DESCRIBING THE MEANINGS OF THE LIVED SPIRITUAL EXPERIENCES OF PATIENTS TRANSITIONING THROUGH MAJOR OUTPATIENT SURGERY

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By

Andrew T. Griffin

Dissertation Committee:

Lois Magnussen, Chairperson
Sandra LeVasseur
Maureen Shannon
Patricia Nishimoto
Paula Morelli
Valerie Yancey
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ABSTRACT

In the past ten years there has been a tremendous growth in outpatient surgery. Technical advancements in surgery techniques and anesthesia delivery have made it possible for lengthy, complex surgical procedures to be done on an outpatient basis. While surgery is dramatically changing, the basic nursing needs of surgical patients remain constant. It is widely accepted that most patients face the same spiritual issues of coping, hope, inner-peace and a sense of emotional and physical well-being, which have long been associated with the surgical experience, yet the newer processes necessitate adaptation at an accelerated rate.

The purpose of this phenomenological study was to describe the meanings of the lived spiritual experiences of patients transitioning through major outpatient surgery. The philosophical framework of this research was operationalized congruent with interpretive phenomenological methodology. The philosophic methodological approach of van Manen formed the foundation for this study while Munhall’s stepwise approach guided the methodology. Seven research participants who had just completed major outpatient surgery were recruited through a purposeful criterion based sample.

The participant interviews resulted in rich descriptions of each individual experience framed within the context of the four existential life-worlds. After interviewing and readdressing the participant’s accounts, four distinct themes emerged. The identified themes were; a) a point in time, b) holy other, c) vulnerability in the operating theater and d) appraisals of uncertainty. Several suggestions for perioperative nursing practice were discussed as well as two general recommendations for future research.
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CHAPTER ONE
INTRODUCTION

Smoke bellows from the tall brick laden stacks at the Mill Brothers Cabinet Company. The workers arrived only a short hour ago and have already taken their places on the assembly line. The machines are tuned, the producers are skilled, the foreman directs as wood quickly metamorphoses into cabinetry ready for delivery. The Mill brothers, Bob and Ray, remember a time not too long ago when the business involved only a few workers, themselves and a small operation behind the family home; a time when every cabinet imprinted an individual memory within them......

To this researcher the previous word picture, though distant in concept, seems to be reflective of mental imagery when pondering changes in surgery over recent decades. Patients now move through outpatient surgery processes in greater numbers, in an environment of increased technology, and in hours as compared to days. While the processes are moving toward a rigid factory-like efficiency, patient needs remain complex and unique to the individual.

In chapter one, the researcher will present the history and background for this study on perioperative spiritual experiences, the philosophical orientation, problem
Background

The past ten years has seen a tremendous growth in outpatient surgery. What was once a novel concept involving a few specific procedures has now become the norm for many surgeries. Technical advancements in surgery techniques and anesthesia delivery have made it possible for lengthy, complex surgical procedures to be done on an outpatient basis (Bettelli, 2006; Cooke, Chaboyer, Schluter, & Hiratos, 2005). In the very near future, it is predicted that outpatient surgical procedures will greatly outnumber those performed inpatient (Cooke, Chaboyer, & Hiratos, 2005; Cooke, Chaboyer, Schluter et al., 2005). Commonly, patients undergoing surgeries such as anterior cruciate ligament reconstruction, cholecystectomies, and modified mastectomies return home the same day.

Even for surgeries still requiring a hospital admission, the movement of patients through the surgical experience has greatly changed. Gone are the days of routine admissions the night before surgery. Patients needing a longer hospital stay now follow the same morning admission procedures as same-day surgery patients, the only difference being a stay on a post-operative surgical unit. Economic pressures are placed on perioperative and anesthesia nurses to facilitate rapid movement of patients through the system. Prompt transference and discharge from surgical units are believed to be essential to efficiency (Bettelli, 2006).

While surgery is dramatically changing, the basic nursing needs of surgical patients remain constant. It is widely accepted that patients face the same spiritual
issues of coping, hope, inner-peace and a sense of emotional and physical well-being which have long been associated with the surgical experience, yet the newer processes necessitate adaptation at an accelerated rate. Cooke, Chaboyer, and Hiratos (2005) note that “…day surgery means that preoperative nursing care must effectively support patient needs in shorter time periods” (p. 146). Throughout the perioperative period, patients undergo multiple “transitions” which could be spiritually challenging.

**Philosophical Orientation**

This researcher ascribes to a philosophy of holistic care, with an understanding of the body, mind and spirit as inseparable. Persons are not viewed as having separate parts or systems, but as whole beings. In accordance with the science of psychoneuroimmunology, there are dynamic interactions among behavioral and emotional responses and the endocrine, immune and nervous systems (Freeman, 2004; Halldorsdottir, 2007). There is a close relationship between spiritual and emotional well-being and immune system function (Halldorsdottir, 2007). Furthermore, spiritual wellness is related to positive health outcomes (Hammermeister & Peterson, 2001; Mahlungulu & Uys, 2004; Polautzian, 2002).

**Problem Statement**

In her emerging theory of “experiencing transitions,” Meleis described surgical procedures as instances of transition leading to a state of increased vulnerability and potentially to negative health outcomes. In fact, most patients facing surgery or a health crisis go through multiple, simultaneous transitions (Meleis, Sawyer, & Messias, 2000). A sense of heightened vulnerability arising from undergoing multiple transitions culminates for some people at the time of surgery.
Cancer survivors, for example, identify the highest level of vulnerability as shortly after discovering their cancer and right before the beginning of treatment, which in many cases occurs during the immediate preoperative period. Patients undergoing surgical procedures often face both a developmental or health/illness transition related to the medical problem which necessitated surgery and a situational transition brought on by the surgical or anesthetic experience itself.

Selder (1989) described transition as a type of disrupted reality which requires restructuring. The disruption often occurs in response to a “crucial” event. Finding oneself in an alien environment disrupts reality in ways not unlike what patients experience when undergoing anesthesia and surgery. Transitions are associated with a complex interplay of spiritually relevant dynamics such as loss of control, hopelessness, feeling “cutoff” from self and others, feeling unsafe or simply “out of sync” with reality (Davidson, Dracup, Phillips, Padilla, & Daly, 2007; Kralik, Visentin, & Van Loon, 2006; Selder, 1989; Sulmasy, 2006). In a qualitative study examining health related quality of life issues among patients undergoing major surgery, the patients interviewed described anxiety, lack of control, changes in self identity and even anger (Morris et al., 2006).

Researchers studying the impact of transition usually describe patients experiencing chronic illness or disabilities, who make transitions over a longer time period. Morse (1997), however, emphasized the importance of “instantaneous disruptions” (non-chronic situations) when considering issues of self-integrity. Persons undergo transitions with experiences of any duration (Morse, 1997). A same-day surgery experience may be relatively short, but an acute sense of heightened
vulnerability, multiple transitional challenges and disruption in spiritual wellness could still negatively impact outcomes and potentially invite crisis for the patient. During the perioperative period, many surgical patients face the fear and possibility of death as they transition through a surgical experience. The anesthetic agent itself may be viewed as producing a ‘near death’ experience triggering spiritual concerns.

In a phenomenological study describing the lived experience of patients undergoing excisional breast biopsy surgery, the authors identified three major themes: a) fear, b) need for information, and c) spiritual needs (Demir, Donmez, Ozaker, & Diramali, 2008). While the authors identified spiritual needs as a major theme illuminating from the patient interviews, a clear understanding of what exactly constituted these spiritual needs was not discussed. Furthermore, except for the mention of prayer, the authors did not address specific spiritual experiences of participants.

It is suggested that if nurses are to provide total patient care, then spiritual components cannot be ignored (Mahlungulu & Uys, 2004). Some go as far as to indicate that ignoring the spiritual needs of patients leads to unethical practice (McBrien, 2006). As further validation of the importance of this concept, The Joint Commission has recently identified spiritual assessment as a requirement in a number of healthcare settings (Hodge, 2006). While asking a patient to state their religious preference on admission paperwork may meet certain accreditation requirements, it misses the mark when it comes to actually addressing the spiritual care of the patient in most surgery settings (Miner-Williams, 2006a).

In order to approach the spiritual complexities faced by patient’s undergoing
major outpatient surgery, nurses must further understand the spiritual experiences and the factors that initiate and prohibit them. Appropriate spiritual interventions are needed. Interventions are best created through rich understanding and as Munhall (2007) stated, “better they be designed in consideration of the patent’s perspective of the experience than from the caregiver’s assumptions” (p.188).

Statement of Purpose

While the development of additional spiritual nursing interventions facilitating spiritual wellbeing is greatly needed for the perioperative environment, it must be preceded by a richer understanding of spiritual experience in the surgical setting. The purpose of this phenomenological study was to describe the meanings of the lived spiritual experiences of patients transitioning through major outpatient surgery.

Research Question

The research question for this study was as follows: “What are the meanings of the lived spiritual experiences of patients as they transition through major outpatient surgery?”

Reflective “Unknowing”

Phenomenologists, van Manen (2001) and Munhall (2007), discussed the importance for the researcher to reflect on presupposed ideas related to the research topic. While it was referred to by Munhall (2007) as “unknowing,” it is essentially another way of knowing. It is important that the personal feelings of the researcher are realized so as not to taint the evidence presented by the qualitative data. This researcher has never personally experienced major outpatient surgery, yet as an anesthetist I have been a part of the experience literally thousands of times. Van
Manen (2001) allows for great liberty when reflecting on presupposition. With the anticipation of framing the final research discussions within the four existentials of spatiality, corporeality, temporality, and relationality, I reflected on my preconceived ideas under the same construct.

**Spatiality (lived space)**

I believed a patient’s need for a “sense of place” lies at the core of spiritual environmental concerns. Environmental contexts provide meaning for patients and give them a sense of identity and security. “Places” are locales for aesthetic experience and foster one’s sense of belonging and relatedness (Williams, 1998). Environments have their own spirit or personality, and create either negative or positive connotations for people in them. For example, a person’s home often provides a sense of familiarity, comfort and meaning. Other examples of the power of place range from simplistic associations (e.g., the awe an avid nature lover experiences when viewing that special, pristine lake) to more complex, symbolic associations (e.g., the meaning ceremonial sites have for Native Americans) (Williams, 1998).

I believed multiple environmental conditions make the operating room disruptive to a person’s sense of connectedness, peacefulness and belonging, all components of spiritual wellness. Cold, sterile, unfamiliar and unwelcoming surgical suites potentially undermine patients’ coping abilities and self confidence. Controlling physical environmental factors e.g., light, activity, sound, and color have long concerned holistic caregivers (Quinn, 1992).

Environments can be described as either ‘authentic or unauthentic” (Williams,
A person perceives an authentic environment as caring and connecting, an environment in which one quickly feels a sense of belonging. In contrast, unauthentic environments often promote spatial separateness and isolation (Williams, 1998). I feel that patients often perceive hospitals in general, and surgical areas in particular, as unauthentic environments in which they experience a loss of control (Williams, 1998).

I also believed that high technological environments block the emergence of healing relationships (Miller & Crabtree, 2005). Few healthcare environments are more technologically oriented than an operating room. The greater the uses of technology in an environment, the more likely care providers are lured into a mechanical delivery of care. While the delivery of safe anesthetic and perioperative care depends on creating efficient, routine spaces, those same environments block empathy and attentiveness to patients’ cues, limiting caregivers’ ability to connect at an authentic, caring level. Unfortunately the surgical team more readily identifies with the disease process and procedures than with patients. In addition, perioperative caregivers work in an environment where human caregivers are somewhat interchangeable and anonymous - even wearing masks - making relationships of more transcendent nature more difficult to achieve (Sulmasy, 2006).

Corporeality (lived body)

Threats to the physical body and future abilities to function in a normal way challenge spiritual well-being. As addressed earlier in this chapter, many patients equate anesthesia to a near death experience which necessitates a certain amount of spiritual coping. In addition, surgical experiences are often associated with pain, a
complex process involving physical, psychological, spiritual and social dimensions of well-being (Wachholtz, 2007). Before and after surgery, patients either cope with existing pain, or anticipate the pain associated with a surgical intervention. A large body of research suggests that many patients rely on spiritual resources to cope with pain. Pain experiences can challenge a patient’s spiritual well-being, or are regarded by some patients as “an enemy” (Sorajjakool, Thompson, Aveling, & Earl, 2006; Wachholtz, 2007).

*Temporality (lived time)*

*Lived time* is time as it is perceived in relation to circumstance; for example, the expression, “time flies when you are having fun.” Literal time around the surgical experience has greatly decreased over recent years. Gone are the days of extended nurse patient interaction prior to the actual surgery. I discerned to some extent, time for interpersonal interaction and connecting to caregivers is perceived as next to non-existent to the patient experiencing major surgery. On the other hand, time of isolated waiting for the surgery to progress probably feels like an eternity. This could possibly facilitate a connection to God through the process but constrain interaction on a higher level between the patient and caregivers. This leads me to discussion of the final existential.

*Relationality (lived human relation)*

Perioperative care providers are a part of a patient’s interpersonal environment (Quinn, 1992). Researchers studying the connections between patient and caregivers described clinical, moral and practical implications of healing relationships. Relational interactions impact the patient’s experience, for the better or for the worse
(Watson, 2005). Halldorsdottir placed relationships along a five-level continuum from biocidic to biogenic (see Figure I) (Halldorsdottir, 2007; Watson, 2005). I perceived that time restrictions, routinization of care and technology influence caregiver relationships during the perioperative period toward lower relational levels. This results in biopassive, biostatic or even biocidic interactions that damage spiritual wellness and lead to increased patient disconnection and vulnerability. After a lower level interpersonal interaction, patients often feel humiliated, powerless, helpless and vulnerable (Watson, 2005). Caregiver arrogance also reduces the ability to achieve a biogenic relationship (Sulmasy, 1997).


d| Type 1 Biocidic (Life-destroying) | toxic, leading to anger, despair, and decreased well-being |
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<td>Type 2 Biostatic (Life-restraining)</td>
<td>cold or treated as a nuisance</td>
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<tr>
<td>Type 3 Biopassive (Life-neutral)</td>
<td>apathetic or detached</td>
<td></td>
</tr>
<tr>
<td>Type 4 Bioactive (Life-sustaining)</td>
<td>classic nurse-patient relationship as kind, concerned, and benevolent</td>
<td></td>
</tr>
<tr>
<td>Type 5 Biogenic (Life-giving)</td>
<td>Mutuality and interconnectedness, openness to love, giving and receiving</td>
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(Watson, 2005, p.15)

Other factors associated with biocitic or biostatic interactions plague caregivers and patients in the surgical environment. Care providers are often desensitized to spiritual issues of patients because of their daily exposure to illness, pain and suffering. I descry that patients generally regard surgery as a unique, even life-changing experience, while caregivers regard the same as ordinary and unremarkable.
Finally, caregivers may feel safer relating at biocitic or biostatic levels because of the inherent risk one takes when entering into higher level, bio-active relationships with patients in an uncertain environment (Sulmasy, 1997). Perhaps it feels safer for some caregivers to cope with poor patient outcomes if they have not formed an interpersonal relationship with a person.

Higher level interactions are bioactive (life-sustaining) or even biogenic (life-giving) (Halldorsdottir, 2007; Watson, 2005). By nature, these relationships are transcendent, facilitating new possibilities for coping with physical circumstances. Transpersonal caring relationships are based on a spirit-to-spirit connection between patient and caregiver. Cloninger’s (2004) research on the science of well-being complemented the research concerning the bio-nature continuum of relationships. He posited that higher levels of thinking are equated with an individual’s ability to transcend a negative situation, leading to freedom from external constraints. In higher levels of thinking or metacognition, wellness is more than the absence of disease. He described a self-aware consciousness as being uniquely human, non-existent in any other species. Neuropsychology and brain imaging provide evidence of neuron activity during metacognition that is facilitated by therapeutic interactions with others. It is important to note that when a person is preoccupied with a negative situation or an obstacle seemingly out of his or her control (the surgical experience), the person’s ability to reach higher levels of thinking is greatly diminished (Cloninger, 2004).

Assumptions

This study was actualized with two basic assumptions in mind: 1) Spirituality
and the human spirit indeed exist. 2) Spiritual care is important to the total care of the perioperative patient, yet is not adequately provided in many instances.

Significance of Study

As alluded to earlier in chapter one, the author of this study believes that appropriate nursing intervention begins with a rich understanding of how a phenomenon is experienced by those living it. Munhall (2007), whose methodological framework will later be described as framing this study, strongly argued that sound phenomenological description is needed to inspire befitting intervention. This study will contribute to the understanding of spiritual experiences of outpatients as they transition through the perioperative arena. The descriptions could potentially benefit many diverse populations facing outpatient surgery.

