THE POST DAY CARE SURGERY EXPERIENCE 
FOR PARENTS OF TODDLERS AND PRESCHOOLERS

By

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Abstract

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This study was designed to explore the parents’ perspective and personal interpretations of the meaning of their childrens’ first time day care surgery experience within the context of their everyday lives. The phenomenological method was used to guide data collection for this qualitative study.

Data were collected through a series of 16 in-depth interviews with nine parents whose young children underwent a day care surgical procedure. The average age of the children was 23.8 months. Sample selection was guided by a purposive sampling technique. A semi-structured guide of open-ended questions was used for parent interviews.

Analysis of the verbatim transcriptions was accomplished using the technique of constant comparative analysis. Informants gave detailed accounts of their experience and described the meanings and interpretations they assigned to it.

The parents’ accounts were synthesized into a descriptive framework of their experience which described three distinct chronological phases: the pre-hospitalization or preparatory phase, the hospitalization or operative phase, and the post-hospitalization or readjustment phase. It was apparent that the parents’ experience extended well beyond the few hours they actually spent in the hospital setting.

The study’s findings revealed that parents perceived their experience as a stressful event in their everyday lives. New responsibilities were added to the usual
tasks of parenting a toddler or preschooler resulting in parental role strain and an increased need for parental support. Parents reported feelings of fear, worry, and anxiety in varying intensity throughout the three phases of their experience. They used a variety of coping strategies to manage the stresses of their experience. The study findings were discussed in comparison to other authors' published works, placing these unique findings in context of the current literature. Implications for nursing practice, education, and research were presented.
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CHAPTER 1

Introduction

This is the report of a study designed to answer the question: What is the parents' experience of having a toddler or preschooler at home following day care surgery? It is this author's opinion, based upon personal experience working as a pediatric nurse, that nurses lack knowledge about parents' own perceptions of the post-hospitalization pediatric day care surgery experience and how they manage at home following their child's surgery. The only way to truly understand this experience is to have parents describe how the event has affected their day to day lives. This writer has been unable to gain insight into this important parental experience from any literature reviewed to date.

Parents of toddlers and preschoolers were selected for this study because it is known that children in these age groups are particularly vulnerable to the real and imagined threats of hospitalization and surgery (Dorn, 1984; Redpath & Rogers, 1984; Robertson, 1970; Vernon, Schulman & Foley, 1966). It is also known that parents commonly feel anxious and concerned throughout their child’s post-hospitalization period (Droske, 1978). It was therefore anticipated that parents of toddlers and preschoolers may have particular needs following their child’s day care surgery. The literature reviewed for this study was unable to offer insight into what these needs might be.

Nurses working in both hospital and community settings have opportunities to interact with and are in postions to influence the experience of parents whose young
children have undergone day care surgical procedures. The findings of this study offer a theoretical base from which appropriate and effective nursing care for such parents may be planned and carried out.

In order to introduce this research study, the remainder of this chapter will present the background to the problem, the conceptual framework guiding the research, and the methodological perspective chosen to explore the specific research question.

Background to the Study

Pediatric day care is widely recognized as a viable alternative to the traditional two to three day hospital stay for children undergoing minor surgical procedures (El-Shafie & Shapiro, 1977; Johnson, 1983; Lawrie, 1964; Shah, Robinson, Kinnis, & Davenport, 1972; Shah, 1980). The physical and psycho-social benefits it offers for the family unit, as well as the financial savings for the Canadian Health Care System, have been well documented (Atwell, Burn, Dewar, & Freeman, 1973; Cloud, Reed, Ford, Linkner, Trump & Dorman, 1972; Lawrie, 1964; Othersen & Clatworthy, 1968; Shah, 1980; Schowalter, 1977).

The first reported cases of pediatric day care surgery were discussed in the literature by Nicoll in 1909. In a ten year period prior to 1909 he successfully performed day surgery on an estimated 9,000 infants and children in Glasgow, Scotland. By 1910, the practice of pediatric day care surgery began in Canada at Toronto’s Hospital for Sick Children (Shah, 1980).

Since a pediatric day care surgery program was first introduced in Vancouver, British Columbia in 1967, the numbers of children and their families receiving this service have continued to grow steadily each year (Shah, 1980). The growth of this program is in keeping with the belief that up to one half of all surgical procedures for
North American children could be done on a day care basis (Brownlee, 1977; Shah, 1980).

During the 1984/85 fiscal period, the number of primary (first time only) pediatric day care surgical procedures performed at British Columbia’s Childrens’ Hospital was 4,792 (British Columbia Ministry of Health, 1985). This represented over 40% of the total number of surgical procedures performed on children at this center. This number is 14.4% above the provincial average for day care surgical procedures (British Columbia Ministry of Health, 1985).

In Vancouver in 1986, the ever increasing demand for pediatric day care surgery resulted in major renovations to the existing day care facilities at British Columbia’s Childrens’ Hospital. The newly expanded Day Care Unit is more than double the original size and now includes facilities for medical as well as surgical day care patients. This expanded Medical/Surgical Day Care Unit accommodates an average of 29 patients per day (B. Laird, personal communication, April 3, 1987).

When a surgical procedure is carried out in a Day Care Unit, the parent(s) and child spend a relatively short period of time, usually about six to eight hours, in the hospital setting. Experience has shown that the success of any pediatric day care surgery program is highly dependent upon the full co-operation of parents who, upon their child’s discharge from hospital, are both willing and able to assume the role of primary caregiver (El-Shafie & Shapiro, 1977; Schowalter, 1977). The acceptance of this "new" caregiver role places increased demands on usual parenting roles. It requires that parents take over responsibilities and decision making that was, in the past, left to the judgement of health care professionals. It is this author’s opinion that by conferring these new caregiving responsibilities on the parents of pediatric day care
surgery patients, health professionals have made assumptions about the parents’ experiences once they leave the hospital and also about their abilities to manage the post-operative care of their child within the context of their everyday lives.

One of the primary functions the family unit serves within our society is in relation to the management of health and medical care for its members (Litman, 1974). Friedman (1986) identified the "provision and allocation of physical necessities and health care" (p. 59) as one of five basic family functions. In both Western and non-Western societies 70% to 90% of all sickness is managed solely within the social network of the family and the community without professional consultation (Kleinman, 1978). Parents then, are quite accustomed to utilizing their own resources to manage a child’s minor illness within their family unit. This is an acceptable practice and well within the scope of a parents’ normal responsibilities.

When a new situation arises within the family unit, however, such as one when a child must undergo day care surgery, the first time experience of hospitalization and a surgical procedure can be very anxiety provoking for both parent and child. Such anxiety may continue during the post-hospitalization period (Droske, 1978; Mahaffy, 1965). Professionals may form their own opinions about the nature of the parents’ experience when they leave the hospital. However, it has been shown that there will be discrepancies and inconsistencies in the ways in which professionals and lay persons view the same health care situation (Kleinman, 1978; Knox & Hayes, 1983).

This study was designed to explore in depth parents’ thoughts, feelings and reactions when caring for their young child at home following day care surgery in order to contribute to nursing knowledge about this important parental experience. The understanding gained from focusing on the parents’ point of view enhances health
professionals' abilities to communicate with parents in a meaningful way (Anderson & Chung, 1982; Knox & Hayes, 1983). An indepth understanding of the parents' experience provides nurses with clear direction for assessment, planning and implementation of appropriate nursing care both during the young child's pre-hospitalization and their post-hospitalization periods. The knowledge gained from this study also adds clarity and validity to aspects of nursing care presently implemented by hospital Day Care Unit nurses for the parents of pediatric day care surgery patients.

Conceptual Framework

The conceptual framework which guided the development of this study was developed by Kleinman, Eisenberg, and Good (1978). The Kleinman et al. (1978) framework adheres to two fundamental notions: The first is a distinction between the concepts of "disease", "illness" and "sickness", and the second is a conceptualization of a health care system with three different but interacting social "arenas". The framework holds that a clear understanding of the perceptions and explanatory models of individuals in each of the arenas in the health care system will lead to improvement in the areas of patient communication, compliance, and satisfaction.

Kleinman et al. (1978) describe "disease" as a biological malfunction, and "illness" as a personal, interpersonal, and cultural reaction to the disease (p. 252). Simply put, diseases are treated and illnesses are experienced. Sickness is defined as a complex human phenomenon encompassing both disease and illness. The human experience of sickness has interacting biological, psychological, and sociocultural components. It is the sickness experience and the resulting difficulties it brings to aspects of daily living that is of primary concern to patients in the health care system.
Kleinman (1978) maintains that in order to overcome sickness, or to successfully complete the healing process, there must be a resolution of both the biological disease and the illness experience.

The three social arenas of Kleinman's health care system are referred to as the popular, professional, and folk arenas. The three arenas serve to socially legitimize sickness and health care for the individuals they represent. In health care relationships transactions occur between individuals in each of these three arenas.

The popular arena is comprised of individuals, families, and social/community networks. The majority of health care activities take place in this arena. The professional arena includes scientific medicine and indigenous healing traditions, while the folk arena includes non-professional healing specialists. Each of these arenas "possesses its own explanatory systems, social roles, interaction settings, and institutions" (Kleinman et al., 1978, p. 254).

The following figure depicts Kleinman's (1978) health care system.

Figure 1. Kleinman's Health Care System (1978)
In each of these three arenas, explanatory models can be elicited from individuals to explain and define particular sickness episodes. Individuals use personal explanatory models to determine and describe what is wrong with them or others, and also to recommend what steps should be taken for successful treatment. Explanatory models are constructed or shaped by an individual's culture, society, knowledge base, beliefs, values, and past experiences. Because individuals from different arenas will have different explanatory models for the same health care situations, the result is often "discrepant expectations and miscommunication" (Kleinman, 1978, p. 88). A common example of this type of discrepancy is that in most situations in the professional arena, sickness is construed as "disease" while in the popular arena it is most often viewed as "illness".

According to the Kleinman et al. (1978) framework, if nurses are to improve the care provided to parents, they must be concerned with the ways in which parents view their children's illnesses since interpretation of a situation may be made very differently by parents and professionals. In general, parents of pediatric day care surgery patients are family members representing the popular arena. The parents' explanatory models for the post day care surgery experience can be understood by eliciting their perceptions and explanations about this experience. An understanding of the parents' explanatory models will provide a solid basis for clear communication between the nurse and the parents and help to facilitate effective nursing intervention. Others have previously demonstrated the relevance of this framework in nursing research and applications to nursing care (Anderson, 1981; Dunn, 1985; Knox & Hayes, 1983; Robinson, 1983; Thorne, 1983).
Statement of the Problem

The general problem that this study addresses is a lack of nursing knowledge about the parents' experience at home following their child's short term hospital stay for day care surgery and the meaning assigned to this experience from the parents' perspective. Therefore, this study was designed to gain an understanding of parents' first time experience of having a toddler or preschooler at home following day care surgery. The results provide insight into the subjective meaning of the post-operative pediatric day care surgery experience by elucidating the parents' personal explanations, perceptions, and definitions of their situation, and also the ways in which they desire to be helped. Hence, the study addressed the following question: What is the parents' experience of having a toddler or preschooler at home following day care surgery?

Introduction to The Methodology

The qualitative research method of phenomenology was selected to address the research question posed by this study. Phenomenology is not just a research method but is also a philosophy and an approach (Oiler, 1982). Considered to be a viable and valuable qualitative methodology, it was chosen because it employs description to identify and understand phenomena (Omery, 1983). As Rist (1979) stated, this type of research method "enables a comprehension of human behavior in greater depth than is possible from the study of surface behavior, from paper and pencil tests, and from standardized interviews" (p. 20).

Phenomenology represents an effort to describe the human experience as it is lived by the individuals being studied. All phenomena, including the individual's perceptions of the human experience and their effect on him/her, are investigated and described (Omery, 1983). All data given by the subjects are deemed to be relevant.
A researcher using the phenomenological method must approach the research encounter naively and with an "open mind" (Omery, 1983). The researcher must recognize his/her own preconceived ideas and attempt to set them aside (Oiler, 1981). The researcher accepts the generated data as subjective descriptions of the meaning the experience has for the individuals being studied, and he/she does not attempt to modify it to fit a preconceived definition of the phenomenon (Omery, 1983).

Phenomenology is an appropriate method to study the parents' experience at home following their child's day care surgery because it strives to understand all data in the experience from the perspective of the parents themselves. In addition, the phenomenological method is congruent with Kleinman's framework (1978), as both approaches emphasize that individuals give subjective meaning to the situations they experience in everyday life.

**Definition of Terms**

The following terms are defined in order to clarify their use in this study:

**Day Care Surgery:** an elective surgical procedure carried out in a special hospital unit where the patient is admitted and discharged from hospital on the same day (Davenport, Shah, & Robinson, 1971).

**Family:** two or more persons living together joined by mutual consent and bonds of blood, marriage, or adoption. These persons share a common culture and assume socially recognized roles such as mother and father, sister and brother, son and daughter (Friedman, 1986).

**Parent:** an adult person who fulfils the primary caretaking role for a child. This person may be the child's biological, adoptive, step, or foster parent.
Parents’ Experience: parents’ reactions, thoughts and feelings, and the personal meaning that they hold for them, which together comprise the parent’s response to caring for a child at home following day care surgery.

Post-hospitalization Period: that period of time which commences when the parent and child leave the hospital setting unaccompanied by any hospital personnel, and ends when the child has recovered physically and emotionally from the surgery and all family members have returned to their regular patterns and activities of daily living.

Preschooler: a child whose current age at the time of the day care surgery is within the range of three to five years.

Short-term Condition or Illness: a non-chronic, non-recurrent, disease or ailment which is self-limiting in nature but requires surgical intervention in order to obtain correction or resolution.

Toddler: a child whose current age at the time of day care surgery is within the age range of one to three years.

Assumptions

The assumptions that guided this study are as follows:

1. The construction of an experience by the individuals involved in it is a valid representation of the experience and can promote further understanding of the phenomenon (Omery, 1983).

2. Parents’ experiences following their child’s day care surgery, and the meanings they assign to these experiences within the context of their situation, can be perceived and understood by the researcher using a phenomenological method.

3. The researcher actively participates in the constitution of the actual research data by virtue of open dialogue with participants and a focus on their subjective
experiences (Giorgi, 1975a).

4. Parents of children aged one to five years who were selected to participate in this study offered comprehensive, relevant and reliable information to the researcher (Morse, 1986).

Limitation

The following study limitation was identified:

1. The reality of an experience constructed by parents in interaction with the researcher is influenced by the social, cultural, environmental, and personal contexts of the situation. Generalizability of findings based on this type of research is limited to similar meanings found in the data (Omery, 1983) since every qualitative research situation is "ultimately about a particular researcher in interaction with a particular subject in a particular context" (Sandelowski, 1986, p. 31). The data therefore represent the experiences of only those parents who participated in the study.

Summary

A growing number of families are experiencing day care surgery as an alternative to more traditional forms of health care delivery for young children. During the post-hospitalization period following a minor surgical procedure, parents' attitudes and abilities to cope have been shown to have a profound effect on a young child's well-being and recovery (Prugh, Staub, Sands, Kirschbaum, & Lenihan, 1953; Robertson, 1970).

This study is designed to explore in-depth the parents' perceptions and personal interpretations of the post day care surgery experience within the context of their everyday lives. Kleinman (1978) purports, and other authors have demonstrated, that eliciting clients' explanatory models enhances health professionals' understanding of
illness as a personal, social and cultural experience and facilitates the provision of care that is mutually satisfying (Anderson, 1981; Anderson & Chung, 1982; Knox & Hayes, 1983).

The results of this research address the lack of empirical knowledge concerning this important parental experience. The findings of this study direct nurses to plan and provide empathic nursing care which reflects the nature and meaning of the post day care surgery experience for this client group. Chapter 2 provides a review of the literature pertinent to this investigation.
CHAPTER 2

Review of Selected Literature

This chapter presents a review of the literature pertinent to this study’s research problem. The intent of the review is to establish a background for what is understood to date about the post-hospitalization experience for parents whose children have undergone a day care surgery procedure and to locate this study within the context of related professional literature. On searching literature from nursing and other disciplines, this author was unable to locate a study that discusses parents’ perceptions of the post-hospitalization pediatric day care surgery experience nor their ability to manage at home during this time. The paucity of literature about the post day care surgery experience from the parents’ perspective highlights a need for further investigation.

This selected review of literature will include both experientially and research-based publications from four relevant subject areas in order to establish a background of information about the study’s research question. These four subject areas explore the more general impact of a child’s illness, hospitalization and/or surgery on the child and his/her parents. The first subject area examines parental role and responsibility changes when a child becomes ill or requires hospitalization. The second subject area relates specifically to the effects of maternal anxiety on the hospitalized child. The third subject area, directly related to the issue in question, explores parental attitudes towards pediatric day care surgery. And finally, the fourth subject area examines short term hospitalization of toddlers and preschoolers and resulting
post-hospitalization behavior changes.

Although the literature reviewed here is related to the research question, it is not meant to generate a mind set about the nature and meaning of the post day care surgery experience for parents. This is consistent with the conceptual framework and the phenomenological methodology.

The remainder of the chapter is organized into sections corresponding with the selected subject areas. Related theory and research will be examined again in Chapter 4, when the findings of this study are presented and discussed.

Parental Role and Responsibility Changes When Caring for A Sick Child

The literature supports that a parent’s role changes when a child becomes ill (Hymovich, 1976, 1981; Litman, 1974; Prugh et al., 1953). Parents of young children are particularly susceptible to such changes because they rely on their childrens’ responses and behaviors to help define their parental role. Conversely, young children rely almost exclusively on their parents to interpret their environment and translate it in a meaningful way to them (Friedman, 1986).

Litman, in his 1974 study of the family as a basic unit in health and medical care, showed that the family "in one way or another tends to be involved in the decision-making and the therapeutic process at every stage of member’s illness, from diagnosis to treatment and recuperation" (p. 501). This is particularly true when the illness affects a child. He emphasized the importance of the family’s response (especially the wife-mother) to any member’s illness and noted that in addition to being the "central agent of cure and care" (p. 505) she also may exhibit considerable variation in her "ability to recognize discomfort or illness in a family member" (p. 505). Litman (1974) also found that because of the demands of her usual role, a mother often found
it difficult to fulfil her obligations to all members of the household when one member was ill.

Based on observation and experience, Hymovich (1976) described in detail the needs of parents when their child is sick. She states that: "whether the illness is acute, chronic, or fatal, treated at home or in the hospital, it will have some impact on all members of the family, not just the ill child" (p. 9). Prugh et al. (1953) also documented that when a child becomes ill a change takes place in the parent-child relationship.

If the child’s illness necessitates hospitalization, changes occur in parental roles and in their everyday responsibilities. During the child’s hospitalization most parents, although willing to participate in their child’s care, are unsure of their role in the hospital setting (Algren, 1985; Knox & Hayes, 1983; Merrow & Johnson, 1968). Algren (1985) revealed that parents receive minimal direction from nursing staff to clarify their role uncertainty.

The hospitalization of a child results in parental separation and relinquishment of the child’s care to persons unknown at a time when parent and child have a greater need for one another (Gofman, Buckman & Schade, 1957). Parents become vulnerable and need special reassurance and explanation (Keane, Garralda, & Keen, 1986; Knox & Hayes, 1983; Wilkenson, 1978). During this time parents experience feelings of fear, guilt, frustration and anxiety (Droske, 1978; Gofman et al., 1957; Smitherman, 1979; Whaley & Wong, 1987; Wolfer & Visintainer, 1975). As these emotions increase in intensity, judgement and memory can be impaired and learning responses become less effective.
A small amount of literature exists which supports the premise that the post-hospitalization period may also be particularly difficult for parents (Droske, 1978; Frieberg, 1972; Wilkenson, 1978). Prugh et al. (1953) partially attributed parents' pre-operative anxiety to concerns about dealing with the child once he/she returned home.

Uyer (1986) described a study of 200 young mothers who brought their sick children to an Out-patient Clinic for treatment of a variety of minor illnesses. Uyer (1986) believes that in order to understand and manage her child's illness, a mother must accurately interpret the facts concerning the child's diagnosis, treatment, care, and follow-up. This author found that 72% of the mothers left the Clinic with incorrect or incomplete information regarding the necessary care for their ill child. An average of 44% also had inadequate information regarding treatment and follow-up. Uyer found that the implementation of an experimental "nursing approach" with the experimental group of mothers significantly improved their comprehension of their sick children's treatment and care thus demonstrating the value of nursing intervention in improving patient communication and education.

Uyer's (1986) study reinforces the fact that mothers do not always remember or value the information that health professionals deem to be "important". In certain cases, it is possible that the well-being and recovery of the child may be at risk if recommendations are not followed.

In summary, the literature supports that parents have unique needs and roles when a child becomes ill and/or hospitalized. A child's illness and the parental reactions to it may affect the functioning of an entire family unit. Parental support is crucial to the physical and psychosocial recovery of a child, and yet a child's
hospitalization may be extremely anxiety provoking for parents, especially mothers.

