regarding the outcome of the procedure and did not obtain the adolescent's perception of the experience.

Several studies examined outcomes of bariatric surgery in adolescents (Bondada, Jen, & Deugarte, 2011; Jarvholm, et al., 2011; Keider, Hecht, & Weiss, 2011; Ratcliff, Reiter-Purtill, Inge, & Zeller, 2011; Widhalm, et al., 2011), but these studies did not examine the patient's perspective. Zeller and colleagues (2011)

examined psychological distress, parenting stress, and family functioning one year after bariatric surgery. This study looked exclusively at the female caregivers' experience of taking care of adolescents undergoing bariatric surgery and concluded that female caregivers did not experience distress or parenting stress from caring for the patients. However, the researchers did not examine the adolescents' perspective regarding their surgical experience.

The review of the cosmetic and bariatric surgery studies indicated that these types of elective surgery may have a negative psychological effect on adolescents, although the results did not indicate if these effects were long lasting or temporary. Many of these authors suggested that adolescents should undergo standardized psychological screening for body image disturbance prior to being scheduled for an elective surgery. It is not known if these results can be generalized to adolescents undergoing third molar extraction. None of the studies that examined cosmetic and bariatric surgeries explored the perioperative experience through the eyes of the adolescent; therefore, the perception of the experience was not obtained. Furthermore, bariatric surgery is an inpatient procedure, thus the experience may be perceived differently by the adolescent than an ambulatory experience. Additionally, none of the studies reviewed examined the entire perioperative experience, only preoperative or postoperative experiences. Due to the limited number of studies that explored the adolescent perioperative experience, a review of studies that included adolescents undergoing a surgical procedure will be presented next.

Studies: Adolescent and Adult

In quantitative studies that examined wisdom tooth extraction, which included participants between the ages of 16 and 56, it was suggested that patients who are about to undergo surgical extraction of third molars had high levels of preoperative anxiety and associated the event with dread (deJongh, et al., 2008; Garip, Abali, Goker, Gokturk & Garip, 2004; Yusa, et al., 2004).

A study by deJongh, et al. (2008) examined psychological impact of wisdom tooth removal and risks associated with development of dental anxiety and post traumatic stress symptoms. Participants were between the ages of 16 and 41 years, ($M = 26.3; \pm 6.0$) and included 21 females and 13 males. The results of this study indicated that a person who undergoes a common treatment such as wisdom tooth extraction responds to this potentially stressful encounter with immediate emotional distress. The authors noted that two participants (8%) displayed symptoms of post-traumatic stress disorder (PTSD) one month following treatment, with pain during treatment the only variable positively associated with PTSD. However, it was found that 92% of participants recovered quickly from such event without long-term emotional distress. The researchers also concluded that long lasting heightened levels of anxiety depends on past exposure to aversive dental situations. The results of the current study align with the results from de Jongh, et al. as suggested by the theme “not as bad as I thought”. In the current study, participants shared postoperatively that “...I worried for nothing”, “not as bad as I thought”, and “I was nervous for nothing”, thus suggesting that most participants recovered from presurgical feelings of apprehension soon after the procedure.

Gilmartin and Wright (2008) examined ambulatory surgical experiences in a qualitative study that included twenty adolescent and adult participants, age 19 to 85 years. The procedures included general, urological, and gynecological surgeries. The participants were interviewed once after the surgical procedure; the interview was conducted in their home. There were four themes identified in this study: feelings of empowerment during preparation, apprehensions encountered, feelings of abandonment in the preoperative waiting area, and dynamics of recovery. Patients described a sense of empowerment from the information that was provided preoperatively, but wished they had been informed about any delays with their surgery. Many of the participants described feeling anxious and fearful in anticipation of the surgical procedure. Their feelings of anxiety included concerns about side effects from the anesthesia. (Gilmartin & Wright, 2008).

The results of the Gilmartin and Wright (2008) study are consistent with findings of the current study. In Gilmartin and Wright (2008), a theme of the feeling of empowerment during preparation aligns with “I know that...” from the current study. In each study, participants were provided information about the procedure prior to the surgery. Continuing with themes from Gilmartin and Wright (2008), the theme of apprehensions encountered aligns with the theme of feelings of apprehension from the current study. In both studies, participants discussed nervousness and unease about the preoperative experience. The participants in the Gilmartin and Wright study also described abandonment, which aligns with one participant in the current study describing her experience “...like I wasn’t there”. The postoperative themes of dynamics of recovery and concerns described similarities in

the postoperative experience of participants in both studies. The participants in the Gilmartin and Wright study described symptoms such as nausea, drowsiness, and pain during the recovery phase. The participants in the current study also shared stories detailing how the anesthesia and sedation affected them, as well as reporting being nauseated, becoming sick, and sleeping a long time after the procedure. While there are several similarities within the results of these two studies, differences exist. In the Gilmartin and Wright (2008) study, only one interview was done during the recovery phase; however, it is unknown as to how soon after the procedure the interview took place. This may have affected accurate recall of the experience. The age range of participants in the Gilmartin and Wright study was 19 – 85 years of age; the specific ages of the participants are not known, nor if the participants had previous surgery, which may have affected their understanding of the surgical experience.

Studies: Adolescent and Child

A quantitative study by Fortier, et al. (2009) sought to identify what perioperative information children wanted to receive before surgery. Data was collected with 143 children, aged 7 to 17, in the preoperative holding area on the day of surgery prior to the scheduled interaction between patients and healthcare providers. The results of this study found that the majority of children preferred to have comprehensive information concerning their surgery including information about pain, anesthesia, perioperative procedures, and information about potential complications. Interestingly it was found the more anxious children requested more information, specifically about pain. Although Fortier and colleagues (2009) provided

information on children's desire for preoperative information, they did not follow up with the participants postoperatively. A postoperative interaction would have allowed the researchers to determine if the preoperative information requested would have remained the same after the procedure. The results of this study indicated children ages 7 to 17 are interested in receiving preoperative information regarding surgery. This aligns with the result of the current study theme of concern: "I didn't know that..." in which participants expressed concern that they wished they had more information about the procedure. In addition, many participants in the current study specifically stated a desire to have had more information provided to them.