Summary

In this chapter the author introduced the background, philosophical orientation, problem statement, purpose, research question, reflective “unknowing,” assumptions and significance of the research dissertation describing the meanings of spiritual experiences of patients as they transition through major outpatient surgery. It was intended that this study be a catalyst for further research, both qualitative and ultimately quantitative addressing the spiritual needs of those facing outpatient surgery.
CHAPTER TWO

Conceptual Analysis

Chapter two examines the concept of spirituality as related to the perioperative period. Walker and Avant was selected as an organizing framework for this analysis (Walker & Avant, 2005). Consistent with this method, a thorough literature review of the concept is included in this chapter.

Purpose of Analysis

In recent history, the spiritual dimensions of health, healing and caregiving have become a familiar topic in nursing literature. While well-recognized as a part of holistic nursing care, the concept of spirituality is considered less frequently in the specialty of nurse anesthesia and specifically as it pertains to the perioperative period. Historically, inclusion of spirituality in nursing dates back hundreds of years (Johnson, Tighman, Davis-Dick, & Hamilton-Faison, 2006). Emphasis on the concept has fluctuated over time, but the past ten years has seen monumental growth in studies on spirituality (Hammermeister & Peterson, 2001; R. W. Johnson et al., 2006; McBrien, 2006; Stefanek, McDonald, & Hess, 2005; Tinley & Kinney, 2007). This is not only a nursing phenomenon; research literature in general has seen a 600% increase on the topic over the same time period (Stefanek et al., 2005). It is unusual to find any health model developed since the mid 1990s that does not incorporate a dimension dealing with spiritual well-being, whether in nursing, medicine, psychology or social science (Hammermeister & Peterson, 2001; Mattis & Jagers, 2001).

The general population also continues to show significant interest in spiritual
well-being (Brennan, 2006). Consistently, more than 90% of the population make an
association with a higher place or being (Miner-Williams, 2006b). Patients in
numerous studies have indicated concern with spiritual needs and specifically, as
addressed in chapter one, includes studies taking place in perioperative settings
(Demir et al., 2008; Lowry & Conco, 2002; Tinley & Kinney, 2007; Walton &
Sullivan, 2004).

One of the obstacles to providing spiritual care is a lack in clarity of the
concept of spirituality (Buck, 2006; Chiu, Emblen, Hofwegen, Sawatzky, &
Meyerhoff, 2004; Mahlungulu & Uys, 2004; McBrien, 2006; Rose, 2001; Tanyi,
2002; Tinley & Kinney, 2007). Nurses at different levels of practice indicate that
they do not feel prepared to administer spiritual care, possibly related to their lack of
a clear understanding of the concept. Feeling unprepared to provide spiritual support
is not a phenomenon unique to nursing; many disciplines have indicated problems in
this area. The educational literature recognizes lack of conceptual clarity as a major
contributor to this deficiency (Speck, 2005).

Another reason to clarify the concept of spirituality can be found in its
relationship to health outcomes. Spiritual well-being (SWB) has proven to be a
strong predictor of health outcomes (Hammermeister & Peterson, 2001; Mahlungulu
& Uys, 2004; Polautzian, 2002). Some areas of particular interest to perioperative
care providers could be the suggested relationship between SWB and stability of
physiological factors, such as blood pressure and pain, as well as SWB and its
relationship to decreased anxiety levels and a greater ability to face crisis with a
positive sense of coping and endurance (Mahlungulu & Uys, 2004; Polautzian, 2002).
In particular studies of women and health behavior, SWB has been a major contributor to optimal health (Banks-Wallace & Parks, 2004).

A deeper understanding of spirituality might also promote cultural sensitivity (Hodge, 2006). In a study of spiritual needs, Moadel et. al. (1999) discovered that minority status was the greatest predictor of a high need for spiritual intervention. Other such studies have indicated spirituality to be a defining feature among certain ethnic groups, especially African-Americans (Mattis & Jagers, 2001; Newlin, Knafl, & Melkus, 2002). Furthermore, addressing such needs would be congruent with the cultural competency mandate of Healthy People 2010.

**Aim of Analysis**

Although spirituality as a concept has been addressed by several authors in recent history, further clarity is needed. On a continuum from the more concrete to the abstract, spirituality would find itself on the more abstract end. This intangible quality increases the difficulty in describing and quantifying it. The aim of this chapter is to contribute toward conceptual clarification of spirituality, as it applies to the perioperative period.

**Method**

As addressed earlier, the strategy of Walker and Avant was selected as the organizing framework for this chapter and will be presented in the following sections (Walker & Avant, 2005). This method was chosen because of its iterative and step-wise approach. The procedures are a modified version of Wilson’s 1963 classic framework (Walker & Avant, 2005). The steps are as follows: the initial selection of a concept, determining the aims of analysis, identifying all uses, determine the
defining attributes, identifying a model case, identifying additional cases, identify antecedents and consequences, and the defining of empirical referents (Walker & Avant, 2005). While these are listed as sequential, in fact they are iterative. The iterative nature leads to stronger analysis (Walker & Avant, 2005). This author found the case illustrations reviewed in previous concept analyses utilizing Walker and Avant’s framework, increased the clarity of spirituality.

Method Application

In accord with Walker and Avant’s methodology, definitions were initially obtained from dictionaries and thesauruses (Walker & Avant, 2005). Entries under spirituality, spiritual, and spirit were studied. As with many English words, a wide variety of meanings were found observing different contexts of use. The root “spirit” was utilized in different contexts, predominantly representing mood or emotional states, such as having ‘team spirit’, the ‘spirit of 1776’, or ‘the spirit of the law’. There was also the use of spirit as representing a supernatural being or an alcoholic drink. The American Heritage online dictionary had several principle definitions of spirituality such as “The principle of conscious life; the vital principle in humans, animating the body or mediating between body and soul,” “the incorporeal part of humans: present in spirit though absent in body,” and “conscious, incorporeal being, as opposed to matter: the world of spirit.” Another use cited in the American Heritage dictionary was “the divine influence as an agency working in the human heart” (Houghton-Mifflin-Company, 2000). Under spirit, the American Heritage dictionary included “the part of a human associated with the mind, will and feelings.” The Webster online dictionary seemed to make a stronger association between
spiritual and religious. Definitions included, “something that in ecclesiastical law, belongs to the church,” “sensitivity or attachment to religious values,” and “the quality or state of being spiritual.” Webster described spiritual as “related to sacred matters,” “concerned with religious values,” and “related or joined in spirit” (Merriam-Webster, 2007).

Review of Literature

A literature search of multiple disciplines was performed using the search engines of CINAHL, Medline, Wiley Interscience, SocINDEX, Philosopher’s index, Springer Link, and Psyc INFO. Nursing research articles were viewed primarily over the past 10 years. Search of the literature in the other disciplines was focused on the past five years. Hundreds of titles and abstracts were reviewed and a collective group of 70 articles were selected which appeared to be the most pertinent to this concept analysis.

As addressed earlier in this article, spirituality has been analyzed in nursing for many years, but has gained momentum over the last decade. Many of the earlier nursing concepts utilized religion and spirituality interchangeably, (Emblen, 1992; Golberg, 1998), until the 1970s, when emphasis was made on their separation (Emblen, 1992). In the early seventies, nursing definitions could be found that placed the spiritual in opposition to the biological, rather than working in accord with it (Emblen, 1992). Placing material and spiritual dimensions within opposing perspectives reflected the predominant reductionistic views of the day. The transcendent values of spirituality began to emerge in concepts from the 1980s, with some emphasis in the late 80s of not only a vertical (reaching upward to God)
transcendence, but a horizontal (connecting with self, others, society/community and nature) as well (Emblen, 1992; Miner-Williams, 2006b). The nursing literature of the 1980s also emphasized spirituality as providing the essence of total personhood and entire being (Emblen, 1992; Miner-Williams, 2006).

In 2001 Touhy addressed spiritual well-being by emphasizing harmony and interconnectedness between nature, self and others (Touhy, 2001). The 2004 NANDA definition of SWB included “the ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, or a power greater than oneself” (Johnson et al., 2006, p.425). In a 2004 South African journal, Mahlungulu described the concept of spirituality as “a unique individual quest for establishing, and/or maintaining a dynamic transcendent relationship with self, others and with God/supernatural being as understood by the person” (Mahlungulu & Uys, 2004, p.15). In a 2006 concept analysis, Buck stated that spirituality was “the most human of experiences that seeks to transcend self and find meaning and purpose through connection with others, nature and/or a Supreme Being” (Buck, 2006, p.288). All of these most recent nursing definitions emphasize connection, both vertically and horizontally, and seem to individualize and separate the experience from religion.

Meaning, purpose, power/force/energy and harmony with nature are some of the themes emerging from Chui’s (2004) nursing study as it addressed spirituality and culture. A particular example described was that of Native Americans and their quest for harmony with the Universe (Chiu et al., 2004). Another example appeared in a study of spirituality in older adults, and was the notation of a positive correlation
found between age and increases in spirituality (Gaskamp & Meraviglia, 2006).

Hodge (2006) outlined the need for spiritual assessment and discussed spirituality from “vertical” perspective, focusing more on a driving force or transcendent reality toward union with God. Little time was spent discussing horizontal planes of connection. Hodge alluded to what he called significant social research interlinking spirituality and religion. In sample assessment questions, ‘spiritual’ and ‘religious’ were used somewhat interchangeably (Hodge, 2006).

Sarason’s (2001) article concerning Community Psychology and the concept of spirituality also suggested a close relationship between religion and spirituality. Two relative facts were emphasized in this presentation. First of all, people always want to be a part of something and need meaning in their lives. He also stated that no one in this world wants to be alone. The significance of belonging as related to prevention of the miseries of isolation is outlined through his discussion of historic work (Sarason, 2001).

It has been argued in a health educational journal that spirituality research should separate spirituality from religion in order to endorse acceptance from a broader range of people. Closely congruent with nursing research, spirituality was defined with themes of connectedness, both vertical and horizontal, as well as finding meaning and purpose (Hammermeister & Peterson, 2001). In another article from educational literature, Buttery and Roberson described spirituality as providing meaning and reason (Buttery, 2005). They also believed that a person’s spirituality finds its base in genetic predisposition (Buttery, 2005).

From the Christian literature, spiritual healing is addressed by Leathard as
aligning oneself with both God and the others around us (Leathard, 2003). In an article in the Journal of Contemporary Religion, Rose (2001) discussed the confusion around the concept of spirituality. Five major religions were researched, and while there were differences, some similar characteristics seemed to emerge (Rose, 2001). Rose perceived that spirituality was not dependant upon practicing a religion (Rose, 2001). She described three characteristics: an ongoing effort, experiencing love, and an ongoing religious experience, or its comparable (Rose, 2001). “Christian, Jewish and Non-traditional respondents thought, for the most part, that all people had such experience; however, Buddhist, Muslim, Hindu and Sikh thought, on balance, the reverse” (Rose, 2001, p.200) The Buddhist professionals felt that spirituality was a more Western term, yet in their context, they made mention of connections and pursuit along a path drawing closer to mindfulness and truth. Muslims where the only group who believed that one could not experience spirituality outside of the context of religious belief (Rose, 2001).

As stated earlier, the literature has progressed greatly over the past ten years. Nursing and health education has led the way in understanding spirituality from a horizontal perspective. This perspective is important to developing effective nursing intervention. Emphasizing the need to facilitate connections would seem vital to effective peri-operative nursing care.

Defining Attributes

Walker and Avant defined the next step in concept analysis as examining the critical attributes (Walker & Avant, 2005). Critical attributes help to clarify concepts and are described as the elements that appear repeatedly in related literature (Walker
& Avant, 2005). Connectedness was the word that appeared the most frequently in the literature reviewed by this author. An important quality of connectedness is that it has both vertical and horizontal components (Chiu et al., 2004; Delaney, 2005; Martsolf & Mickley, 1998; McBrien, 2006; McSherry & Drapter, 1998; W. Murgatroyd, 2001; Newlin et al., 2002; Polautzian, 2002; Rose, 2001; Tinley & Kinney, 2007; Touhy, 2001). A few sources described this phenomenon as a building of relationships. Transcendence was another element frequently mentioned (Chiu et al., 2004; Golberg, 1998; Mahlungulu & Uys, 2004; Martsolf & Mickley, 1998; Newlin et al., 2002; Sarason, 2001; Speck, 2005). Transcendence could be described as rising above, or going beyond the normal limits. To the perioperative caregiver this could be seen as a valuable trait in surgery patients. Meaning and purpose in life are elements included in pertinent literature dating back a few decades (Golberg, 1998; Martsolf & Mickley, 1998; Miner-Williams, 2006; Newlin et al., 2002; Polautzian, 2002). Transformation, also described as recreating the self, was found to be a defining attribute and may be consistent with the process that some authors allude to as leading to change (Newlin et al., 2002; Touhy, 2001). Energy, power and force were elements often linked together in a few recent works (Martsolf & Mickley, 1998; Miner-Williams, 2006).

Two additional elements which appear together in the literature were belief and faith (McBrien, 2006; Tanyi, 2002). Belief and faith can be, and are often, associated with God or a higher power, but they can also be relative to self or others and might include a belief or faith in health care providers. Emotion is an element which encompasses many other surfacing terms, such as love, empathy, compassion.
and caring (Golberg, 1998; Miner-Williams, 2006b; Newlin et al., 2002; Touhy, 2001). Finally, a reappearing term throughout the literature was uniqueness (Mahlungulu & Uys, 2004; McSherry & Drapter, 1998; Rose, 2001; Tinley & Kinney, 2007). Article after article described attributes, but brought attention to the unique ways in which individuals display them. Many factors contribute to this phenomenon of uniqueness, such as ethnicity, gender, power relationships, religion and community. It can be noted that even those participating in a certain religious service often display a wide variety or broad continuum of spiritual practices.

Case Examples
In order to facilitate understanding of a concept, Walker and Avant’s framework requires case examples (Walker & Avant, 2005). These cases can be constructed or can be real life experience (Walker & Avant, 2005). Three different case types were selected to promote better understanding of spirituality. These cases were constructed and include the following; a model case - one that encompasses all of the defining attributes of a concept; a borderline case - one that contains some attributes but does not include all; and a contrary case - one that is clearly not an example of the concept (Walker & Avant, 2005).

Model case.

Edna was schedule for a mastectomy after a positive mammogram and biopsy diagnosis of breast cancer. The holding room nurse, Ann, noted that Edna was appropriate, but very quiet when answering questions regarding the procedure. The nurse sensed uneasiness and asked Edna if she was okay. Edna politely answers yes, but went on to explain how all of this had come at her so fast. She indicated the
anxiety was getting to her. Edna stated that it was strange to think that only a few minutes ago she had walked through the doors of the surgery center and now, she was facing surgery, general anesthesia, and the realization that in hours she would be walking out the same door without a breast. Edna indicated she was not sure she had “what it takes” to get through it all, and even wondered if all of this would ultimately be worth it. The holding room nurse questioned Edna on her support systems. Edna said she had always been very close to family, but right now it seemed that they needed support too. Edna indicated she gets strength from God and her church, but sadly admitted the events of the past few days had challenged her faith. The nurse assured Edna that soon after the surgeon marked the surgical site, Edna could receive medicine to help her relax.

The nurse anesthetist, John, and circulating nurse, Linda, entered the holding area. Ann gave them a quick report on Edna. John discussed with Edna her fears of general anesthesia. Putting a hand on her shoulder, he explained to her that he would be with her the entire time she was under the anesthetic. Linda confirmed she would be in the room making sure Edna was “taken care of.” Both caregivers proceeded through their preoperative questioning, making it a point to continue to reassure Edna. Once the room and patient were ready, John and Linda brought Edna into the operating theater. The room was made to appear as relaxed as possible. The bright surgical lights were not shining on her; the environment was relatively quiet and relaxing music was being played. Other personnel in the room devoted their attention to Edna, as general anesthesia was induced.

One week later, John received a comment card from hospital administration
with a written note attached. This card was from Edna. It described how much the staff meant to her on that day of surgery. She explained that whether they knew it or not, she gained strength from them. She also stated that she had come through a lot in the past week or so and her faith had been challenged, but she was already realizing how much she had to be thankful for and looked forward to what God and life had in store for her.

_Borderline case._

Sam, a 44 year old construction worker was going through the normal admission procedures prior to gallbladder surgery. Sam remained rather quiet and somewhat stoic in the holding room. The holding room nurse asked him if everything was okay and he politely answered yes. She asked him if there was anything he needed and he stated “just to get this over with.” He indicated he had been through difficult things before and that he could make it. When questioning Sam regarding who was with him, he replied, “no one,” but he had a friend he could call to pick him up when he was discharged.

When the anesthetist and circulating nurse entered the room, the conversation was perfunctory and to the point. As per normal routine, Sam was taken to the operating room as surgical techs connected him to monitors and scurried to finish room preparation. General anesthesia was induced and surgery continued as scheduled. Sam was discharged home and picked up by his friend.

_Contrary case._

It is the view of this author that every individual has a spiritual side. So in order to construct a contrary case, some freedom was exercised to ensure clarity.
Walker and Avant stated that invented cases can be more like science fiction at times (Walker & Avant, 2005). Many authors have used more creative approaches to case examples in concept analyses. The following case makes the point.