Much is still not known about the parents’ experience at home following a child’s hospitalization: How do parents cope with new responsibilities and their increased need for information? How do they adjust to role changes during the post-hospitalization period? When do they readjust to former roles and regular patterns of daily living after the child has been discharged from hospital?

Because the perception of an event is more significant than the actual circumstances (Whaley & Wong, 1987), it is necessary to learn about an experience as it actually lived by the persons involved in it. It was thought that a study such as this one investigating the post day care surgery period would provide insight into how we can better prepare parents for the transitions they must face during this time.

The Effects of Maternal Anxiety on the Hospitalized Child

There have been several studies which have demonstrated the degree and effects of maternal anxiety during a child’s pre- and post-operative hospitalization period. In the three studies to be examined here, all of the children underwent minor elective surgical procedures while hospitalized for short periods of time. These studies are significant because, by 1988 standards, most of the surgical procedures described in them would be considered suitable pediatric day care surgery cases. The findings of these studies, documenting levels of maternal anxiety, may be generalizable to the reactions of mothers when their children undergo these same types of procedures on a day care surgery basis.

Mahaffy (1965) studied a sample of 43 randomly selected children aged two to ten years who were admitted for tonsillectomy and adenoidectomy. These children had no previous hospitalizations. Mahaffy proposed that hospitalization is an anxiety
provoking experience for both parent and child and that a "mother must be comfortable and secure" (p. 12) in order to meet her child’s needs. The researcher introduced an independent variable of "supportive nursing care" to mothers of the 21 children in the experimental group in order to test the hypothesis that reducing parental stress would measurably reduce distress in the child both during the hospitalization and post-hospitalization period. The study's findings clearly supported the hypothesis, although generalizability of Mahaffy's (1965) findings must be made with caution as the study size was small and not all dependent variables were controlled.

Mahaffy revealed, by means of a post-hospitalization questionnaire, that all of the children who participated in the study showed behavioral manifestations of anxiety in the post-hospitalization period. There were, however, statistically significant differences between the control and experimental groups in the manifestation of three types of behavior. A greater number of children in the control group (their mothers did not receive "supportive nursing care") exhibited disturbed sleep, fear of medical personnel, and an increased dependency on their mothers. The implication of this finding is that the experimental nursing intervention used with the mothers may have had an effect on the child's behavior upon returning home. This finding can be explored further by investigating the post-hospitalization period as described by the parents themselves, a task undertaken by the author of this research report.

In a similar study, Wolfer and Visintainer (1975) hypothesized that children and parents who receive special psychological preparation and continued supportive care from a Clinical Nurse Specialist (CNS) would show less behavioral upset and better coping abilities during the hospitalization period and fewer post-hospital adjustment problems. Eighty children aged three to 14 years scheduled for minor surgery and their
parents were randomly assigned to control and experimental groups. The children had not been hospitalized in the previous year and were admitted for procedures such as tonsillectomy, adenoidectomy, myringotomy, and inguinal or umbilical herniorrhaphy.

As with Mahaffy's (1965) study, there was evidence of anxiety in both the control and experimental groups. Parents in the latter group (with CNS support) however, had significantly lower self ratings of anxiety, higher ratings of adequacy of information provided, and greater satisfaction with the care given. The children in the experimental group showed significant physiological evidence of reduced anxiety while in hospital (e.g., lower blood pressure readings, reduced incidence of crying & vomiting, etc.) and also obtained significantly lower post-hospital adjustment scores on the Posthospital Behavior Questionnaire (Vernon, Schulman, & Foley, 1966). These findings add support to the premise that nursing intervention plays a role in reducing anxiety in hospitalized parents and children.

Of further interest was Wolfer and Visintainer's (1975) finding that the anxiety ratings in both parental groups proved to be significantly higher for parents of young children. In addition, children whose ages were between three and six years consistently demonstrated greater upset and less cooperation than those in older age groups. These findings support the need for an investigation which focuses on the experience of parents of children under the age of five. It is important to note that the Wolfer and Vinsintainer (1975) study had a number of methodological problems regarding the possible bias of parents in the experimental group with whom the research nurse spent considerably more time than those parents in the control group.

In 1978, Vardaro reported an investigation designed to determine a relationship between anxiety in the preschool child and anxiety in the parent prior to the child's
hospitalization for elective surgery. She studied 18 subjects aged 18 to 66 months and their mothers. The children had no previous hospitalization experience or preparation.

Vardaro (1978) employed three different instruments to measure anxiety: A urine test for 17-hydroxycorticosteriod was done on samples collected from both mother and child; the State-Trait Anxiety Inventory Self-Evaluation Questionnaire (STAI) was given to the mother; and the Prehospital Behavior Questionnaire was given to the mother to fill out about her child.

Statistical analysis of the data showed a highly significant positive correlation between anxiety in the mother about hospitalization of her preschool child for elective surgery and anxiety in the preschool child. According to the State Questionnaire of the STAI, eighty-nine per cent of the mothers experienced medium or high anxiety when completing the questionnaire at home two days prior to the hospital admission. Of interest was the finding that the level of maternal anxiety was significantly higher for mothers of one child versus those mothers with more than one child. Limitations of this study include the small sample size, use of a Prehospital Behavior Questionnaire which lacked previous reliability and validity testing, and using mothers who were experiencing anxiety to rate the behavior of their own child.

The findings of the three preceding studies as well as those done by Frieberg (1972), Skipper, Leonard, and Rhymes (1968) and Prugh et al. (1953) provide support for the "emotional contagion hypothesis" which holds that a parent's emotional state may be readily transmitted to a young child (Wolfer and Visintainer, 1975). Emotionally upset parents are often unable to assist their children to cope with a stressful situation, yet parental support and comfort is essential when a young child is
facing any type of new experience (Vardaro, 1978).

Maternal anxiety may effect the child’s emotional responses both during hospitalization and in the post-hospitalization period. The literature also supports the premise that selected nursing interventions can have a significant impact on reducing parental anxiety during a child’s hospitalization. In summary, the findings discussed in this section support an investigation to explore the parents’ experience from their perspective in order to address parental needs. As the findings of these studies revealed, in seeking to meet parental needs health professionals will also indirectly meet the needs of their pediatric patients who may be significantly affected by their parents’ perceptions of the health care encounter.

**Parental Attitudes Towards Pediatric Day Care Surgery**

The literature searched for the purpose of this report has not revealed any studies which specifically examine parents’ experience in the post-hospitalization period following their young child’s day care surgery. There are, however, three studies that addressed the attitudes and impressions of parents towards their child’s day care surgery before it was undertaken. These are included here because all three were conducted in the same city as the current research.

In 1969, prior to the establishment of a pediatric day care facility in Vancouver, British Columbia, Shah, Papagiorgis, Robinson, Kinnis and Israels surveyed the attitudes of a group of 611 parents towards this alternative form of health care delivery. The children of the participant parents ranged in age from infancy to 18 years. The authors collected nominal level data by the administration of a questionnaire to selected parents following their child’s conventional hospital stay for a minor elective surgical procedure. The quantitative questionnaire required parental responses which indicated
only agreement or disagreement with the statements presented.

The major finding of their study was that 45.3% of those parents who qualified for day care stated they would have preferred day care if such an alternative had been available at the time. In relation to the questionnaire's statements assessing level of anxiety, the authors failed to reveal significant differences between the responses of the two parent groups (choosing day care or conventional hospitalization). Both groups agreed that they were anxious when their children were in the hospital and also that their children were anxious during this time.

One interesting finding of the study was that certain surgical procedures (i.e., repair of hernia or squint) were associated with greater parental preference for conventional hospitalization than others (i.e., cast change or removal, cystoscopy). The authors suggested that this difference might be because "parents are more anxious about procedures which result in readily visible changes or effects of procedures which are considered serious for adults" (p. 346).

Unfortunately, the authors' use of a structured, close-ended questionnaire did not allow the study participants to openly express opinions or concerns such as those related to their feelings of anxiety. The questionnaire forced parents to respond to the perceived concerns of the researchers rather than those identified by the parents themselves.

As a follow-up to the 1969 study, Shah et al. (1972), undertook a controlled study of medical complications and parental attitudes following the day care surgery of 318 children. The children were alternately assigned to either the control or the experimental groups and were matched for age, sex, type of surgery and socio-economic class. Although the authors failed to comment on the reliability and validity of their
data collection tools, they reported that 56 percent of the parents in the study chose the
day care option for their child's surgery as opposed to having the child stay in hospital
overnight.

Shah et al. (1972) concluded that it was probably a higher degree of anxiety in
the parents caring for their children at home which accounted for a significantly higher
number of post-operative reports of pain and coughing in this group. The day care
surgery parents also expressed a stronger preference for post-hospitalization home visits
by a nurse and considered this visit to be important. The authors attributed this finding
to an increased need for reassurance. Despite acknowledging that the post-
hospitalization period following a child's day care surgery can be an anxious time for
parents, these authors did not suggest further investigation of these findings and in fact
recommended that the one support that was available to the parents--the home visits by
the nurse--be discontinued in light of the few medical complications in the postoperative
period. This action failed to take into account the impact of the mother's emotional
well-being on that of the postoperative child.

In another basic level descriptive study, Davenport et al. (1971) reported on a
study population of 833 children who underwent day care surgery over a 27 month
period. Ninety-six percent of the subjects had a hospital stay of eight hours or less.
During the last three months of their data collection period for other research purposes,
184 study parents were contacted by telephone on the day after the child's operation
and asked to respond with yes/no answers to eight attitude statements concerning their
experience with the day care surgery program. A large majority of parents agreed that
their child was both happier (94.6%) and safer (90.8%) at home than in hospital
following surgery.
In this study there was no home visit made by a nurse after discharge from hospital. Over 90% of the parents responded "no" to the statement that home visits by a nurse would have been of value. This contrasts the findings of other authors and lends support to an investigation of the post-hospitalization period to examine in detail the parents' perspectives of their experiences. The authors of this study stated that the parents' attitude towards the home visit was "logical in light of the few and mild complications following surgery" (p. 500). It is noteworthy that this conclusion does not concur with the findings of other studies reviewed in this section which have clearly demonstrated the value of nursing intervention in decreasing anxiety in the parent with subsequent beneficial effects for the child. Again, this study did not allow the parents an opportunity for open expression regarding their experience.

In summary, parents support the concept of day care surgery for their children. The findings the studies presented in this sub-section did not explore the pediatric day care surgery experience from the parents' point of view and fail to provide any insight into the parental post day care surgery period experience. Because of the strength of the parent/child relationship and the potential effect that one member of the dyad could have upon the other, literature describing the effects of a short term hospitalization on toddlers and preschoolers will be reviewed here.

The Effects of Short Term Hospitalization on Toddlers and Preschoolers

Pioneering research on the emotional significance of illness, hospitalization, and surgery on young children was done in the 1930s and 40s. Authors such as Beverly (1936), Jackson (1942), and Langford (1948) described in detail the psychological and physiological impact of parental separation and hospitalization for children of different ages. Bowlby's 1952 report to the Geneva Conference of the World Health
Organization brought further attention to the psychological consequences of hospitalizing children. In 1953, Prugh et al. published what is now considered to be a classic study investigating the emotional reactions of children and families to long term hospitalization. In 1958, Robertson published the first edition of his insights into the behavior of young children in hospital.

By 1965, Vernon, Foley, Sipowicz, and Schulman presented a review of over 200 publications that dealt with the effects of hospitalization and illness on children. These early works made significant contributions to our present understanding of the emotional reactions of children to the experiences of illness, hospitalization, and surgery.

Despite an abundance of literature directly concerning the hospitalization of children, there has been less attention paid to the psychological consequences of the experience once the child has returned home. Children often exhibit some degree of behavioral change following any type of illness, not just one involving hospitalization or surgery (Wilkenson, 1978). The term "psychological upset" has been used here to refer to any adverse behavioral change observed in children following the experience of illness, hospitalization and/or surgery. The remainder of this section will discuss the findings of several researchers who have examined psychological upset in children following their hospitalization. This review is included here because it was felt that the nature of the child’s experience may affect the parent’s experience during the post-hospitalization period.

Vernon et al. (1966) were forerunners in examining post-hospitalization behavior changes in young children. In the early 1960’s they developed the Posthospitalization Behavior Questionnaire. The questionnaire is a 28 item instrument which has since been
used widely in the field of post-hospital behavior changes in children and has extensive reliability and validity (Brown, 1979; Hannallah & Rosales, 1983; Mahaffy, 1965; Sipowicz & Vernon, 1965; Vernon, Schulman, & Foley, 1966; Wolfer & Visintainer, 1975). For each of the 28 items in the questionnaire, the parent compares the child’s typical behavior before hospitalization with his/her behavior during the first week after hospitalization.

The first published study utilizing the Posthospitalization Behavior Questionnaire (PBQ) was conducted by Sipowicz and Vernon (1965). They conducted a comparative study of 24 sets of twins, where one of each set was not hospitalized and one was hospitalized for medical or surgical intervention. The range of the hospital stay was one to more than twenty-one days. The PBQ was mailed to each mother six days after discharge. The results showed that the majority of the hospitalized twins, particularly those aged 6 months to 4 years, showed more psychological upset upon return home than the non-hospitalized twin. Although the number of subjects was small, this study’s strength lies in the fact that the methodology included a well matched control group.

Vernon et al. (1966) studied the post hospitalization behavior of 387 children aged one month to 16 years who were hospitalized for a variety of surgical and medical conditions. The mean duration of their hospital stay was 8.8 days. In this study the PBQ was mailed to each set of parents six days after discharge therefore only parents who were motivated to do so returned the questionnaire. The researchers acknowledged that even though not all items on the questionnaire were suitable for all of the age groups in the study, all the items were scored. Factor analysis of the questionnaire responses revealed six categories of post-hospitalization behavior
disturbances. These were: general anxiety and regression, separation anxiety, sleep anxiety, eating disturbances, aggression, and apathy-withdrawl. The investigators examined their findings in light of several variables: gender, prior hospitalization, degree of pain experienced during hospitalization, birth order, age, duration of hospitalization, and parental occupational status. Only the latter three variables were shown to be significantly related to one or more of the post-hospitalization behavior disturbances.

The authors of this study concluded that children between the ages of six months and four years were most likely to demonstrate psychological upset in the post-hospitalization period. The behaviors manifested by this age group would be: increased sleep and separation anxiety, and increased aggression towards authority. Such findings support an investigation of the experience of parents of toddlers and preschoolers during the post-hospitalization period as the parental experience could be significantly affected by the child's psychological upset.

Using an experimental design, Davenport and Werry (1970) investigated the post-hospitalization effects of brief hospitalization, minor surgery, and general anesthesia on 145 children aged one to 15 years who were hospitalized for less than 48 hours. Thirty percent of the subjects in their study were aged six months to four years. The children were selected from two different hospitals and matched with a corresponding non-hospitalized control group. The control groups were comprised of siblings of the participants or children who attended a pediatric Out-Patient Clinic for a routine physical examination.

The Posthospitalization Behavior Questionnaire was verbally administered by a research assistant to the mother of each child on the day of her child's admission and
again two weeks after hospital discharge. Davenport and Werry failed to find statistically significant evidence of residual post-hospitalization psychological upset in either the experimental or control groups of their subjects as rated by the subjects’ mothers. This finding is inconsistent with that of other researchers using the same instrument. This inconsistency in findings lends support to an investigation designed to explore the nature of the post-hospitalization period from the parents perspective.

Brown (1979) studied the post-hospitalization behavior of 40 children whose ages ranged between three and six years. Each child was hospitalized for five days for a tonsillectomy and adenoidectomy. Brown conducted three interviews with each mother using the categories in the Posthospitalization Behavior Questionnaire (Vernon et al., 1966). All interviews were conducted in the child’s home. She found that there were four categories of behavior which were described by parents as "worse" at one month post-hospitalization but "improved" at six months. These categories were: general anxiety, separation anxiety, aggression, and sleep disturbances. The researcher found that instances of psychological upset decreased with the duration of the post-hospitalization period. Although age, length of hospitalization and type of surgery were included in the study design, other potentially influencing variables were not mentioned. Brown’s findings agree with those of Vernon et al. (1966) and point to a need to further investigate the post-hospitalization period from the parents’ perspective.

Hannallah and Rosales (1983) undertook a study to examine the effects of eliminating parent-child separation during anaesthesia induction for preschool children undergoing day care surgery. The purpose of their study was to determine whether or not it was safe and feasible to allow parents of young children to be present during the anesthesia induction of their child. The children, aged one to five years, were admitted
for a variety of day care surgical procedures such as dental work, hernia repairs, circumcision, and eye surgery. Fifty children had parents present during anesthesia induction and fifty did not. A notable finding of this study was related to the results of the Posthospitalization Behavior Questionnaire (Vernon et al. 1966) completed by parents through an interview two weeks after their child’s surgery which revealed a significant number of post-hospitalization behavior disturbances. Over 60% of the children in the experimental and control groups manifested behaviors related to sleep anxiety, over 45% demonstrated separation anxiety, and over 34% showed increased signs of aggression. The authors failed to acknowledge the high incidences of these post day care surgery behavioral disturbances or discuss the parents’ reactions to them.

The preceding studies have investigated the occurrence of post-hospitalization psychological upset in young children. As many of the researchers acknowledge, it is a difficult area to study because psychological upset in the post-hospitalization period is influenced by numerous variables related to the child, the family, and the actual hospitalization experience. Known variables that affect the experience include: age of the child, pre-hospital personality, past experience with hospitalization, parental separation, quality of the parental-child relationship, level of maternal anxiety, status of family equilibrium, length of hospitalization, reason for hospitalization, and preparation for hospitalization (Belmont, 1970; Vernon et al., 1966; Wilkinson, 1978). A definite weakness in the design of most of the studies reviewed here is the minimal control exerted over these variables during the research.

In order to quantify psychological upset in the post-hospitalization period, most researchers used the Posthospitalization Behavior Questionnaire (Vernon et al., 1966). Published reports of reliability and validity of this instrument have been made by
several authors (Vernon et al., 1966; Vernon, Foley, and Schulman, 1967). Although the questionnaire was apparently designed to be administered within one week after discharge from hospital, some investigators have used it up to six months following hospital discharge (Brown, 1979). Also contrary to its original intent, it has been administered to parents of non-hospitalized children (Davenport & Werry, 1970) and to parents of children who fell outside of the age groups to which some of the questions apply (Vernon et al., 1966).

Of the studies reviewed here, all but one (Davenport & Werry, 1970) reported that subjects exhibited behavior during the post-hospitalization period that was different from their pre-hospitalization behavior. The children’s behavior changes were interpreted to be as a result of the hospitalization/surgical experience and consequently would likely affect the parent’s perceptions and experience during the post-hospitalization period.

In 1981 Fletcher reviewed the available literature related to psychological upset in post-hospitalized children. He concluded that the identification of psychological upset is considerably more complex than "focusing on the hospitalized child and comparing pre- and post-hospitalization behavior" (p. 193). This writer was unable to locate any studies examining post-hospitalization behavior changes in children using a qualitative methodology. Yet this perspective would add much needed description and depth to this complicated issue as well as provide some insight into how the parents might respond to these changes in the child during the post-hospitalization period.

In summary, the review of this section of literature appears to support the statement that "the combination of hospitalization and illness is psychologically upsetting to children in general, even in the case of brief hospitalization for routine
illness" (Sipowicz & Vernon, 1965, p. 230). Children between the ages of six months and five years are particularly susceptible to "psychological upset" following hospitalization and surgery because of their level of cognitive development and coping mechanisms (Dorn, 1984). Psychological upset in this age group manifests itself most commonly as sleep disturbances, separation anxiety, and aggression. Because such behaviors can be reinforced and intensified by parental anxiety, nurses must explore the meaning parents assign to these changes in their child's behavior, and ascertain how the parent's post-hospitalization experience may be influenced by changes.

Summary

This chapter has reviewed selected literature related to four major subject areas in order to establish what is known about the post day care surgery experience for parents of young children. This author was unable to locate a study which specifically investigates the post day care surgery experience from the parent's point of view or even describes the impact of this type of health care encounter on the parent. This literature review therefore explored the more general impact of a child's hospitalization and surgery on the parents, and on the children themselves. The current published research does not provide an indepth understanding of the parents' experience in the post-hospitalization period following their child's day care surgery.

In 1972, Shah et al. came to the following conclusion after studying medical complications and parental attitudes towards day care surgery for children:

While it is necessary to sample the attitudes and opinions of consumers of health services concerning changes in care, this study shows that when the expert providers endorse change in the pattern of delivery of care, patients will accept expert advice and judgement. (p. 48)
To-day, many parents have in fact "accepted" day care surgery as an alternative to the traditional overnight stay in hospital for their children. Despite this apparent parental acceptance there is still stress and anxiety associated with this experience. As health professionals it is important that we do not assume to know the parents' perspective on this form of health care delivery. Nurses working in both day care surgery units and community health settings need to understand the experience of parents in order to provide appropriate preparation, support, information, and guidance.