Studies: Adult and Child

Studies that examined adults and young children undergoing a surgical procedure have demonstrated the prospect of surgery can be psychologically threatening (Johnson, Rice, Fuller, & Endress, 1978). The experience of surgery can be stressful, and provoke feelings of concern, and uncertainty (Maligalig, 1994; Stewart, Algren, & Arnold, 1994; Visintainer & Wolfer, 1975; Watson & Visram, 2003). These concerns can result in stress and anxiety for the patient (Bailey, 2010; Bodner, 2005; Fortier, et al., 2009; Maligalig, 1994; Stewart, et al., 1994; Visintainer & Wolfer, 1975). Feelings of anxiety and stress can be associated with poorer health outcomes and a less than optimal surgical result. Studies that examined adult surgical experiences found that well-informed patients were less anxious than patients who did not receive preoperative information (Chahal et al., 2008, Dewar, et al., 2003; Johnson, Leventhal, & Dabbs, 1971; Lithner & Zilling, 2000; Ng, Chau, & Leung, 2004; Semple & McGowan, 2002; Sjolting, Nordal, Olofsson, & Asplund, 2003). In

a study of children, it was found that children with less knowledge regarding a procedure appraised it as more threatening, which led to higher anxiety preoperatively and postoperatively (Claar, Walker, & Smith, 2002). What is known from these studies is that surgical experiences are stressors and causes stress, which can have a negative effect on surgical outcomes in both adults and children. These negative outcomes include longer recovery times, greater postoperative pain, and compromised wound repair (Bodner, 2005; Lago-Mendez, et al., 2006). The results of these studies align with the themes of feelings of apprehension and concern in the current study as well as the overall essence of the perioperative experience, that the experience was stressful. Due to limited qualitative research examining the adolescent in the perioperative setting, it is not known if adolescents have the same surgical experiences as adults and young children. A review of studies that included adolescent participants will be presented.

Studies: Adult

Rhodes, Miles, and Pearson (2006) conducted a meta-synthesis of five qualitative studies that focused on patient satisfaction of an outpatient surgical experience in adults, age 18 and above; specific age range of participants were not provided. The objective of this meta-synthesis was to identify nursing interventions that contributed to patient feelings of satisfaction during their ambulatory perioperative experience. The results determined that preadmission contact between the healthcare provider and patient played a major role in decreasing patient anxiety and improving patient outcomes. By communicating preoperatively, the patients felt it was an opportunity to receive specific, relevant information and education to assist

them during the surgical experience. In addition, the information assisted the patients in planning for discharge, pain management, and recovery at home. It has been determined from this meta-synthesis that preoperative information and contact could alleviate anxiety in the adult surgical patient, thus potentially increasing patient satisfaction. It must be remembered that although information provisions are necessary for patients to psychologically prepare themselves for a surgical procedure, information alone does not assure a stress-free experience (Weinstein, Getz, Ratener, & Domoto, 1982).

Summary

The literature suggests that a surgical experience can be stressful and provoke feelings of concern in adults and children. The current study has discovered how adolescents perceive their perioperative experience, which indicated that they also found the experience to be stressful. Additionally, the current study has identified how developmental and life concerns affected the perioperative experience, specifically autonomy and loss of control.

While the findings from the current study align with results from previous studies, new information regarding a surgical experience has been uncovered. The current study explored the entire perioperative experience by conducting two interviews, whereas previous studies interviewed the participants once. By interviewing participants twice, it was found that feelings of apprehension changed from the preoperative experience to the postoperative experience, a finding that would have been lost with only a single interview. This information is important so that appropriate interventions can be developed to address both preoperative and

postoperative concerns. The results from this current study will provide information to the discipline of nursing that may be used to guide future interventions for adolescents in the perioperative setting and begin to fill the gap in the literature.

Implications for Nursing Theory

Nursing theory defines professional boundaries that distinguish nursing from other caring professions. The use of theory provides organization to nursing practice and allows the nurse to provide care that is appropriate. This study is one of the first qualitative studies that examined the perioperative experience of the adolescent, and has provided preliminary findings that may provide insight into a nursing theory that may be appropriate to the perioperative experience for all ages. The development of a theory may also provide a framework for adolescent perioperative nursing practice that will promote a safe perioperative experience and provide guidance for future study within the perioperative setting.

Incorporating theory into perioperative nursing practice is vital for the future of perioperative nursing. A nursing theory applied to adolescent perioperative care may allow the nurse to focus on appropriate nursing action through goals and outcomes of care that will address the unique needs of the adolescent throughout the perioperative experience. The result of the current study has indicated that the perioperative experience was stressful for the adolescent, which aligns with previous studies examining surgical experiences with adults and children (Bailey, 2010; Bodner, 2005, Fortier, et al., 2009, Maligalig, 1994; Stewart, et al., 1994; Visintainer & Wolfer, 1975; Watson & Visram, 2003). What makes the results unique to the adolescent is that adolescents encounter many challenges on numerous levels. The

adolescent is attempting to achieve normal developmental milestones as well as facing great turmoil which is related to developmental tasks and concerns that are unique to this age group.

The NSM is a theoretical framework that addresses stress and coping with a connection between the client and environment. The primary aim of nursing within the NSM is stability of the client system through nursing interventions, which consists of primary, secondary, and tertiary interventions to reduce stressors and reactions to stressors. An adolescent perioperative systems stability theory can be developed based on the NSM. A brief review of the concepts within the metaparadigm of nursing: human being, environment, health, and nursing as described by Fawcett (2005), will be presented, from here interventions and how the interventions can be applied throughout the perioperative experience will then be presented.

As the adolescent perioperative systems stability theory is substructured from NSM, the theory includes key concepts such as stressors, stress reaction, and environment. As the NSM refers to the patient as client, the adolescent perioperative systems stability theory will also refer to the patient as client. The discussion of the adolescent perioperative systems stability theory will focus on the concept of nursing, which is prevention as intervention.

In the perioperative setting, adolescents bring unique needs and experiences that shape the perioperative experience. When providing care to the adolescent throughout the perioperative experience, the nurse must address developmental tasks and concerns while providing nursing care that recognizes these stages as well as

addressing what is stressful to the adolescent throughout the perioperative environment. The environment within the perioperative setting includes the preoperative, intraoperative, and postoperative phases and consists of internal, external, and created environment. The created environment encompasses the internal and external environment. Because the created environment is based on perception, it is important to develop interventions that will address what is perceived as stressful within the perioperative setting. Health is achieved when the outcome of a perioperative experience is successful and the client moves toward wellness. It is through nursing actions and behaviors that a successful perioperative experience can be promoted. These nursing actions address the physical, psychological, developmental, sociocultural, and spiritual components of the client.

The findings from this study provided preliminary information that can help in addressing what the adolescent found stressful throughout the perioperative experience. The major concern for nursing is promoting and maintaining well-being through actions that retain, attain, and maintain wellness. To assist the adolescent in achieving optimal well-being, the nurse must identify stressors perceived by the adolescent and then assist and guide the adolescent in addressing these stressors. It is through primary, secondary, and tertiary interventions that nursing care will address what the adolescents perceived as being stressful throughout the perioperative experience. Primary, secondary, and tertiary interventions are implemented to address the effect of the stressor on the specific person variable affected (i.e., physiological, psychological, developmental, sociocultural, spiritual) as it is the interrelationship of these five variables that determine overall stressor reaction. Based on data from this

study, Table 6.1 identifies potential perioperative stressors and provides examples of nursing interventions to minimize a stressor reaction. Although the spiritual variable was not well represented in the participants' descriptions in the current study, the perioperative nurse must assess spiritual beliefs when providing care to the adolescent and address any needs that may be identified.