Gary went to work at the toy and electronics factory like every other day to repair defective products. First on his list of defective products was “Amazing Amanda,” a doll capable of multiple functions. She can sit, talk, cry, respond to simple voice commands, eat, and even wet the bed. Amanda’s problem today was that her left eye was not opening in sync with her right. This was not a major issue for Gary; he had seen this problem before. He quickly gathered his tools and went to work.

After 45 minutes or so, Amazing Amanda worked properly once again. She successfully completed all of her functions, her left eye now in sync with her right eye. Amazing Amanda was put back in her box and put back into circulation once again.

In the Model case, Edna displayed uniquely all the defining attributes related to spirituality. Sam, in the borderline case, was more difficult to understand. While he did display some of the attributes, others were not revealed. At that moment in time, little evidence of connection to those around him was displayed. Emotions were somewhat absent or possibly hidden. From the given evidence one could not conclude his spiritual well-being, but might postulate that a better connection between the patient and caregivers might improve the ultimate outcome. And then there was Amazing Amanda. While she could do so many things and looked very real, she displayed no defining attributes of spirituality. Gary had no need to provide spiritual
care to Amanda.

**Antecedents**

According to Walker and Avant, antecedents are events or things which occur prior to the identified concept (Walker & Avant, 2005). After reviewing related literature, a few themes emerged. Religious belief was included in many studies as preceding spirituality. Another antecedent is Religious practice and expression, such as church attendance, meditation, prayer, music/singing, testifying, art and literature (Banks-Wallace & Parks, 2004; Dann & Mertens, 2004; Gaskamp & Meraviglia, 2006; Leathard, 2003; Newlin et al., 2002; Polautzian, 2002; Walton & Sullivan, 2004). Life adversity/pivotal life event, which can take many different forms, qualifies as an antecedent (McBrien, 2006; Newlin et al., 2002; Tanyi, 2002). Many authors have discussed certain “places” as being associated with spiritual events (Watson, 2005; Williams, 1998). The last antecedent is physical touch and support (Banks-Wallace & Parks, 2004; Leathard, 2003; Walton & Sullivan, 2004).

**Consequences**

Consequences, in contrast, are events or occurrences that result from the concept (Walker & Avant, 2005). Five positive consequences and one negative were synthesized from this work. The positives include: coping, hope, empowerment, inner-peace, and a sense of emotional and physical well-being. Overall hope was described most frequently in the literature (Buttery, 2005; Chiu et al., 2004; Hammermeister & Peterson, 2001; Mahlungulu & Uys, 2004; Mattis & Jagers, 2001; McBrien, 2006; Tanyi, 2002; Touhy, 2001). In contrast, a negative consequence from a spiritual encounter could be guilt. Negative association was addressed in
several articles reviewed (Mattis & Jagers, 2001; McBrien, 2006; Miner-Williams, 2006).

Empirical Referents

Measuring a concept is often more difficult than it first appears. While some concepts lend themselves to quantification, others do not. It is the most abstract of concepts that are the most difficult to adequately measure (Walker & Avant, 2005). As was addressed earlier in this chapter, spirituality is generally considered an abstract concept. Even so, there are several tools already available to measure spirituality. Most tools are constructed from what are considered the defining attributes of the concept (Walker & Avant, 2005).

The Spiritual Well-Being Scale (SWBS) has been successfully used for 25 years (Fisch et al., 2003; Hammermeister & Peterson, 2001; Polautzian, 2002). The SWBS is a 20 question survey which uses a likert-type scale. In his 2002 article, Paloutzian reviewed the first 20 years after the development of this tool. He stated that 700 requests to date had been granted for its use in research (Polautzian, 2002). While it was not developed for use in nursing research, nursing is the discipline which has utilized it the most (Polautzian, 2002). The SWBS has been well-tested and is accepted as both valid and reliable. Fisch et al. compared the SWBS with assessment of quality of life in cancer patients and found SWBS to be directly related to judgments of quality of life (Fisch et al., 2003). The SWBS has constantly demonstrated reliability and validity in spiritual health measurement (Hammermeister & Peterson, 2001).

There are other tools available for addressing spirituality. The Spirituality
The Index of Well-Being is a more recent scaled developed by Daaleman and Frey (2004) for family practice health related outcomes. Daaleman and Frey’s (2004) tool contains 12 questions; “six from a self-efficacy domain and six from a life scheme domain” (p.499). They concluded that the tool was a valid and reliable index (Daaleman & Frey, 2004). The Spiritual Perspective Scale is a ten-question instrument addressing the existential aspects of spirituality (Delaney, 2005). The Spiritual Assessment Scale is a tool with 28 items looking at relational aspects (Delaney, 2005). Delaney’s 2005 research found reliability and validity in evaluation of a holistic nursing tool called the Spirituality Scale (Delaney, 2005). The Joint Commission has a tool which consists of 15 questions designed for spiritual assessment of the patient on admission (Hodge, 2006). A measure alluded to in the educational literature is the Temperament and Character Inventory (Buttery, 2005). This tool measures self-transcendence.

While these tools exist, they are difficult to apply to the surgical setting. The SWBS as well as the others are measures of a more chronic generalized state of being and are not fully applicable to the acute transitional nature of day surgery. The appropriateness of several of the individual items would be questionable in this environment. This author is working on the development of a tool more appropriate for perioperative care which requires additional qualitative research to support its validity.

Summary

The attributes, antecedents and consequences have been outlined in this chapter and provide a foundation for understanding spirituality. The clearer the
concept, the more pertinent further study can be. Spirituality can be defined as follows: a uniquely human, uniquely individual experience, transcending self, seeking to find a greater purpose and meaning by connections with others, self-value, nature and/or a higher being. These connections lead to coping, hope, empowerment, inner-peace, and a sense of emotional and physical well-being. These connections can also lead to feelings of guilt if one finds interpersonal conflict within the experience. While spirituality has been studied in many ethnic groups, gaps in the literature still exist in the understanding of spirituality among numerous additional minority groups. Other gaps in the literature can be found in the understanding of what facilitates SWB. While spirituality is unique to the individual, what general interventions would facilitate optimal spiritual care and how could these broad interventions become unique to perioperative patient need?

Strengths and Weaknesses

Walker and Avant’s framework has been criticized for developing from a positivist paradigm (Tanyi, 2002). Some would argue that such an approach would be inconsistent with a concept of such abstract nature. Yet, Walker and Avant have provided the framework from which a multitude of nursing concepts have been developed (Rodgers & Knafl, 2000). This framework has also been previously used for this particular concept (McBrien, 2006; Meravigila, 1999; Tanyi, 2002). Since the topic is important to the personal views of the author, care needed to be taken not to moralize the concept when analyzing value implications (Walker & Avant, 2005). While there is a tendency to add superfluous defining attributes when analyzing a concept, care was also taken to include only those attributes found in repetition
throughout the literature.
CHAPTER THREE

Chapter three introduces the methodology used as the framework for this study. Details of general phenomenological understandings and utilization as well as specific application are addressed. The chapter begins with an introduction of phenomenology as both a philosophy and research methodology. The two basic schools of thought are then contrasted regarding both the philosophical and methodological underpinnings. Finally, I have addressed the application of phenomenology to this study, including particulars of research design and validity.

Introduction

Phenomenology is both a philosophy and a research methodology. The phenomenologist’s cynosure is the way humans experience the world (van Manen, 2001). As individuals experience a phenomenon, phenomenological researchers search to find meaning (Creswell, 2007). The understandings are contextual and temporal. As phenomenological schools of thought developed, nursing and other researchers have taken different perspectives on how it is operationalized.

Philosophical arguments have existed regarding the correct use of phenomenology. Debates concerning philosophical and methodological distinctions of phenomenology continue (Benner, 1994; Munhall, 2007; Paley, 1997).

The focus of my research is describing the meanings of the lived spiritual experiences of patients transitioning through major outpatient surgery. Spirituality is an abstract concept. Its seemingly intangible qualities do not readily yield to quantification and precise description. The aim of this chapter is to describe the philosophical framework and methodological process of phenomenology and its
application to researching the meanings of the lived spiritual experiences of patients transitioning through major outpatient surgery.

Phenomenology as a Conceptual Approach

Phenomenology developed into two primary schools of thought in the early 1900s. The two major approaches are generally addressed when discussing the philosophical framework of phenomenology: Transcendental and hermeneutic/existential. Husserl’s philosophy formed the basic constructs of transcendental phenomenology. His student, Martin Heidegger (1889-1976), differed philosophically from Husserl. Heidegger’s work formed the foundation of hermeneutic/existential phenomenology. Appendix A is used to illustrate the philosophical definitions and methodological application of phenomenological terms associated with Husserl, while Appendix B is used to illustrate the philosophical definitions and methodological application of phenomenological terms associated with Heidegger. Scholars from these schools of philosophy share certain commonalities, yet they also possess basic differences.

The philosophical tradition was crystallized by Edmund Husserl (1859-1932), a German philosopher and was a radical departure from the classical Western philosophy of that era (Benner, 1994). Philosophers such as the logical positivists described the nature of knowledge as being that which can be perceived and quantified by the physical senses (Guba & Lincoln, 2005). To the contrary, Husserl posited that all truths cannot be measured by a mathematical-based instrument without a concern for the subjective experience (Husserl, 1913). He argued against this bias toward objective existence, as it presupposed the world.
Transcendental Phenomenology

Husserl’s (1913/31) writings led to the development of transcendental phenomenology, a conceptual approach used to describe a phenomenon as it is experienced (Rapport & Wainwright, 2006). Husserl (1913/31) claimed that by describing the way we perceive the world, we can determine the meaning of phenomena in the world. This exploration is based on putting the researcher’s assumptions and previous experiences (sedimented views) on hold so that what is examined will have a firm grounding in perception (Husserl, 1913; Rapport & Wainwright, 2006).

Epoché is the term to describe the process of suspending presuppositions (sedimented views) and is the basis of Husserl’s (1913/31) ideas about scientific inquiry. He explained that knowledge is gained when we suspend all assumptions (those cultural views that constitute the “natural attitude”), thereby bracketing the world in order to clarify its essence (Husserl, 1913). Husserl (1913/31) stated, “We put out of action the entire ontological commitment that belongs to the essence of the natural attitude, we place in brackets whatever it includes with respect to being” (p. 111). The term transcendental comes from this context and basically means a state in which the phenomenon is perceived, as if for the first time or without any prior frame of reference or sedimented views. Husserl (1913/31) described that all preconceived ideas need to be set aside in order to clearly see the world. In the state of pure consciousness, the mind can focus on objects of consciousness, whether they are physical or abstract concepts (Husserl, 1913; Rapport & Wainwright, 2006).
The essence of a phenomena is beneath our preconceptions and is understood when the basic structure, or parts, are viewed un tarnished in our pure conscious (Husserl, 1913; Rapport & Wainwright, 2006). Husserl (1913/31) wrote of the essence of a phenomenon being discovered when its basic structure is clear and complete. The essential structure (essence) identifies what a phenomenon is and what it is not.

The Hermeneutic Phenomenology

In contrast, Heidegger (1927/62) believed that we cannot separate ourselves from the world. His ideas form the framework of hermeneutic/existential phenomenology. Heidegger’s (1927/62) Being and Time, focuses on the individual within the lifeworld. Lifeworld, or being-in-the-world, describes how humans make meanings that cannot be separated from the world in which they live. While Husserl (1913/31) and Heidegger (1927/62) both posited that people are embedded in the world so that their lived experience is sedimented within cultural, social and political contexts, it was Heidegger’s position that the researcher cannot just set it aside. Heidegger (1927/62) utilized the term throwness to indicate that humans are cast into existence. Throwness is a phenomenon of one’s existence being not of choice. An individual is essentially placed in the world from which they make meaning. Fundamental meaning is defined through their existence and context. Hermeneutic phenomenologists postulate that the meaning of existence lies within the individual’s narrative. Thus, humans are embedded in a world experienced through language. The language provides a person with understanding and knowledge (Heidegger, 1927/1962).
Hermeneutics is a process for interpreting language in text format and is described by Heidegger (1927/62) as a method of textual understanding. The word hermeneutics was derived from the Greek god, Hermes (van Manen, 2001). It was Hermes’ role to interpret and communicate messages from the gods to mortals (van Manen, 2001). During the Renaissance, this methodology became central to the efforts of interpreting the Bible (Benner, 1994). It was presented as a principle foundation for the humanities in the 19th century by Wilhelm Dilthey (1833-1911) (Dilthey, 1987; van Manen, 2001). It was further developed in the 20th century by Martin Heidegger and Hans-Goerg Gadamer (1900-2002), another German philosopher and a student of Heidegger (Benner, 1994; van Manen, 2001).

Gadamer’s (1960/75) main philosophical hermeneutic work was *Truth and Method* (Benner, 1994; Gadamer, 1975).

*Dasein* is an important hermeneutic concept introduced by Heidegger (1927/62). While the word literally means being there, Heidegger (1927/62) stressed that *dasein* was not just about being there, but included being engaged in the world. Being is not that of a subjective and an objective, but is that of coherence of existence (Heidegger, 1927/1962). Interpretation is a natural part of what humans do and is fundamental to *being-in-the-world* (Dreyfus, 1991; Heidegger, 1927/1962, 1962). Heidegger (1927/62) believed we approach understanding of being with preconceived (sedimented) ideas from world experience. He spoke of a 3-fold fore-structure; (a) *fore-having*, our practical familiarity with the experience; (b) *fore-site*, the point of view we have entering into the experience; and (c) *fore-conception*, the preconceived expectation expected from the experience (Benner, 1994; Heidegger, 1927/1962,
Hermeneutic Phenomenology and Existentialism

Heidegger’s (1927/62) phenomenology essentially encapsulates both hermeneutic and existential philosophy. Existentialism is a school of philosophy whose practitioners focus on the state of existence or the experience of being. The philosophical framework of existentialism was introduced to western philosophy by Soren Aabye Kierkegaard (1813-1855). The continued development of the philosophical concepts of 20th century existentialism grew from Heidegger’s and the post WWII French philosophers’ (Jean-Paul Sartre and Maurice Merleau-Ponty) work (Benner, 1994). Most existentialists view the world as an “absurd universe,” one in which meaning is not inherent; thus, individuals are essentially free to create their own meaning (Camus, 1991). Contrary to Husserl’s (1913/31) writings about consciousness preceding meaning, existentialists posit that meaning resides within a context of existence, preceding essence and consciousness (Earnshaw, 2006; Kierkegaard, 1843/1985). The early existentialist, Kierkegaard (1843/1985) indicated understanding of existence stems from understanding where one finds meaning.

Knowing how an individual’s perceives reality, leads to a better understanding of the language used to describe their existence. Todres and Wheeler, (2001) posited that knowing an individual’s ontological view of being-in-the-world, is the first step to understanding their world. Being-in-the-world is not a one dimensional experience (Merleau-Ponty, 1962; van Manen, 2001). Merleau-Ponty (1962) posited that all humans experience the world through four fundamental existential themes: lived space (spatiality), lived body (corporeality), lived time (temporality), and lived
human relation (relationality). Spatiality is the perception or feelings created by the space around us (Merleau-Ponty, 1962; van Manen, 2001). For example the huge space of an indoor football stadium may make us feel rather small or inconsequential. Corporeality refers to the fact that we are always physically or bodily a part of the world (Munhall, 2007; van Manen, 2001). Temporality refers to “subjective time as opposed to clock time or objective time” (van Manen, 2001, p.104). It might be well described by the expression “time flies when we’re having fun.” Finally, relationality is the interpersonal space we share with others. Fundamentally, these four existentials provide a window as to how one experiences the world. Van Manen (2001) wrote, “this is not difficult to understand, since about any experience we can always ask the fundamental questions that correspond to these four lifeworld existentials. Therefore, spatiality, corporeality, temporality, and relationality are productive categories for the process of phenomenological question posing, reflecting and writing”(p.102).

Another important aspect of existentialism is the rejection of logical reasoning. Contrary to hermeneutics, existentialists argue against humans as rational beings. Essentially, decisions are made based on individual meaning as opposed to objective rationality. This philosophical view was thought to be a reaction to traditional western philosophies. Existentialists described that human decisions are frequently made based on emotions, addictions, whims, and other non-logical reasons. The concept of existential anxiety is based upon this premise. Kierkegaard (1843/1985) stated that if everyone was rational, then there would be nothing to fear. Existentialists posit that terms of a human’s existence are crucial to language
and textual interpretation (Todres & Wheeler, 2001). Without these terms, it is impossible to fully understand the meaning of their dialogical language. This concept is fundamental to the philosophical connection between existentialism, hermeneutics and interpretive phenomenology. Hermeneutics/existential phenomenologists go beyond a simple description of a phenomenon as taken from narrative (Dowling, 2007). Heidegger (1927/62) argues against the ability to describe a phenomenon without an understanding of the ontological view of the participants and their context and called for the utilization of appropriate contextual interpretation.