This study was therefore undertaken for the purpose of eliciting parents' perspective on the post day care surgery experience and its impact on their day to day lives. The results of this writer's investigation are a significant addition to current knowledge. The next chapter outlines the implementation of the selected methodology for this study.
CHAPTER 3

Methodology

This chapter describes the application of the phenomenological method of inquiry in a study of the parents' experience of having a toddler or preschooler at home following day care surgery. A brief introduction to phenomenology was introduced in Chapter 1. The purpose of this chapter is to review the design of this methodology in further detail and discuss the implementation of phenomenology in relation to this study's: selection of participants, setting, implementation procedures, data collection, data analysis, and ethical considerations.

Research Design

"The phenomenological method is an inductive, descriptive research method." (Omery, 1983, p. 50). The origins of phenomenology began with the work of the European philosopher, Edmund Husserl, who believed that "the study of philosophy should have not only 'rigor' but also a new humanism" (Ray, 1985, p. 83).

Phenomenologists believe that human beings act in accordance with the way they construct meanings for the situations they face (Davis, 1978). Phenomenologists emphasize the "lived context" of phenomena--life in the everyday world as it is understood and interpreted by one living through the situation (Giorgi, 1975a). "Phenomenology accepts experience as it exists in the consciousness of the individual" (Field & Morse, 1985, p. 28).

It is the phenomenologist's task to ensure that the subject's viewpoint of the situation under study is revealed through description in an unbiased way (Giorgi,
1975b). It is the subject's point of view that provides the "rich data which must be obtained" (Giorgi, 1975a, p. 100). Because language is the major means of communication in everyday life, phenomenology depends almost exclusively on language to obtain a description of the experience under study. Anything that the subject feels is worthy of mentioning is registered as data. This allows the reality of the subject's experience to be fully expressed (Ray, 1985). It is through this process of exhaustive description that one develops an understanding of the phenomenon under study (Lynch-Sauer, 1985).

Critical to the researcher's approach in a phenomenological study is a heightened awareness of the participant, the setting, and a minimum of preconceptions about the experience under study (Davis, 1978). A truly presuppositionless description of a phenomenon is impossible because a researcher will presuppose implicitly in the questions and answers of an open-ended dialogue according to the intentions and aims of his/her research (Davis, 1978; Giorgi, 1975a). What is suspended by the researcher, however, are assumptions which extend beyond his/her initial questions. The researcher accepts the data as they appear without trying to modify them to fit a preconceived definition of the phenomenon (Omery, 1983).

The goal of the phenomenological method is to derive consensually validated knowledge from a systematic examination of human experience (Lynch-Sauer, 1985). Validity in the phenomenological method is "formulated in light of a client's conception of himself or herself in the world" (Ray, 1985, p. 89). Descriptions of an experience should be recognized as true by those who live the experience.

Control in phenomenological research comes not from an expectation for duplicate behavior from duplicate data but rather from the researcher's perspective of
the data. The key criterion is not whether another position with respect to the data could be adopted, but whether a reader, adopting the same viewpoint and situation of the researcher, could also seen what the researcher saw, whether or not he/she agrees with it (Giorgi, 1975a; Sandelowski, 1986).

Selection of Participants

In a phenomenological study, the participants must have lived or be living the experience under investigation. They must also be interested in understanding and expressing the feelings which accompany their experience (Omery, 1983). Consistent with the phenomenological method and the purpose of this study, the participants sought were parents who cared for toddlers and preschoolers at home after the child's surgery because they could provide the data to "illuminate the phenomenon being studied" (Sandelowski, 1986, p. 31).

A purposive sampling technique was utilized to select study participants (Diers, 1979; Morse, 1986). Using this nonprobability method, parents were selected on the basis of specific characteristics which would enable the researcher to collect the in-depth data required to answer this study's research question. Both mothers and fathers were approached to participate in the study. All of the parents who agreed to participate were selected from the Day Care Unit of a tertiary level pediatric hospital in Vancouver, British Columbia.

Criteria for Selection

The specific criteria established to select the families for participation in this study were that:

1. The age of the child at the time of surgery ranged between one and five years.
2. The child resided with his/her parent(s).

3. The child had not had previous day care surgery or overnight hospital admissions.

4. The child was admitted for elective surgical correction of a short-term condition or illness.

5. The child was discharged home to the care of his/her parent(s) on the same day of hospital admission.

6. The parent(s) assumed the care of the child during the post-hospitalization period.

7. The parent(s) were able to understand, speak, and read English, regardless of ethnic background.

8. The parent(s) had not had previous experience with a child who underwent day care surgery.

9. The family resided in the Vancouver Metropolitan area.

Setting

The setting chosen for the data collection process was the parents' own homes. The parents' home environment was chosen in order to ensure privacy and to promote their comfort and ease when describing personal experiences. When using the phenomenological method "a relaxed atmosphere and sufficient time to express the feeling or experience are essential" (Omery, 1983, p. 56).

Implementation Procedures

The following steps were followed in order to implement this study:

1. After permission to conduct the study was obtained from the appropriate screening committees (Appendices A & B, pp. 143 & 144), the researcher met with the
Head Nurse of the Day Care Unit to inform her about the nature of the proposed study and seek her co-operation in carrying it out. As requested by the Head Nurse, a summary of the research proposal was prepared and made available to all of the nursing staff on the unit.

2. All of the physicians and dentists who admitted children to the Day Care Unit received a letter from the researcher informing them about the nature and purpose of the study (Appendix C, p. 145). Further details of the research project would be provided if they wished to contact the researcher directly. The researcher did not receive any inquiries about the project from this group of professionals.

3. In order to select parents who met the established selection criteria, the researcher visited the Day Care Unit on the evening before a regular surgical day to review the operating room schedule and the patient charts for the following day.

4. On the day of surgery, the researcher personally contacted the potential study participants in the Day Care Unit after their child had been taken to the operating room (the rationale for this approach is discussed under Ethical Considerations p. 43). The researcher introduced herself and offered a brief verbal explanation about the study. After determining if the parent(s) met the selection criteria, the researcher offered a written letter of information which explained the purpose, nature, risks, and benefits of the proposed study (Appendix D, p. 146). It was suggested to parents that they might read the researcher’s information letter during the waiting period prior to their child’s return to the Day Care Unit from the post-anesthetic recovery room (PARR).

5. After consultation with the nursing staff in the Day Care Unit, the researcher returned to see the parents after their child returned from PARR in order to address any questions or concerns regarding the study information letter. This method of approach
was used with the first three participant families, and it was found that parents’ interest/willingness to participate in the study was quickly established during their first contact with the researcher. It was also found that parents were occupied with concerns related to the well-being of their child after his/her return from PARR. Therefore in order to be sensitive to parental needs at this time, it was decided that for the remainder of the participant selection process the researcher would not return to see the parents a second time in the Day Care Unit.

6. If the parents agreed to be so contacted, the researcher telephoned them at home the following morning to ascertain or confirm their willingness to participate in the study and, as appropriate, arrange a convenient time to visit. The parent’s verbal agreement and release of their telephone number to the researcher constituted permission for further contact.

7. Informed written consent from the participants was obtained by the researcher at the first home visit and prior to commencing an interview (Appendix E, p. 148). Subsequent interviews were arranged on a date and time convenient for the parent(s).

**Data Collection**

"The goal of phenomenology is to describe accurately the experience of the phenomenon under study" (Field & Morse, 1985, p. 28). In order to answer the research question posed by this study, the data collection process consisted of in-depth interviews conducted by the researcher. A total of 16 interviews were carried out with nine parents of post-operative toddlers and preschoolers over a six month period. Eight first interviews and eight second interviews were conducted.
Prior to arranging each of the interviews it was made clear that both parents were invited to participate. In all cases except one however, the interviews were conducted with the mother alone. In the case of one family, mother and father were present for the first and second interviews. The parent’s individual decision to participate in the interviews, even if their spouse did not choose to do so, is consistent with this study’s methodology.

The interviews were designed to explore "the meaning of that experience as it unfolds for the participants" (Omery, 1983, p. 54). The interviews were semi-structured in nature and ranged in length from 45 to 105 minutes. An interview guide (Appendix F, p. 149) was used during the first interview to facilitate the exploration of general content areas and help elicit the parents’ descriptions of their experience. The guide consisted of several open-ended questions which had evolved from the study’s theoretical framework and the review of relevant literature. Open-ended questions are designed to create a conversational atmosphere and allow for free expression (Diers, 1979).

Consistent with the analytic method, the content of the second interviews was drawn from analysis of the material discussed during the first interviews and from interviews with other parents. During the second interview the researcher sought clarification and a deeper understanding of issues initially raised. The second interviews also gave opportunity to attend to new topics that were raised by the parent. Third interviews, although an option, were not deemed to be necessary for further clarification of data.

For six of the eight families the first interviews were conducted on the child’s first post-operative day. Due to difficulties co-ordinating the researcher’s schedule with
the family’s schedule, two families were seen for the first time on the child’s second post-operative day. The second interviews were conducted between the child’s seventh and tenth post-operative day. These time periods were chosen in order to elicit parents’ immediate responses to the experience and as well to give them some time to assimilate its impact. Several investigators (Droske, 1978; Frieberg, 1972; Robertson, 1970) have documented an increased parental concern regarding post-hospitalization behavior changes, such as sleep anxiety and increased dependency, in toddlers and preschoolers one to two weeks after hospital discharge.

As was agreed to by the participants, all of the interviews were audio-recorded in order to obtain accurate verbatim accounts of the interviewee’s responses. The tape recordings were transcribed either by the researcher or a qualified dicta-typist. Following transcription, the interview data was then analyzed by the researcher. As an addendum to the taped interviews, the researcher kept written field notes of telephone conversations and discussions with the parents that were not audio-recorded (Anderson, 1981; Lofland & Lofland, 1984). Specific data related to the characteristics of the parents and families, and general observations about the interview process were also compiled as field notes.

It was necessary on two occasions, due to failure of the audio-recorder, to record portions of the parent interviews as field notes. These notes were made from the researcher’s memory immediately after leaving the family’s home.

The approach to data collection as described in this section is in keeping with the framework and methodology chosen for this study as it allows for exploration and clarification of issues related to a particular experience. The field notes and the verbatim transcripts of the taped interviews comprised the data for this study.
Data Analysis

In a qualitative research methodology, data collection and data analysis are not distinct phases of the research project. According to Morse (1986), in a qualitative methodology, data collection and analysis do not cease until "the theory is complete, does not have gaps, makes sense, and has been confirmed" (p. 184). The process of collecting, coding and analyzing data began at onset of this study and continued after completion of all the interviews until the parents’ accounts were synthesized into a descriptive framework of their experience with a toddler or preschooler after the child’s day care surgery.

For the purposes of this research project the data were analyzed according to the five step method proposed by Giorgi (1975a; 1975b):

1) Following transcription of a taped interview with a parent(s), the researcher read the entire description through in order to get a sense of the whole.

2) Next the transcript was reread slowly and delineated each time that a transition in meaning was perceived with respect to the post day care surgery experience for parents of toddlers and preschoolers. The result of this procedure was the identification of a series of "meaning units". For example, one of the meaning units identified after reading and rereading several transcripts was the fear and anxiety felt by parents during the pre-hospitalization period and related to the unknown outcome of their child’s surgical and/or anesthetic procedure.

Lofland and Lofland (1984) state that meanings are "consciously singled out as important aspects of reality" (p. 71). Meaning units in qualitative data analysis are described as "transbehavioral" (Lofland & Lofland, 1984, p. 72)—they not only describe behavior but also define, justify, and interpret it.
3) In the third step, the identified meaning units were compared to each other and to the sense of the whole. Redundancies were eliminated and remaining units were clarified and elaborated. This comparative analysis continued within the individual transcript, between transcripts from the same parents, and among transcripts from other parents. There was continual movement back and forth between the transcripts.

4) Next the researcher "systematically interrogated" (Giorgi, 1975b, p. 75) each of the identified meaning units in order to reveal its contribution to the post day care surgery experience for parents of toddlers and preschoolers. Many of the meaning units were common across the parents' accounts of their experience. The meaning units were then transformed from the everyday language of the participants into the language of nursing science. For example, one meaning unit identified was an increase in the frequency of parental observations of the child during the initial post-operative period. This finding was transformed into a concrete classification called "protective behaviors".

5) In the fifth step, the researcher integrated and synthesized the meaning units drawn from the parents' accounts into common themes and concepts forming a descriptive framework of the meaning of the post day care surgery experience for parents of toddlers and preschoolers. The final point of the phenomenological approach is communication of the findings to other researchers for the purpose of confirmation or criticism.

As was previously stated, these steps were not carried out sequentially but rather formed the basis of the analytic process that was ongoing during and after the data collection for this project. The final result of the process is a synthesis of the parents' accounts of their experience with a post day care surgery toddler or preschooler into the framework described in Chapter 4.
Ethical Considerations

In order to ensure that the rights of the parents who participated in this study were protected, certain ethical recommendations were followed (Canada Council, 1977; Diers, 1979). These were:

Research Clearance Procedures. Approval to carry out the proposed research was sought and received from both the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects and British Columbia’s Children’s Hospital In-Hospital Research Review Committee (Appendices A & B, pp. 143 & 144).

Informed Consent. Potential participants who met the study criteria were contacted in person by the researcher and received verbal and written information about the purpose, nature, implications, risks, and benefits of the study (Appendix D, p. 146). Due to the method used for booking children for day care surgery procedures at British Columbia’s Children’s Hospital at the time the study was conducted, there was no practical opportunity to contact parents by mail in advance of their arrival at the Day Care Unit on the day of the child’s surgery. There was no collusion or deception by the researcher in her approach to potential study participants.

The right to refuse to participate or withdraw from the study at any time without prejudice to current or future health care for their children, was explained verbally and in writing to all participants. The right to refuse to answer any questions, or to decline the use of a tape recorder was also made clear.

The participants were asked to read and sign a consent form (Appendix E, p. 148) in the presence of the researcher after she had ensured all questions had been answered to the parent’s satisfaction, and prior to commencing data collection.
Privacy. In order to ensure confidentiality and anonymity, participant’s were assured that their names and all other identifying information did not appear on any interview tapes or transcripts. A code, known only to the researcher, was used to identify the transcripts. Access to the coded data was restricted to the researcher, the two members of her thesis committee, and the typist (the latter two in only a limited manner). The data were stored in a locked filing cabinet.

The data collected were used for the stated research objectives only. Participants will not be personally identified either directly or indirectly in any publication related to this study. Arrangements were made to erase the tapes and shred the transcripts, the field notes, and the study consent forms within three to five years of the study.

A brief summary of the study’s findings was submitted to the clinical agency and also to those parents who had previously indicated their wish to be so informed.

Summary

This chapter discussed the implementation of the phenomenological method to study parents’ post-hospitalization experience with toddlers and preschoolers who underwent day care surgery. Nine parents participated in the study and 16 in-depth interviews were conducted. The researcher assumed the role of facilitator in the exploration of the meaning of this parental experience and contributed to the construction of the accounts. Data collection and analysis were intertwined. Chapter 4 represents the researcher’s interpretation and synthesis of the participants’ accounts into a description of the meaning of the post day care surgery experience for parents of toddlers and preschoolers. Chapter 4 also discusses and interprets the study’s findings within the context of current, related literature.
CHAPTER 4

Presentation and Discussion of Findings

What is the parents' experience of having a toddler or preschooler at home following day care surgery? The findings of the study designed to answer this question are presented in this chapter. These findings provide insight into the parents' broad perspective of the pediatric day care surgery experience within the context of their everyday lives.

Although it was the researcher's original intent to describe the "post" day care surgery experience for parents of toddlers and preschoolers, it soon became apparent during the data collection process that the post-hospitalization experience was only meaningful when viewed within the context of the events and occurrences that had led up to it. Parents articulated that the total experience began with their realization that something was "wrong" with their child and ended only when the child's behavior and appearance, as well as the activities and routines of all family members, had returned to acceptable patterns. This "large picture" provided the context for the experience of having a toddler or preschooler undergo day care surgery.

The parents' broad view of their pediatric day care surgery experience contrasts with the narrower perspective held by many health care professionals. Unlike parents, who describe their experience as occurring over a span of time ranging from weeks to years, health care professionals tend to view the parents' experience primarily within the context of the immediate preoperative, operative, and initial post-operative surgical days (Davenport, Shah, & Robinson, 1971). Parents who participated in this study were
clearly focused on the management of their "illness experience" rather than the
treatment of their child's "disease" therefore consistent with the way the two concepts
are defined by Kleinman et al. (1978).

This chapter begins with an introduction to the study's analytic framework.
Next, the concepts and themes which form the analytic framework will be presented
and discussed in relation to existing theory in the literature. The purpose of
incorporating the literature in this manner is to present a deeper understanding of the
concepts and themes forming the analytic framework through the presentation and
discussion of relevant theoretical perspectives. This chapter also includes a detailed
description of the participant families, and a detailed presentation of the parents'
accounts organized according to the structure of the analytic framework.

Throughout the section of this chapter presenting the parents' accounts, both
theory and research based publications will be incorporated in order to examine,
support, compare, or contrast the study's findings in the context of theory currently
available in the literature. Although there has been much literature published on the
advantages of pediatric day care surgery, this author has been unable to locate any
published studies which explore the pediatric day care surgery experience from the
parents' perspective. Some of the empirical studies previously reviewed in Chapter 2,
that were conducted with parents of children hospitalized for reasons other than day
care surgery, will be reevaluated here from the perspective of the current findings.

The Study's Analytic Framework:

This study's analytic framework is the writer's interpretation and conceptualization of the similarities and shared aspects of the parent's accounts of their experiences as revealed by in-depth data analysis. These shared aspects have been
synthesized and organized into concepts, themes, and sub-themes and three temporal phases. This conceptual structure forms the theory generated from this study. Although it is the author’s intent to present data which enhance the reader’s understanding of the shared aspects of the parents’ experiences, it remains important to recognize the unique nature of the experiences of the individual parents who participated in this study.

Because the parents’ perceptions of the experience and the intensity of their reactions and responses to it changed over the span of their total experience, the concept of time is important in an examination of this study’s findings. During analysis of the parents’ accounts, it became apparent to the researcher that the parents’ were describing three distinct, chronological stages to their experience. The writer has named these three temporal phases and, using parameters described by the participants, defined their boundaries and their characteristics.

The three phases of the parents’ experience were: a pre-hospitalization or preparatory phase, a hospitalization or operative phase, and a post-hospitalization or readjustment phase. The three phases will be briefly introduced to the reader here and will be described in detail later in this chapter. The pre-hospitalization or preparatory phase began with the parents’ realization that something was "wrong" with their child and ended with the child’s admission to hospital to undergo corrective surgery. During this phase the parents readied themselves and their families emotionally and physically for the day care surgery event. The hospitalization or operative phase occurred during the three to six hours that the parent(s) and child were actually in the hospital setting. This was a highly emotional, intense phase of the experience as the final preparations for surgery were made and the parent(s) relinquished their child to the care of health
care professionals in order that the surgery could be performed. The post-
hospitalization or readjustment phase began upon hospital discharge and continued until
the child had recovered physically and emotionally from the surgery and all family
members had returned to acceptable patterns of daily living. It was the parents’
individual experiences that dictated the rate at which they moved through these three
phases.

The identification of the three phases of the parents’ experience not only reflects
a common thread in the parents’ accounts of their experiences, but also serves to
provide a structure for the analytical framework in order to examine and contrast the
parents’ thoughts, feelings, behaviors, and reactions as the events of the experience
evolved in sequence over time. Throughout the three phases of the experience parents
experienced different feelings and emotions in varying intensities. Parents also used a
variety of coping mechanisms and social supports to manage during the various phases
of their experience.

The core concept that emerged from an analysis of the study’s data was
stress—parents who participated in this study perceived their experience as a stressful
event in their everyday lives resulting in feelings of fear, worry, and anxiety throughout
the three conceptual phases of the experience. The core concept of stress is the basis
of the study’s analytic framework and encompasses underlying themes, and sub-themes
developed from analysis of the data.

The major themes identified in data analysis represent dimensions of the parents’
experiences that contributed to their interpretation of the event as stressful. These were
increased parental responsibility and role strain. Additional themes from the parents’
accounts also reveal dimensions of their experience that enhanced or inhibited their
ability to manage within the context of their everyday lives. These themes have been identified as coping strategies and social support.

The study's conceptual framework is therefore based on a core theme of stress and is organized according to a chronological structure consisting of three distinct phases. The components of the framework, along with underlying themes and sub-themes, are significant in terms of how the parents understand and explain their experience with their child's day care surgery and will be introduced to the reader here.

Day Care Surgery as a Stressful Experience

The literature abounds with references to the hospitalization of a child as a stressful event for the parents (Freiberg, 1972; Gofman, Buckman, & Schade, 1957; Knox & Hayes, 1983; Prugh et al., 1953; Terry, 1987; Wolfer & Visintainer, 1975). Although these aforementioned studies were conducted primarily with parents of children who were hospitalized for periods longer than those associated with day care surgery, the findings of the current study reveal that the parents' experience with a child's short term hospitalization for a day care surgery procedure is also stressful. One mother described her experience with her daughter's day care surgery as something that "changed her life for a little while."