Preoperative phase

Within the preoperative phase, a variety of stressors were identified. The most common stressors arose within the physiological, psychological, and developmental variables. For example, concerns about body image, anesthesia, loss of control and autonomy were gleaned from the stories shared by the participants during the preoperative phase. In addition, numerous fears were identified from within the stories told by the adolescents. Specifically, fear of the unknown, equipment used, pain and discomfort, and a loss of privacy.

Primary interventions. Primary intervention strategies are used to protect the clients' usual wellness state. These interventions are done to identify and reduce risk factors associated with environmental stressors in order to prevent stress reactions.

Prior to the surgical event, adolescents should be educated regarding the surgical experience. The preoperative nurse should provide the adolescent with information that includes body changes to expect, how pain will be managed, and what the procedure will entail. In addition, information about anesthesia should be provided, specifically how anesthesia will be administered and the effects of anesthesia. The adolescent must be informed of intraoperative and postoperative activities restrictions and be provided a timeline of events that will occur. The above

interventions will address potential stressors such as body image and anesthesia concerns as well as address environmental stressors. In addition, the preoperative nurse should offer tactile contact, for example, touching the adolescent's hand.

To address psychological concerns, such as fear, the preoperative nurse should assess the adolescent for level of fear and anxiety. Details about the procedure should be provided to adolescent that includes noises and sounds that may be heard during the perioperative experience. The adolescent should be kept informed of events/tasks the perioperative staff will be performing. The above interventions will address potential stressors such as fear of the unknown.

To help the adolescent maintain a sense of control, the nurse must interact with the adolescent in a respectful manner and encourage communication. In addition, confidentiality must be maintained throughout the preoperative phase. As most preoperative settings allow for visitors, the nurse must be vigilant that the adolescents' privacy is protected and refrain from asking questions that may cause uneasiness or create discomfort for the adolescent in the presence of other individuals. For example, questions regarding previous surgeries, use of illegal drugs, or body piercings should be asked in private. The adolescent should be encouraged to ask questions with the nurse being available to answer questions.

To address developmental concerns, such as loss of control, the adolescent should be provided with information about the routine and tasks of the preoperative staff. In addition, the adolescent must be aware of signs and symptoms to report immediately while waiting to be taken to the operating room. These interventions will help the adolescent have a sense of control in the preoperative phase.

Secondary interventions. Secondary intervention strategies are implemented to assist the client in returning to system stability by focusing on treating symptoms and reducing harmful effects.

The preoperative nurse should offer reassurance and answer all questions that the adolescent has regarding the surgical experience. In addition, it is important for the preoperative nurse to validate and allay as much as possible any fears or concerns of the adolescent. When possible, the adolescent should be encouraged to make choices during the preoperative phase of the experience, or if the situation permits, be included in decision-making for their care, thus allowing for some control in the experience. The adolescent must be encouraged to communicate and ask questions. However, the preoperative nurse must remember to provide the adolescent with privacy and a comfortable environment.

The above interventions primarily address physiological, psychological, and developmental variables, and offer examples of interventions that can be provided to the adolescent throughout the preoperative phase. It must be remembered that each adolescent brings unique needs. These needs must be identified so that the adolescent will be provided with the best possible care to promote a positive experience.

Intraoperative phase

From the stories shared by the adolescents, common stressors within the physiological, psychological, developmental, and sociocultural variables arose during the intraoperative phase. Examples include concerns about loss of control and privacy as well as confidentiality. Fears that were gleaned from the stories shared by the

adolescents include fear of the unknown and an unfamiliar environment which included strange noises and strangers.

During the intraoperative phase nursing actions are to include providing the adolescent with a safe environment where privacy is assured. Adolescents should be educated regarding the events within the operating room. Throughout the experience, the nurse should offer support by being available to the adolescent. In addition, the preoperative nurse should offer tactile contact such as holding the adolescent's hand.

Primary interventions. Prior to induction of anesthesia, the operating room nurse must provide the adolescent with education about the environment. Specifically, explaining the purpose of keeping the operating room temperature cool, the reason why monitoring devices are being used, and the types of sounds they can expect to hear. Also, offering a warm blanket and the use of safety devices, such as a safety belt and arm boards should be explained to the adolescent. It should be clear to the adolescent that these nursing actions promote a safe environment.

The operating room nurse must assess the adolescent for fear and anxiety. The adolescent should be introduced to the operating room staff and encouraged to ask questions upon arriving into the operating room. Prior to events taking place in the operating room, the adolescent must be told what is going to occur and the reason (e.g., positioning devices). Also, procedural information should be provided which includes noises and sounds that may be heard in the intraoperative phase.

The operating room nurse must continue to educate the adolescent about the procedure and routine of the operating room. In addition, offering choices, if appropriate, to the adolescent may offer a sense of control. For example, allowing the

adolescent to choose the site for placement of the cautery pad may offer a sense of control. The adolescent must be encouraged to ask questions and provided ample time to ask questions.

The operating room nurse must acknowledge the adolescent's culture and practices. Care must be planned that is appropriate for the culture and honors any practices unique to the culture. For example, if an adolescent's culture has beliefs regarding hair removal, or the presence of a member of the opposite gender in the room, the nurse must ensure that the practice is honored.

Secondary interventions. Secondary interventions are implemented to assist the client in returning to system stability by focusing on treating symptoms and reducing harmful effects. During the surgery, the primary role of the nurse is advocate as the adolescent is in a compromised state. Functioning in this role, the nurse assures client privacy and confidentiality and ensures a safe environment for the adolescent.

Functioning in the role of client advocate, the operating room nurse must ensure a safe environment for the adolescent. For example, by monitoring the sterile field for breaks in technique and ensuring all equipment is functioning, the nurse provides an environment that promotes a successful surgical experience.

Within the intraoperative setting, the nurse must offer reassurance and validate any fears or concerns the adolescent may have. The operating room nurse must respond to verbal and non-verbal cues while talking to the adolescent and when explaining different procedures as they are being done. It is important to limit staff conversation while the adolescent is in the room. The adolescent must be included in

decisions within the operating room, if possible, to allow for a sense of control. While in the operating room, privacy must be maintained, and cultural beliefs considered when providing care. Upon emerging from anesthesia, the operating room staff must remember to keep the noise level down and only have one staff member engage the adolescent in conversation; this may alleviate any confusion for the adolescent while emerging from the anesthetic.