*Phenomenology as a Methodological Approach*

It is important that methods agree with the philosophical foundations of the research being conducted (Lopez & Willis, 2004). None of the phenomenological philosophers discussed in the previous sections of this paper developed research methods (Dowling, 2007). Giorgi (1997) argued that to participate in scientific research, the philosophical framework must be operationalized. The two major philosophies subsequently lead to two similar but distinct methodologies.

The two distinct phenomenological schools of thought have been operationalized by researchers. Transcendental philosophy led to a descriptive methodology, while hermeneutic philosophy became the foundation of the interpretive methodology. Both descriptive and interpretive phenomenological methodologies take an emic approach, realizing the participant as the authority.

*Descriptive Phenomenology*

The outcome sought when using a descriptive methodology is a rich description of the essential structure of a specific experienced phenomenon. This
description is void of any interpretation or self interest of the researcher (Paley, 1997). Appropriate questions are those asked by researchers seeking a description of the essence of an experience or phenomenon.

The first step in descriptive phenomenology is *bracketing* the world. The researcher must set aside all preconceptions and assumptions before addressing the phenomenon. The concept of *Epoché* is addressed methodologically by attempting to explore a phenomenon only as it is experienced. In the process of phenomenological *reduction*, descriptive phenomenologists often describe an experience of being lifted above the world, to then look upon it with keener vision (Giorgi, 1997; Rapport & Wainwright, 2006).

Consistent with transcendental philosophy, the data are only collected from people who have experienced the phenomenon being researched (Creswell, 2007). The data sources are most often verbatim transcribed interviews. Moustakas (1994) described the process of *horizontalization*, in which significant statements or sentences that lead to understanding are highlighted. The highlighted data from all interviews are placed in clusters of meaning, or themes (Creswell, 2007). Descriptive phenomenologists search for certain features of lived experiences that are shared by all who experience them. The features form the basic structure of the phenomenon. Descriptive phenomenologists strive for the result of an intrinsic meaning (*essence*) within the context (Rapport & Wainwright, 2006). A thick description, with all preconceptions and assumptions of the researcher set aside, is the final outcome of thematic analysis.

Modern descriptive methodologies draw from the phenomenological
psychology work of Giorgi (1997), Van Kaam (1966) Colaizzi (1978) and Moustakas (1994) (Creswell, 2007). Moustakas’ popularity comes from his guidelines for major procedural steps to the descriptive process (Creswell, 2007; Moustakas, 1994). Van Kaam and Colaizzi (1978) also made major contributions to procedures of data analysis (Colaizzi, 1978; Creswell, 2007; Van Kaam, 1966). Nursing researchers who contributed to the descriptive phenomenological approach early in its development include Davis (1973), Oiler (1982) and Knaack (1984). More recent descriptive phenomenological nursing researchers who have contributed to descriptive phenomenology are Wheeler, Clark, Wall and others. Wheeler has written several articles dealing with phenomenological research, and along with Clark, conducted research on the phenomenon of caring (Clark & Wheeler, 1992; Todres & Wheeler, 2001). Nurses and nurse educators Wall, Mitchinson and Beech have published on descriptive phenomenological methods, specifically related to bracketing, in nursing research (Beech, 1999; Wall, Glenn, Mitchinson, & Poole, 2004).

_Interpretive Phenomenology_

As would be expected from the philosophical framework, interpretive phenomenologists take the position that the researcher cannot be separated from the world in which they are embedded. Interpretation encompasses both the interpreted and the interpreter in dialogical interaction, and is the basis behind the hermeneutic utilization of the term co-creating (Benner, 1994). An interpretive phenomenologist starts by exploring a phenomena within the lived experience, and then, through reflection and further analysis, arrives at the goal of discovering the meaning.
Understanding the meaning of the lived experience is gained through constant reworking of interpretations. The interpretation of meaning is a *co-creation* between the interpreted and the interpreter. When discussing the methodology of interpretive phenomenology, Lopez and Willis (2004) stressed that meaning is not always apparent to the study participants, but “can be gleaned from the narratives produced by them” (p. 728). It is important to understand that the interpretation is a joint effort involving the participants as well as the researcher.

The hermeneutic circle is essential to interpretive phenomenological methods. Hermeneutic methodology assumes that humans are social dialogical beings (Benner, 1994). Hermeneutic inquiry is a process that results in a meaning related to a specific context and time. Humans are always in a hermeneutic circle (Benner, 1994; Heidegger, 1962). Interpretation involves movement back and forth between initial understanding, refocusing and further understanding (Benner, 1994; Heidegger, 1962). The hermeneutic circle is dynamic and has no clear end. Hermeneutics is based in wholeness and context (Benner, 1994). Understanding the text as a whole involves understanding the context, and repeatedly moving from an individual focus to the big picture.

Data or material are gathered in much the same way as descriptive phenomenology, minus the *bracketing* process. Thus, the researcher begins from a ego-logical starting point of personal experience (Creswell, 2007). Transcriptions of in-depth interviews provide the bulk of the data for further analysis. Most often these transcriptions are subsequently coded into themes. Rapport and Wainwright (2006)
said that interpretation of themes “is achieved, by the circular process of continuous re-examination of propositions” (p.233). This process potentially includes revisiting participants and recoding. Munhall (2006) argued we must be careful about reducing material into themes because of the potential loss of individual meaning. Two major assumptions of this process are: (a) perceptions provide us with evidence of the lived experience, and (b) our existence is meaningful (Morse & Richards, 2002). Congruent with existential philosophy, researchers must find meaning from a co-constructed reality. If one has the assumption of existence as meaningful, then what gives it meaning must be understood.

Two hermeneutic/existential phenomenological researchers with whom this author shares similar philosophical views are Max van Manen and Patricia Munhall. Van Manen focused on the lived experiences of learning in children and applied a hermeneutic approach to his educational research. Patricia Munhall is a nursing researcher who approaches phenomenology in much the same way. Her method of phenomenological inquiry is philosophically congruent with van Manen, but she takes a more operationally stepwise approach (Munhall, 2007). This approach is generally easier for novice phenomenological researchers to follow.

Application

The motivation for the extensive review found in the previous sections was not only for a greater understanding of phenomenology, but to provide a foundation for application of its philosophy and methodology in my personal research. The following sections will be utilized to support the congruency of phenomenology with researching the meanings of the lived spiritual experience of patients transitioning
through major outpatient surgery. It will address the conceptual fit of hermeneutic/existential phenomenology as well as the methodological application of interpretive phenomenology to this research.

*Philosophical Suitability*

The spiritual experience of individuals is indeed a unique phenomenon (Mahlungulu & Uys, 2004; McSherry & Drapter, 1998; Rose, 2001; Tinley & Kinney, 2007). The terms, uniqueness or individual, appear over and over in the nursing literature regarding spirituality. The definition utilized for this research comes from my recent concept analysis defining spirituality as: A uniquely human, uniquely individual experience, transcending self, seeking to find a greater purpose and meaning through connecting with others, self, nature and/or a higher being (Griffin, 2007).

Heidegger’s (1927/62) *lifeworld* is based on the idea that individuals are embedded in a world from which they find meaning. Spirituality is a part of this lifeworld. Cultural, political and social circumstances all greatly affect the way individuals experience spirituality and how they make meaning from it. A spiritual phenomenon is not something you visualize a person experiencing. Language is the key to understanding such an encounter. Hermeneutics, a process for interpreting language in text format, is at the core of understanding spirituality in this context. It is interesting that the word hermeneutics came from Hermes, a Greek god who interpreted messages between gods and mortals, which in itself has a very spiritual connotation (van Manen, 2001). Further proof of the hermeneutic spiritual connection is evidenced by Crotty’s (1998) definition of hermeneutics as the science
Dasein, an important hermeneutic concept of Heidegger’s (1927/62), stressed not just being a part of the world, but being engaged in the world. Connection resides at the core of spiritual experience and is a similar concept to being-in-the-world. Two attributes that are important to consider when conceptualizing spirituality and connection are: (a) it is not just about a vertical experience (God and/or a higher being), but (b) is also a horizontal experience (self, others, society/community and nature) (Chiu et al., 2004; Delaney, 2005; McBrien, 2006; Wanpen Murgatroyd, 2001; Newlin et al., 2002; Polautzian, 2002; Rose, 2001; Tinley & Kinney, 2007; Touhy, 2001). Many authors considered the human spirit as that which allows one to interact with the world on a higher cognitive level (Cloninger, 2004; Watson, 2005a).

Existentialism has many philosophical underpinnings that share congruency with human spirituality. As discussed earlier in this chapter, Kierkegaard (1843/1985) indicated understanding of existence stems from understanding where one finds meaning. He posited that individuals relate their existence to one of three spheres: aesthetic, ethical, and religious (Kierkegaard, 1843/1985). It is not hard to make the association between at least two of these spheres, religious and aesthetic, and human spirituality. Furthermore, the four existentials (Merleau-Ponty, 1962; van Manen, 2001), provide an enticing way of approaching the meaning of spiritual experience. One must also understand the ontological views of an individual in order to find the meaning of their textual language regarding spirituality.

Considering the unique individual nature of spirituality, it is philosophically difficult to describe all spiritual experiences from any one presupposed context (i.e.,
that of a particular religion). Moreover, it is also difficult to reduce participants’ experiences into a few precise themes. The individual nature of spirituality requires realization of the ontological and epistemological views of both the researcher and the individual participant and application of those views to a specific context and time.

Research Design

The philosophical framework of this research was operationalized congruent with interpretive phenomenological methodology. The research was conducted from an emic perspective, realizing the participant as an authority.

In accordance with interpretive phenomenological methodology, the bulk of the material took the form of textually verbatim accounts of in-depth interviews. The meanings of the spiritual experiences resided within the textual descriptions. This was only the beginning, as understanding required in-depth interpretation. The philosophic methodological approach of van Manen formed the foundation for this study while Munhall’s (2007) stepwise approach guided the methodology. This combination is referenced by the exemplars in Munhall’s (2007) text.

Sample Selection

The research participants were recruited through a purposeful criterion based sample. Creswell (2007) emphasized criterion sampling as being congruent with phenomenological research, because it is essential that participants have experienced the phenomenon. Munhall (2007) also expressed the importance of recruiting individuals who are interested in speaking about the particular experience. The researcher desired to interview five to ten participants who met the criterion.

Research participant inclusion criteria
Participants had just completed major outpatient surgery, defined as surgery requiring general anesthesia with an operating room time in excess of one and a half hours. Participants were over the age of twenty-one and were fluent in English. Participants desired to participate in an in-depth interview and were available for potential future consults. The participants’ personal definition of spirituality did not affect their inclusion in the sample.

Research participant exclusion criteria

For the purpose of this study, participants were excluded if: (a) they experienced a complication the day of admission requiring a higher level of care, (b) they were assigned an American Society of Anesthesiologists (ASA) classification greater than III, (c) they were diagnosed as mentally challenged (d) or they experienced a significant post-operative complication in the days following the surgery requiring unanticipated medical care.

Irrelevant criteria

Spiritual belief, gender, ethnicity, and religion did not exclude a participant from the study. While religion, and spirituality as a whole, was viewed non-pertinent to the initial consideration of the individual, the participants were encouraged to discuss individual spirituality and associated religious experience throughout the interview.

Protection of Human Rights

All surgical patients could be considered vulnerable. This vulnerability is arguably exaggerated by participating in a research study (Leavitt, 2006). Protection of all participants is vital. While Federal and institutional safeguards are in place for
the protection of study subjects, the ultimate responsibility still fell on the researcher (National Institute of Health, 2004).

Participants signed the Agreement to Participate form (Appendix C) prior to participating in the research. This form clearly stated that they do not have to participate in the research and that they would not be disadvantaged in any way if they declined. It was also clearly noted that they could leave the study at any time of their own choosing, should they no longer feel comfortable. Participants did not need to feel that they were forced to be a part of this or any study (Mendias & Guevara, 2001).

Participants were also advised, through their agreement to participate, that their names and information would be kept confidential to the extent allowed by law. Only the primary investigator and his chairperson, had access to the names. Materials have remained locked in the office of the primary investigator and all audio tapes will be destroyed following final verification of transcription. There is no need to publish the full names of any participants in the final research report.

The primary researcher requested and was granted approval from the Institutional Review Board (IRB) of both the University of Hawaii at Manoa and Memorial Medical Center of Springfield, Illinois.

Co-Researcher Recruitment

Participants in the research were recruited from patients receiving major outpatient surgery at the Baylis outpatient center of Memorial Medical Center (MMC) in Springfield, IL. MMC is a not-for-profit community based medical center with 562 registered beds. Eighteen thousand nine hundred and eighty four total
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surgeries were performed at MMC in 2007. In 2006, MMC received Magnet recognition in nursing excellence from the American Nurses Credentialing Center.

Patients who were anticipated as meeting the criteria were approached by the nursing staff during the outpatient surgical unit admission process. If they showed initial interest in being a co-researcher, then the Research Questions and Answers for the Participant outline pamphlet (Appendix D) were briefly reviewed with them. Once a participant agreed to be a co-researcher, their contact information was given to the primary researcher for scheduling of the initial interview.

In addition to the experience, a small gift card ($25.00) was given to all study participants. While no model of reimbursement or payment fits all research situations, the researcher in this study believed that the small gift would promote community and principles of justice while avoiding any undue inducements (Sears, 2001). The participants were appreciative of the gift cards.

Reflection and Decentering

Munhall (2007) described the importance of taking the time to “reflect on your own beliefs, preconceptions, intuitions, motives, and biases so as to decenter” (p.170). This researcher, as well as many, believes that to totally cast ones own ideas and thoughts aside is an impossible thing to do (Heidegger, 1962; Munhall, 2007; van Manen, 2001). That being said, purposeful exploration of one’s own thoughts on a phenomenon, and subsequent liberation from the preconception to the greatest extent possible is vital to discovering the true meaning of a researched phenomenon. As discussed earlier, Munhall (2007) referred to this as “unknowing,” but truly it is another form of knowing. The researcher’s role in this process is of vital importance.
Later interpretation by the researcher requires an initial realization of his own experience with the phenomenon (Creswell, 2007). Thus, understanding builds from this point, and it is reinforced through further revisiting by both the researcher and the study participants.

Van Manen (2001) described different ways of reflecting on one’s own beliefs. This researcher has never experienced major outpatient surgery as a patient. So reflecting on the phenomenon from that perspective would not be possible. As a nurse anesthetist, however, I have participated in the experience with literally thousands of patients over the past thirteen years. Therefore, I have many preconceptions of the phenomenon.

The researcher’s preconceptions were discussed thoroughly in Chapter One in the discussion of theoretical and practice considerations of spiritual experiences in outpatient surgery. The discussion need not be reiterated at this time, but will be revisited by the researcher throughout the study in order to maintain proper perspective. The four existentials unearth unique preconceptions that must be set aside.

In addition, application of existential philosophy requires realization of one’s own reality, as well as an open-minded understanding of reality. The personal ontological spiritual views of the researcher will be realized, but cannot shape or change what is spiritually real to the participant. This context of understanding spirituality is quite complicated and must be acknowledged yet set aside. Spiritual views are often closely associated with specific religious teachings (Wachholtz, 2007). Many religions are based on a single concept of reality; not allowing for
alternative views. To truly understand the spiritual experience of an individual, the researcher must realize the ontological view of the participant.

Interview Setting

It was the intent of the primary researcher for the initial encounter to take place within two weeks of the surgery. The primary researcher offered options to the participants regarding meeting locations. If preferred by the participant, the meeting took place in their home. The use of a mutual public location was also made available and utilized when desired by the participant. If the participant was of the opposite sex, the principle investigator was accompanied by a female to both of the above locations. The facilitating female did not participate in the interview itself. Finally, if it had been desired, the meeting could have taken place in a conference room made available at Memorial Medical Center in Springfield, Illinois. As expected most of the participants lived close to Springfield, since that was the location of the outpatient surgery center. One resided three hours away. The researcher worked to create an environment of trust, with assurances of privacy. Follow-up interviews could have been housed at any of the different locations, but primarily consisted of phone interviews, because of the goals of the encounter.

The pamphlet description (Appendix D) of the research study, as well as the signed Agreement to Participate (Appendix C), were thoroughly reviewed with the participant prior to beginning the interview. The demographic Data sheet (Appendix E) was also filled out with the participant prior to the initial question.

Demographic Data

Interpretation of the textual accounts of the interviews were relative to the
individual participants lifeworld (Heidegger, 1962; Munhall, 2007; van Manen, 2001). While a multitude of factors make up the lifeworld, basic demographic data is important information that could enhance understandings of the meanings of the spiritual experiences. Information collected on the Demographic Data sheets (Appendix E) consisted of age, sex, ethnicity, educational background, religious and or spiritual orientation, basic surgical history (types of previous surgeries), and identification of the surgical procedure just completed.

Central Interview Question

As addressed earlier in this chapter, the primary investigator conducted the semi-structured interviews. The initial and central material generating question was:

“In relation to going through the entire outpatient surgical experience, describe your experiences and what they meant to you.”