Although the concept of stress has been defined in the literature as both a stimulus and a response, for the purposes of this study stress is defined as a "transaction between the individual and his internal or external environment" (Clarke, 1984, p. 4). This interactional or phenomenological definition of stress is based upon the work of Lazarus and colleagues (Lazarus, 1966; Lazarus, Averill, & Opton, 1974; Lazarus & Folkman, 1984; Lazarus & Launier, 1978). These authors adhere to the view that stress is a personal experience that reflects a deficit between the way an
individual perceives a demand made by the environment and the person’s ability to manage or tolerate the demand.

The theoretical perspective of stress and coping developed by the aforementioned authors provides a basis for understanding how parents who participated in this study interpreted and assigned meaning to the day care surgery experience and coped with it in their everyday lives. According to Lazarus and colleagues, each situation or demand in the environment is cognitively appraised or evaluated by the individual according to its meaning or significance for the person’s well-being. It is the meaning that the situation holds for the individual that determines if the situation is appraised as irrelevant, benign-positive, or stressful (Lazarus & Folkman, 1984). This theoretical perspective was particularly helpful because it holds that stress is an interactive phenomenon and takes into account one’s ability to act on the environment.

The parents who participated in this study appraised the situation of their child’s day care surgery as a stressful one. This was particularly apparent when parents were unable to cope in usual ways to meet the demands of their new situation. For example, one mother described the stress she experienced the morning of surgery due to her inability to meet her child’s demands in usual ways:

I was concerned a little bit how I was going to keep him happy for a few hours before his surgery because, you know, I couldn’t feed him and I thought, "Oh, this little guy’s going to be hungry and cranky. It’s going to be horrible."

If a situation is appraised by individual as being stressful, the transaction is further appraised as challenging, threatening, and/or involving harm or loss (Lazarus & Folkman, 1984). Threat is experienced if a situation is appraised as physically or
psychologically hazardous. "Threat concerns harms or losses that have not yet taken place but are anticipated" (Lazarus & Folkman, 1984, p. 32). Threat appraisal can be conscious or can occur outside the realm of awareness. For the parents who participated in this study, their child's day care surgery represented a major event in their lives. The parents expressed that the surgical event held serious implications for the child's present and future well-being as well as a potentially fatal outcome. One mother was very frank about her fears: "My big concern was that...he [child] was going to die."

How an individual appraises or perceives a situation depends upon a number of influencing factors. Lazarus and Folkman (1984) discuss eight properties of situations that may contribute to their appraisal of being harmful, dangerous, or threatening to the individual. Two of these properties--event uncertainty and temporal imminence--were found to contribute to this study's participants' perceptions of their children's day care surgery situation as "threatening". Parents also reported experiencing emotions of fear, worry, and anxiety. These emotions have been described in the literature as consequences of a "threat" appraisal (Lazarus & Folkman, 1984).

It has been acknowledged that stressful situations are an expected component of family life and that there are many maturational or developmental stressors associated with parenting young children (Aguilera and Messick, 1978; Friedman, 1986; Miller & Sollie, 1986). Aguilera and Messick (1978) classify the hospitalization of a child as a situational stressor--"a random stress event not related to the developmental stage of the family" (Miles, Spicher, & Hassanein, 1984, p. 334). In the experiences of the families who participated in this study, the stress associated with their child's day care surgery was superimposed on the stress associated with parenting a young child in everyday
Parents who participated in this study also described increased parental responsibilities and role strain as factors contributing to the stressful nature of their experience. In order to understand how additional parenting responsibilities contributed to the stresses associated with this experience it is necessary to examine some of the literature related to normal or usual parenting responsibilities.

Parental Responsibility

Parenthood is a position firmly embedded in our social structure and one that is bestowed with the principal task of preparing children to become adult members of society (Handel, 1970). Parenting responsibilities begin during the prenatal period, are intensified with the birth of the first child, and continue 24 hours per day throughout infancy, childhood and sometimes beyond (Friedman, 1986). Levine (1974) describes three categories of parenting responsibilities: 1) to promote the health and physical survival of the child to ensure that the child lives long enough to produce children of their own; 2) to foster the skills and abilities that the child will need for economic and self-maintenance as a adult; and 3) to foster the capabilities for maximizing cultural beliefs and values. Other authors have documented extensive lists of specific parenting responsibilities (Arnold, 1978; Handel, 1970) which could be encompassed within Levin’s (1974) categories.

The responsibilities for parenting a young child are ever constant. A young child’s need for surgical intervention to correct a short-term condition or illness heightens a parent’s awareness of his/her responsibilities to ensure the health and physical safety of a son/daughter. One mother described her feelings of responsibility to protect her son from the pain and discomfort she associated with surgery this way:
"You don’t want anything to hurt your little baby [four years old]. He could fall down on the street and probably get hurt more...but it’s different [surgery]. I just can’t explain it. It’s different."

By virtue of the nature of the experience, day care surgery also adds responsibilities for the preparation and care of the operative child over and above usual parenting. These added responsibilities, inherent in what is perceived to be a potentially serious event, contribute to the stresses of this experience.

Parental responsibilities change over the years as the child matures and parents adapt to their children’s developmental needs. During the toddler and preschooler years, parental responsibilities are focused on caretaking, protection, limit setting, nurturing, and the fostering of social and independent behaviors. Feeding, bathing, toilet training, disciplining, maintaining close physical contact, and providing for a safe environment (Friedman, 1986; Handel 1970) are specific behaviors parents carry out to fulfil the responsibilities of their parenting role for young children. As the average age of the children whose parents participated in this study was 23.8 months, the study participants were accustomed to carrying out the previously mentioned parenting behaviors to ensure their children’s well-being.

Kestenberg (1970) offers a theoretical perspective of parents’ involvement with, and responsibility for, the child from birth to school age. He refers to parenting the child five years of age or younger as "total parenthood". Accordingly, parents are held accountable for their children’s well-being at all times and therefore must take direct responsibility for the child at all times or ensure that someone else does (Boulton, 1983). Along with this responsibility comes an element of "control" over the child and his/her environment. The parents who participated in this study were accustomed to
having the responsibility of parental "surveillance" and control over their child and his/her "world". During the hospitalization phase of day care surgery parents were required to relinquish this control to health care professionals. One mother described it this way, "You’re putting him into someone else’s hands and, you know, it’s just completely out of your control from then on."

Society places expectations for the fulfillment of responsibilities on roles (Johnson, 1979). Responsibilities guide the parent in when, where, and how to perform or enact their role. When parents are unable to fulfil their parenting responsibilities through the implementation of their parent role, the result is role strain. Role strain is another of the major themes identified from an analysis of this study’s data and will be discussed next.

**Role Strain**

Adequate role functioning is crucial for a family’s successful functioning (Friedman, 1986). Role is defined as a "more or less homogeneous sets of behaviors which are normatively defined and expected of an occupant of a given social position" (Nye, 1976, p. 7). Roles are based on role responsibilities or expectations and are learned through past experiences and cultural upbringing. Every role has a partner or a "relevant other" (Johnson, 1979, p. 320). For parents, their mother/father role is complimentary to the child’s role. Parents enact their role expectations or responsibilities for parenting a young child through behaviors such as feeding, bathing, and ensuring contentment and safety.

Goode (1960) defines role strain as the stress generated within a person when one either cannot comply or has difficulty complying with the expectations of a role or sets of roles. In other words, the individual has difficulty in attempting to fulfill role
responsibilities or obligations (Friedman, 1986). Parents in this study experienced role strain when they were unable to fulfill normal role expectations. At certain points during the experience, compliance with surgical standards/instructions interfered with parents' ability to fulfill their normal roles of nurturing, caring, and protecting the operative child. This was particularly apparent for the parents in this study during the pre-hospitalization and hospitalization phases of their experience. Feelings of worry, anxiety, and guilt often result from the stress of role strain (Nye, 1976) because individuals feel that they are inadequate in their enactment of the responsibilities of their new role (Friedman, 1986). As one mother stated in reference to her child's day care surgery, "You tend to, when you don't know, you tend to worry about every little thing, I think."

When a family member becomes ill, roles among the family members change (Johnson, 1979). When a child has to undergo a day care surgical procedure, the parents must assume role behaviors related to pre and post-operative expectations for care of the child. "Learning a new role or changing a role can be very stressful" even in normal circumstances (Johnson, 1979, p. 321). Because it was their first time experience with pediatric day care surgery, the parents in this study had little opportunity to learn the role associated with caring for the surgical child. For example, one mother described feeling very unsure of what was appropriate to take with her to the hospital and how she should dress her child. She actually phoned the hospital, spoke to a nurse and said, "Well, this is probably a dumb question, but what should [child] wear?" The result of not knowing how to fulfill her new role was role strain.

In order to manage the stresses associated with role strain and other aspects of their experience, parents coped in a variety of ways. The following section will
describe the theme of coping and how it was used by the parents in this study.

Coping

Coping is defined as a process of problem solving (thoughts and actions) directed toward meeting the demands of the situation and/or control of the emotional feelings engendered by it (Lazarus & Launier, 1978; Lazarus, Averill, & Opton, 1974). Fundamental to the concept of coping is the assumption that individuals are actively responsive to forces that impinge upon them (Pearlin & Schooler, 1978). Through patterns of daily living the individual learns to use many methods to cope with stress and decrease anxiety. Lazarus and colleagues describe a secondary appraisal process used by individuals to assess available coping options in light of a particular situation appraisal. An individual’s selection of a response is based upon actions that have successfully relieved anxiety and tension in the past (Aguilera & Messick, 1978).

As parents coped with the experience of their child’s day care surgery within the context of their everyday lives, they made concrete changes to their established patterns and activities of daily living. Some of these changes were a direct result of the nature of the surgical procedure (eg., casts, bandages) whereas others were a result of the parents’ interpretation of their situation and their best choice for management.

Parents in this study used both direct and indirect coping strategies (Clarke, 1984) throughout their experience in efforts to meet the demands of their situation and cope with the stress they experienced. The parents’ use of coping strategies enabled them to act as "key figures in minimizing the sequelea resulting from stressor events" (Miles, Carter, Spicher, & Hassanein, 1984, p. 334). Direct coping involves action that will affect the demand of the situation in some way. For example, one mother was creative in her attempts to distract her hungry child in the period just prior to the actual
surgical procedure: "It took us only two toys. One toy got us [from home to 2/3 of the way to the hospital] and the other toy from [there] right up to just before they called him for the surgery. He was getting real fidgety and hungry then."

Indirect coping consists of "strategies which do not alter the demand in reality but alter the way the individual experiences the demand or his own coping, or both" (Clarke, 1984, p. 11). Two mothers in this study described a coping strategy of "thinking positive" as a way of coping with "unknowns" that contributed to their feelings of stress. For example, one mother stated:

I always look on the positive. I knew it [surgery] had to be done, so what's the point of making such a big thing out of it? It has to be done, that's it, you know.

Despite the stressful nature of the parents' experience, the participants expressed that they felt they were able to cope effectively with their child's day care surgery experience. For example, "So far, it's only been a week [post-operatively], it's been pleasantly surprising I guess, that how easy it's been."

It was evident for the families who participated in this study, social support was a factor contributing to their ability to cope effectively throughout the experience. One mother stated that for her the key to coping with her son's day care surgery was her "[Husband] being there and all the support I've had from everybody." This final theme of social support, developed from analysis of the data, will be discussed next.

Social Support

The dimensions of the theme of social support became apparent as parents shared aspects of their experiences which they perceived as both supportive and non-supportive. Such aspects included interactions with family members, friends, and
health professionals throughout all phases of the experience.

For the parents who participated in this study, their needs for social support changed over the three phases of their experience. Certain types of support were perceived by the parents to be more appropriate at particular points of their experience. For example, emotional support and information to reduce anxiety and the distress of uncertainty were an obvious need during the pre-hospitalization and hospitalization phases of this experience. Support in the form of information and tangible assistance to assist the parent to manage a recommended treatment regime was most appropriate during the post-hospitalization phase of the experience.

Social support has been described as a major factor in adaptation to stressful life events (Cobb, 1976; Kaplan, Cassel, & Gore, 1977). It is generally agreed that "human beings need social support, that receiving it contributes to well-being and ability to withstand stress, and that the need for social support persists throughout life" (Dimond & Jones, 1983, p. 238). Social support is an interpersonal transaction that functions to "buffer" or protect individuals from the effects of many kinds of life stresses (Cassel, 1976; Cobb, 1976; Cohen, 1985; Pilisuk & Froland, 1978). In addition, social support has "a mediating effect that stimulates the development of coping strategies" (Dimond & Jones, 1983, p. 242). In other words, people mobilize needed support to cope with change (Roberts, 1988).

Dimond and Jones (1983) reviewed the vast literature on social support, and proposed a composite definition of the concept of social support emphasizing four main points: communication of positive affect, social integration, instrumental behavior, and reciprocity. Communication of positive affect involves feedback of information that encourages self-esteem and offers warmth, caring and concern (Cobb, 1976). Social
integration offers support by virtue of belonging to a group, sharing common experiences, and knowing that there are others who will come to one's aid in time of need (Pilisuk & Froland, 1978). Instrumental behavior as a component of support involves the provision of material or tangible aid (Sussman, 1965). Reciprocity refers to mutuality in a relationship and an exchange of need gratification between the parties involved (Caplan, 1976).

The structure of a social network and its interactional properties determine the adequacy and appropriateness of social support in times of stress (Dimond & Jones, 1983). Most often, social support derives from a network of family, friends, neighbours, and/or community groups (Ferrari, 1986). "Neighbors can best handle immediate emergencies; kin are most appropriate for long-term commitments, and friends can help in areas that require agreement and positive affect" (Litwak and Szelenyi, 1969). Professionals and clergy are useful authority resources during times of uncertainty as they may offer guidance (Dimond & Jones, 1983). It is important to note that "a network structure that may assure effective social support in one situation may not be effective in all situations" (Dimond & Jones, 1983, p. 238). Because social support is an interpersonal transaction, there are times when interactions are not perceived as supportive but rather are construed as stressful (Heller, 1979).

In summary, this study's analytic framework is grounded in finding that the pediatric day care surgery experience was stressful for parents. The major themes identified in data analysis represent dimensions of the parents' experiences that contributed to their interpretation of the event as stressful. As stated earlier, these were increased parental responsibility and role strain. Additional themes from the parents' accounts also revealed dimensions of their experience that enhanced or inhibited their
ability to manage it within the context of their everyday lives, namely, coping strategies and social support. The framework presents the themes identified in the data within the context of the temporal phases of the experience because the latter provides a chronological sequencing for the experience.

**Description of Participant Families**

In order to familiarize the reader with the families who participated in this study, their general characteristics and demographics will be described here.

Parents from eight family groups participated in this exploration of the parental experience. A total of 16 interviews were carried out over a six month period with nine parents of post-operative toddlers and preschoolers. Prior to arranging each of the interviews it was made clear that both parents were invited to participate. In all cases except one however, the interviews were conducted with the mother alone. In the case of this one family, mother and father were interviewed together. The parent’s individual decision to participate in the interviews, even if his/her spouse did not choose to do so, is consistent with the phenomenological method.

Six parents who met the study criteria and initially expressed interest in participating, declined to do so when contacted on the child’s first post-operative day. The reasons they cited included family commitments (lack of time), parental illness, and experiencing a "terrible night" with the post-operative child. During telephone conversations with most of these parents, they indicated they were feeling somewhat overwhelmed with the responsibilities of meeting their usual family commitments as well as the needs of the post-operative child. This observation is consistent with the theme of stress which was prominent throughout the accounts of the participating parents. The parents who chose not to participate made it clear that an additional
commitment to participate in the research study was simply not feasible for them. Declining to participate in this study was a known variable parents' could clearly control in their attempts to manage the experience within the context of the time and energy commitments of their everyday lives.

All of the parents who did participate in the study thanked the researcher for the visits and stated they were pleased to have opportunities to share their personal "stories" and contribute to an understanding of parents' experience with pediatric day care surgery.

The Families

All eight of the participant families were dual parent families although this was not one of the study selection criteria. Three families had only one child; five families had two children. All of the husband/fathers were employed full time; four were professionals. Of the eight wife/mothers, three were employed part time and one full time. Two had previously been employed on a seasonal basis but were not working at the time of the child’s surgery. Seven of the eight families owned their own homes.

In six of the eight families the parents were born and raised in Canada. One set of parents had immigrated to Canada from a German community in South America; one set of parents had immigrated from China. The latter parents had only a basic conversational command of the English language. Although this was inconsistent with the selection criteria, it was decided to include them in this study because it was the researcher's only opportunity to explore the post day care surgery experience from a father's perspective. It was also felt that the influence of the Chinese couple’s cultural background could add another dimension to the data. It is interesting to note that Gould-Martin and Ngin (1981), in their study of the medical practices of immigrant
Chinese-Americans, stated that tasks involving medical information and decisions are "very likely to involve men" (p. 152).

The Children

The age range of the children who underwent surgical procedures in the Day Care Unit was from 11 to 45 months. Their average age was 23.8 months. In the group, seven were defined as toddlers and one as a preschooler. One 11 month old infant was included in the study because his parents met all of the other selection criteria and were very interested in participating in the study. Five of the children were boys and three were girls.

The children underwent a variety of surgical day care procedures: Two had corrective eye surgery (unilateral), two had bilateral manipulations and casts for equinovarus, two had hernia repairs (one umbilical, one inguinal), one had an orchiopexy, and one had bilateral myringotomy and insertion of tubes as well as an excision of a lipoma on a lower limb.

The Hospitalization

All of the children whose parents participated in this study were admitted to hospital the morning of their surgery. They spent an average of 28 minutes in the operating room (range: 13 to 42 min.) and 53 minutes in the post-anesthesia recovery room (range: 32 to 72 min.). The average total length of time spent in the day care surgery unit was three hours and 13 minutes (range: 2 hrs. 15 min. to 4 hrs. 35 min.).

As is consistent with the day care surgery experience, the parents of the pre-operative children were telephoned by the day care unit "preadmission nurse" the day before surgery to collect some basic demographic information about the child, his/her condition and health history, and also to identify any parental concerns. Three
of the eight mothers contacted voiced pre-operative concerns to the nurse who telephoned them. The concerns were documented by the nurse as follows: "mother nervous, needs emotional support"; "mother slightly apprehensive, concerned re: separation, would like to be in PAR"; and "mother concerned re: child’s cold". A review of the patients’ charts following hospital discharge failed to reveal any written documentation describing follow-up of these concerns by the day care unit staff.

The eight children were discharged home to the care of their parent(s) on the day of their surgical procedures. All of the parents recalled receiving verbal and written instructions from the day care staff prior to their hospital discharge and, although not specifically asked by the researcher, three mentioned receiving follow-up telephone calls from a day care unit nurse on their child’s first post-operative day.

The Parents’ Accounts of Their Experience and Discussion

As was previously stated, the parents’ accounts of their day care surgery experiences—their thoughts, feelings, reactions, and explanations—were woven into major concepts and themes which, along with the structure of a three phase experience, formed the analytic framework for presentation of this study’s findings. The major concept of the analytic framework was parental stress and the four major themes identified were: parental responsibility, role strain, coping, and social support. The parents’ accounts will be presented according to the three chronological phases of their experience: pre-hospitalization, hospitalization, and post-hospitalization. As will be illustrated in the parents’ accounts, the five major concepts of the analytic framework varied in importance and intensity during the three different chronological phases of the experience. The presentation of the parents’ accounts according to the three phases allows the reader to compare and contrast the meaning the experience held for them at
different chronological points and its impact on their everyday lives. Included in this section of the chapter will be an integration of relevant, current literature.

Verbatim accounts from parent interviews will be used extensively for illustrative purposes and to demonstrate to the reader how the researcher interpreted and evolved constructs directly from the data (Anderson & Chung, 1982). The quotations serve to represent not only the commonalities but also the exceptions to the concepts, themes, and sub-themes identified in data analysis.

The abbreviations used in this chapter to identify the speakers being quoted are as follows: M: Mother, F: Father, and R: Researcher. All other individuals who have been personally named in the text of the conversations will be identified only by their position or relationship to one of the speakers. This information will be placed in square brackets, for example [child].

The Pre-hospitalization Phase

The pre-hospitalization phase of the parents’ experience began with the parents’ realization that something was "wrong" with their child and ended with the child’s admission to hospital to undergo corrective surgery. During this phase the parents readied themselves and their families emotionally and physically for the day care surgery event. This phase was typically a period of decision making, uncertainty, and anticipation that lasted for a period of weeks to years.

There were particular aspects of this phase of the experience that contributed to the parents’ interpretation or appraisal of their child’s day care surgery as "threatening", resulting in feelings of anxiety, worry, and fear. Parents held the view that their young children were particularly vulnerable to the negative effects of an operative procedure. Parents also perceived that responsibilities related to
decision-making and pre-operative preparation for their young children were added to the usual parenting responsibilities. The new, extra responsibilities required role adjustments in order to enact them. Given that the study parents had not had previous experience enacting such roles, the result was "role strain" characterized by feelings of worry, anxiety, and guilt (Nye, 1976).