Postoperative Phase: Immediate

The stories shared by the adolescents included concerns experienced after arrival into the recovery room. Common stressors during the immediate postoperative phase were within physiological, psychological, and developmental variables. Examples include concerns about discomfort and pain, the environment, loss of control and privacy. In sharing stories about the postoperative phase, many adolescents shared fear of the unknown and a concern about anesthesia, specifically talking while still sedated.

Following the completion of the surgical procedure, the role of client advocate continues for the nurse. Safety and privacy continues to be assured throughout the postoperative phase. In addition, the postoperative nurse should offer tactile contact, for example touching the adolescent's hand; this will provide reassurance to the adolescent. The postoperative phase, which includes a phase after discharge, provides another opportunity for the adolescent to be educated about the perioperative experience.

Primary interventions. The adolescent is to be placed on a stretcher with side rails up and safety strap securely fastened. The nurse assesses the adolescent for

any change in health status and addresses any concerns immediately. The adolescent is to be kept informed of all events that are to occur throughout the postoperative phase, which includes monitoring devices and an explanation of noises and sounds of the postoperative phase. The adolescent must be given an opportunity to ask questions, and if appropriate, must be given the opportunity to make choices. To address psychological and developmental concerns, the postoperative nurse must assess the adolescent for fear and anxiety, paying close attention to verbal and non-verbal cues from the adolescent. Details about the routine of the recovery room and the purpose of procedures that will be performed during this phase should be presented to the adolescent. Privacy must be maintained throughout the postoperative phase. The above interventions will address potential stressors such as fear of the unknown and loss of control.

Secondary interventions. Upon awaking from anesthesia, the adolescent should be monitored constantly for issues emerging from anesthesia. Conversations between staff members must be limited until the adolescent is fully awake. Given some of the adolescents' concerns about what was said while sedated raises ethical issues regarding the types of anesthesia given, as well as who should be in the recovery room while the adolescent is not cognitively alert. Therefore, prior to bringing parents or parental figures into the postoperative room, the adolescent must be fully awake and aware of their surroundings and provided the choice of having visitors in the recovery room. If possible, the adolescent should be included in decision making in order to allow the adolescent a sense of control. The nurse must respond to verbal and non-verbal cues and offer reassurance in the hopes that any fears experienced by the

adolescent will be addressed. The adolescent, if appropriate, can be offered a visit by clergy.

Postoperative Phase: Post-discharge

Upon discharge from the clinic, all participants returned home. Stories shared by the adolescents suggested stressors from within the physiological, psychological, developmental, and sociocultural variables affected the postoperative experience. Concerns about body image, loss of control, and fear of the unknown were shared by the adolescents. In addition, concerns about developing dry sockets, swelling, medication side effects, dietary restrictions, and resuming normal activities were expressed.

Primary interventions. The process of discharge allows for an educational opportunity as information provided to the adolescent throughout the perioperative experience should be reviewed, and post-discharge instructions should be provided at this time. The adolescent should be informed of how the anesthesia, sedation, and medication affects cognition and behavior as well as expected lingering affects they may experience. Education should also include how the anesthesia and sedation may make them drowsy, which may in turn, cause them to sleep more than usual after surgery. The adolescent must have an understanding of what bodily changes to expect throughout the recovery phase of the experience as well as dietary and activity restrictions. In addition, a timeline of what to expect should be provided to the adolescent. The adolescent must be given ample opportunity to ask questions regarding any of the information received throughout the perioperative experience.

The interventions described will address physiological, psychological, developmental, and sociocultural concerns shared by the adolescent during the post discharge phase.

Secondary interventions. Prior to discharge, the nurse must review post-discharge care instructions. Information regarding post-discharge wound care and signs and symptoms of a dry socket must be provided. A review of dietary and activity restrictions should be given along with a clear explanation of and the reasons for these restrictions. Instructions regarding all prescribed medications must be provided. Specifically, how to take the medication, what to expect from the medication, and any side effects that might be experienced or should be reported to the physician. It is important that adolescents have a clear understanding of how to safely manage their pain and discomfort.

The adolescent must be given an opportunity to ask questions prior to discharge and made aware of how to contact the clinic following discharge. Any fears or concerns the adolescent has must be validated prior to discharge and the adolescent should be provided with names and numbers of staff members that can be contacted at anytime to discuss new fears or concerns that arise throughout the post discharge phase. If the adolescent expresses a spiritual need, it should be suggested that clergy be contacted. These interventions address physiological, psychological, development, and sociocultural variables that may have been affected by the perioperative experience.

Pre-, Intra-, Postoperative Phases

Tertiary interventions. Tertiary interventions protect client reconstitution and return to wellness following treatment Tertiary interventions can begin at any

time following treatment when some degree of system stability has occurred. Because tertiary interventions can occur at any time, they can be seen in all phases of the perioperative experience. Also, since tertiary interventions take place as reconstitution begins, interventions may be seen to move in a circular manner back toward primary interventions. Therefore, many previous interventions (e.g. maintaining confidentiality, ensuring privacy, providing a safe environment) need to continue in order to foster the adolescent's return to wellness. Clear, understandable post-discharge instructions are especially important in assisting adolescents to return to usual wellness state.

Summary

The previous discussion has demonstrated how an adolescent perioperative systems stability theory can be used to guide perioperative nursing practice. Although many interventions will be implemented based on specific developmental concerns of the adolescent and what the adolescent perceives as being stressful in the perioperative setting, several interventions must be provided throughout the perioperative experience. Throughout all phases of the perioperative experience, the nurse must interact with the adolescent in a respectful manner and encourage communication, as well as ensure privacy and confidentiality. The adolescent must be encouraged to ask questions and be provided with honest answers. In addition, the adolescent should be included in decision-making and offered choices whenever possible. Educational information provided to the adolescent is important so the adolescent will be aware what to expect throughout the perioperative experience.

Throughout the perioperative experience it is important for the nurse to build a

foundation for a positive relationship with the adolescent. Although the time spent with the adolescent is limited, it is imperative that the adolescent feels comfortable in the setting. The nurse must be truthful and provide the adolescent with accurate information. It is important for the nurse not to be judgmental and take adequate time to listen to the adolescent.

The interventions suggested in the adolescent perioperative systems stability theory highlight the importance of addressing stressors and concerns arising within each of the five person variables and may address concerns within the physiological, psychological, developmental, sociocultural, and spiritual variables.