Topical Questions

Since the primary researcher has had limited experience with conducting interviews and in order to gain richer information into the topic, a list of open-ended questions was assembled and made available for prompts during the interviews (Appendix F). Creswell (2007) advocated subquestions as a way of keeping the interview focused and to enhance the researcher’s narrative construction. The researcher’s goal is an existentially based narrative text; thus the subquestions were grouped relative to the four existentials of experiencing a phenomenon (i.e., temporality, spatiality, corporeality, and relationality).

Method of Material Collection

The material for the research was gleaned from four primary sources:
1. Verbatim transcripts of the audio-taped interviews.

2. Journal notes kept by the researcher immediately before during and after the interview (focusing on non-verbal cues) and related to interactions with those positioned around the experience.

3. Journal notes made by the researcher during review of the interview video.

4. Journal-type notes recorded as “memos” in the Atlas.ti® program while studying interview texts.

Material Storage and Management

The researcher had the audio taped interviews professionally transcribed. Once the transcriptions were received, they were checked for accuracy by the researcher. The transcripts were then placed in the qualitative analysis scientific software program Atlas.ti®. The original copies were lock-box secured and the program hermeneutic unit was password secured for access by the primary researcher.

While Atlas.ti® has several functions; it was utilized for this research primarily as an organizational tool for material management. It allowed for quick access to memos and code assignments. It also enabled organization of text into the four existential units.

Material Analysis

The researcher utilized Munhall’s (2007) Method for Phenomenological Inquiry to analyze the research material (p.154). The flexible stepwise approach was not intended to be utilized literally as successive steps, for some of them are, and others can be concurrent processes (Munhall, 2007). A broad outline of these steps is
as follows:

1. Immersion
2. Coming to the phenomenological aim of the inquiry.
3. Existential inquiry, expressions, and processing.*
4. Phenomenological contextual processing.*
5. Analysis of interpretive interaction.
6. Writing the phenomenological narrative.
7. Writing a narrative on the meaning of your study.

*concurrent processes

In the following section, each step will be reviewed and an outline of the particular application to this study will be discussed. As has been previously emphasized, the steps were not necessarily completed in succession. Some of them were initially addressed, and were continually revisited throughout the research experience.

**Immersion**

Munhall (2007) described the initial action of immersion as studying and describing the underpinnings of a phenomenological perspective. Besides studying the basics of phenomenology found in qualitative doctoral classes, the researcher completed an intense independent study on the philosophy and methodology of phenomenology with Dr. Joan Dodgson at the University of Hawaii Manoa. A description of basic understandings was presented at the beginning of this methodology chapter. Appendices A and B provide definitions of basic concepts of each approach.
Two additional elements are addressed in Munhall’s (2007) description of the operationalization of immersion. One involves the ongoing practice of phenomenological questioning. The researcher has been, and will continue, practicing these interview techniques both formally and informally. Secondly, Munhall (2007) discussed “becoming your study” (p.168). To truly become a repository for the experience, it is suggested that the researcher must go well beyond academic exercise; it needs to become a passion within (Munhall, 2007). Congruent with most who are investing themselves in a dissertation; this researcher has no problem identifying with the subject matter on a higher level (passion), versus that of routine academic exercise.

Coming to the Phenomenological Aim of the Inquiry

Four activities are listed by Munhall (2007) to help the researcher address the aim of the phenomenological study. These were covered extensively in chapter one. Both van Manen (2001) and Munhall (2007) allow for some creativity when coming to “unknowing.” The reflection was framed relative to the four existentials.

Existential Inquiry, Expressions, and Processing

This step appears to this researcher to be somewhat overlapping, yet a natural outgrowth from the immersion and phenomenological aim process. It involved, in part, a heightened attentiveness to not only self, but those around the experience; providing expressions from those who have experienced the phenomenon, as well as those who were engaged in that experience. In this research, the expressions from the co-researcher are primarily in the form of verbatim transcriptions of interviews. The information deemed from others engaged in the phenomenon were represented in
journal notes taken by the researcher in relation to interactions with other perioperative caregivers. Journaling did not only serve this purpose, but was an ongoing process of recording personal observations from the interviews, as well as thoughts and other “ah-hah” moments occurring throughout the study.

Munhall (2007) also encourages the researcher to engage in the arts in order to develop deeper understanding from aesthetic experience. The researcher is encouraged to keep narratives of such experience. Munhall (2007) went on to write, “If you find a paucity of material in this realm, begin to write verse, take photographs, or paint to represent what you have heard from your participants or from your own soul or spirit” (p.190). This was very intriguing to this researcher, since I have often reflected on feelings in the form of verse or songs, several of which are published. To this researcher poetic or lyrical reflection frequently serves as a way of focusing thought processes. Prior to the construction of the final narrative on meaning, my thoughts did take the form of a simple song of reflection.

Phenomenological Contextual Processing

Munhall (2007) listed the following as ways to achieve phenomenological contextual processing; a) Analyze emergent situated contexts, b) Analyze day-to-day contingencies, and c) Assess life-worlds (p.156). Each individual narrative was described from an individual experience. In contrast with many phenomenological studies, the discussion did not focus on grouping or reducing the narratives to common themes, but centered on individual descriptions of the experiences of participants framed in their lifeworld through a spatiality, corporeality, temporality, and relationality perspective. Munhall (2007) emphasized that people do not talk in
themes. Though ultimately, for ease of development, the similarities and differences were thematically discussed as they matured in the final narrative of meaning.

*Analysis of Interpretive Interaction*

The previous steps in combination led to existential expressions of the spiritual experiences of major outpatient surgery. The researcher applied the philosophical underpinnings of phenomenology to contextual processing. Meanings were expressed through integration of language (voiced and non-voiced), context, thoughts, emotions and feelings. The non-voiced information resided in the journal notes of the primary researcher relating to expressions and body language noted during the interview. Participants were revisited throughout this process of discovery.

*Writing the Phenomenological Narrative*

A vivid narrative was written describing the experiences and meanings gleaned from the research. The writing was framed in the four existentials. Care was given to be inclusive of “particular” experience and meanings, not just “general” interpretation. The writing is inclusive of language and expression situated in the context. The text appeared as if narrating individual stories of major outpatient surgery and spiritual experiences. The participants were a part of this ongoing process through validation of their expressions and meanings.

*Writing a Narrative on the Meaning of Your Study*

The final step addresses the broad focus of the study. What did this all mean? As health caregivers, what was the relevance of the phenomenological discovery? This is the point that the passion of the researcher is truly revealed. Interpretation has
small and large system meaning. It is the hope of the researcher that the narrative will have multimodal implications. Nursing is a service-based profession. It should be our desire to improve quality of life. The researcher desires that knowledge of the meanings will lead to enrichment of care through the perioperative period. Munhall (2007) expressed understanding of meaning as the beginning of intervention, and went on to emphasize the importance of the patient’s perspective.

Establishing Validity

The correct method of establishing validity in qualitative research has been argued by numerous researchers (Creswell, 2007; Lincoln & Guba, 1985; Morse & Richards, 2002; Munhall, 2007). Some go as far as to argue that measurements of validity have no place in qualitative work (Creswell, 2007). Even the term validity is viewed by many qualitative researchers as too quantitative. They prefer a different vocabulary (i.e., the replacement of “validity” with “trustworthiness”). While arguments continue, this researcher believes establishing validity or trustworthiness to qualitative research remains crucial.

While many strategies exist, Creswell (2007) argued that researchers need to choose an accepted strategy, and then use it to validate the study. One such strategy that has stood the test of time is that of Lincoln and Guba (1985). They recommended substituting the concepts of reliability and validity with the terms trustworthiness: truth value. These words represent the credibility of a qualitative research study. Applicability, in essence, is the transferability of results, and the consistency of the research becomes the dependability and confirmability of the results (Lincoln & Guba, 1985; Morse & Richards, 2002).
Credibility

Several terms are used to describe credibility in qualitative research. Leininger (1994) used words such as “truth,” “value” and “believability” to discuss concepts of study credibility (p.105). Establishing “truth” in a study involves attention to several research dynamics. In particular, emphasis is placed on: a) prolonged observations and engagements, (b) review from both emic (participant) and etic (outsiders view) perspectives, (c) and triangulation of material (Leininger, 1994; Morse & Richards, 2002). These three concepts will be discussed in the next few paragraphs.

Prolonged observations and engagements were initiated by the researcher through the appropriation of adequate time for interviews, observations, and revisiting of material. No time limits were placed on any interviews or research interaction. In addition, ensuring comfort and confidentiality encouraged more honest engagement, promoting free dialogue. The researcher feels that this effort led to interaction at a deeper and richer level.

As discussed earlier in this chapter, the participants were revisited to insure accuracy and appropriateness in translation. This review is imperative for research credibility (Munhall, 2007). Review with outsiders was approached in a few different ways. At the initiation of the analysis of interpretive interaction phase, the researcher met with the dissertation chair to review initial demographic data, transcripts and journal notes together. The researcher has also arranged for peer reviews of the overall essence of the research study. Reviewers included a PhD nursing researcher, a PhD psychologist, and a nurse anesthetist. It is anticipated that the material gained
from these sessions enhanced the credibility of the research as a whole.

Triangulation of all sources of material was imperative to success of the study (Munhall, 2007). Collaborating evidence strengthens the research. The materials included transcripts, journal text, Atlas.ti® memos, and demographic information.

Transferability

Transferability refers to the ability of the reader to transfer meanings from the research to other experiences of similar context or situation (Leininger, 1994). This becomes a unique philosophical concept in phenomenology in that meanings are constructed as contextual and temporal. Therefore, the research is not designed to produce generalizations that widely apply to all related situations, but provides meaning and knowledge from a particular phenomenon which can have particular inference to similar experience. Rich thick description is the building block of transferability. The final step in Munhall’s (2007) method, *writing a narrative on the meaning of your study*, is necessary toward establishing what the research means for nursing. The researcher feels that transferability was fully addressed in this section.

Confirmability

Confirmability as addressed by Leininger (1994) “means obtaining direct and often repeated affirmations of what the researcher has heard, seen or experienced with respect to the phenomena under study” (p.105). Evidence, in part, comes from the participant’s reconfirmation of findings and meanings. In addition, external sources play an important role. The presence of “audit trails” within a study are key to establishing confirmability (Lincoln & Guba, 1985). The dissertation chair was the primary reviewer of the audit trail.
Limitations of the Study

All research methodology has limitations. Sometimes elements viewed by some as strengths are perceived by others as weaknesses. In the ensuing paragraphs the researcher addresses a few potential limitations of interpretive phenomenology; a) time, b) lack of inference, c) leveling of banality, d) and potential bias, followed by the particular limitations of this study.

Time is a distinct issue facing the phenomenological researcher (Benner, 1994). Conceptually, the hermeneutic circle is never ending, yet realistically, a research study must end at some point in time. An interpretive phenomenological study requires an extensive commitment and an abundance of the researcher’s time.

A phenomenological study is not predictive. Phenomenology does not infer anything; it is used to describe an experience relative to a context and time (Morse & Richards, 2002). However, understanding a phenomenon is valuable and should have significance in understanding future events (Benner, 1994; Munhall, 2007).

One argument in hermeneutic phenomenology is that when an account is reworked over and over, it loses its context and is what Dreyfus (1991) referred to as “leveling of banality” (p. 267). Heidegger (1927/62) also made a similar philosophic reference in his writings. There is a possibility a phenomenon may actually degenerate when it is placed in the context of some form of understanding outside of the specific contextual experience (Benner, 1994).

What is argued as a strength of interpretive phenomenology is viewed by some as a weakness or limitation. The restructuring of the researcher’s own understanding being acknowledged as a part of the research experience is viewed by
many as a critical error creating bias in the research (Benner, 1994). Yet, it is arguable that all research is subject to bias. Benner (1994) stated that interpretive phenomenology tries to approach this issue by uncovering and addressing such biases.

The limitations particular to my research that were anticipated prior to the study were: (a) the layered interpretation implications of a particular definition of spirituality (i.e., the abstract nature of spirituality leads to multiple understandings of its basic, overall meaning. Because spirituality is an abstract concept, it may be more complicated to understand in the context of outpatient surgery), (b) the study was limited to participants from the Midwest in order for the researcher to conduct the interviews and (c) the number of participants was limited (5-10).

Conclusion

Conducting phenomenological research requires a complex understanding of both its philosophical underpinnings, and its methodological application. The researcher must be cognizant of the different schools of thought and the many ideas that encapsulate its utilization in research. The aims and goals of the study were appropriate for the phenomenological method utilized.

This study, aimed at describing the meanings of the lived spiritual experiences of patients transitioning through major outpatient surgery, was correctly addressed from a phenomenological standpoint. More specifically, the ideas founding hermeneutic/existential phenomenology, and its application through interpretive phenomenology, were well suited for researching meanings of the spiritual experiences of patients transitioning through major outpatient surgery.
CHAPTER FOUR

Phenomenological Narrative

Consistent with Munhall’s (2007) method of phenomenological inquiry, chapter four will be utilized to reflect upon each individual participant’s spiritual experience as they transition through major outpatient surgery. The descriptions will be presented case by case with pertinent meanings organized within the context of the four existential life-worlds. For ease of data management, each participant will simply be referred to by an assigned number (1-7). Working definitions of the italicized spirituality terms are represented in Appendix G at the end of this manuscript. The chapter will conclude with a brief collective review of the experience culminating with the identification of emerging themes.

Twelve participants were initially recruited by the Nursing staff of the Baylis outpatient center of Memorial Medical Center. Two were contacted, but ultimately could not participate because of complications which excluded them from eligibility. Two participants ultimately declined the interview, and one could not be reached within the two weeks from surgery time-frame set forth in the study design.

A total of seven individuals participated in the study, three men and four women. The ages ranged from thirty-one to sixty-three years. All the participants were Caucasian. Four were college graduates; one had some college; one graduated high school and one did not finish high school. All participants indicated they were raised Christian; two indicated they were involved in a Baptist church, two were Methodist, one was Catholic and two indicate they do not participate in any religious activities. All participants had experienced prior surgeries. The above paragraph’s
information was primarily captured in the Demographic Data Sheet for each participant.

Participant One

Participant one was a sixty-three year old Caucasian female. She is a long time breast cancer survivor who was having bilateral breast reconstruction surgery secondary to unsatisfactory results from prior breast surgery. She was very anxious to share her story and required minimal prompting throughout the initial interview.

Temporality (lived time)

One of the first desires of participant one was to begin the description of her surgical experience, not with the surgery itself, but with the medical, surgical and spiritual experiences leading up to that day. To her, the spiritual experience began long before the actual arrival to the surgical center. Later descriptions continued to bounce back and forth between current and past experience. Not that the surgery itself was insignificant, but rather she regarded it as a distinct point on a long running timeline of dealing with the effects of cancer. That timeline and the story it represents must be known in order to understand how she experienced this surgery. The negative nature of her previous surgery created a cloud which negatively skewed her perception of how her current surgery would transpire, both physically and interpersonally.

Another significant experience in temporality was evident as the participant described waiting for her surgeon, who was perceived as late for the procedure. In the initial interview significant statements regarding the surgeon’s lack of punctuality were made a total of sixteen times. Anxiety escalated as the time of wait wore on,
And I sat there in that little room there, and I think they - that’s what the problem was. They were waiting for the doctor because she was late. And that did kind of key me up. Because when you’re supposed to be ready to go at a certain time, you get in there on time and then you wait - and they kept saying, well, we’re still waiting for the doctor. So I’m by myself, sitting there and then they’d come in and check on me. That was very nerve wracking.

The participant perceived that time should have an order, and the deflection from her understood schedule created a tension that challenged her wellness. She described time as moving very “slow” throughout the wait. The participant did admit that having some personal time allowed her to pray and seek strength from God, yet as time wore on anxiety and doubt began to creep in, in essence negating much of the spiritual gains made through prayer. While time really dragged on during the waiting period, once the surgeon arrived, she indicated time seemed to fly by.

Relationality (lived human relation)

Descriptions of the human interactions encountered during the perioperative period dominated the initial interview as well as most subsequent contact with participant one. Within this context, two particular people became the main focus. While these were her main focus, oddly enough they resided at two different ends of the interpersonal spectrum. One could be classified as a biogenic (life-giving) relationship while the other biocidic (life-destroying).

The interactions between the participant and her surgeon were very low level. The level was greatly influenced by previous experience. Participant one entered the surgery arena harboring a lack of trust for her surgeon. She described laboring over
the decision whether or not to stay with her physician, ultimately deciding to do so.

Once at the surgery center the lack of punctuality of the surgeon, as perceived by the patient, only fueled the fire of mistrust, even adding an anger component. This set the stage for what would be an initial biocidic human interaction at the surgery center.

As described by the patient in a couple of interview segments,

She came in with her street clothes on, flying in and out. Which makes me feel bad. I don’t know, I’m sorry. I just feel like, I’m just - like you say, it’s one of those assembly line things, I don’t know.” “But I just, I’m sorry I didn’t trust her. And I shouldn’t say this, should I? But I just was afraid. So that’s why - so anyway…

One can see how the interactions described above negatively affected the participant’s spiritual wellness as she transitioned through the surgical experience. Because of the lack of time given to the patient and the superficial low level interaction, she felt very much like an object, devoid of human qualities. This was made evident by the reference to an “assembly line.”