Other dimensions of this phase of the experience that contributed to the appraisal of the situation as threatening was "event uncertainty" (Lazarus and Folkman, 1984), or not knowing what to expect during or as an outcome of the experience. One mother stated it this way: "This was the first time, so it was really hard to understand it, I guess."

Waiting during this phase of the experience was also particularly stressful for parents and, as the day of surgery approached, "temporal imminence" (Lazarus and Folkman, 1984) added to feelings of anxiety, fear, and worry. For example, one mother recalled it this way: "Leading up to it [the day of surgery] I was really anxious for weeks, but particularly the last few days".

Parents' attempts to manage this phase of their experience within the context of their everyday lives resulted in concrete changes in their regular patterns of routines and activities. Social supports enhanced their decision making ability. A variety of coping strategies were used to minimize the stresses of this phase of the experience.

The parents' accounts revealed that it was with the initial "discovery" that something was wrong with their child that their understanding and interpretation of their day care surgery experience began. For seven of the nine parents, the process of parental decision making relating to the child's actual surgical procedure was a
significant component of the pre-hospitalization phase of the day care surgery experience.

As will be illustrated in the quotations later in this section, the responsibility for decision making rests solely with the mothers and fathers. In three of the eight families who participated in this study, the mothers described that both they and their husbands were actively involved in making the decision related to the proposed surgery. These three sets of parents attended the doctors' appointments together and spent considerable time discussing options and timing for the event.

In the families where fathers did not attend doctors' appointments, many of the mothers saw it as part of their role to "ask the right questions" and obtain sufficient information in order for the couple to make an informed decision. Mothers reported that their husbands relied upon their opinions but in the end were not always satisfied: "I get frustrated when he asks me all the hundreds questions when I come from the doctor; I say, 'Why don't you go, if you're not satisfied?'"

In five families, it was the mothers who attended doctors' appointments by themselves and made the decision to proceed with the child's surgery after only brief consultation with their husbands. Overall, it was the mothers in this group who tended to assume a more primary role related to the decision making process related to the day care surgery. Depending upon circumstances, the process leading up to the decision to proceed with the surgical procedure took days, weeks, or even months to complete.

For three of the parents the "discovery" of the child's potential problem was apparent at birth: "When he was born he had a hernia". For the remaining five sets of parents, it was within the child's first two years that a problem became suspect.

M: Ever since she was six months old I noticed her eye...we only noticed
one eye, wouldn’t look at you, it would look out somewhere else.

M: The Public Health Nurse noticed that he tilted his head a little bit to one side and she...suggested that I have it looked into.

These parents are recalling when they first became aware that something might be "wrong" with their child. Feelings of concern led to a visit to the family practitioner to seek information, advice, and professional validation and to fulfil their sense of responsibility for their child’s well-being.

Medical validation had two kinds of immediate outcomes. For some parents, the validation of their observations came as a "shock", while for others it was a confirmation of what they already knew. The following quotations illustrate parental reactions of shock and surprise to the medical confirmation that something is wrong with their child:

M: It was a bit of a shock actually, because the pediatrician had been so, umm, definite that it wasn’t an eye problem, and all of a sudden I had an eye specialist telling me it was an eye problem that needed surgery, I was quite concerned, so I actually got a second opinion.

This parent’s concern regarding the opinion of the specialist illustrates how heavily the responsibility for decision making is seen to rest with the mother and/or father. Seeking a second opinion was this mother’s way of fulfilling her sense of responsibility for making the best informed decision for her child’s well-being.

M: When I mentioned it to [family doctor] and he said he’d refer me to [pediatric surgeon] I was sort of in shock for a while 'cause I thought he’d say "Oh, don’t worry about it".
This mother has acknowledged that she was visiting the physician to seek reassurance that her observations of her child were not significant. The response she received was not the one she expected or "wished for".

As was previously stated, not all parents were shocked by the news. The following quotations illustrate the common responses of parents who had anticipated that their child might require a surgical procedure later in life:

M: It wasn’t a surprise. Before I went to [pediatric surgeon] I know he [child] need the operation.

M: I knew about it, I mean I knew when it came to the time of having it done that he [child] was going to have it done you know, it wasn’t a shock to me.

Even following validation of the condition and recommendations for surgical intervention, five sets of parents remained hopeful that surgery might not be necessary.

M: In the meantime, actually, my husband and I noticed his neck got better, that his tilt was noticeably improved, and so we began to wonder if it was something that was correcting itself.

M: Sometimes you don’t see it [condition]. You don’t see it all the time. And so, I never know whether it [surgery] was necessary.

These two parents were hesitant to proceed with the surgery unless "absolutely" necessary. This was related to their perception of the day care surgery event as threatening to their child’s well-being as well as their lack of knowledge about their
child's condition. Both of these facts contributed to their feelings of uncertainty and anxiety.

Another set of parents actually delayed a decision to proceed with their child's surgery because of their hope that it might not be necessary. The decision to delay changed their situation and temporarily eliminated the stresses associated with proceeding with their child's surgery. Pearlin and Schooler (1978) identify changing a situation as one type of functional method of coping with a stressful situation.

With only one exception, all of the study parents made their decision to proceed with the surgery with some feelings of doubt and ambivalence. Their primary obligation to fulfil their expected parenting responsibilities (ensuring the safety, protection and well-being of their child) was weighed against subjecting their child to a surgical procedure with known risks, discomforts, and pain—usually for a more long term gain. As the following quotation demonstrates, the decision making process weighed heavily upon some parents, contributed to their appraisal of the situation as "threatening", and resulted in feelings of fear, guilt, and anxiety:

M: You know, if you are making your decision you're responsible for him, and you're making a decision that even based on what other professional people told you, that he has to go in for surgery and uh, you know, I guess 'cause he's such a little guy that you think...it's a big responsibility and you feel sort of guilty for having put him through something that's quite traumatic for him, really probably not as traumatic for him as it is for us [laughter] but that is how we perceive it anyway as being.
This quote illustrates the sense of ambivalence that parents feel as they fulfil their responsibility for the decision making process. The perceived vulnerability of the young child and feelings of parental guilt are obvious factors in the ambivalence. Although this mother had to struggle somewhat to get her ideas clear, she indicates a strong parental reliance on professional opinions during the decision making process and parental needs for support at this time.

Another mother expressed her sense of responsibility for making a decision for her child this way:

M: When you have to make a decision that affects someone for the rest of their lives or even like [child], for a few weeks, or even if this draws on for a couple of months. It’s going to affect her, you know.

For this mother even the fact that the consequences of her decision may only affect her child for a short period of time did not make a difference in the way she approached her decision making. Her sense of responsibility for her child’s well-being was her foremost concern. This same mother went on to state how heavily burdened she felt by having to make this decision and compared her perspective to that of health professionals:

M: To the nurses, it’s probably routine. This is my thought. They probably don’t feel like it’s a major decision...or even [pediatric surgeon]. Whereas to me, it’s something I think about all the time.

Again, this mother is expressing how "major" the decision making process related to her child’s day care surgery is for her.

In contrast to the above quotations, the Chinese family who participated in the study approached the decision to proceed with the surgery in a very matter of fact way,
without the ambivalence that other parents had expressed:

M: 'Cause we know for us is no need to make, no need to talk, discuss about the decision. We have to do it, you know, so nothing to try, nothing to anxious, nothing to worry.

The decision making process for this family was very straight forward, based upon their observations of their child's condition and their physician's recommendations without the anxiety and guilt expressed by other parents. Gould-Martin and Ngin (1981) in their study of the medical practices of Chinese-Americans found that immigrants were usually prompt seeking Western medical care for conditions requiring surgery. Anderson & Chung (1982) found that in Chinese immigrant families the contentment and happiness of an ill child is of primary concern.

The findings of the current study revealed that parents were much more ambivalent about surgery that was of a cosmetic rather than a functional nature. In these cases, the added responsibilities related to decision making were seen almost as a burden. Because of the unknown outcome of their child's surgery the parents felt less secure about their decision to proceed with the surgery:

M: It will never affect her vision, her vision was always fine, but it was a cosmetic type thing. So, to put her through all of this, you know, we had to be sure that we wanted to, and the surgery isn't always 100 percent.

This mother is recounting how she struggled with a decision that, in her perception, had an uncertain long-term outcome and would result in short term "trauma" for her child.

The notion that parental action taken now will be beneficial for the child in his/her later years has been discussed by others as an example of parents' enacting responsibilities to attain optimal physical appearance or "normalization" for their
children (Anderson & Chung, 1982). The following quotation illustrates another mother’s uncertainty about surgery that was primarily cosmetic in nature along with her considerations for her daughter’s future physical appearance:

   M: We thought about leaving it, but then when she got older she might come to us and say "Well, why didn’t you get my feet fixed when I was younger?"

The parents who participated in this study had not had previous experience with a child who had undergone day care surgery (see selection criteria, Chapter 3, p. 35). As a result, the study parents brought only limited knowledge regarding day care surgery with them to the experience and were unsure of what new needs and demands their young child might have. Although all parents were told in advance by health professionals some of what to expect from the experience, they still expressed feeling at least partially unprepared for the it.

Four of the study parents articulated that feelings of uncertainty lead to the anticipation of a very negative, unpleasant scenario. For example, despite having been given pre-operative information, one mother stated that it "Doesn’t register...until you are actually there [in the Day Care Unit], because you have set in your mind the way you think things are going to be." She clearly anticipated her experience to evolve in a certain way. Another mother stated that despite being told what to expect, she was sure that "my kid’s going to be different". Both these mothers went on to describe how they anticipated their experience to be "much worse" than it actually was.

Four other study parents revealed that they anticipated changes in their children, but were unable to predict what these changes would be or specifically what the course of their child’s day care surgery might be like. Feeling unsure of what to expect, or
anticipating a negative experience, contributed to the stress of their experience and resulted in feelings of fear, worry, and anxiety. One mother described it this way:

M: I was afraid for her [child]. I think that's it. I don't know anybody who's ever had surgery, no one in our family...no one close. No one has ever been in the hospital, even grandparents, you know, no one has had anything. So, it was really scary.

Note how this mother articulates her lack of previous experience related to any type of hospitalization or surgical procedure as contributing to her appraisal of her daughter's day care surgery as threatening and resulted in feelings of anxiety and fear related to an unknown outcome.

Even though parents have been told that specific procedures are considered to be minor from the medical viewpoint, fears of the unknown and/or preconceived notions contributed to their perceptions of day care surgery as a "major" event. One mother expressed her fears this way:

M: Well, I think, actually [pediatric surgeon] was very good, I mean she kept emphasizing that it was minor surgery and would only take about thirty minutes, and that he would really only have a little discomfort in his own way. So it was if, it was low-key you know, no big deal here, but I think that we made it a big deal, you know, ourselves, probably just because, it's probably not knowing what to expect, so that all of these things go through your mind: "Is this going to happen? Is this going to happen?"

This parent is noting that "even a little discomfort" is a "big deal" to the mother of a young child as she feels responsible to protect her child from harm. This mother is
also saying that because of her lack of experience, the uncertainty of not knowing what to expect related to her son’s day care surgery contributed to her interpretation of the event as a "big deal" despite assurances that from a medical standpoint it was considered quite "minor". Her interpretation of this event is clearly different from that of her physician. This finding is consistent with the framework of Kleinman (1978) who states that lay persons and health professionals have different explanatory models for the same health care situation. This finding has also been made by other nursing authors (Anderson, 1981; Dunn, 1985; Knox & Hayes, 1983; Robinson, 1983).

This same mother went on to emphasize how a lack of information about the impending procedure and her child’s response to it also contributed to her anxiety. To her, information is perceived as a support for her ability to cope. Also note that she is expressing that she felt that there was no opportunity to obtain the information that would have decreased her anxiety related to the upcoming event. The larger issue related to the decision to proceed with the surgery seemed to overshadow the information this mother needed to cope with this experience in her everyday life. She also pointed out that her "little questions" are a "bother" to the doctor in her estimation:

M: You don’t want to ask the doctor every little question. Plus there wasn’t an opportunity to ask all those little questions, you know, you were concerned with whether or not [child] really needed the surgery and was it a good time to do it in terms of his age, or was it better to wait until later, and those kind of sort of more major questions than the little things. So I think probably, it was probably just ignorance that made us sort of build it up in our minds into this thing that was going to be much worse, no better than it was.
Another mother described her need for information in the days prior to the day of her child’s day care surgery this way, "I had 50,000 questions [about the surgery] and nowhere to ask them". In addition to expressing her need for information this mother also felt she did not have any resources to acquire the information she wanted. She also went on to mention that she did not want to "bother the doctor" in order to seek the answers to her questions.

It is evident that parents in this study had a prominent need for information during the pre-hospitalization phases of their experience. Terry (1987) conducted a study with 22 parents of children aged three to 10 years hospitalized for a period of 14 to 30 days. Parents clearly identified that their most prominent need was for information, particularly information about what was wrong with their child and what would happen to their child. Other authors have also documented that parents need information in order to cope effectively with their child’s hospitalization and discern their roles as parents of sick children (Frieberg, 1972; Hayes & Knox, 1984; Hymovich, 1976; Smitherman, 1979).

The perceived vulnerability of the young child by the parents is apparent in the block quotation on page 74 as well as in the following account:

M: I wasn’t really a nervous wreck until the week before and then I started to think about it...you know, just things like, you know, first child you had, and going into an operation, even a little minor operation, still it’s hard to take. It wasn’t depressing, it was just hard in a way to take because he’s so young and he was by himself.

Again, the mother quoted above is pointing out that her interpretation of "minor" is much different than health professionals’. She feels a strong responsibility to protect
her child due to his young age. Her inability to be physically present to protect him during his surgery is a source of anxiety for her. This quotation also illustrates the effect of "temporal imminence" (Lazarus & Folkman, 1984), as the time for the event draws closer, the stress associated with it rises. In separate studies, Skipper (1966) and Skipper, Leonard, and Rhymes (1968) each found approximately 60 per cent of parents of hospitalized children rated their fears as "intense" on the day before their child's surgery.

In an attempt to cope to the best of her knowledge with a new experience, one study mother actually "imposed quarantine" on herself and her child over a period of several weeks prior to the surgical event. This was her way of minimizing her child’s potential risk of acquiring a cold or infection prior to the scheduled date for the surgery.

M: We just thought maybe we should keep him [child] away from other babies and, you know, shopping malls and stuff like that, to sort of try to keep him healthy as possible.

This self-imposed form of isolation affected all members of the family.

R: So, for the last couple of weeks then, you haven’t been going out as much as usual, you’ve really been sort of homebound.

M: So has my husband to a certain extent. Because, you know, we would do things on the weekend with him together and, you know, when my husband came home from work and things like that. So, you know, it’s had more of an effect on me, but certainly on him as well.

Needless to say, the weeks prior to the child’s surgical procedure were "out-of-the-ordinary" for this family. Their lack of knowledge and understanding of
necessary and practical preparation for day care surgery led them to implement this form of self-imposed, temporary isolation.

Other parents also expressed that the weeks of waiting prior to the actual surgical procedure contributed to increased anxiety about their child's well-being. For example, one mother recalled that "you wish the three weeks [preceding the day of surgery] would be over". Despite stating that she wasn't "scared in any way" this mother did express that the waiting period was hard for her.

During the pre-hospitalization phase of the experience parents anticipated some of the concrete changes they were going to have to make in their day to day lives in order to cope with the needs of the post-operative child. Parents communicated that they anticipated these changes to have a negative impact on their family life, and such anticipation was a source of anxiety for them. For example:

M: For her, the fact that she enjoys having baths and going in the water so much and that she wouldn't be able to do this for, you know, a couple of months and I don't know, just the sheer nuisance with having it all on top of all the adjustments we were going to have to make and how she was going to react to that.

This mother was anticipating how she would cope with the added parental responsibilities related to post-operative care (cast care) within the context of her every day life. She was anticipating a negative post-hospitalization experience. Another mother simply stated: "I thought, ahh, she's [daughter] going to be impossible".

In their efforts to enact new responsibilities as part of their parental role, the study parents experienced role strain during the pre-hospitalization phase of this experience. The added responsibilities of preparing their child for the operative
procedure were seen as a burden and in conflict with normal parenting responsibilities. Parents who participated in this study saw it as their primary responsibility to nurture their child, not carry out behaviors that in their opinions, contributed to the child’s discomfort. The result of role strain is often feelings of worry, anxiety, or guilt (Nye, 1976) as is illustrated in the following:

M: I guess I just wasn’t looking forward to having, first of all, I thought he was going through this horrible experience and, you know, the day of the surgery, I didn’t really want to be part of contributing to any anxiety or anything on his part earlier in the day, I thought, give him to somebody else and let them have him for awhile, umm, so I don’t have to look the big meany that’s starving him and putting him through the blood test and all that.

R: You didn’t want to be associated with all that.

M: No.

R: That puts a lot of responsibility on you as Mom.

M: Well, that’s it. And I think you just want to get rid of it, and you just feel, I think, you’ve made a decision for your child, that’s he’s got to have surgery and that’s enough to think about, you don’t want all the other stuff as well.

This mother is expressing that the added responsibilities related to preparing her child for surgery were anxiety provoking for her—she felt like a "big meany". She is also pointing out that she anticipates the experience to be "horrible" and she will be unable to protect her young child from harm. A third emphasis is apparent in her comment about the effect of having decided to proceed with the surgery. Clearly this mother
feels ambivalent about the new responsibilities related to her child’s day care surgery. Wyckoff and Erickson (1987) studied the effects of stress on 120 mothers of children hospitalized for an average of nine days. These authors identified that the child’s age was a factor in parents’ ability to cope with the child’s hospitalization. "Differences in parental coping in relation to the child’s age may be related to differences in reactions to hospitalization, dependent on the child’s developmental stage" (Wyckoff & Erickson, 1987, p. 5).

The common practice of withholding food and fluids from the pre-operative child in preparation for surgery was a significant factor contributing to parental role strain. The provision of food and fluids to young children is central to social norms for parental role behavior (Handel, 1970; Friedman, 1986). Here the average age of the children (23.8 months) whose parents participated in this study was a significant factor in the parents’ feelings of role strain. Withholding food and fluids was particularly difficult for the parents in this study whose children were unable to comprehend why this preparation was necessary. For example:

M: Of course you feel guilty 'cause, you know, you felt bad. 'Cause the child doesn’t understand why you’re not giving him anything to eat. You know, you can’t tell him unless of course he’s old enough to understand, but [child] is not. So, you know, it’s really hard to say, "Well, you can’t eat, it’s for your own good, you know". And he’s too young to understand that and it bothered him, and it bothered me.

Parental guilt and anxiety is clearly evident in the previous quotation. Parents communicated to the researcher that while carrying out the pre-operative day care surgery instructions, they felt they were literally "starving" their children:
M: I didn’t want him to get upset, you know. The hardest part was keeping him happy, you know, from that time [breakfast] on ’til we left [for the hospital]. It was difficult, you know, ’cause he couldn’t drink, he couldn’t eat, he was looking all over his playpen, you know, everything—I vacuumed everything so he couldn’t find a single crumb, and he was looking for crumbs, it was just terrible, you know, poor child was starving and it was my fault, I couldn’t do anything about it.

As is noted above, parents in this study complied "to the letter" with the pre-operative instructions for restriction of food and fluids. This mother’s feelings of guilt and helplessness regarding not fulfilling her usual nurturing role for her child are evident in the above quote.

Although parents expressed that they knew such procedures were in the best interest of their child’s well-being in light of the impending surgery, the following quotation illustrates how one mother did not feel understood or supported, in relation to the difficulty that such a task posed to her:

M: If somebody had just recognized that I had a right to be upset about it, that to them it wasn’t anything maybe, but it was to me, it really was, that my little boy was going to have to do without something to drink, something to eat, and was going to have that [surgery] done. And I was more upset with how I was going to cope with him not eating and drinking than anything else.

Coping with the withholding of food and fluids posed a major task for this mother and resulted in feelings of anxiety.
During the pre-hospitalization phase of their experience parents received both solicited and unsolicited opinions and advice about the proposed surgery, a particular physician/surgeon, and/or a particular health care agency. Such opinions often significantly influenced parents' trust and confidence in the medical information and recommendations they received. As might be expected, favourable opinions were perceived as supportive and vice versa. Negative opinions often eroded the parents' confidence. For example:

M: I talked to other people, my mom, [laughs] and she gave me other ideas and, gee, she said there is some doctor from Oregon...saying that the scar tissue will be left and if it [the proposed surgery] doesn't work, then the eye has to fight against the scar tissue, and so on, and so forth, and, you know, that put negative thoughts in my mind and I think, gee, am I doing the right thing, or whatever?

M: I considered postponing it [the surgery] until the Fall, my friends would say "Oh, it's so hot in the summer and the casts are going to bother her", and "she's going to be itchy, and whatnot."