It is essential that nursing practice be guided by theoretical approaches. The examples provided for the adolescent perioperative systems stability theory are based on the results of the current study. It must be recognized that other interventions may be required based on specific individual needs of a client. The results of this study were consistent with the NSM as this conceptual model is concerned with stressors in the environment, and response to stressors; therefore it is appropriate to utilize the NSM for developing an adolescent perioperative systems stability theory. By implementing primary, secondary, and tertiary interventions the nurse will be guided to provide care that will promote a positive surgical experience. For the adolescent undergoing a surgical procedure, nursing care should be guided by the unique developmental stages and concerns the adolescent is experiencing.

Table 6.1 Theory of Adolescent Perioperative Systems Stability

Theory of Adolescent Perioperative Systems Stability

Person Variable by Phase	Potential Stressors	Primary Interventions	Secondary Interventions	Tertiary Intervention
Preoperative				
Physiologic	Body Image Anesthesia Cold environment	Educate – For example: <ul style="list-style-type: none"> • what body changes to expect • how pain will be managed • what the procedure will entail • how anesthesia will be administered • effects of anesthesia • intraoperative/postoperative activity restrictions • timeline of events Offer tactile contact: touch hand	Offer reassurance Answer questions Warm blanket	
Psychologic	Fear of: unknown equipment used pain/discomfort loss of privacy	Assess for level of fear/anxiety Educate- For example: <ul style="list-style-type: none"> • procedural information, what and why • environmental sounds/sights • keep informed of events/tasks nurses will be performing Offer tactile: touch hand, etc	Offer reassurance Validate: Fears Concerns Respond to cues: Verbal Non-verbal	
Developmental	Loss of control	Educate – For example: <ul style="list-style-type: none"> • routine/tasks of nurses 	Include in decision Allow choices**	

		<ul style="list-style-type: none"> • signs/symptoms to report to nurse • availability of nurses <p>Allow time for questions</p>		
Sociocultural	Interdependence	<p>Educate –</p> <p>For example:</p> <ul style="list-style-type: none"> • activity restrictions: daily activities, team sports <p>Allow time for questions</p> <p>Offer privacy</p> <p>Allow choice of having visitors in preop areas</p>	<p>Encourage: communication questions</p> <p>Provide privacy</p>	Maintain privacy
Spiritual		Assess beliefs*	Offer clergy services to client*	
Intraoperative				
Physiologic	Environment: unfamiliar cold	<p>Educate –</p> <p>For example:</p> <ul style="list-style-type: none"> • purpose of cold environment • monitoring devices used <p>Provide warm blanket</p> <p>Provide safety devices</p> <ul style="list-style-type: none"> • safety belt • arm boards <p>Offer tactile: touch hand, etc</p>	<p>Provide safe environment</p> <p>Client advocacy</p> <p>Assure privacy</p>	<p>Limit traffic</p> <p>Maintain privacy</p> <p>Provide warming blanket (e.g. Bair Hugger)</p>
Psychologic	Fear of : unknown equipment used discomfort loss of privacy noises strangers	<p>Assess for level of fear/anxiety</p> <p>Introduce staff</p> <p>Educate -</p> <p>For example:</p> <ul style="list-style-type: none"> • procedural Information: • what and why • environmental sounds/sights • keep informed of tasks/events nurse will be performing 	<p>Offer reassurance</p> <p>Respond to cues: verbal non-verbal</p> <p>Validate fears</p> <p>Assure privacy</p> <p>Talk to client explaining different procedures as they are being done</p> <p>Limit staff</p>	<p>Provide choices**</p> <p>Maintain privacy</p>

		Offer tactile: touch hand, etc	conversation while client is in the room	
Developmental	Loss of control	Educate – For example: <ul style="list-style-type: none"> • procedure • routine of activities Offer choices** Allow time for questions	Include in decisions Assure privacy	Offer explanations Maintain privacy
Sociocultural	Confidentiality	Acknowledge culture Cover client	Provide privacy Provide care based on cultural beliefs	Respect cultural beliefs by adhering to practices
Spiritual		Assess need*	Assess need*	Assess need*
Postoperative: Recovery:				
Physiologic	Incision site Pain	Educate – For example: <ul style="list-style-type: none"> • procedure • check incision site • check dressing • how to manage pain 	Reinforce dressing Manage pain Answer questions	Postoperative instructions Prescriptions Reinforce dressing
Psychologic	Fear of: unknown equipment used discomfort loss of privacy noises strangers	Educate – For example: <ul style="list-style-type: none"> • procedural information - • what and why • environmental sounds/sights • keep informed of tasks/events nurse will be performing Offer choices** Offer parental visit Tactile: touch hand	Offer reassurance Respond to cues: verbal non-verbal Validate fears Assure privacy Talk to client explaining different procedures as they are being done Limit staff conversation while client is in recovery Offer parent visit	Orient to: surrounding environment
Developmental	Loss of control Talking while	Educate – For example:	Offer choices Explain	Offer choices Allow visitors

	sedated	<ul style="list-style-type: none"> • activities within recovery room Provide safe & secure environment	routine(s) Limit visitors	after fully awake
Sociocultural		Offer privacy	Provide privacy	Maintain privacy
Spiritual		Assess needs/beliefs*	Offer visit from clergy*	
Postoperative: Post Discharge				
Physiologic	Pain/hurt Dry Sockets Swelling Eating Feeling “out of it” Medication side effect	Educate- For example : <ul style="list-style-type: none"> • wound care • dry socket prevention/care • signs of infection to report • effects of sedation/ anesthesia • medications: purpose, dosage, side effects • what body changes to expect • restrictions: activity, diet • timeline of recovery 	Educate- For example: <ul style="list-style-type: none"> • wound care • pain control • complications to report • Diet restrictions • Medication regimen & side effects to report 	Reassess pain Treat complications Resume normal diet Restrict activities
Psychologic	Body image Fear of unknown	Educate – For example: <ul style="list-style-type: none"> • post procedure events • what to expect swelling numbness 	Reassurance Respond to concerns Validate fears	Address any fears/concerns
Developmental	Loss of control	Educate- For example: <ul style="list-style-type: none"> • what to expect once at home • how to control: medication side effects; lingering sedation side effects, pain, prevent infection • why diet and activity restrictions are needed Be available to	Answer questions Explain routine: follow up visit	Discharge Instructions

		answer questions		
Sociocultural	Activity restrictions	Educate – For example: • Rationale for activity restrictions	Educate – For example: Limit activities	Return to normal activities
Spiritual		Assess need *	Encourage client to contact clergy*	

*If adolescent indicates a need

**If appropriate for adolescent to make choices

Implications for Nursing Practice

The outcomes of this study are important to nurses who specialize in providing perioperative care as it has identified the importance of an individual's perception about the surgical procedure. By exploring the perioperative experience through the lifeworld, understandings of what the experience meant to adolescents were gleaned. These understandings were further explored by utilizing the NSM, which provided insight into the developmental tasks and concerns of the adolescent and how these tasks may affect the perioperative experience.