In contrast, the participant’s interaction with her “primary nurse” (PN) was quite life-giving. She described an initial interaction that quickly made her feel at ease. This interaction and subsequent exchanges with PN lead to a significant change in the trajectory of her spiritual wellness. She described PN as being nurturing and peace giving. She also discussed a certain informal quality that PN possessed and its association with helping her feel at ease and “human.” The participant mentioned multiple times how PN utilized humor throughout the experience, stating she “made me laugh, which…that, all that is involved with your peace of mind.”
As further evidence of a high level interaction, PN was addressed throughout the interview with descriptions giving her god-like qualities, even distinguishing her as an extension of God. Statements such as, “guardian angel,” “cool little angel,” “its nice to have angels,” [she] “took care of everything,” [she] “makes everything fine,” and “So I just felt like everything was going to be okay and that [PN] was His voice,” all gave PN God-like qualities.

Other peri-operative providers also were described in a positive manner by the participant. Statements related to their honesty and confidence were used when explaining how they gained her trust. The participant also mentioned the word “smile” or “they were smiling” multiple times when discussing her caregivers. In later discussions, the participant equated smiling people as being welcoming, inviting and comforting.

The positive experiences seemed to be divergent from the participant’s preconceptions of how it would be. The following statement made by the participant, “I’m sorry, I can just say nothing bad about this place” might seem contradictory in that one would think this ‘good’ thing would not necessitate an apology. Only in context does it make sense, as it appears the apology is to herself.

While statements were made regarding caregivers in a positive manner, when asked for additional specifics, the conversation seemed to always go back to PN. Her connection to PN seemed to permeate everything, shaping her perception of all the unnamed peri-operative staff. She indicated that others were not as “warm and fuzzy” as PN, but overall, interactions with all staff changed her spiritual trajectory.

Finally, it should be noted that the participant had very little support from
friends while at the surgery center. She described having a lot of friends and having a lot of support during previous surgeries. But the friend she had with her this time was very tired because of work responsibilities and, thus, was unable to stay with her during the entire surgical event.

*Spaciality (lived space)*

Consistent with the participant's focus all along, the description of her environment focused on people. All spaciality prompts led to descriptions of the people she saw in different areas of the environment. What she saw when entering the operating room was lots of people, “a lot of smiling people.” For the most part she could not identify exactly who those people were, only that they were smiling (welcoming). Truly, these caregivers were her perceived environment. She did not notice any of the equipment, chairs or tables.

When asked about the surgical room environment in particular, she also stated that God was there. She literally said that she looked for ghosts but all was well. She believed God was in control. This feeling relieved much of her anxiety.

*Corporeality (lived body)*

Fear of disfigurement resided at the center of participant one’s concerns. Because of previous history and related outcomes, she wrestled greatly with whether or not to even have the surgery and with her choice of surgeon. She desired not only a good outcome, but a final one as well. This inner struggle played havoc with her spiritual wellness long before even arriving to the surgical center. She understood that she was given a wrong implant in her initial surgery, and could not understand how that could happen. She could not let go of her feeling of fear and mistrust.
Participant one had difficulty dealing with the fact that she would not have control at the point at which the new implant would be put in place. She discussed looking over the implant choices during her “brief” preoperative meeting with her surgeon. She also described trying to find them once she entered the operating room, “Like I said, I kept looking. I did look around, trying to find the implants.” Her fear of anticipated disfigurement was so overwhelming it overshadowed the whole experience. She did not express any concerns with physical safety issues.

The participant did mention the comfort she received post-operatively when the nursing staff brought her warm blankets. She also felt very cared for and comforted when the nursing staff offered her juice and crackers. In her words, “…and then they gave me the juice and the crackers and all this stuff. I said, they were just, they were like mother hens and their little chicks…. I said, I just felt like, “oh, wonderful.”

Participant Two

Participant two was a fifty year old female who had breast reconstruction surgery secondary to breast cancer and bilateral mastectomies. She had no previous surgical experience prior to her cancer diagnosis. She lived in a rural Southern Illinois setting, not far from a small farming/mining town. She presented as very stoic and seemed to struggle some sharing the intimacies of her experience.

**Temporality (lived time)**

Much of the second participant’s spiritual experience of surgery is found within the opening statement of the initial interview and can be associated with the lived time of her outpatient surgery. She stated,
Actually, I was relieved that I was finally getting this last surgery, because this was the third one that I - it was basically finishing up something that had began way back in February of this year. And I had lots of people praying for me; my church family, my own family. And I just felt like, praise the Lord, I’m finally getting to hopefully the end of this long year that I’ve had.

Her spiritual experience of outpatient surgery began nearly a year before, when she discovered she had breast cancer. She hoped that this experience would be the end of her journey. *Spiritual preparation*, while not totally complete, began a long agonizing year prior. As the interview progressed, a greater sense of a prolonged anguish was evident.

While the time waiting and preparing for surgery seemed quite long, in contrast the actual peri-operative experience at the surgery center was described as “very quick.” Processes moved in an organized manner and expectations were basically met. The participant perceived that God had things in control and that the timing was “right.”

Finally, it is interesting to note the participant was very aware of the actual time during the surgery center process. Throughout the interview she commented on time as it related to when an event was occurring, such as, “I knew the time exactly. It was a quarter till four.”

*Relationality (lived human relation)*

Participant two’s spiritual experience of human relationships began with the confidence and support she gained from her home church family. Reflections upon their intercessory prayers and the connected support it gave her were made multiple
times throughout the interview and subsequent contacts. Her husband was also a big part of her support system. That being said, it was interesting to reflect back on the transcriptions and see how she also felt the need to support him. This allowed her to retain an important role that she has played for many years. A small piece of control in an environment she could not otherwise control.

Participant two had a high level interaction with a surgical nurse that greatly surpassed any of her expectations. She connected with who she later referred to as “My Nurse” (MN) because MN had had a similar experience and was willing to share it with her. The relationship became “personal” which nurtured the participant’s spirit. The participant perceived it as being sent from God.

She’d already experienced the surgery basically that I was getting ready to have. And just kind of - you just - when you connect with somebody you just feel a little more at ease because they have been there. She encouraged me and she said, oh, you’re going to feel much better once the expanders are out and the other ones are put in. We kind of laughed about that, but yeah, take off some bricks here. So it just, and my husband and I looked at each other because he was in the room with me, and we just kind of got that look like, here’s God’s hand again. Giving me an RN that’s already been where I’m going.

It is also important to note how humor was utilized to also diffuse anxiety and promote the relationship. The participant was surprised at the willingness of the nurse to share this experience with her. She also was ultimately surprised at herself for being able to open up as well. The participant was pulling down barriers and was
becoming much more personal and vulnerable than she had planned. This is illustrated by the remainder of this description.

And it’s funny because I showed them what I looked like before the surgery because my procedure had been done differently. And they were curious about what I looked like. And it didn’t bother me to share it with them and I think it was because she had been there. And she even said, well here, I want you to feel what it’s going to look like afterwards. She stood up before she left and let me actually touch her. She said, you’re going to feel so much better and this is what you’re going to feel like…. I was a little bit surprised because that’s…but I guess she felt that connection even with me, even by me sharing and showing her where I had been.

The connection made between MN and the participant and the significance of the resulting spiritual effects were easy to see. MN had responded to her patient’s vulnerability by becoming much more vulnerable herself. It was after describing this interaction that participant two referred to MN as “My Nurse.” This interaction and the mutual vulnerability had everything to do with the participant perceiving that the timing of this surgery was “right.”

**Spaciality (lived space)**

Participant two included very little description of her physical environment even when prompted. It seems as if the surroundings, for the most part, were very much as expected. She did however mention the surgical table multiple times. As she entered the operating room she described that the surgical table appeared “very narrow” to her. She questioned in her mind what would happen if she was much
larger in stature. She also noted that it appeared to be turned in a different direction related to what she had experienced in previous surgeries. Throughout the initial interview she used phrases pertaining to the smallness of the table and the way in which it was placed in the room a total of nine times. In addition to the table, she also mentioned the bright surgical lights.

Finally, she discussed the multiple people moving throughout the environment. She commented that most of them took time to introduce themselves to her, but she did not remember who they were or the role they played. They appeared to be doing “their thing.”

Corporeality (lived body)

As the participant reflected on experiences of the past year, she focused on the fact that it had been tougher than she expected. Initially she thought the cancer had been caught in its early stages and that she only had a small “stage 0” lesion. She then discovered shortly after her mastectomy that the cancer was much more advanced, including “stage 4” lesions in both breasts. The chemotherapy, while curative in nature, was viewed as an obstacle to healing. She perceived that it led to complications which prolonged her ability to reach the final reconstructive surgery. She desired a “normal” body again.

Consequently, this surgery was viewed as a desired final step. Prayer support was aimed at facilitating an end to the cancer and her lack of normal functioning. She did not fear the surgery and was relieved it was finally here. Upon entering the surgical room, she was relieved to be anesthetized. It needed to be finished so she could feel whole again. Surgery was anticipated, not as a barrier but as a physical
Participant two dealt with issues related to loss of control. She described the feeling of waking up in the recovery room and fighting to stay awake. When asked why, she commented that she was worried what she might say or do while being half asleep. She also expressed discouragement when she realized that drain tubes were left in her body. This was viewed as a barrier to her ability to function independently once she arrived back home. She did not want to appear “needy.” Ultimately her coping mechanisms were adaptive and focused on the reality that some things are simply uncontrollable. Her physical body was under attack, but because of her faith she surrendered that control to God. As stated in her words,

I learned that I was not in control, the doctors were not in control, even though they had their plans set up and we were going to do this, this, and this. As things progressed, everything got changed. So I realized then the Lord was in control of it. And that’s, I guess, why I had to walk through it the way I did.

The patient believed that she needed to accept God’s control in the situation because she knew that if her spirit was at ease, then it would, “enable my body to be at ease.” The whole experience, from discovery to what is hoped to be the end was perceived by the patient as a spiritual exercise.

I just think that things had to – I had to go through different things…actually I think God was dealing with me through…(pause)…while things got more complicated and what they were. For me to grow, my character to grow and to trust – (pause) because I had never been sick and all of a sudden I had this major life
changing illness.

To participant two, death meant a better place, so fear of mortality was not an overriding issue. Her main goal was that God would be glorified through her life, whatever happened. Small events throughout the surgical experience, such as the interaction with MN helped her to resolve that God was indeed in control and that things would be alright.

Participant Three

Participant three was a forty-nine year old male who was a truck driver prior to going on disability related to a shoulder injury. He had experienced multiple surgeries on his shoulder and underwent shoulder arthroplasty surgery this time, to remove painful hardware. He lived in a small house very near the hospital.

Temporality (lived time)

As the initial interview progressed, participant three quickly began discussing an earlier surgery. The conversation then moved from this surgery to an in-depth description of the entire sequence of events surround his shoulder injury. As the story continued, he described events of infection, immobility and pain that eventually led to feelings of anger and despair. He discussed the challenges he faced in deciding whether to proceed or not with his current procedure. He had many doubts concerning his last surgery. He felt that placing the hardware as planned would ultimately lead to greater pain issues. Interestingly enough, his concerns became reality, leading to a need to have it removed. Thus, it was made quite clear that this surgery was a small part of a much bigger picture. It was difficult for the participant to express any feelings concerning this surgery without mixing them with prior
events. He spent many hours reviewing options and scenarios in preparation for this surgery.

Particular to this surgical center event, the participant had two contrasting stories related to concepts of time. He initially felt like time was standing still as he waited to move into the initial stages of the process. He described becoming very “tired of waiting.” He also complained of the length of time before his pastor was allowed to come back to visit and pray with him. He could not understand why they the staff did not realize that he should just come on back. Once things began to happen, such as changing clothing and getting his IV, things were perceived as moving exceptionally fast.

While perceived time moved at different rates throughout the process, participant three was aware of actual time, and viewed events as having a schedule. His perception was that all-in-all, things “went with the program” and did not vary greatly from a prearranged plan. His only anxieties related to the actual time of waiting before his pastor was allowed to visit with him prior to the procedure.

Relationality (lived human relation)

Participant three did not expand on relationships within the hospital. Consistent with his theme of connecting this event to his other surgeries, he did state that he felt as if the staff at this day surgery center cared more than those at prior facilities. He felt that he connected some to surgery personnel. His was able to connect more with those he perceived as giving him their time. He also stated that honesty and confidence were traits that facilitated connection. There was no evidence of high level interpersonal interactions with the day surgical center staff.
The participant spoke of the importance of the time he spent with his pastor. As stated earlier, he did not understand why his pastor could not spend more time with him and was frustrated by this. Ultimately the pastor was able to spend some time praying with him. The pastor was viewed as an extension of God. He stated, regarding the short prayer time with the pastor, “Basically gave me the assurance that everything was going to be fine and the Lord was looking after me.”

*Spaciality (lived space)*

The hospital environment was viewed by this participant as a place where he could focus on healing. He wished that he could stay there longer so he would not have to worry about other things. In contrast, the participant associated his home with worry and discomfort. He feared that once he left the day surgery center, added pressures would come on him. He also worried about the physical comfort of a bed at home that was not adjustable, to relieve pressure on his shoulder. As anticipated, the participant shared he was having difficulty gaining physical comfort at home.

Objects in the pre-surgery holding room appeared much as anticipated. The participant paid very little attention to their physical properties. He did discuss that the table in the operating room appeared very small and the lights appeared quite large. The desired anesthesia medication came shortly after he was positioned on the table.

*Corporeality (lived body)*

When discussing physical issues, the participant was quick to state that his expectations of gaining any real use out of his shoulder were slim to none. The initial injury complicated by a muscle wasting MRSA infection had destroyed the tissue.
He had researched options, but worried about aggressive procedures that require grafts from other sites stating that it just means another body part could be messed up. He did not worry that this surgery could disrupt his shoulder because “the damage is already done,”

The participant’s main focus was pain relief. He has dealt with pain in his shoulder for years and wanted to see an end. He desired that the pain be gone. The pain has become his identity. He predicted that it would get worse after the last surgery and it appeared that his life was now ruled by it. He even joked that he can predict the weather each day by the way his shoulder is feeling. Thus, it was not surprising to hear him say that the first thing he remembered when waking up from the anesthesia was requesting a pain medication. While, as predicted, it has been uncomfortable recovering at home, he was seeing a change in the way his shoulder felt and had confidence that things will be better.

Another interesting concept is the way in which the participant perceived anesthesia. He equated it with a near death experience. At one point he said,

Yeah, that’s what I was thinking too with this operation. You know, the anesthesia, that’s a rough deal, anesthesia is. One little mess up and it’s a matter of being dead or alive … and I let the man upstairs take care of worrying about it for me.

As he perceived that it is totally out of his control, he was able to delegate it to God. Knowing this helps one to understand why he placed the importance on the visit from his pastor.

Participant Four
The fourth participant was a 62 male factory worker. He underwent a left shoulder rotator cuff repair/reconstruction. He had a similar procedure on his right shoulder four years prior. The previous surgery had a good outcome and the participant was quick to indicate he was satisfied with this experience so far.

*Temporality (lived time)*

Participant four entered the actual surgical experience perceiving that there would be a certain order to things. He was very aware of actual time throughout the process. One of the first things he mentioned was that it was about one hour and forty-five minutes after his arrival before he actually went back to surgery. That being said, he did note that he had arrived about an hour before he was instructed to. This did not strike him as being too early.

Once he was in the holding room, he had a longer wait, related to a delay in the arrival of his surgeon. As stated by the participant, “...the surgery was scheduled for 10:30 and the doctor got held up somewhere and I didn’t get in there until 12:30.” While all the waiting seemed long to the participant, interestingly enough it did not seem to be associated with anxiety.

Participant four came to the surgery center with a positive expectation. His past surgery had gone well and he greatly trusted the surgeon. While he did not know why the surgeon was delayed, he perceived it as necessary. He believed he probably got tied up with someone that required more of his time. He stated, “I mean it happens…I was hoping it’d be the same thing for me if it happened to me.” The participant indicated he planned to just “go with the flow.” Thus, a two hour delay seemed to slow time, but did not create a *negative deflection* of his spiritual well-
being. When asked directly about this, the participant responded, “Even though there was a two hour delay, they…me and her [wife] sitting there and talked for two hours. They kept coming in and checking on me. I didn’t have any big problems with that.”

Once the surgeon arrived, He perceived that things moved quite fast. The only subsequent event that appeared slow was waiting in the recovery room for the requested pain medications to work. Ultimately, comfort was achieved. The patient knew the precise time (6 pm) that he was discharged.

Relationality (lived human relation)

As addressed earlier in this section, the participant had a lot of trust and respect for his surgeon. This relationship developed prior to this surgical experience through earlier patient physician interactions. The participant commented both on the care he had received from him, and the “time” that the physician would give to him. Because of this high regard, the patient’s spirit was put at ease. In the participant’s own words, “I mean, if you got confidence in your doctor, you’re probably not too worried about what’s going to happen.” It was as if the surgeon held a supernatural quality to control outcome.