Both of the above parental comments indicate that when parents are making decisions related to their child's day care surgery, comments from family members and friends that are not in agreement with their stance may be readily interpreted as sources of doubt or as non-supportive. This latter finding is congruent with that of Lynam (1987) in an examination of the parent support network in a pediatric oncology setting. Her observations were part of a larger study on hospital related stress (Knox & Hayes, 1983). Although she reported on parent support networks among parents of children
hospitalized with long term conditions, she states that the data from this qualitative study indicate that certain types of parent relationships "can contribute to the stresses associated with the hospitalization of children" (Lynam, 1987, p. 7).

Parents also received input from friends and relatives that had a very positive effect on their anticipation of the surgical event. For example:

M: No one was against it [the surgery] or anything, in fact, everyone that I talked to that had had it or whatever, or I mentioned it to, felt that it was the best. It kind of helps to know that other people feel like it is good, too, to have it [the surgery].

Knowing that friends and family supported the parents’ decision to proceed with the surgery was an important aspect of the experience for most families in this study. For example:

R: So you felt a lot better when--
M: After I had family support, yes, after my mom agreed [with the decision to proceed with the surgery].

The literature on social support agrees with this finding that friends and family can help in areas that require agreement and positive affect (Pilisuk & Froland, 1978). One family who participated in this study was a notable exception to the reliance on the support of family and friends, particularly in the process of decision making about the child’s surgery. The Chinese parents in this study deliberately did not consult or even inform their parents or family members regarding the decision to proceed with the surgery because they felt that non-medical persons did not have sufficient knowledge to offer opinions on the matter. These parents also mentioned to the researcher that the child’s paternal grandmother had not agreed with the need for surgical correction of the
child's condition.

F: It doesn't matter if you got big surgery or small surgery. Even you ask anybody, your mother, your father, your family, they can't help you at all. They don't know anything about that. Is only one thing you can trust is doctor, nobody else. You tell them this and that, what can they do? [laughs] Even they say "yes", or they say "no", they may wrong.

This finding is inconsistent with the work of Gould-Martin and Ngin (1981) who found that Chinese-immigrant families will most likely turn to family members for sympathy or suggestions in matters of physical illness. However, Anderson and Chung (1982) in their study of immigrant Chinese families, found that if parents disagreed with the attitude of their significant others in relation to their child's medical condition and/or treatment, their response was to "limit their contact with these significant others" (p. 47).

In addition to the Chinese immigrant parents, four other study parents also expressed a high level of trust and faith in their physicians, although for these latter parents, criteria for judging the physician/surgeon included the way the he/she interacted with parent and child.

M: Doctor [pediatric surgeon] is the one who took care of [child]. I had a lot of faith in him, he seemed to be a very good doctor. He is a very nice doctor, so I felt very at ease with him. So, it's not like when you meet a doctor and you got this strange feeling about him, you know, I mean you're wondering, you know, you just got strange feelings about certain doctors, and he gave me a comfortable feeling.
This is an example of communication of positive affect as a component of social support and promoting parental confidence. Parents were satisfied if the health professionals appeared to care about their child and themselves. Kupst, Dresser, Schulman, and Paul (1976) noted in their study on improving physician-parent communication that a feeling of caring from health professionals helps enormously in maintaining communication.

Several of the physicians/surgeons who were consulted by the parents in this study, were highly recommended by family and friends:

M: The fact my girlfriend [name], her little boy, [pediatric surgeon] took care of him...and [female friend] was absolutely pleased with him when I told her I was going to see him [pediatric surgeon]. She was just like "Oh, you're going to be so happy with him".

This mother felt supported through her friend's strong positive recommendation. This is another example of the importance of communication of positive affect as a component of social support for the parents in this study.

In summary, parents who participated in this study appraised their child's day care surgery to be stressful for them during the pre-hospitalization phase of their experience. The dimensions of their experience contributing to this appraisal including decision making, lack of information, and added responsibilities, were reported in this section. The next section presents the study's findings related to the hospitalization phase of their experience.

The Hospitalization Phase

The hospitalization phase of the experience refers to that period of time that the parents and child were actually in the hospital setting. As was previously noted, the
average time spent by the families in this study in the day care unit was three hours and 13 minutes. During this acute phase of the encounter with the health care system, their child’s final preparation for surgery was completed and parents relinquished him or her to the care of health care professionals in order that the actual surgical procedure could be performed. Although the span of time during this phase of the experience was short, the parents’ feelings and emotions during this time were intense.

The dimensions of this phase of the experience that contributed to the parents’ interpretation of their experiences as stressful were primarily related to event uncertainty, or not knowing what to expect due to their lack of previous experience. Role strain was a dominant theme in this phase particularly when parents were physically separated from their child during the actual operation. Waiting during this period of time was very difficult for parents. There were particular aspects of the day care surgery environment—routines and communication with health care professionals—that also contributed to parents feelings of fear, worry, and anxiety.

During this phase of the experience, parents relied on coping mechanisms that functioned to control or manage the stressful feelings (Pearlin & Schooler, 1978). As all parents were asked to have someone accompany them to the hospital, social support was also a factor in parental coping during this phase of the experience.

By the time the parents in this study arrived at the hospital, as previously reported, they were already feeling anxious and guilty as a result of their anticipation of a rather negative experience and their inability to feed and comfort their young children in their usual ways. Because of the intensity of their feelings at this time, delays in admission procedures or in the scheduled time for surgery added to their interpretation of the event as stressful.
A particularly difficult time for parents during the hospitalization phase of the day care surgery experience was when they had to relinquish the child to the operating room staff in order that the surgery could proceed. Three of seven mothers reported breaking down and crying at the point of separation from their child. Parents communicated initially feeling relief that the event was actually proceeding, and anxiety because of giving up control and their "protector" role.

M: We waited in the play area with [child] which, I guess, was a little bit hard, that's when I started to cry, because, I guess, it [the surgery] was going ahead, and I was sort of worried.

M: I was really very good up until when you saw me [researcher met with parent] when I started crying. I held up right until then, and then I thought, oh, it was just the release, you know, because there she goes [to the operating room].

The ambivalence associated with this point of the experience is evident from the mothers quoted above. These mothers felt relief and fear simultaneously. Crying was a way of releasing their feelings of fear is an obvious indicator of the acute need for support at this time. For four of the parents, social support was provided to them by the person that had accompanied them to the day care unit.

Additional factors that contributed to parents' anxiety, fear, and worry, were lack of knowledge and situational control as is evidenced in the following quotations:

M: It was difficult because, again, I think the thing is, you don't know what's going on, and you don't have any control. Not that you could do anything if you were there [in the operating room] anyway, but somehow,
you know, you have this sense that even if you couldn’t do anything, if you were there, it would be more reassuring, so I think it’s hard not knowing what’s going on and having a feeling that you don’t have control over the situation and you aren’t there to assist if something goes wrong. I guess you just want to know what’s going on, and you don’t know what’s going on, so it makes you worry more 'cause you don’t know what’s going on.

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M: The control of being there, and you are the one that’s in charge of him, whereas when he goes into surgery and the doctor’s in charge of him, you have no say in the matter or anything, and you just have to sit there and wait patiently, and just wait 'til he comes out.

Note that these two mothers are saying that during the hospitalization phase of the day care surgery experience, the usual sense of control they have which enables them at all times to care for and protect their child was gone when they were physically separated from their child. "Being there" somehow meant being able to fulfill a role to protect their child. Not having control over their young child resulted in intense feelings of role strain, guilt and anxiety. Clarke (1984) states that "perceived lack of control where coping is important leads to negative emotion and this is associated with loss of self-esteem" (p. 8).

Without exception, all of the parents in this study expressed fears and concerns about allowing their child to undergo a general anesthetic. Parental consent for what they perceived to be a large risk for their child resulted in feelings of conflict and anxiety.
M: I was concerned because he had the cold, but even if he hadn’t had the cold I would have been concerned. You know, each individual reacts differently and he’d never had one [operation] before, and I was, quite frankly, my big concern was that something was going to happen with the anesthetic and he was going to die, brain damage or something as a result. I mean, that was my big concern, it really was. So I was quite petrified of that, and I mean, I knew that it doesn’t happen very often but it was still in the back of my mind.

M: That’s mainly every parent’s concern is the anesthetic, you know. Wonder how it’s going to, you know, affect. Because you have heard a lot of gruesome stories about anesthetic so, you know, I’m not really too happy about it.

Note how these two mothers are forthright about the intensity of their fears regarding an anesthetic for their child. Parents specified that the sources of the "gruesome stories" they had heard were primarily newspaper and television reports about mortality and morbidity associated with general anesthetics. One mother cited "news reports in the back of my mind" as the source of her fears.

The period of waiting while the child’s surgery was actually taking place contributed to feelings of anxiety and worry.

M: Well, you see, it’s really hard to explain; it’s just that you go through different emotions. It’s like you’re wondering if you’re going to make it, if he’s going to sleep through the whole, you know. I mean, if he’s going to wake up in the middle of it or [pause], it’s silly things, but you
do go through it, you know. You do think about it and if he’s ever going to wake up from it...You’re sitting there because you got all that time to kill and, what else would happen when you have nothing else to amuse yourself with? You know, your mind starts playing games on you, you can really get upset.

In addition to expressing how difficult the waiting period is while the child is in the operating room, this mother is expressing her confusion and fears related to her child’s anesthetic. Another parent stated that the waiting was difficult because she was very aware that "something freak can happen [while child is in the operating room]."

One of the coping strategies parents used during the waiting period for their child to return to the day care unit from the recovery room was that of "social comparison" (Pearlin & Schooler, 1978). This strategy involves the comparison of one’s misfortune with the misfortune of others and is perceived by some as a form of support. For example,

M: I was watching this lady in front of me [in the waiting area]. Her little boy was in for an ear operation or something...apparently her son’s operation took an hour...You know, for what [child] was having [surgical procedure], it didn’t seem as terrible as what her little boy was going through.

By comparing her plight to that of other parents in the waiting area this mother is saying that her situation didn’t seem as bad as that of other parents. Through use of the technique of "social comparison" this mother is indicating that she felt reassured.

Parents in this study had clear ideas about how their children were going to appear and how they would behave in the immediate post-operative period. For
example,

M: I thought, general anesthesia and everything, go home right after a couple hours, I was a bit concerned, but not when I saw him. When he came out and everything, there was actually no problem. I was very happy when they told me I could take him home.

This mother is expressing how she had not really believed that her son would be well enough to go home within a few hours of his surgery. What changed her opinion was her son's actual physical appearance when he returned from the recovery room which, she's implying, was more positive than she had thought it would be.

Other parents also expressed that they did not expect the child to do well in the post-operative period. Parents' negative expectations were based on their appraisal of their son or daughter's day care surgery as an event that may involve harm to their child. For example, one parent described it this way, "She looked a lot better when she came out [of the recovery room] than I thought she was going to be". A number of parents echoed the feelings of one mother who said, "I guess I expected him to be very groggy, you know, very sleepy from the anesthetic. Actually, he wasn't that sleepy." These parents' experience in the immediate post-operative period was more positive than they had expected. Their intense feelings of fear and worry were replaced with ones of relief.

Parents reported that the moment of reuniting with their child after returning from the recovery area was a very special one: "It was a very special moment just to see him. I guess, you know, just go and run up to him and give him a big hug". Physical contact with their child was very important for the parents to know that their child was alright and also to renew their parental role of providing comfort and care.
As one mother stated: "The minute I got him [child] in my arms, I knew he wasn’t [sick]". Another mother commented on her frustration of not being able to physically "reunite" with her child because she was left alone immediately after her child returned to the day care unit and she did not know how to put siderails down on the hospital crib therefore was unable to physically comfort her child. She explained:

M: Where they [nurses] disappeared to all of a sudden I don’t know. If they would have stayed with me just for a second until I could find out what I could do. You know, it was kind of a matter of, "Your daughter’s back" [from PAR], and I went in there [to the cubicle], and they were gone.

This mother went on to emphasize the importance of physical contact for her in those first few minutes after the child returns from the recovery room. She is also commenting on how her reuniting with her child might have been better handled by nursing staff.

Three other study parents commented that they did not anticipate their child’s arrival back in the day care unit at the time that it occurred and this contributed to their feelings of stress related to this phase of their experience. Although the parents had been informed of an approximate time for their child’s return to the day care unit, parents recalled feeling surprised upon the child’s actual return and somewhat unprepared for the way their child’s return was handled. One mother described her child’s return this way:

M: All of a sudden, you know, we heard the doors open and then this lady, who we didn’t know, came out and said, "Who does this one belong to?"

And, uhh, so that was it and we said "Well, he’s ours" and she handed
him over to us and that was it...I didn’t think the whole recovery thing was handled very well for us. Just, you know, we were very happy and reassured just to have him back with us.

This mother’s comments reflect a lack of knowledge regarding both when and how her child would be returned to her. Although she is expressing relief at having her child back with her, she would like to have known in advance when her child was returning from the post-anesthetic recovery room and perhaps have a more personal and empathic approach used in reuniting her with her post-operative child.

Another mother described a much more positive scenario related to the waiting period prior to her son’s return from the post-anesthetic recovery room. In the following quotation she is emphasizing how important information and a caring attitude helped allay her anxiety during the difficult waiting period.

M: I was so concerned about, was he in Recovery or whatever? And I never even had to ask them. This nurse came up to me and said, "I just thought I’d let you know, I phoned Recovery and your son is doing just fine". You know, I didn’t have to ask, like she did it.

The nurses anticipation of this mother’s needs had an obvious positive effect on this parent.

The hospitalization phase of the experience was difficult for parents because they experienced the fears and anxieties associated with role strain while waiting for their child to return from the operating room. All parents, as requested by the day care unit staff, had another person with them at the hospital. Most relied heavily on the other person for support during this time. One mother said this regarding her husband’s presence with her that day:
M: I mean, he took the day off, you know, from work to come and spend, you know, to go to the hospital with me, so that was very special. If it wasn’t for him, I don’t think I could really have gone through it as well as I did.

This mother is referring to the component of social support others refer to as integration (Dimond & Jones, 1983). She feels supported just knowing that her husband was there to help her in time of her need.

A number of parents adopted a positive attitude and used positive "self-talk" to support themselves during this time. For example:

M: [It was me] telling myself not to worry about it, you know....Not to worry because [child]'s in good hands...the doctor's fine, the baby's going to be fine, it's not a major operation.

Pearlin and Schooler (1978) describe this coping strategy of "selective ignoring" as one that is attained by seeking some positive attribute within a stressful situation.

Three mothers stated that they found nurses to be supportive during their waiting period after the child had gone to the operating room. One mother in particular remembered it this way:

M: I remember when I was really upset, when he [child] went into the thing [the operating room]. And then I came back and sat down, and this nurse came over, and kneeling down, like talking to me on eye level, and just, you know, talking to me about it. I don’t remember what she said even, just talking to me, I remember that 'cause that got me under control. And, I guess, it was that I felt that they cared--they cared about [child], they didn’t know him...and they cared about me. I guess that is what it
The feeling that the described nurse cared about them was an important criterion of support during a difficult time.

For these study parents, trust and faith in health professionals was extended to a belief that they would always act with the child’s best interest in mind. For example, parents communicated that they were confident that health professionals would ensure that they received the appropriate information about caring for the pre- and post-operative child.

M: I mean, if it was something that is really sort of a pressing question, you know, I don’t think I would hesitate to ask it. But, when they’re sort of little things, that you think "Oh my goodness, well, that’s probably a dumb thing to ask because if it was an important thing, they would have mentioned it," or something like that. You tend not to ask those things.

This mother is under the assumption that the health care professional knows and understands what information is important to her in order for her to manage her child’s care within the context of her everyday life. Such a finding corresponds to the research done by Robinson and Thorne (1984) who identified one phase in the development of relationships between consumers and health care workers as "naive trust", where families "wait passively for the professional health care providers to fulfil their responsibilities" (p. 599). One parent who participated in the current study described her feelings this way: "You tend to put a lot of trust in people in the hospital I think. And you know, you figure, well, this is the way it’s done."

Interactions with health care professionals were not always perceived to be helpful or supportive. In several instances, inconsistent information about what parents
should expect in terms of contact with the child’s surgeon contributed to increased anxiety and worry. The majority of study parents were anxiously "waiting to get the news, to hear that yes, he’s [child] out of there [O.R.] and yes, he’s O.K.". One mother described her experience this way:

M: Well, it’s probably just silly things, but the nurse said the doctor was going to come right out after the cast. He didn’t, either he didn’t or we missed him, went down to have lunch or something. So we thought he was still in there doing cast and all, and all of a sudden [child] appeared and she was finished [soft laugh]. So, I, you know, I back in my mind I knew there was probably nothing wrong, but you know these little doubts you have.

This mother is saying that when the surgeon did not come out to talk to her as she had been led to expect, it introduced a strong feeling of doubt that something had gone wrong with her daughter’s procedure. This contributed to her fears and anxiety about her child’s well-being. Another parent described it this way:

M: I understood that he [pediatric surgeon] would come out once he finished [the surgery], he would talk to me about it. And then I thought "What’s going on?" you know, "Why isn’t he coming?"

R: Yeah, and then you start to worry.

M: You start to worry, yeah. But I thought, if there was something terribly wrong he’d come out and tell me, you know, if, if, they would just tell me that if I lost him [child].

R: So you sort of had that in the back of your mind.
M: Well, if it takes longer...than you expect, I think every normal mother
does that, pray for nothing [to happen]. And it can happen, you know, it
can happen if the anesthesia or something goes wrong. And sometimes I
think there is nothing people can do.

These parents' are describing their acute sense of time while they are separated from
their child as well as a their sense of helplessness. They are expressing that
discrepancies in what they have been led to expect in terms of communication with
their physicians is particularly stressful if not followed through. One mother stated, "I
think it's really nice if he [surgeon] makes sure he sees the parents right afterwards
[after the surgery is performed]." Other authors (Hayes & Knox, 1984; Terry, 1987)
have documented that parents want information directly from their physicians who they
see as primary sources of information regarding their child's diagnosis, treatment
regime, and expected outcome.

In summary, there were several dimensions of this phase of the experience that
contributed to the parents' interpretation of their experience as stressful. These were
related to event uncertainty and relinquishing the responsibility for control and
protection of their child to health professionals resulting in role strain and anxiety.
Parents described particular aspects of the day care surgery environment--waiting, fears
of a general anesthetic, reuniting with the post-operative child, and communication with
health care professionals--that contributed to their feelings of fear, worry, and anxiety.
During this phase of the experience parents relied on coping mechanisms that function
to control or manage the stressful feelings (Pearlin & Schooler, 1978). As all parents
brought someone with them to the hospital, social support was one such factor in
parental coping during this phase of the experience.
The next section presents the findings related to the post-hospitalization phase of the day care surgery experience for parents.

The Post-Hospitalization Phase

The post-hospitalization phase began when the child and parent(s) were discharged from hospital and continued until the child had recovered physically and emotionally from the surgery and all family members had returned to their regular patterns and activities of daily living. Although the parents’ individual experiences dictated the rate at which they moved through the phases of their experiences, five families in this study clearly identified when the recovery phase of their experience had ended, usually within a week to 10 days of the actual surgical procedure. Due to uncertainty about the effectiveness of the surgical procedure, one parent when interviewed for the second time, was still unable to articulate when she felt this phase of her experience would actually end.

Like the pre-hospitalization and hospitalization phases of the parents’ experience, the post-hospitalization phase was also stressful for parents. Parents reported feeling worried and anxious during this time. Dimensions of the post-hospitalization period that contributed to parents’ interpretations of the events as stressful included new responsibilities for the care and supervision of the post-operative child, changes in the child’s behavior and patterns of activity, and changes in family activities and routines. A lack of information regarding these dimensions of the post-hospitalization phase of the experience was identified by the parents as contributing to the stressful nature of this phase of the experience. Parents implemented several coping strategies and utilized social support to manage this phase of their experience.
Despite having received information and instructions from day care unit staff, the following quotation reveals one mother's concerns regarding her new responsibilities in the post-hospitalization phase. She describes a lack of information regarding her "minor" concerns once she has returned home and her need for support at this time.

M:  Maybe what happens is, you know, right after the surgery you have certain main concerns like, well, is [child] back to normal, you know? Is he recovered from the anesthetic? Which was one of the major things. So that all of those other things you forget about them for awhile. And then it's not until you get home, and those major concerns have kind of settled down, but then the minor concerns become more obvious, or you start to worry.

This mother indicates that at home the parents' perception and appraisal of their situation changes. The major issues become less of a source of stress, but these are replaced with immediate issues related to caring for a post-operative child at home. Kupst, Dresser, Schulman, and Paul (1976) in their study on improving parent-physician communication, found that parents tend to focus their attention on areas where they, as parents, are directly responsible such as instructions about medications and physical activities. These authors also noted that parents often think of questions for health care practitioners after they leave the hospital. This was also the case for parents who participated in this study.

In their attempts to fulfil parental responsibilities for the care, protection, and nurturance of their post-operative child, parents implemented a pattern of "protective behaviors" particularly in the first 24 to 48 hours after returning home. The implementation of protective behaviors on the part of the parents served to comply with
parental role expectations and decrease role strain. Parents reported that the first or second night at home was often the most difficult for the child and the parent:

M: The first night, yeah, he was fussy about that. 'Course I was fussy too. I was always making sure everything was fine, you know.