This study is one of the first to discover the meaning of a perioperative experience for adolescents. As it is now known this experience is stressful to the adolescent, nursing practice can be changed that will address these feelings of apprehension and concerns expressed by the adolescent. Nursing interventions and actions should be initiated to retain, attain, and maintain well-being through nursing actions. Interventions focused on the perioperative experience should address three levels of interaction: primary, secondary, and tertiary, as discussed above.

Implications for Future Research

This study generated preliminary information that may provide guidance for future studies to examine perioperative experience of adolescents as well as provide

insight as to why adolescent behavior is different than adults and children undergoing a surgical procedure. The research question for this study was “What is the meaning of the perioperative experience to adolescents?” Much like adults and children, the adolescents found the perioperative experience to be stressful as indicated by their stories that expressed apprehensions and concerns. The overall meaning of the experience was influenced by developmental and life concerns specific to this age group. Autonomy was affected as the participants were dependent on others throughout the perioperative experience. In addition, participants experienced a lack of control over the events, which was troublesome for several participants as the adolescent is struggling with the need to be independent. The findings from this current study will allow guidance for future studies that should include adolescents.

Qualitative studies should be performed to further understand the perioperative experience through the eyes of adolescents. To penetrate more deeply into perioperative experiences, future qualitative research should continue to focus on the full surgical experience: the preoperative, intraoperative, and postoperative phases. Findings from the current study revealed that the perceptions and needs of the adolescent varied between the first and second interview. It is important to know why these perceptions and needs between the first and second interview changed so that the needs of the adolescent are appropriately addressed. In addition, future research could focus on the behaviors that are exhibited by adolescents throughout the perioperative experience to understand why these behaviors are specific to this age group. For example, understanding why adolescents rarely ask questions or why they fail to maintain eye contact could be important in developing interventions for this

age group. Also, issues related to the phenomenon of emergence delirium could be explored. It is important to understand this phenomenon so that care can be provided to the adolescent to minimize potential safety issues that are associated with this event.

Drawing from cognitive theories, the adolescent should be able to appraise threatening events, draw conclusions, and respond to the event, thus maintaining a sense of control. Future research should be done to determine if adolescents are in fact, able to appraise, assess, and respond to the stresses of a surgical procedure. To determine this, additional qualitative inquiry based on stress and stress reactions could provide richer results that may provide deeper understandings of the perioperative experience.

Future research could focus on types of anesthesia and sedation used in an ambulatory setting. Participants expressed concerns about what they might have said while sedated. This concern may have been prompted by the knowledge that medications used for sedation can have an effect on patients where questions are answered truthfully with no recollection of the conversation. This is a concern for adolescents as they are fearful they may say something their parents find disappointing or disapprove of while they are emerging from anesthesia. To address this concern further, research might also examine the most appropriate time to reunite patients with loved ones during the recovery experience.

Future studies need to be extended to a more diverse populations, including males and younger adolescents. In addition, exploring perceptions of adolescents undergoing elective inpatient procedures is needed. Future studies with different

methodologies could also be done. These include the use of quantitative intervention studies to examine the effects of different primary, secondary, and tertiary interventions in producing improved health outcomes.

Nursing research is important for the development of a relevant body of knowledge. There is a limited amount of research that examines the perioperative experience of the adolescent, therefore continued research is needed for this population. In addition to defining the unique role of the perioperative nurse, research can generate information which will help guide care that will address the specific needs of the adolescent in the perioperative setting.

Limitations/Challenges

As with all studies, limitations existed with this project. The researcher experienced minor difficulties with recruitment and composition of the sample. Specifically, due to the elective nature of this procedure, access to the participants was limited. Data could only be collected during holiday and school breaks as patients and families do not schedule surgery that may disrupt school attendance. Another possible limitation is that participants for this study were all females, as no males that were scheduled for the procedure met inclusion criteria. It is not known if the experience would be the same for males. Despite these limitations, the project provided new information regarding the perioperative experiences of adolescents.

Reflection. In addition to limitations with sample and recruitment, researcher inexperience may have impeded the project, specifically data collection, interpretation, and saturation.

Data collection. The researcher has extensive experience in the perioperative setting which affected the manner in which data was collected and the interviews took place. While qualitative interviews are open-ended and seek depth in answers, patient interviews in the perioperative setting are often very short, clinically focused and conducted with time constraints and the importance of keeping the surgical schedule on time. Due to this culture's influence on the researcher's experiential background, closed-ended and directive questions slipped into the qualitative interview and limited the richness of the descriptions of the surgical experience that might have been obtained. This foreshortening of the data might have been rectifying if the researcher followed the interview guide more closely and asked more probing questions and less directive questions to elicit a deeper understanding of the perioperative experience. For example, questions such as "can you describe what that means to you", "can you explain (that) in more detail" and "can you tell me more about..." and including a wider range of questions may have provided an opportunity for the adolescent to describe their experience in a voluble manner.

In addition, the researcher often rephrased participant wording into common medical terminology (e.g., nervous became worry). Committee members who have expertise in qualitative research and do not have perioperative experience were instrumental in refocusing the researcher and played an important role in data analysis. The iterative process of the hermeneutic circle, with reflection and re-reflection, discussion with committee members helped ensure participants' voices could be heard. But the results of this study are necessarily limited because of the lack of depth in the interview data.

Interpretation. Due to the extensive background the researcher has in the perioperative setting, it was difficult to explicate assumptions and pre-understandings. As van Manen (1990) states “our common sense pre-understandings, our suppositions, assumptions, and the existing bodies of scientific knowledge predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question” (p. 46). van Manen (1990) emphasizes that reduction in thinking facilitates reflection on the phenomenon in the lived world and that holding prior knowledge and assumptions in abeyance is important. It is suggested for the researcher to maintain a reflective journal (Munhall, 2012); the researcher did maintain a reflective journal to note personal beliefs, feelings, and prior assumptions. However, due to her extensive perioperative experience, the researcher had difficulty in holding her beliefs, feelings, and prior assumptions in abeyance when conducting the interviews, which interfered with data collection, and with interpretation of the data.

Researcher assumptions and beliefs included that preoperative behaviors indicate a stress reaction. Because of this assumption, the researcher may have been “looking” for responses that indicated a stress reaction and did not use questions that may have elicited deeper meanings of the perioperative experience from participants. Because of this, the researcher’s failure to follow up and ascertain in the participants words what was going on led to premature closing of discussions.