As for the other caregivers, the participant felt they did a “fine job.” There was little evidence in our discussions of any extra special interactions that occurred between the participant and the nursing staff. Statements such as, “they were nice enough” and “you could trust them” were made throughout the interview. When asked why he could trust them, he responded that they did what they were suppose to do and also added, “Everybody I talked to seemed like they were pretty confident and knew what they were doing. That’s what I put my trust in.” He even stated that he
trusted the students, if they talked like they knew what was going on. Age also promoted trust as the following quote suggests.

The anesthesiologist was a middle aged guy at least, and that means, at least he knows what he’s doing. He’s done it before, you think. The nurse I’d been talking to, she was middle aged. That meant at least she knew what she was supposed to have been doing.

The participant also mentioned that the nurse who worked with him regarding his post operative pain did what she “needed to do.” To him she had fulfilled her basic role as a recovery room nurse. In the participant’s words, “well, you gotta trust people when you’re in that situation because they’re the ones doing you, you know?” I believe it was a little difficult for him to truly admit he was giving up total control.

Spaciality (lived space)

Participant four did not describe much of the physical surgical environment until prompted to do so. Consistent with other responses, he first stated that they seemed to have everything they needed there. He described his preoperative holding room as “just a plain room. A couple of chairs and a computer in it.” He thought that the computer was probably just for business use and was pretty confident it did not have any games on it. The surgery center was there to do its business. The participant desired to get things done then go back home to heal. He did notice that the operating room appeared “sterile and barren” and thought that the surgical table “wasn’t much.” He later described it as a “little uncomfortable bed.” Participant four stated, “The anesthetist said I’m going to give you the shot now and that’s all I remember.” The physical environment very much met his expectations as a place that
would provide effective, efficient care. It was a safe place but not necessarily a place of comfort. Participant four found comfort in his home and was anxious to get back there.

Corporeality (lived body)

Participant four described that he was not afraid for his physical safety throughout the surgical experience. He regarded himself as an “optimistic guy” who has been there before. Besides having the benefit of a positive prior experience, he also had great confidence in his surgeon. As predicted, most of the experience went much as planned.

The only unexpected physical outcome occurred during the initial recovery period in the Post Anesthesia Care Unit. The participant’s blood pressure was running high and that concerned him. He did not understand why, but thought it was related to pain. As addressed earlier, the pain was eventually relieved. In the participant’s words “I finally got rid of it. So it only took about four - three or four shots.” The utilization of “only” and “three or four shots” in the same sentence indicate the positive approach to the experience that the participant had.

The patient also thought he would be hungry, but once he started trying to eat, he realized different. Eating was nauseating to him.

I thought I’d get a Saltine and a can of soda. But my mouth was so dry from the anesthesia that the more you chewed the Saltine the bigger it got. And you couldn’t drink enough soda to get rid of it. That was pitiful, let me tell you, so I just kind of forgot that deal. I drank a soda and got rid of that one cracker finally. That was all I could handle of that. Of course I kind of thought I was
going to get sick there for a minute or two but that didn’t happen.

Participant four spoke of things as he perceived they were going to occur instead of how they occurred (I thought I would get, I thought I was going). He had preset expectations for much of the experience. Ultimately, what he actually needed was a good mouth “lubricant.” All in all, he perceived that things went okay and that his body did well, in his words because, “they let me go home.”

Participant Five

Participant five was a sixty-one year old female. She was having a mastectomy and reconstruction. She learned she had breast cancer only a couple of weeks prior to the procedure. She was initially very nervous concerning talking about it, but was willing to participate. In later communication, she indicated actually talking about it was somewhat therapeutic.

Temporality (lived time)

The spiritual experience of having an outpatient mastectomy began two weeks prior to participant five’s arrival at the surgery center. When prompted to start at the beginning, she began describing what it was like to hear that the results of her biopsy indicated that she would require a mastectomy. She described it as being totally unexpected, because she had understood that the chances were very high that no further procedures would be necessary, “and they didn’t give me a lot of time, two weeks. I guess maybe two weeks before I actually had the surgery.” In some ways the two weeks crawled by, in others ways it flew. Participant five indicated that it took the full two weeks just to be okay with the surgery and she was still “scared to death.” “Okay” seemed to be a relative expression, indicating only that she had
enough strength to consent to the procedure.

Participant five arrived at the surgical center 45 minutes early but was taken immediately back to the holding area. Her case had an afternoon start. She spent her time in the holding room, wishing that it was all over. At this point in the interview, she said under her breath, “Yeah, basically just talked and wishing this was over with (pause) … about a month ago.” The participant wanted the cancer to be over with. In her grand timeline, the surgery was an important pivotal point in what she perceived was a long road ahead.

*Relationality (lived human relation)*

Participant 5’s husband was her major source of support while at the surgical center. She spoke as if that was a given. He helped her while she was waiting, but also was a help to her later, just knowing he was there. He seemed very protective of her while I visited for the initial interview.

Otherwise, she did not identify anyone at the surgery center with which she had a high level interaction. She did think it was nice that the anesthesiologist took time to explain things to her, and connected with one nurse because she “gave her time” by seemingly breaking her regular routine and talking with the participant about other things except surgery.

*Spaciality (lived space)*

Participant five had little to say regarding the holding room, but did remember some outstanding things about the operating room. She was struck by all the people that were in the room when she arrived. “They all said their names and introduced theirselves *(sic)* and [how] they would be taking care of me. But I don’t really
remember any names or anything.” She also commented twice on the “huge lights.”

The surgery center was perceived as a safe place. With so many unknowns in her life, it was nice to be near medical help. In contrast, the participant’s home was a source of anxiety which will be discussed in more detail in the following section.

_Corporeality (lived body)_

There were three major issues that the participant was dealing with in relation to her physical body. Fear of the surgery itself, fear of recovering at home and ultimately fear of her mortality. These three will be discussed in the next few paragraphs in that order.

As addressed earlier, learning that she needed a mastectomy “scared her to death.” She realized only a couple of weeks ago that her body had been invaded by cancer and now she was facing major surgery. The participant required an anxiolytic medication as soon as she arrived at the surgery center. That being said, she seemed to fear the outcome of the surgery more than she feared the procedure or the anesthetic itself. How would she deal with the disfigurement and insult to her body?

The patient greatly feared “going home” after surgery. Upon further exploration with the participant, her fears were directly related to physical safety. Her home was in a very rural area, miles from any hospital and greater than fifty miles from her primary doctor. She questioned herself over and over regarding what she would do if she started bleeding or something else bad happened. She worked to rationalize with herself,

I would have felt more comfortable even staying one more day at the hospital because I could see an improvement……. I realize a lot of people go through
a lot worse, then come home. But it’s still fairly traumatic.

Interestingly enough, while she did not suffer any complications, she ultimately did stay at the hospital for a day. Her concern was somewhat self fulfilling.

Even though she had significant fears related to the procedure and the initial recovery period, these were somewhat dwarfed by her ultimate fear of immortality. She feared that the cancer could win. During the interview she expressed that her greatest fear related to the procedure was “that maybe they wouldn’t get it all this time too.” She could not control the cancer and she was having difficulty spiritually dealing with it. She stated that she just took one day at a time. She desired it to be over and gone all together, but at this point she just “had to come to terms with it.” She said she had “faith that it would be okay,” but again, “okay” seemed quite relative.

Participant Six

Participant six is a thirty-eight year old female. She is a nurse who practices in a urology office. This procedure was a vaginal hysterectomy and was her third surgery, but second “major” operation. She indicated on the Demographic Data Sheet that she was raised Christian, but did not attend any particular church.

Temporality (lived time)

The participant began the initial interview by stating that her surgeon was late. While it did not seem to cause a great deal of anxiety, she was well aware of a delay in her progress. Thus, time seemed to move very slowly during the first part of the experience. Once he arrived, things were perceived as moving rather quickly.

In order to put this perioperative experience in context, she reflected on a
surgery that took place a few years prior. The participant had a biogenic interaction with her anesthesia provider during the earlier surgery that extended into the current procedure. The connection led to her ability to cope with the uncertainties of the current anesthetic. She also related a specific fear of the operating room that was carried over from an uncomfortable event that occurred at the onset of that same previous surgery.

Participant six mentioned numerous times throughout the interview how she appreciated the nursing staff and other care providers who “gave her time.” Whether it was during preoperative visits or in the actual perioperative environment, the participant welcomed caregivers being available to her.

Relationality (lived human relation)

As described in the previous paragraphs, participant six felt connected with the caregivers she perceived were giving her extra time. Those who checked-in on her, those who gave her extra attention, those who sat down with her, were all an important part of the process. She also found it important that caregivers displayed confidence. Because of this, she perceived that individuals at the surgery center knew what they were doing.

Most of participant six’s support and higher level interactions came from, or occurred with, individuals outside of the surgery center. Her husband, for example, provided basic support not because he was always with her, but in her words, “just the fact of knowing that he was going to be there and that he would be there when I woke up.” In addition, her surgeon took the time during the preoperative visit to thoroughly explain the procedure and answer all her questions. This relieved much of her
anxiety. The trust that she gained in her surgeon helped to shape her later perception concerning why he was late for her surgery. She did not know, but thought he was probably helping an expectant mother in the obstetrical unit.

Finally, her highest level interaction, and the one that might have had the greatest impact on the procedure, occurred years prior, during a previous surgery. As addressed earlier, an anesthesia provider earned her trust which allowed her to feel comfortable with the anesthetic. She viewed anesthesia as near death. She needed to feel safe and allow him to control that which she could not. His knowledge, honesty and humor all worked together to promote the connection. Below is a small part of the description of their interaction.

He did sit down; he didn’t chuckle at me or think that it was an inappropriate question, which was nice. Whether he thought it or not, he didn’t display that. He looked at me, he answered my question, because it was truly a fear. He said, ‘I can’t guarantee you, nothing’s ever 100%’, which I understand that. At the end, he just patted my leg and said, ‘but don’t worry, I haven’t lost one yet’. And chuckled, and that’s just what I needed.

The relationship with the provider helped participant six to be at peace with the uncertainty she was facing. As result of their interaction, she was able not only to let go of her fears for that surgery, but was able to quickly establish a trusting relationship with the anesthesia provider in her current procedure.

Spatiality (lived space)

As a nurse, participant six has worked almost every day in environments that resembled a lot of the areas in the outpatient surgery center. Thus, the waiting and
holding space appeared much as expected and felt comfortable and safe to her. The people working around her represented much of the experienced environment. She indicated it was important to know their names so that they were not “strangers” working on and around her.

The operating room was a different story. Participant six requested a sedative (Versed) prior to entering that venue. Because of prior experience, and what the surgical theater represented, the participant did not want a memory from the operating room. That being said, she stated that she vaguely remembers being placed in a supine position on the table. Perhaps the stimulation of movement compounded with the peak of anxiety overcame the amnestic effect of the sedative. That indeed is her only memory of the operating room from this outpatient surgery. Moreover, the patient indicated she is glad that she doesn’t remember the operating room.

Home was also an important topic discussed by participant six. The participant referred to going home as a good thing. Home was more comfortable. Home was where she could recover. Participant six even made a point to state that she required less pain medication at home. She truly was ready to be home. In her own words,

It’s just more of a soothing environment ... It was just being at home. It was my bed, my pillows. Being where I felt, I don’t want to say safe, because I felt safe at the hospital too. But this is my home. And I know where things are and I know - that’s just hard to explain. But they’re my surroundings. So that was okay.

Corporeality (lived body)
Participant six focused on three major areas when addressing issues of corporeality. The initial issue was more predominant with prior surgery, yet deserves attention. The participant had a morbid fear of anesthesia. She equated it with near, or possibly actual death. She questioned whether or not she would ultimately “wake-up.” In her previous surgery, it was the first issue she raised when she arrived at the hospital. As discussed in the earlier paragraphs, an interaction with an anesthesia provider helped put her at peace with the issue. Once she was able to trust the caregiver, she became comfortable with him controlling what she could not. As also addressed earlier, the developed trust led to the capacity to more easily trust her anesthesia providers during the hysterectomy. Thus, her related anxiety with this experience was minimal.

Other physical concerns of the patient were also addressed prior to actually arriving to the outpatient surgery center. Participant six described her need for information regarding exactly how the repair would be done and to a greater extent, how it would affect her future. As a nurse in a urology office, she dealt with many women who had physical issues years after having a hysterectomy. Her desire was to find some sort of hope that this would ultimately not be her outcome. Having precise information regarding these issues was an important part of her feeling safe with the procedure. This information was provided to her by her surgeon during a preoperative visit. In her words, “once I had the answers that I needed for that, then I was fine with the surgery.”

Finally, important information regarding vulnerability surfaced at the end of the initial interview. As stated earlier, the participant did not want to remember the
operating room. There are several reasons for this, but one particular occurrence in her previous surgery might indicate why it had become an even bigger issue. As we further explored this subject, she explained that she remembered them removing her pants while she was drifting off to sleep and she described it as being humiliating. While she knew it had to be, she did not desire to experience it.

I can remember them pulling my pants off before I was ever under, and I did not like that feeling… (pause) … No. It just, it did not seem right to me.

Because you’re starting to go under, oh here, it was just like I wasn’t a person. We’re going to take these off; we’re going to get this started, blah, blah, blah.

Wait a minute, I’m still awake!

This experience was obviously very humiliating to the patient and became a focal point of the current procedure. Participant six desired not to face this level of vulnerability again.

Participant Seven

Participant seven is a thirty-one year old male. He injured his shoulder while working as an engineer on a bridge building project. He underwent a Left shoulder reconstruction. Prior to the interview, while reviewing the consent, he explained that he was not a very spiritual person and was not sure if he could help me. I assured him that his experience was important to this study.

Temporality (lived time)

At the onset of the initial interview, after being asked the opening question, participant seven began to describe to me how he was injured and the events which led up to his surgery. He did this in order to help me understand his practical
approach to the procedure. He viewed the surgery as a means to an end. Not a big
deal, “just an obstacle” to move past. The surgery had to be done in order for him to
function as he wanted, without constraint. The “big picture” was his injury and road
to recovery. The surgery was a point along that progressive timeline.

He appraised outcome based, in part, on his previous surgical experience. He
knew that a prior surgery went fine, so perceived that this one would as well. Once
he made the informed decision to have this surgery, he was ready to move on with it.

Actual time in the perioperative environment was observed closely.
Participant seven knew the time he arrived, the time he went back to the holding area;
the time he was awakened in the recovery room and the time he went home. He even
stated the time he first left his home to travel to his parents after the surgery. Over
all, he perceived time at the surgery center as moving “very, very quick.” This was as
he desired.

Relationality (lived human relation)

Participant seven did not identify anyone in particular, or any interaction at
the actual surgical center as standing out above the rest. He was satisfied with care
and indicated his basic needs were met. Most of his confidence with the procedure
was the result of his confidence in the surgeon. He described meeting with the
surgeon well before the surgery to discuss options. The surgeon impressed the
participant with his knowledge and experience. To participant seven, this was most
important. The biggest part of his anxiety was relieved during the preoperative office
visits, as is illustrated in the following quote,

It was his ease about discussing what would happen and what possibly could
happen as fallouts, and having ready memorable access to the statistics about the primary downfalls of the surgery that he was suggesting and the recovery rate. And he didn’t have to refer to some website or some reference manual or books or anything. He knew what he was focused on and had ready knowledge of that at his - at the tip of his tongue to allay any of my fears that I may have had…(pause)… And was very, very knowledgeable about what he was going to do and how he was going to do it, and said that he has performed a number of these particular procedures in the past. And he’s had a very good success rate. So for me and in my mind, a good track record is a good track record and I am not so abnormal that I would be that - I have a whole lot of chance of being that one anomaly for him. So basically that was what pretty much set my mind at ease.”

Once again, the participant displayed a very pragmatic approach to his upcoming surgery. He trusted the outcome to the surgeon, who he appraised as having the appropriate knowledge and experience.

In contrast to his desire for information from the surgeon, the participant indicated he did not want much information from the nursing staff at the surgical center. As stated in his words, during the perioperative period he liked “talking more about mundane life things; you know, how are you doing, how’s the weather, this and that kind of thing.” He had received the needed information preoperatively; had found resolve, and now it was time to get over the obstacle and move on. Again in his words, “I kind of took it at face value and just wanted to have it done.”

*Spaciality (lived space)*

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Participant seven found most of the surgical center environment to be as expected. The waiting area, the changing and holding area all felt like a basic doctor’s office. He even referred to the space as resembling what one might see on a medical television show or movie.