M: Naturally as a mother you get up a couple of times to check, "Is he alright?"

Note how these mothers cope with the new responsibilities of their parenting role by increasing the frequency of their physical checks on the post-operative child.

All study parents acknowledged some degree of "over-protectiveness" during the initial post-operative period. Carlson, Simacek, Henry, and Martinson (1985) in their description of a home care program for terminally ill children state that home care of an ill child is stressful and "potential sources of stress include uncertainty about what to expect and about how to care for the child and the assumption of full responsibility for the child's comfort" (Carlson et al., 1983, p. 115). Parents who participated in the current study also expressed uncertainty about caring for their child during the post-operative day care surgery period.

In assuming the responsibility for the care of their child during this phase of their experience, most parents carried out post-operative instructions "to the letter". For example,

M: I wouldn't let him [four year old] walk anywhere yesterday [day of surgery] without holding my hand because he [doctor] told me he [child] could get dizzy and fall, and I didn't want to take a chance.
M: All he [child] did was cry for something to eat and something to drink all the way home [from the hospital]...they [day care staff] told me not to feed him for four hours you see. So I didn't. I gave in 15 minutes before the four hours and let him have a couple of crackers.

These mothers are describing how vigilant they were in their approach to implementing post-operative instructions for their child's care. This mother also indicates her limited knowledge and experience with post-operative care which does not allow her to interpret the post-operative instructions with any degree of flexibility.

Parents reported that in the week following the day care surgery they noticed behavior changes in their post-operative children. These behavior changes often influenced usual patterns of activity and as a result, contributed to the stresses of this phase of the experience. For example:

M: She's really good around home, but when we're out some place shopping or something, she won't walk. She wants me to carry her...she just seems really unsure of herself.

M: He hangs on more to me, you know. He cried so hard when I left, and even on Monday and Tuesday he wouldn't let go of me, and cried and cried.

Behavior changes involving fear of separation from mother required extra time, energy, and planning on the part of mothers during the first week at home. Other parents described increased aggressiveness and irritability that was not characteristic of their child. For example:

M: He'd try to get away with more things.
M: He was just miserable to get along with...you know what he acted like?
    Like he was over-tired. But he had had enough sleep.

Parents were often puzzled by the changes, "He was just terrible...and I don't know why!" Parents coped with their children's behavior changes by increasing parental attention, permissiveness, discipline, and/or affection.

These findings that indicate a change in the children's behavior following day care surgery are consistent with the findings of other authors who stated that behavior changes such as increased separation anxiety, increased sleep anxiety, and increased aggression following surgery and a general anesthetic are common (Brown, 1979; Hannallah & Rosales, 1983; Sipowicz & Vernon, 1965; Vernon et al., 1966).

One of the most prominent dimensions of the post-hospitalization period, identified by all the study parents as contributing to their interpretations of this phase as stressful, were changes in family routines and activities. These changes affected all family members not just the post-operative child. The changes were dictated by the child's treatment, the child's reaction to treatment, and/or by the parents' attempts to manage the experience within the context of their everyday lives. Most of the changes were concrete in nature and related to the post-operative child's activities such as bathing and sleeping. Family members were affected by changes in the frequency and nature of family outings and activities. Parental management of changes in family activities and routines often led to creative and flexible coping strategies on their part which served to allow them to fulfil their responsibilities and minimize role strain.

Bathing the post-operative child was a major change common to all families in the study. The regular bath time routine for almost all the children was changed to
sponge bathing at least for the first few post-operative days. This was a significant change in an activity that was considered to be a "special time" for these children.

M: He just loves his bath, you know...and he’s not allowed to. And he doesn’t understand that now. Not yet, I don’t think...he climbed in the bathtub all day [post-operatively], in and out, no water in there.

This mother is describing how the age of her child makes it difficult to explain the change related to bathing routine, and how this influenced her child’s behavior. She is also expressing her frustration with this change in routine.

One parent clearly acknowledged the inconvenience of the change in the child’s bathing routine:

M: I’ve always kind of enjoyed bathing little kids in the tub. So, you know, for me it was kind of the inconvenience of having to start sponge bathing over again.

Some of the bathing changes were for obvious reasons such as casts or bandages. Other parents based their rationale on their interpretation of the child’s condition, and the risks they perceived to be associated with tub bathing. For example:

M: I didn’t give him a bath for a few days because I was worried about water getting in his eye and getting infected and stuff. I just gave him one of those sponge baths ’cause he tends to splash a lot.

In order to decrease the stresses associated with this significant change in routine, alternate forms of activity were implemented in many families to take the place of bath time. The following quotations illustrate the impact of this change in family routine as well as the involvement of both parents in implementing alternative activities.
M: We've decided that we're going to have some sort of entertainment after dinner [laugh] to take the place of bath time because that's the time she really enjoys. So, we're planning on taking lots of long walks outside to try to occupy the evenings a little bit differently than we have been.

M: When he couldn't have his bath for a week, boy, we went through times where, you know, like it was after dinner for instance, he always has his bath, and my husband would go have his shower, and [child] would hear the water and go try running after it, and go into the bathroom and have his bath.

R: Not being able to have the bath time was really quite a change in his routine. What kinds of things did you do to make that time easier?

M: I really don't know. We played a lot with him, and let him run around more than we usually do, kept him occupied, and I gave him sponge baths, but he hated sponge baths. But sometimes he didn't mind it, there was water, so I let him play with the dish. It went all over the floor, but at least he was happy, you know.

These parents are saying that they had to make modifications to their routines in order to please their child and meet developmental needs. The increase in parental permissiveness evident in the above quotation was exemplary of attempts to minimize parental role strain. That is, while restricting some activities, parents took advantage of any other available opportunities to keep their children happy and content.

The children's sleeping and napping routines were also changed. These changes affected the parents' ability to plan and implement their own day-to-day activities.
M: Tuesday [the sixth post-operative day] was the first day he settled down for both naps.

R: So that would really change your activity in the day.

M: Uh huh, for a more exhausting day [laughs]. But, yeah, it did make it harder to get things done and everything. And you can’t predict when he’s going to go to sleep, or if he’s going to go to sleep, ’cause usually I can count on an hour in the morning and an hour in the afternoon type thing, and usually around the same time.

As this mother expressed, changes in family activities and routines as a result of the child’s day care surgery were, at times, "exhausting". Such changes demanded more energy and flexibility on the part of the parents and are exemplary of the stresses parents felt during this phase of their experience.

Another example of change in family routines was a decrease in the frequency of activities outside the home such as shopping and visiting. This curtailment of outside activities occurred during both the pre- and post-hospitalization phases of the experience and lasted from a few days up to several weeks. For example:

M: We sort of stayed in on the weekend, although I went out, I left him [child] with my mom, and I went out and tried to do some shopping. Didn’t get much done but, other than that I didn’t take him out into any of the stores or anything ’cause I was still sort of worried about him.

So, by Monday both of us were back to normal.

This quotation illustrates the carry-over of worry and anxiety to the post-hospitalization phase. Parental adjustments in usual routines, such as not taking the child shopping, reflects the responsibility theme for doing what was interpreted to be in the best interest
of the child.

M: It's kind of curtailed our activities a little bit...I don't take her shopping as much. I don't think we've been out as much, I don't know what the reason is.

Even though the mother quoted above was unable to articulate her rationale for adjusting family activities, she nonetheless changed her daily routine, similar to other parents in the study who identified that such behavior was "better" for the post-operative child.

Parents identified that siblings of the child who underwent the surgical procedure were also affected by the changes in family activities and routines. For example, the change in bathing routine for the post-operative child also affected the bathing routine for siblings:

M: We don't bath [sibling] in the evening any more when [child] is around. We wait 'til she [child] goes to bed and then bath [sibling]. I guess it's pretty much the same except that we have to have activities to fill that spot.

Note how the change in routine for the post-operative child affected the routines of the sibling. Such changes required more creativity on the part of the parents to come up with "activities" to fill the time usually used by bathing.

Some activity changes were specifically related to seasonal opportunities. For example, in four families, summer activities were curtailed for all the children, not just the post-operative child.

M: I was going to put them [child & sibling] both in swimming lessons, but now, I guess I won't put either one of them in swimming lessons.
This mother is citing another example of changes in routine and activities required by the post-operative child that also significantly affected the activities of the sibling. This decision was made by the mother because she felt it would be "too hard" on the post-operative child if her sibling was in swimming lessons and she was not.

Other changes described by parents that occurred within the family unit during the post-hospitalization phase included protective behavior patterns on the part of older siblings.

M: I think he’s [sibling] been a little more, umm, concerned about her than he usually is, in a way, not quite as quick to push her over, which is nice.

M: I guess he [sibling] just accepted it but, umm, actually he seems quite protective of her right now. He knows there is something wrong with her, so he’s been pretty good about it. But I think it will bother him eventually, because she’s going to take more time.

In addition to commenting on the sibling’s protective behaviors, this latter parent is also expressing concern that the extra time required to care for the post-operative child might be perceived by the sibling in a negative fashion.

The theme of social support was prominent during the post-hospitalization phase of the experience. Parents perceived their primary sources of support to be family members and friends. Again, knowing that there were others who cared about the parents’ situation and experience and having someone available to listen were important components of support. For example:
It sounds like you’ve had a lot of family support and input from your friends.

Oh yeah, a lot of support from my family. Especially my family and [husband]'s family, you know, both our families. We’ve had a lot of support, and friends, a lot of friends, too. Always telling me not to worry about it, and everything like that. And if I need help just give them a call. You know, things like that. It’s nice to know that everyone cares. You understand family always cares but friends, you know, it’s nice to know that you have friends that care.

As is consistent with the literature (Heller, 1979), helpers were rated highly when they engaged in activities involving affective support (eg. comforting).

Who was there, who did you rely on to help you work through those feelings when you were so upset on Friday [due to unsuccessful surgical procedure]?

Oh, just friends, because my husband had other things on his mind, too...he was upset...so I couldn’t really talk to him....I told the girls at work and then I felt better.

This mother, like others in the study, sought support from friends and colleagues as opposed to her husband. Unger and Powell (1980) in their descriptions of the role of social networks in supporting families under stress, stated that support may be situation specific that is, "co-workers may support each other exclusively at work" (p. 570).
This was the case for the mother quoted above.

As was previously stated, five families in this study clearly identified when the post-hospitalization or recovery phase of their experience had ended. These parents expressed satisfaction with their experience and viewed it as "fait-accompli" within approximately ten days of the surgery. Parents often described a sense of relief from the stressful feelings of worry and anxiety when their experience had ended.

M: Oh yeah, it is a nice feeling, I’m glad it’s over with, done with, finished, nothing to worry about again.

...........................................

M: [I’m glad it’s] really behind me [the surgery experience]. I think on Friday [fourth post-operative day], you know, he was running around and screaming, and climbing like nothing else happened. I thought, "Well, it really doesn’t hurt him or he’d be crying more, or doing something else."

So I thought, "That’s it--it’s gone."

In addition to expressing her feelings of relief, this mother is saying that it was her child’s response to the surgery that allowed her to conclude that the experience for her was "over". Other parents also commented on the post-operative child’s level of activity as an indicator that the experience was over.

Other parents who participated in the study were not as definite in concluding that their experience was "over". For two study parents, the changed physical appearance of their child in the post-hospitalization period contributed to the stressful nature of their experience and led to continued feelings of anxiety and worry regarding possible failure of the anticipated outcome for the surgery. For example:
M: Then I saw her this morning and her eye was all red. And then I again had my doubts, gee, am I doing the right thing? It just looked awful.

For this mother, the physical appearance of her daughter was a factor determining her satisfaction with the experience and the timing of her sense of completion.

Three parents in the study viewed the surgeon’s opinion about the child’s post-operative progress as a key point in being able to feel satisfied with their experience and being able to conclude that this final phase was over. During the waiting period prior to obtaining the surgeon’s opinion, parental feelings of anxiety, fear, and worry that had typified the pre-operative phase continued to be present.

R: Would you say at this point that things are back to normal?

M: Yeah, I guess so, yeah.

R: You sound a little hesitant.

M: Well, I guess the only thing is I think in my own mind, things will really be back to normal when he goes back to another visit to the eye doctor and she says everything is O.K. Then I guess I’ll feel that things are back to normal when I have some reassurance that, you know, the operation has really done the trick.

R: So that will allay some of the things you are still worried about in the back of your mind there. So, you are still wondering, has this whole thing...?

M: Well, it’s just that, yeah. It’s very, very encouraging for me that he’s walking that, you know, the other moms said how straight his head looked. But, I still, you know, I guess I just want to hear it from a doctor, "It’s great, it really worked." So, for me, no, things won’t be
back to normal completely ’til I see her [pediatric surgeon].

This mother is emphasizing the importance of the role of the physician in providing her with information and reassurance regarding the results of her child’s surgery. For her, it was not until she received such information and reassurance that her feelings of anxiety and worry were relieved and she was able to conclude that this final phase of her experience was "over".

Although the post-hospitalization phase of the parents’ experience was typified by changes in behavior patterns and family routines as well as feelings of worry and anxiety, parents did report that, in general, this phase of the experience was more positive than they had anticipated. In fact, the majority of the parents were pleasantly surprised by their child’s reaction to the surgical event. For example:

M: I really expected more crying and I was going to carry him around all day, and he wouldn’t want to walk, you know. And having problems like that, but he surprised me [laughs]. It’s a good feeling, you know.

M: I wouldn’t have anticipated that she would do that well. I mean, people told me she would, but I couldn’t quite picture it.

M: But afterwards, he [child] was fine. It wasn’t nearly as bad as I thought it was going to be.

It is evident from the above quotations that parents had imagined expectations regarding their child’s behavioral reactions to this event. The parents’ lack of previous experience contributed to their anticipation of a more negative post-operative course. One mother stated, "It [day care surgery] wouldn’t bother me as much the second
time...I would understand it more, you know."

This section has discussed the parents’ experiences during the post-hospitalization phase of their child’s day care surgery. Dimensions of this phase that contributed to parents’ interpretation of the event as stressful included new responsibilities for the care and supervision of the post-operative child, changes in the child’s behavior and patterns of activity, and changes in family activities and routines. A lack of information regarding these dimensions of the post-hospitalization phase of the experience was also identified by the parents as contributing to the stressful nature of this phase of the experience. Although parents had anticipated a rather negative post-operative course, in general, they were pleased with their child’s response to the surgical procedure. Parents implemented several coping strategies to manage this phase of their experience.

Summary

This chapter has presented the theory generated in answer to the research question: what is the parents’ experience of having a toddler or preschooler at home following day care surgery? The accounts presented in this chapter represent a synthesis of this study’s data into a description that provides a basis for understanding how participant parents interpreted and assigned meaning to the day care surgery experience and coped with it in their everyday lives.

As can be seen from the presentation of the parents’ accounts, the experience of having a toddler or preschooler at home following day care surgery was only one aspect of the parents’ much broader experience of having their son or daughter undergo a day care surgical procedure. The time span of this broader experience extended far beyond the few short hours the parents actually spent in the day care unit. The major findings of this study revealed that the nine participant parents interpreted their
experience as a stressful one and that they and their families were significantly affected by their child’s day care surgery.

The chapter began with an introduction to the study’s analytic framework. Next, the concepts and themes which formed the theory developed from the parents’ accounts were presented and discussed in relation to theory existing in the literature. There was a detailed description of the participant families and finally a presentation of the parents’ accounts of their experiences according to the structure of the analytic framework.

The four major themes which characterized the parents’ experiences, and formed the structure of the study’s analytic framework, represented dimensions that either contributed to the nature of the stressful experience or enhanced parents’ ability to manage the stresses. The themes were: parental responsibility, role strain, coping, and social support. Related literature was used throughout the chapter to discuss the specific findings of this study and offer evidence to either support or contrast them.

The theory generated from the parents’ accounts is based on the finding that parents that it is stressful for them to have a child undergo day care surgery—more stressful than health professionals may perceive or understand. One mother, who was employed as a technician in an acute care hospital, compared her perspective as both a parent and a health care professional while undergoing the experience of her child’s day care surgery. This particular mother stated that as a health care professional she knew "it’s so routine...it’s nothing, it’s no big deal", and yet when her own daughter had to undergo a surgical procedure, she described herself as just another "upset parent". This mother’s personal experience highlights the stressful nature of this experience as well as the discrepancies between the explanatory models held by parents and health
professionals for the same health care situation. Such differences often result in misunderstandings and dissatisfaction with care (Kleinman et al., 1978).

Three-quarters of the parents who participated in this study described, in retrospect, that the overall pediatric day care surgery experience was much more positive than they had thought it would be. As one parent stated, "I guess overall the whole thing was not as bad as I had anticipated" in essence highlighting that the anticipation of it was worse than the actual event itself.

Chapter 5 offers further discussion of the study's findings, summarizes the study, draws conclusions, and identifies nursing implications for practice, education, and research.
CHAPTER 5

Summary, Conclusions, and Implications for Nursing

This chapter begins with a summary of the study which answered the research question: what is the parents' experience of having a toddler or presholder at home following day care surgery? Following this, the conclusions, implications, and recommendations for nursing practice, education, and research are presented. Although the core findings of this study are rich in both the general and specific implications and directions they offer for nursing practice, only the major conclusions and implications for nursing are briefly summarized in this chapter.

Summary of the Study

This study has provided an answer to the question: What is the parents’ experience of having a toddler or presholder at home following day care surgery? Using a phenomenological method, the study explored in-depth the parents’ broad perspective and personal interpretations of their child’s first time day care surgery experience within the context of everyday family life.

Although there is much documentation that pediatric day care surgery offers both psycho-social benefits for the family unit as well as financial savings for the Canadian Health Care System (Atwell et al., 1973; Cloud et al., 1972; Johnson, 1983; Lawrie, 1964; Shah, 1980) there is a lack of empirical knowledge addressing this topic from the parents’ perspective. Because parents are the primary caretakers for pre- and post-treatment children, it was argued by the researcher that it was mutually beneficial to truly understand the parents’ perceptions and personal
interpretations of the day care surgery experience within the context of their everyday lives. Parents of toddlers and preschoolers were selected for this study because it is known that parents are anxious and concerned about their children’s illnesses and hospitalizations, and also because children in these age groups are particularly vulnerable to the real and imagined threats of hospitalization and surgery.

The number of children and families receiving treatment in medical and surgical Day Care Units is growing steadily every year (Shah, 1980; British Columbia’s Childrens’ Hospital, 1987). Nurses working in both hospital and community settings have opportunities to influence the experiences of parents whose young children undergo day care surgery, both before and after the event.

The conceptual framework for the study was based upon the work of Kleinman and his colleagues (1978). Kleinman’s model adheres to two fundamental notions: the first is a distinction between the concepts of "disease", "illness" and "sickness", and the second is a conceptualization of a health care system with three different but interacting social "arenas": popular, professional, and folk. These three arenas serve to socially legitimize sickness and health care for the individuals they represent. Within the context of this framework, diseases are treated and illnesses are experienced. Sickness is defined as a complex human phenomenon encompassing both disease and illness. Individuals represented by each of the three social arenas use different explanatory models to explain and define particular sickness episodes.

Kleinman (1978) directs health care professionals to elicit the clients’ explanatory models in order to enhance health professionals’ understanding of illness as a personal, social, and cultural experience and, in doing so, facilitate the
provision of nursing care that is mutually satisfying. The parents, represented by
the "popular" arena of Kleinman's Health Care System, have explanatory models for
the post day care surgery experience that have been shaped by their knowledge,
beliefs, values, culture, and past experiences. The parents' explanatory models can
only be fully understood by eliciting their perceptions and explanations about their
experience.

The investigator selected the phenomenological method of qualitative research
to guide the investigation because it emphasizes life in the everyday world as it is
understood and interpreted by one living through the situation (Giorgi, 1975a).
Phenomenology allows the reality of the participant's experience to be fully
expressed and, through a process of exhaustive description, the researcher can
develop an understanding of the phenomenon under study (Ray, 1985; Lynch-Sauer,
1985). Using this method, the author was able to learn how the parents interpreted
and gave meaning to their experience of having their young child undergo a surgical
day care surgery procedure.

In order to substantiate the need for research on the specific topic of parents'
experience with their young childrens' day care surgery, and to establish a
background of information about what was generally known about families with
children who undergo hospitalization for a short-term illness, a body of related
literature was reviewed. The paucity of literature about parents' experience with
pediatric day care surgery lead to a review of several subject areas exploring in
general the impact of pediatric hospitalization and surgery on children and their
parents.
The literature review documented that: parental roles and responsibilities change when a child becomes ill or requires hospitalization even on a short term basis; maternal anxiety affects the child’s level of anxiety during hospitalization; and the short term hospitalization of toddlers and preschoolers results in post-hospitalization behavior changes. It was apparent that the current published literature did not provide an in-depth understanding of the parents’ own experience in the post-hospitalization period following their child’s day care surgery.