Saturation. Sample size and saturation may also have been affected as the researcher obtained a smaller number of participants than needed due in part to research inexperience and lack of clarity about how saturation might be determined.

Saturation is achieved when no new information of importance to the study emerges. The researcher was guided by Morse (1994) who suggests saturation usually occurs in phenomenology with six participants and Creswell (1998) who states saturation should occur with five to 25 participants. The researcher thought saturation was achieved because all participants' stories seemed to reflect the experience was stressful. Instead of probing further, new questions were presented to the participants, which led to premature closing of data collection. This premature closing of data collection likely affected the findings of the study, as additional themes may have been discovered. To assure saturation in future studies, the researcher will have a peer review the data collection and analysis more frequently throughout the study, as well as having a seasoned qualitative researcher audit the data prior to ceasing data collection. By the time the issues with saturation were discovered, school was back in session and availability of participants diminished.

Strengths

Despite the stated limitations, there are still strengths to be noted for this study. This study is among the first to examine the lived experience of adolescents undergoing an ambulatory perioperative experience and was interested in preoperative as well as the postoperative experience. It is projected that the number of surgeries performed on an ambulatory basis will continue to increase; therefore, the results from this study have relevance for clinical practice. In order to provide patients with the best possible care to promote an optimal ambulatory perioperative experience, nurses need to understand the factors causing stress in adolescent patients. The results from this study have the potential to improve clinical practice by

sensitizing perioperative nurses to the concerns adolescents express during their perioperative experiences, which can facilitate the future development of more effective, age-appropriate clinical interventions. Results also demonstrate the relevance of the lifeworld and NSM as a guide to understanding the perioperative experience of the adolescent and perioperative nursing practice and research. In addition, the utilization of developmental theories added to the results of this study. By reflecting on the perioperative experience through Erikson's psychosocial stages, a deeper understanding of the adolescents' perioperative experience was gleaned as this theory provided insight into the experience.

Summary

In summary, the aim of this study was to understand the meaning of the perioperative experience of adolescents. The research question for this study was "What is the meaning of the perioperative experience to adolescents?"

The researcher was guided to phenomenology because of the hope that discovery of meaning would shed new light on the perioperative experience for adolescents. The qualitative, phenomenological approach to inquiry was an appropriate method to capture the essence of perioperative experience of adolescents. This phenomenological study is the first to explore the perioperative experience of the adolescent, as most studies examined preoperative or postoperative experiences. The results of this study have demonstrated that a common and minor surgical procedure resulted in stress as indicated with feelings of apprehension and concerns. Also, this study may have identified that some anesthetics should not be used with adolescents in an ambulatory setting based on experiences voiced by the participants, such as an

uneasiness of receiving anesthesia and fears of what the adolescent may say while under anesthesia and emerging from anesthesia. In addition, this study has introduced how nursing care could be guided by the NSM in the hopes of addressing the feelings of apprehension and concerns expressed by the participants. The results of this study also demonstrated how the developmental and life concerns may influence perceptions of a stressful event for adolescents, which may account for patterns of behavior that is specific to this age group.

It is important for healthcare professionals to understand how people make sense of illness and to explicate the processes that guide adaptive attempts to cope with a health situation. In addition, it is important to acknowledge developmental and life concerns specific to this age group as this will allow for interventions that address these tasks and allow for an understanding of perioperative behaviors that are known to occur in adolescents. This information will allow a change in perioperative nursing practice that will promote a positive and successful surgical outcome. In addition, by uncovering the insider perspective of perioperative experiences, findings will begin to bridge the gap in the literature and provide information expected to guide health professionals as they plan and implement interventions for adolescents who are undergoing operative or invasive procedures.

This study has provided preliminary information about how the adolescents perceived the perioperative experience. Past research with adults and children demonstrated the event proved to be stressful; this was also found to be true with adolescents. The lifeworld, as described by van Manen, provided a guide to understand how the adolescent perceived the perioperative experience through lived

space, body, time, and relations. Next, guided by the NSM, the perceptions of the perioperative experience were further explored. From here, interventions that assisted in the experience were described, with suggestions for further intervention development.

What is unique with the findings of this study is that developmental and life concerns of the adolescents played an active role in the perception of the experience, which added to the meaning of the perioperative experience. It is the researcher's belief that the developmental and life concerns of an adolescent is what makes the perioperative experience different for the adolescent when compared to adults and children. For example, as an adolescent strives to be autonomous, this experience proved to be troubling as they were dependent and relied on others for care and support. The procedure also placed the adolescent in a compromised state due to the sedation, anesthesia, and activity limitations thus affecting their sense of control. Adolescents are also self-focusing and concerned with their appearance as they struggle with identity development. Many participants voiced a concern on how they looked, referred to swelling, and being embarrassed by their appearance.

Although this study provided preliminary data, it has identified experiences that adolescents have regarding a surgical experience. Future qualitative studies will further help understand the unique needs of the adolescent undergoing a surgical procedure and will allow a change in perioperative nursing practice to ensure a safe and successful perioperative experience for the adolescent.

APPENDIX A

Recruitment Protocol

My name is Janean Monahan and I am a student at Wayne State University in the College of Nursing. I am doing research to learn about adolescent ambulatory surgery experiences. Specifically, I would like to understand how adolescents perceive their surgical experiences. I am interested in adolescents between the ages of 18 and 21 years who are scheduled for an ambulatory surgical procedure and who have not had surgery before. The study involves meeting with me twice: on the day of surgery and at the appointment after the surgery, approximately one week after your surgery. During these meetings, I will ask questions regarding your surgical experience. Your answers will be audiotaped so that I can make sure our conversation is recorded accurately. You will be referred to throughout the interviews by a fictitious name to ensure your privacy. This name will be used throughout the study and anytime the results of the study are discussed. Both meetings should take approximately one hour, but may be shorter or longer depending on what you want to say about your experience. There is no cost to you and this is voluntary. You can choose to participate and change your mind at any time. All information will be kept confidential. A member of my committee will be reviewing the information I obtained, however, your identity will not be revealed.

To ensure your privacy and comfort, a private office will be available for us to meet. Every effort will be made to protect your health and personal information from inappropriate disclosure. Research records will be kept in a separate research file that does not include names or other information that is likely to allow someone other than myself to link the information to you. Your identity will be kept on a password protected computer. I will be the only person that uses the computer and will be the only individual that has the password to the computer. All other information that will be identified by your fictitious name will be kept in a locked file cabinet. I will have the only key for the cabinet. After the conclusion of the interviews, your identity will be deleted from the password protected computer. The audiotapes will be destroyed after the completion of the study.

As a participant in this research, there may be no direct benefit for you, however, you may benefit by having the opportunity to talk about your experience. Information gained from this study may benefit adolescents in the future by providing information to improve nursing practice with adolescents undergoing elective surgery in ambulatory surgery.

APPENDIX B

Research Informed Consent

Title of Study: Perioperative Experience of Adolescents

Principal Investigator (PI): Janean Monahan
College of Nursing
Wayne State University
5557 Cass Avenue
Detroit, MI 48202
313.577.0342

Purpose

You are being asked to be in a research study regarding the experiences of older adolescents undergoing a surgical procedure. This study is being conducted by a doctoral student in the College of Nursing at Wayne State University and will be done at Summit Oral & Maxillofacial Surgery. The estimated number of study participants to be enrolled at Summit Oral & Maxillofacial Surgery is between 10 and 20. **Please read this form and ask any questions you may have before agreeing to be in the study.**

Study Procedures

In this research study, you will be asked to participate in two private interviews; each will last about an hour. One interview will take place on the day of your surgery about one hour prior to your surgery. The second interview will take place on the day of your post-surgical appointment, approximately one week after your surgery. During both interviews, you will be asked questions regarding your surgical experiences, specifically the experience before, during, and after your surgery. Both interviews will be tape-recorded but your name will not be recorded. Instead, a code name will be used to protect your information. This code name will be used throughout the study. I will be the only person who will know how you answered the questions. A faculty member of Wayne State University will review the tape-recording, but will not know your identity. Participation is voluntary and at any time, you may choose not to answer a question, or you can withdraw from the study.

Benefits

As a participant in this research study, there may be no direct benefit for you other than an increased awareness of how you coped with your surgical experience. However, information from this study may be used in the future by nurses and doctors to improve the care they provide to older adolescents undergoing surgery.

Risks

By taking part in this study, there is a slight risk that you might experience feelings of anxiety or stress as you talk about your surgical experience.

There may also be risks involved from taking part in this study that are not known to researchers at this time.

Study Costs

Participation in this study will be at no cost to you.

Compensation

For taking part in this research study, you will be compensated for your time and inconvenience. You will receive a \$25 gift card for Target after completing each interview.

Confidentiality

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. Although the interviews will be audiotaped, your identity will be protected. The code name assigned to you will be the only identifier on the audiotape and you will be identified in the research records by that code name.

When the results of this research are published or discussed in conferences, no information will be included that would reveal your identity.

Although the interviews will be audiotaped, your identity will be protected. The code name assigned to you will be the only identifier on the audiotape. The tape will be used once and destroyed at the end of the study.

Voluntary Participation/Withdrawal

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you decide to take part in the study, you can later change your mind and withdraw from the study. You are free to only answer questions that you want to answer. You are free to withdraw from participation in this study at any time. Your decisions will not change any present or future relationship with Wayne State University or its affiliates, nor will it affect the care you will receive at Summit Oral & Maxillofacial Surgery or other services you are entitled to receive.

The researcher may stop your participation in this study without your consent. The researcher will make the decision and let you know if it is not possible for you to continue. The decision that is made is to protect your health and safety, or because you did not follow the instructions to take part in the study.

Questions

If you have any questions about this study now or in the future, you may contact Janean Monahan at aw0786@wayne.edu, or her faculty advisor, Dr. Rosalind Peters at 313.577.0432. If you have questions or concerns about your rights as a research participant, the Chair of the Human Investigation Committee can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call (313) 577-1628 to ask questions or voice concerns or complaints.

Consent to Participate in a Research Study

To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study, you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read, or had read to you, this entire consent form, including the risks and benefits, and have had all of your questions answered. You will be given a copy of this consent form.

Signature of participant / Legally authorized representative Date

Printed name of participant / Legally authorized representative Time

Signature of witness/Date

Printed of witness/Time

Signature of person obtaining consent/Date

Printed name of person obtaining consent/Time

APPENDIX C

Interview Guide

The first interview will take place preoperatively, prior to the procedure.

The grand tour inquiry for the first interview is:

“Tell me about your surgery”

The second interview will take place at the postoperative visit, approximately one week post procedure. The grand tour question to be asked for the second interview is:

“What has this surgical experience been like for you?”

For both interviews, probing questions may also be asked to obtain greater detail or clarity. Examples of probing questions include:

“Can you tell me more about.....?”

“Can you describe [that] further?”

“Can you explain [that] in more detail?”

A final question at the end of each interview to ensure that participants have had sufficient opportunity to tell their story:

“Is there anything else you would like to tell me about your experience?”

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ABSTRACT**PERIOPERATIVE EXPERIENCE OF ADOLESCENTS**

by

JANEAN CARTER MONAHAN**August 2012****Advisor:** Dr. Rosalind Peters**Major:** Nursing**Degree:** Doctor of Philosophy

Research has shown that preoperative stress is associated with poorer health outcomes in adults and young children, but there is little in the literature about the stress experienced by adolescents. Clinical experience, however, has shown that adolescents behave differently throughout the perioperative experience than either adults or children. For example, common behaviors of adolescent's emerging from anesthesia include combativeness, thrashing, and crying. To promote adolescent health and to provide adolescents with appropriate interventions that will support a positive surgical outcome, research is needed to discover the perceptions and meanings adolescents attribute to the perioperative experience.

The purpose of this hermeneutic phenomenological study was to describe and capture the meaning of perioperative experiences of adolescents. The research question for this study was "What is the meaning of the perioperative experience to adolescents?" Max van Manen's phenomenological approach especially guided uncovering the descriptions of the meanings provided by the participants through the lifeworld: lived body, lived relation, lived space, and lived time. Although the lifeworld provided a way to interpret the perioperative experience,

the Neuman Systems Model (NSM) allowed for further exploration of the perioperative experience.

Nine female adolescents, ages 18 to 20 years, undergoing a surgical procedure were interviewed twice: once preoperative and once postoperative. The themes for the perioperative experience of adolescents' were "I knew that..." and feelings of apprehension for the preoperative experience. Following the surgical procedure, themes gleaned from the postoperative stories were "not as bad as I thought", concern, and "I needed my mom." What the stories told was that much like adults and children, the overall perioperative experience was stressful for the adolescent. However, the developmental concerns unique to adolescents added another layer to the meaning of this experience. Specifically, issues with autonomy and loss of control were gleaned from the stories shared by the adolescent about their perioperative experience.

This study is significant because it generated new knowledge that could facilitate development of interventions specific to the needs and concerns of adolescents undergoing a surgical procedure. It is unique as it is one of the few studies that explored the preoperative experience through the voices of adolescents and compared and contrasted the preoperative and postoperative experiences.

AUTOBIOGRAPHICAL STATEMENT

EDUCATION

2012	Doctor of Philosophy	Wayne State University	Detroit, MI
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