The data were collected by means of 16 in-depth interviews with nine parents of post-operative toddlers and preschoolers who underwent a variety of pediatric day care surgery procedures. The interviews were audiotaped and then transcribed verbatim. Eight first interviews and eight second interviews were conducted. The interviews were semi-structured and an interview guide (Appendix F, p. 149) was used during the first interviews to help elicit the parents’ descriptions of their experience. The content of the second interviews was drawn from analysis of the material discussed during the first interviews and from interviews with other parents. During each of the interviews, the researcher explored and clarified the meaning the parents assigned to their child’s day care surgery experience.

The process of analyzing data began with the onset of data collection and continued concurrently throughout this phase of the research process. Following completion of all of the interviews, data analysis continued until the parents’ accounts were synthesized into a descriptive framework of their experience with a toddler or preschooler’s day care surgery. In the presentation of the parents’ accounts, verbatim quotations from parent interviews were used extensively for illustrative purposes.
The study’s analytic framework represented the researcher’s conceptualization and interpretation of the similarities and shared aspects of the parent’s accounts of their experiences as revealed by in-depth analysis. The study’s analytic framework was based on a core concept of stress and was organized according to a chronological structure consisting of three distinct phases described by the parents. These three chronological phases were named the pre-hospitalization or preparatory phase, the hospitalization or operative phase, and the post-hospitalization or readjustment phase. The major themes identified in data analysis represented dimensions of the parents’ experiences that contributed to their interpretation of the event as stressful. Additional themes from the parents’ accounts also revealed aspects of their experience that enhanced or inhibited their ability to manage within the context of their everyday lives. The concepts and themes which formed this study’s analytic framework were presented and discussed in Chapter 4 in relation to existing theory in the literature.

According to the study participants, this "first time" experience was perceived as a stressful event in their everyday lives. Despite having received assurances from health care professionals that pediatric day care surgery was not only safe, but also considered minor and routine, the parents in this study were unable to view it as such for their child. The events, occurrences, and decisions inherent in the experience intensified parental feelings of responsibility for their child’s present and future well-being. Throughout the course of the experience, new responsibilities such as monitoring the child’s post-operative course and assessing the need for analgesia, were added to the usual tasks of parenting a toddler or preschooler. The addition of new responsibilities resulted in the parents’ reporting feelings of role
strain at particular points of the experience, such as when they were required to
withhold food and fluids from the pre-operative child. As parents coped with the
experience of their child’s day care surgery, they made concrete changes to their
established patterns and activities of daily living. For example, in all of the
participant families the operative child’s bathing routine was changed from a tub
bath to a sponge bath for at least several days post-operatively.

Throughout the three phases of their experience, the parents’ thoughts,
feelings, behaviors, and reactions changed and varied in intensity and parents
expressed feelings of fear, worry, and anxiety. Parents used a variety of coping
strategies, including social support, in order to manage the stresses of their
experience. Retrospectively, the majority of the study parents reflected on their
experience with their young child’s day care surgery as being more positive than
they had anticipated.

For discussion purposes, the findings of this study were compared with the
findings of numerous other studies. Although there have not been any other studies
exploring this experience from the parents’ perspective, the literature reviewed does
offer support for this writer’s findings and vice versa.

Conclusions

The major conclusions drawn from the findings of this study are:

1. Parents of toddlers and preschoolers view the day care surgery experience
as one which occurs over a span of time much greater than the few hours actually
spent in the hospital setting.

2. Parents interpret and assign meaning to their experience only within the
context of all three phases (pre-hospitalization, hospitalization, and post-
hospitalization) of their experience.

3. Parents of toddlers and preschoolers interpret this first time experience as stressful and identify particular dimensions of the experience that contribute to their interpretations.

4. Parents of toddlers and preschoolers view this experience within the broad context of everyday family life and describe significant changes that take place in family life as a result of the event.

5. There are specific applications of the theory generated from these parents’ accounts which could be applied to improve the quality of nursing care to pediatric day care surgery families. A selection of these follow:

**Implications for Nursing Practice**

Although the findings and conclusions of this study suggest implications for nurses involved in the assessment, planning, implementation, and evaluation of nursing care for parents whose young children undergo day care surgery, it is "important to point out that the application of research to practice is typically not a straightforward process" (Knafl, Cavallari, & Dixon, 1988, p. 297). The nurses who provide care for pediatric day care surgery families may be employed in Medical/Surgical Day Care Units, community health care agencies, or doctors’ offices, and may come into contact with parents at different phases of this experience.

The conclusions drawn from this study reflect the finding that parents have their own unique explanations of their illness experience which are constructed from the personal meanings of the experience held within the individuals’ personal, social, and cultural contexts. This is consistent with the work of Kleinman et al. (1978)
who argue that health professionals hold explanatory models that differ from those held by individuals in the popular culture system or, simply put, these parents’ views of the day care surgery experience differ from those held by health professionals.

Discrepancies between the explanatory models utilized by parents and health professionals often result in misunderstandings and dissatisfaction with care. It is therefore implied that in order to provide care that is mutually satisfying and supportive to parents during the first time experience of their toddler or preschoolers’ day care surgery, nurses must elicit parents’ perspectives and acknowledge the parents’ interpretation of the event. As a result of exploration of the parents’ explanatory models for their day care surgery experience, the findings of this study have emphasized the importance of anticipating parental needs, concerns, and responses in order to provide empathic parent care and minimize the stresses parents associate with this experience.

In addition to exploring the parents’ explanatory models, nurses also need to examine their own explanatory models, values, and attitudes about parents’ experience of their child’s day care surgery. By doing this, nurses will ensure that they do not assume to know what parents need and understand about the experience. Nurses will begin to establish the "ground of common understanding" (Kleinman et al., 1978) between themselves and the patient that is essential in order to negotiate a mutually acceptable plan of care. If a pediatric health care agency adheres to a philosophy of family centered patient care, the need for mutual understanding between parents and members of the health care team is further emphasized. As Knafl, Cavallari, and Dixon (1988) observed,
To be family centered implies that consistent, systematic efforts are made to understand one another’s viewpoints and that open negotiation between family members and nurses is encouraged and valued. Family centered nursing care requires that nurses and family members work together as equals in defining and managing the pediatric hospitalization experience (p. 300-301).

The conclusions drawn from the findings of this study reveal that pediatric day care surgery is viewed by parents as a threatening, stressful experience occurring over a span of time beginning with the realization of a problem, and extending to when the parent(s) decides the experience is over. The parental experience is much longer than the few hours actually spent in the hospital setting and is viewed in the broad context of every day life as an important family event.

The implications for nurses are twofold. First, nurses must examine their current practices and address the finding that parental needs for nursing care extend beyond the parents’ stay in the pediatric Medical/Surgical Day Care Unit. Second, nurses must consistently apply the four steps of the nursing process at each of the three temporal phases of the parents’ experience.

In relation to application of the nursing process, the need for ongoing assessment is imperative in order to ascertain the dimensions of the parents’ experiences that contribute to feelings of stress. Planning and nursing intervention will vary according to the individual needs of the client and the phase of their experience. In general, nursing interventions will be directed towards enhancing parents’ coping strategies to manage stress. Evaluation, the essential fourth step of the nursing process, will ensure that nursing goals for parent care continue to be
Examples of specific implications for nursing practice will be presented here according to the framework of the three chronological phases: pre-hospitalization, hospitalization, and post-hospitalization. It is expected that these examples may assist nurses working in various settings to identify common concerns which should be anticipated by health professionals when planning care for the parents of toddlers and preschooler who undergo a day care surgery procedure.

The pre-hospitalization or preparatory phase of the parents' experience began with the parents' realization that something was "wrong" with their child and ended with the child's admission to hospital to undergo corrective surgery. During this phase parents readied themselves and their families emotionally and physically for the day care surgery event.

During the pre-hospitalization phase of the experience the nurse must assess the parents' interpretation, understanding, and expectations of the event. In particular, gaps and misinterpretations of information, as well as potential sources of stress, should be identified. The parents' usual methods of coping with stressful situations and sources of social support, should also be assessed in order that these may be strengthened and enhanced as needed.

An example of a specific implication for nursing practice during this phase is the provision of anticipatory guidance regarding the possible factors contributing to the stresses of this experience. This nursing intervention may include parental guidance related to: decision-making regarding the actual surgical procedure; increasing anxiety and uncertainty as the event approaches; and/or parental feelings of guilt and worry due to added responsibilities (particularly withholding food and
fluids).

At the present time, in the agency where the study was conducted (British Columbia’s Children’s Hospital), the opportunities to assess parents during the pre-hospitalization phase of their experience are limited. When the surgery is actually booked by the physician, the parents may or may not be seen by a nurse, however, they do receive a detailed information pamphlet "Getting Ready for Day Care" (British Columbia’s Childrens’ Hospital). In addition to providing important and essential information, the pamphlet addresses concerns related to the child’s reaction to the surgery. Although an excellent source of information for parents, the pamphlet does not address parental fears related to the anticipation of day care surgery event or the resulting impact of the event on family life. A pamphlet cannot be considered a substitute for systematic nursing assessment and intervention, and information offered to parents should, whenever possible, reflect an individual assessment.

In addition to the pamphlet, there is a preparatory videotape available for viewing by parents and children prior to the child’s day care surgery. There is also an experienced day care nurse available for one hour per week to address parental concerns regarding preparation of the child. The availability of both of these resources is a positive factor in the preparation of families for day care surgery.

The "Getting Ready for Day Care" pamphlet clearly states that parents may call the Day Care Unit if they have any questions or concerns about their child’s impending surgery. It is important to note, however, that based on the findings of this study and others (Knafl, Cavallari, & Dixon, 1988; Robinson & Thorne, 1984), first time parents assume that health professionals tell them everything they need to
know and are often very reluctant and afraid to make requests for further information. Parents in the current study stated that they thought their questions are "dumb", that they should already know the answers, or their concerns were too insignificant to "bother" a health professional with. Health professionals who are not aware that parents hold this perspective may inadvertently reinforce to parents that they think parental concerns are insignificant.

At British Columbia's Childrens' Hospital, one or two days prior to the actual day care surgery a preadmission nurse from the Day Care Unit phones the parent to obtain some basic demographic information about the child, "answer any questions and remind parents of fasting instructions" (British Columbia's Childrens' Hospital, 1986, p.3). Unfortunately, between the time that the child's surgery is booked and prior to the nurse's telephone call, there is a significant gap in contact with the day care surgery families. Community health nurses or nurses employed in doctor's offices may come into contact with these families during the prehospitalization phase of their experience and may have an opportunity to assess their perceptions of the event, offer reassurance regarding the validity of their concerns, and answer questions.

The preadmission nurse's telephone call to the parent one or two days prior to the child's surgery is timely because it is known that the parents' anxiety about their child's day care surgery increases as the event approaches. If time permits, this telephone call is an excellent opportunity to discuss parental anxieties and address parental concerns in an empathic manner. Parental worries and fears at this point are real. If parents are told that they have "nothing to worry about", it only serves to reinforce the differences between the parent's perspective of the event and
that of the health professional (Knox & Hayes, 1983).

The hospitalization or operative phase occurred during the three to six hours that the parent(s) and child were actually in the hospital setting. This is a highly emotional, intense phase of the experience as the final preparations for surgery are made and the parent(s) relinquish their child to the care of health care professionals in order that the surgery can be performed. The findings of this study reveal that parents arrived at the Day Care Unit feeling anxious as a result of being unable to comfort their children in usual ways and feeling uncertain about the impending event and its outcome. Relinquishing the child, waiting for the child's return, and then reuniting with him/her were all stressful points of this phase of the experience for parents. At these points, nurses have an important role to play in demonstrating sensitivity to the parents' needs by providing relevant information, reassurance, and support. For example, when parents felt prepared for their child's return to the Day Care Unit from the Recovery Room, it had a very positive effect on the parent and his/her feelings about their day care surgery experience.

A particularly stressful time for parents was during the waiting period for them in the Day Care Unit after their child had left for the operating room. Parents expressed acute fears related to their children's morbidity and mortality especially related to the risks inherent in receiving a general anesthetic. Appropriate nursing interventions at this time should include not only reassurance but an empathetic acknowledgement of the intensity of parental fears. Nursing interventions to enhance parental coping strategies at this time would also be appropriate. The fact that all parents are asked to have another adult accompany them to the Day Care Unit is important in the provision of social support at this time.
While in the Day Care Unit, most parents remain focused on the child’s immediate pre- and post-operative needs. It is often not until they return home that the more minor issues affecting their day to day lives become apparent. During the hospitalization phase, nurses need to offer anticipatory guidance that is relevant to parents’ needs and perspectives in order to aid in their transition to the post-hospitalization phase of their experience.

Post-operative instruction pamphlets and verbal post-operative teaching help to bridge the gap between hospital and home. Pamphlets, however helpful, are by nature forced to be somewhat general therefore cannot address the concerns of all parents and should not be considered a substitute for individualized nursing interventions. During the hospitalization phase of the experience parents may fail to "take in" all of the information that has been offered to them. Their lack of previous experience and their faith in their care providers, often prevents them from asking pertinent questions. This highlights the need for nurses to provide appropriate and relevant anticipatory guidance, rather than wait for these parents to ask questions.

The post-hospitalization or re-adjustment phase began upon hospital discharge and continued until the child had recovered physically and emotionally from the surgery and all family members had returned to acceptable patterns of daily living. The telephone call that parents receive from a nurse in the Day Care Unit (at British Columbia’s Childrens’ Hospital) on the child’s first post-operative day is a very timely opportunity to address some of the parental concerns that may have arisen since the arrival home. Specific nursing implications for this phase of the parents’ experience relate to enhancing creativity and flexibility in parental coping
abilities. Providing information and support will assist parents with the concrete changes they face in their daily routines and activities.

In addition, this follow-up telephone call is an excellent opportunity to begin the evaluation phase of the nursing process. A "flow-through" nursing care plan, which could be initiated by the preadmission day care nurse, added to by the nurses caring for the family during the hospitalization phase, and completed by the day care nurse making the follow-up telephone call, would facilitate application of the nursing process and ensure continuity of nursing care for these families. Provision should be made for further follow-up of families if needed. Referrals to community health and home care nurses to provide follow-up home visits may be appropriate in some situations.

The findings of this study not only reveal implications for nursing practice but also show that parents are resourceful in the management of their child’s care during the day care surgery experience. In general, parents reflect that this first time experience was more positive than they had anticipated.

Nurses have a significant role to play in the care of families with young children who undergo day care surgery. As was stated by Knafl, Cavallari, & Dixon (1988), the "uniqueness of the pediatric nurse's work rests in the fact that she practices her nursing skills on children and must take the parents into account as she provides care" (p.272). In the following section, implications for nursing education will be discussed.

Implications for Nursing Education

The findings and conclusions from this study point to several implications for nursing education. First, if nurses are to provide responsible, supportive, and
effective health care, they must develop the communication skills needed to explore clients’ explanatory models for their illness experiences. Inservice educational opportunities within agencies, continuing nursing education courses, and opportunities in formal nursing education programs should be made available to support the development of such skills.

As nurses and nursing students learn to enlist clients' explanatory models, they must also carefully examine their own assumptions, values, and beliefs, and learn to incorporate this understanding and awareness into clinical practice (Anderson, 1987). As the findings of this study indicate, an understanding of the parents' experience from the parents' point of view would enable nurses to incorporate this knowledge into a mutually satisfying plan of care.

Another implication from this study relates to the care of the client outside the acute care setting. Nursing curricula, with their prominent acute care foci, often fail to emphasize the care of the client outside the hospital environment. Client preparation for hospitalization and planning for discharge are often not emphasized in nursing course content. As the findings of this study indicate, the hospitalization phase of the parents' experiences was only one aspect of the total illness experience. It is therefore implied that nursing education emphasizing the needs of the clients in the pre- and post-hospitalization phases of their illness may better prepare nurses who practice outside the hospital setting to provide quality care to particular client groups. It may also sensitize the nurses who work in acute care settings to the needs of their clients before and after hospitalization.

A third implication for nursing education is related to family centered nursing care in a pediatric setting. As is well documented by other authors
(Hymovich, 1976 & 1981; Litman, 1974), a child’s illness involves and affects all members of the family, especially parents and siblings. As nursing models often focus care on the client as an individual, nursing educators must continue to emphasize the need for family centered care.

Family centered care in the acute care setting has often been equated with certain policies such as open visiting hours and increased parental participation in care. In the application of research findings to practice and education nurses must be aware that "too often programs of family-centered care reflect what professionals think families should want as opposed to what families actually may want" (Knafl, Cavallari, & Dixon, 1988, p. 299). It is therefore essential that parents’ perspective of their health care encounters be included in nursing curricula. In the following section, implications for nursing research will be discussed.

**Implications for Nursing Research**

During the process of the current study, the researcher became aware of implications for further research in the area of parent care and pediatric day care surgery. First, although the current study explored the parents’ first time experience with young children undergoing a day care surgical procedure, a large proportion of day care procedures performed are second or subsequent procedures. With a high percentage of families experiencing repeat procedures on their children, it would be valuable for nurses to learn how the parents’ perspective of the experience changes with subsequent hospital admissions. The results of such a study would offer nurses guidelines as to how they could best assess, plan, implement, and evaluate care for parents returning to the Day Care Unit for repeat admissions.
The current study examined the experiences of parents of toddlers and preschoolers only. A valuable addition to current knowledge would result from an examination of the perspectives of parents of younger or older children who undergo day care surgery. In addition, a study incorporating the perspectives of a greater number of fathers as well as siblings would add a family perspective to this important experience.

A further implication for nursing research would be to use a reliable and valid measurement tool to measure the levels of stress parents feel at various points of their experience. The findings of such a study would document in a quantified manner the need for intervention at particular points of the parents' experience.

A logical follow-up to the current study would be a combined qualitative and quantitative research project designed to evaluate and compare the effect of nursing interventions on the experiences of two groups of parents undergoing their son or daughter's day care surgery for the first time. The experimental group of parents would receive nursing intervention directed at reducing the stresses inherent in this experience. The control group would be well-matched subjects who would receive only standard nursing care. The intent of such a study would be to support or reject the value of specific nursing interventions in improving the quality of care offered to these families.

It is evident from the suggestions presented here that parent care in pediatric day care surgery requires continued investigation. The need for further research in this important area is emphasized by Robinson (1972) who observed that "much is known and written about child patients, their behaviour, their needs and their treatment, very little is known systematically about the attitudes and behaviour of
their parents" (p. 447).

In conclusion, the nine parents who participated in this study contributed an abundance of rich data about their first time experience with their children's pediatric day care surgery. From the data collected, the writer developed a theory which significantly contributes to health professionals' current knowledge about the parents' perspective of this experience. The findings of this study suggest that understanding the parents' perspective is necessary in order to positively intervene in their illness experience and improve the quality of nursing care offered to this large group of health care consumers.
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APPENDICES
APPENDIX D

Participant Information Letter

Dear Parent:

My name is Pamela Otterman and I am a student in the Master of Science in Nursing Program at the University of British Columbia. I am also a pediatric nurse. I am conducting a study to learn more about what parents experience when their young child has been hospitalized for day care surgery.

There is very little information available about what parents think about this experience and how they manage at home with a child who has just had an operation. This letter is to inquire if you are interested in participating in my study. Should you agree to participate, I will talk with you two or three times in your own home after you return from hospital with your child. The first interview will be the first or second day after you return home, and the second interview will be one to two weeks after your child’s operation. A third interview may be arranged if necessary. Each meeting will be approximately one hour long and will be arranged at a time most convenient for you and your family. With your permission, the interviews will be tape recorded, transcribed (typed), and analyzed after our visits.

During the interviews, I am interested in learning about your reactions to the day care surgery experience and how it affected you and the other members of your family. All of the information that you share with me will be kept strictly confidential and your identity will never be revealed in any way whatsoever. The tape recordings are so that I do not have to take written notes while we talk. They are for my personal use and will only be shared with two of my advisors who are also experienced pediatric nurses. I will assume all responsibility for the tape recordings and will personally destroy them when I have completed the project and any related publications (in general, this takes about three to five years).

I believe that if pediatric nurses learn more about the experiences of parents related to their child’s day care surgery, we could use the knowledge to better prepare parents for coping with a similar experience. Other parents who have had an opportunity to talk with a nurse after their child’s hospitalization have indicated that they enjoyed and benefited from the interviews.

You are under no obligation to participate in this study. If you should decide to participate, you have the right to change your mind and withdraw at any time. You also have the right to refuse to answer any questions that I may ask or comment on any topic during the course of an interview. If you should decide not to participate, your refusal will not in any way affect your child’s scheduled surgery or any subsequent nursing or medical care.

With your permission, I will call you at home tomorrow to find out your
APPENDIX F

Initial Interview Guide

1. Would you describe your son/daughter's condition for me please?

2. How would you describe your child's reaction to his/her day care surgery?

3. How have the day to day activities of your household changed, if at all?

4. Could you describe some of your impressions on the first night at home after the surgery?

5. What has it been like for you looking after (child's name) since you arrived home from hospital? Is this what you expected?

6. Can you think of a reason why the experience of your child's day care surgery has affected you the way it has?

7. What/whom has been most helpful to you during this time? What would have been more helpful?