The operating room was a little different. While he said all along that his anxiety level was low, he did raise some interesting pictures when describing the operating room; pictures that would indicate some uneasiness with the environment. His focus once he entered the operating theater was on the operating table and the lights. He stated that he really didn’t notice much else. His description was quite telling; “So I remember the bright, the surgical lights and the table that was - it was almost like a crucifix but the arms weren’t quite straight out.” He then went on to describe a device on the table that was there to hold his body in lateral position for the surgery. He described it as being “kind of amusing.” During the interview, I sensed that this amusement was more him coping with discomfort than actually thinking it was funny. Perhaps, fulfilling his male role expectation, along with his desire to seem in control, made it difficult for him to admit anxiety. He went on to discuss that the anesthesiologist provided a subtle distraction from the table and lights and smoothly put him off to sleep. When talking with him later, he did verify that the operating room was a bit ominous.

Corporeality (lived body)

Participant seven had a very practical approach when dealing with issues related to his physical body. As a matter of fact, he used the word practical or pragmatic several times when he discussed preparing for surgery. He needed a
healthy shoulder in order to do the on-location job he enjoyed. He did not want to be assigned to a cubicle office for the rest of his life. As far as he was concerned, his shoulder did not function as he needed it to, so if there were complications of surgery it wouldn’t make much difference. He was already living with mobility complications resulting from the injury. In his words, “I had more apprehension about not having it, as opposed to following through with it.” Thus, his appraisal of uncertainty pointed toward opportunity.

As addressed earlier, participant seven’s anxiety was lowered when he was able to trust his surgeon’s ability. His approach to dealing with the process resembled how he planned engineering jobs. He stated, “As an engineer I put a lot of my faith in scientific process and the upfront preparation, so that the final product comes out the way that you expect it to.” Thus, he focused on the surgeon’s success rate with prior surgeries and his level of expertise. He became comfortable with what he found. Science provided him with security.

Aggregate Analysis

In this final section, the four existential life worlds will be reviewed collectively. It is the intent of the author not to restate each experience, but to highlight pertinent similarities and differences. Many of the concepts will be further developed in the final chapter. The section will culminate with the identification of emerging themes.

Temporality (lived time)

The spiritual experience of participants did not exist within the time confines of the surgery center. In the first few minutes of the interview, most every participant
began describing events that led up to the day of their surgery. Eventually all participants discussed events prior to surgery. Stories describing an injury, the discovering of cancer, preoperative visits with medical providers, pain and prayer, dominated much of our initial interaction. In one common reflection, participants focused on previous surgery experience. Every participant spoke of prior surgeries and how they affected preconceptions of the studied perioperative experience; the good and the bad. Participants also focused on overall outcome goals, which resided well beyond the perioperative environment. The surgical day was a point along their spiritual health/illness continuum.

Upon arrival to the surgery center, most participants paid very close attention to order and time detail. In the initial interviews, participants mentioned events associated with an actual time (i.e., 8:35, 9:25, 11:15, etc.) twenty-one times. Most were also well aware of delays. Three participants stated that the surgeon was late. Of those three, only one associated anxiety with the event. All in all, the participant’s perception of time was quite different during the first segments of the perioperative experience. To some it went slow, to others quite fast. After the surgeon’s arrival, everyone agreed that time moved quickly.

Relationality (lived human relation)

While stories of human interaction dominated the descriptions of the lived spiritual experience among many participants, others had to be prompted to discuss relationships they experienced during the process. A wide range of interpersonal needs existed among the study group. All but one participant mentioned a specific interaction that seemed to make a significant difference in their spiritual well-being.
As described earlier in the chapter, these individuals represented different people within and outside of the surgery center. To some it was a special nurse, to others it was the surgeon, to one it was his pastor and to another it was an anesthesia provider. All these individuals shared the common assignment of controlling that which the participant could not control. In most cases these individuals were associated with or viewed as an extension of God; a connection to the Holy. In others the association was more pragmatic, yet even in those cases, participants assigned them god-like qualities. All of these special interpersonal interactions shared the common elements of trust and confidence and were biogenic in nature. This concept will be further described in the final chapter.

Other important interactions occurred during the perioperative period. When discussing these interactions, the importance of providers being competent or confident came up thirty-five times. Another concept that was described often was a reference to caregivers being there or giving time when needed. All participants also mentioned spouses, close friends and church members when discussing the people who supported them through the event.

Spaciality (lived space)

Of the four existential life-worlds, the experience of the lived space of the surgery center shared the most consistent description among the participants. All the participants felt that the waiting and holding areas were very much as expected. Many referred to them as resembling other places where they seek health care. All were comfortable in that space.

In contrast, the operating room was given ominous descriptors by every
participant. Five of the participants referred to the table with vulnerable adjectives such as small, narrow, and uncomfortable. One participant actually compared it to a crucifix. Five mentioned the big lights. Only one person made mention of the other equipment in the room, and in that case the participant was looking on the instrument table to see if they had the correct breast implants. Lots of unnamed people were also mentioned when describing the operating theater.

The participants’ home was brought up many times when discussing the environment. As described earlier in this chapter, many differences were associated with going home. While some could not wait to get there, others feared going there.

Corporeality (lived body)

Significant statements regarding corporeality occurred more than the other lived existentials. A total of one hundred and twenty-five coded statements were related back to the lived body. When addressing the physical, the primary concern for all participants was their health/functional status, not at the end of the day, but at the end of their related journey. While the grand goal was similar, the hopeful end was quite unique but relative to the issues faced. The desired outcomes included, absence of disfigurement, relief of pain, release from cancer, regaining or maintaining normal physical function in society or just being alive. In many cases participants referred to a health status which was projected several years in the future.

In relation to the physical uncertainties of the surgical day, all participants had formed appraisals long before their arrival. The appraisals were a culmination of past experience and present spiritual and mental coping abilities. As described in the individual accounts, the transition through the perioperative period very much
mimicked the prior perceptions. Five participants established the surgical experience as an opportunity to reach life goals, viewing it as a step along the way. The other two had not come to that point prior to their surgical center arrival.

The perceptions of being anesthetized were quite different. While some feared anesthesia greatly, equating it with near death, others had not given it much thought. To them, anesthetic was a means to an end. Overall the participants believed that their physical needs were met that surgical day.

**Emerging Themes**

After interviewing and readdressing the participant’s accounts of the lived spiritual experiences of major outpatient surgery, four distinct themes emerged. It is not the author’s intent to overly reduce the experiences of each participant, but to place them in a context conducive for additional development. The identified themes were; a) a point in time, b) holy other, c) vulnerability in the operating theater and d) appraisals of uncertainty. These themes will be thoroughly addressed in chapter five.
CHAPTER FIVE

Chapter five will begin with a discussion of the identified themes which emerged from the individual meanings. This discussion will include a comparison of the outcomes with other current literature.

Consistent with Munhall’s (2007) methodology, the discussion will be followed by an examination of the possible outcome implications for nursing practice. Final thoughts, recommendations for further research and study limitations will be addressed in the conclusion.

Thematic Discussion with Current Literature Review

This study was designed to describe the meanings of the lived spiritual experiences of patients transitioning through major outpatient surgery. As addressed in chapter four, exploration of the individual meanings led to four recurring themes; a) a point in time, b) holy other, c) vulnerability in the operating theater and d) appraisals of uncertainty. The identified themes will be discussed individually in the following section.

A point in time

The theme *a point in time* addresses a phenomenon that was described over and over during the interviews and subsequent contacts with the participants. It represents the finding that the surgery experience was a small part of a bigger picture relative to the *spiritual journey* and the health/illness continuum. This is not meant to belittle the surgery experience, only to put it in perspective. Thus, the major outpatient surgery event is a distinct point in an ongoing timeline of dealing with a health issue.
The participants all had a story to tell. Several of the participants asked if it was okay to go back and describe the experiences that led up to the actual surgery. The story of their lived spiritual experience of major outpatient surgery began, not upon arrival to the surgery center, but with the discovery of the illness/injury that would require surgical intervention. In order to comprehend their experience, it was necessary to understand their story. It was this story that placed their experience in context.

This finding is consistent with a recent phenomenological study aimed at describing the post-discharge experience from colorectal cancer surgery. Interestingly enough, though prompted to discuss postoperative outcome, participants in that study “chose first to talk about their preoperative experience” (Worster & Holmes, 2008) (p.418). Subsequently, the preoperative experience became the focal point of Worster & Holmes’ (2008) journal publication. A related concept was also identified in a phenomenological study describing the lived experience of patients undergoing surgical treatment for colorectal cancer. One theme was assigned to address how patients discussed their decision to have surgery, not as a single event, but as a series of relevant choices during a long continuum of the disease experience (McCahill & Hamel-Bissell, 2009). In my 2009 publication, it was noted that literature supported the idea that patients preparing for surgery were undergoing multiple transitions which affect the spiritual experience (Griffin & Yancey, 2009).

Just as the surgery experience did not begin with arrival at the surgery center, neither did it end as the participant headed for home. A desire for an end was discussed by all participants of this study. It is important to note that the end did not
literally refer to the conclusion of the surgery. Participants desired an end to the illness or injury that had plagued them. Thus, a point in time signifies that the spiritual experience resides before, during and after the surgical event.

The focus of a desired end to the injury/illness, and not just the surgery, is also confirmed by the literature. In a 2009 study of uncertainty in adults with cancer, the author described the significance the disease had on life plans. While treatment had an effect on short term plans, uncertainty was more associated with feasibility of reaching life goals (Corbeil, Laizner, Hunter, & Hutchison, 2009). In another article, during their discussion of women’s negative emotional responses to having a hysterectomy, Williams & Clark (2000) discussed the phenomenon that most of the emotional responses of hysterectomy patients occurred preoperatively, because the hysterectomy was ultimately viewed as a means to a hopeful end.

Stories of life’s journey and how they relate to healthcare is an important concept. In a qualitative communication study, the importance of knowing a patient’s story was stressed as a platform to understand a patient’s overall outcome goals (Young & Rodriguez, 2006). A person’s spirituality alone is commonly referred to by many different religions as a journey. Bush & Bruni (2008) described a spiritual journey when addressing their study among palliative care providers. The concept of spiritual journey represents a story on a continuum, not a specific point in time.

Holy Other

The concept ‘Holy Other’ is used to describe how participants bestowed God-extending or God-like qualities on certain individuals who were encountered during the surgical experience. At times of extreme vulnerability patients realize that power
resides somewhere else. This author noted a similar concept in a Chaplaincy care publication (VandeCreek & Lucas, 2001). Authors in that text described the concept of Holy or Other as a relationship with something or someone that existed beyond themselves, being “about power, about miracles about human suffering, about heaven or an afterlife, about dying, about living, and about healing” (p.96). They also discussed how chaplains in general are living reminders of one who is greater than us. They are often associated with the workings of God.

The participants in this study bestowed that power not only on clergy, but also on other caregivers who were perceived as being used by God or as being beyond or in control of the experience. Generally these relationships had a strong religious overtone and were often associated with prayer. As discussed in chapter four, when referring to the holy other the participant often used words with a supernatural context (i.e., guardian angel, cool little angel, hand of God, etc.). The importance of the religious connection cannot be ignored in this study and has not been ignored in recent literature. Authors across many disciplines continue to connect religious rituals and activity with improved health outcomes (Ai, Corley, Peterson, Huang, & Tice, 2009; Coruh, Ayele, Pugh, & Mulligan, 2005; Hollywell & Walker, 2008; Pesut, Fowler, Taylor, Reimer-Kirkham, & Sawatzky, 2008). Prayer specifically has been associated with lowering anxiety and providing a promising outlook in the face of adversity (Ai et al., 2009; Hollywell & Walker, 2008).

The God-like or God-extending attributes were placed on a specific individual by all but one of the participants. Interestingly, the one who had not discovered that connection was the one who seemed to be in the greatest spiritual despair.
Participant five verified in our last discussion that she had not really connected with anyone special throughout the perioperative experience. While her husband was supportive, he was struggling with how to deal with it all as well. While this does not demonstrate cause and effect, for there are many major issues that participant five was dealing with, it was intriguing. The assignment of these God-like qualities was always secondary to a high level interaction. The participants trusted these individuals to the extent that it led to the association of a positive outcome with the surgery experience.

In an earlier pastoral care study, the capacity to trust in someone was found to be a major predictor of a good recovery period in patients having lung transplant surgery (Palmer & VandeCreek, 1996). As described in a later related publication, “it seems not to matter who patients trust, God, the surgeon, the chaplain, the hospital, the city…it’s the capacity for trust in relationship that seems to make a difference” (VandeCreek & Lucas, 2001, p.17). In a qualitative study of patients experiencing hip surgery, trusting in someone was also found to be associated with higher well-being and feelings of greater control over the situation (Mauleon, Palo-Bengtsson, & Ekman, 2007). While it cannot be said that the capacity for trust was explored in this study, the experience of a high level relationship in which an almost supernatural trust was manifested was evident. In each case the relationship had a profound effect on the described spiritual wellness of participants. In two instances, it literally changed the spiritual trajectory.

As alluded to in earlier paragraphs, these relationships were facilitated by biogenic interaction. In some cases the experience was with someone known for a
long period of time and in others with someone the participant only came to know in the surgical environment. No matter what the case, the *holy others* were willing to share of their time and energy in a more personal way. Participants described this concept as “giving of their time” or “being there” when needed. If achieved by a healthcare provider, either description involves taking time away from normal routine and presenting themselves in a more personal and more vulnerable way. Other current researchers have focused on the importance of *being there*. The concept is stressed throughout the discussion in a recent phenomenological study regarding spiritual care and palliative care professions. Of special interest, the authors proclaimed that all references to *being there* made by the participants were connected to a positive experience (Bush & Bruni, 2008).

**Vulnerability in the Operating Theater**

Small table, big lights and lots of people were frequently mentioned when participants discussed the actual operating room. Regardless of the level of anxiety and fear possessed by participants, the operating room represented the pinnacle of vulnerability within the outpatient surgery center. Descriptors such as cold, sterile, empty and barren were used by participants in this study and are also represented in current literature (Griffin & Yancey, 2009).

Participants related to the actual operating room much differently than other areas of the surgery center. The waiting room and the holding rooms all were perceived as normal places to receive health care. They appeared very much as participants expected and resembled other healthcare sites such as doctor and dentist offices. While the preoperative holding area was not as authentic as home, it still was
deemed an appropriate place to receive needed healthcare. The operating room on the other hand had a certain mysteriousness about it, an unknown and intimidating environment.

A recent study published in the Journal of Clinical Nursing would seem to support this finding. The authors found that anxiety levels were significantly raised upon entry into the actual operating theater and then continued to escalate, reaching their maximum level just prior to the induction of anesthetics (Haugen et al., 2009). They cited the physical environment as contributing to the anxiety. They also found that generalized anxiety prior to the surgery experience had a significant positive relationship with anxiety issues in the operating room.

New surgical care policies make the appearance of the operating theater much more pertinent to today’s outpatient care. Most patients who had surgery in years past have little if any recollection of the actual surgery room. Pharmacological interventions were administered to patients well prior to their operating room arrival. Now with emphasis on verification of the surgical site by the surgeon and operating room staff, many patients enter the theater well aware of their surroundings.

The operating room table is center stage of an operating theater of vulnerability. Metaphorically, what participants described as a “small, narrow” table, could represent the weakness and helplessness of the patient within the environment. For that is indeed where the patient will lay while the “unnamed” people and “big lights” bear down upon them. The mental picture created by participants’ descriptions shares an interesting similarity to classic art depicting the same event. 

*The Agnew Clinic* was painted by Thomas Eakins in 1889 to capture the surgical
experience at the University of Pennsylvania Medical School, with surgeon David Hayes Agnew (see Appendix H). This piece is thought by many to have defined the public’s perception of the operating theater for the last one hundred years. The following written description of his work holds an interesting resemblance to study participants’ portrayals.

The surgical team is set off from the attentive students by the illumination from an unseen source of daylight. A young member of the surgical team administers open drop ether vapors through a gauze cone to a limp female form. The surgical team labors as Dr. Agnew elaborates on his surgical technique for cancer of the breast (imageofsurgery.com, 2010).

In my words, multiple people and an overwhelming light bear down on a nameless limp naked tiny female body as the surgeon considers his next move - a mental picture representing the epitome of vulnerability. Further exploration of the painting led to another interesting finding. Archives at the University of Pennsylvania contain an outline sketch of the painting with numbers on each figure and a corresponding numbered list identifying thirty-two names of those present that day and the role they played. However, the patient was not given a number, name or an identified role.

Interesting mental pictures of modern surgery were also discovered when searching music venues. Songs depicting surgery often had mutilation and injury as the focal point. The popular video website You Tube contains cheaply made music videos which appear more like a bad horror film. One particular video showed scrub tables with weapons and ammunition mixed in with the common surgical instruments.
Personal experience and observations have noted the discomfort of numerous patients as they give up their clothing, often their teeth, and quite possibly their dignity prior to being placed on the operating table. Knowing the difficulties and vulnerabilities certain study participants faced when revealing mutilated bodies to those they had connected with, might put in perspective what is faced when revealing themselves to “unnamed” people under the lights of the operating theater.

There are two final related elements worthy of discussion. One participant emphasized that the people in the operating room were “smiling.” She placed great importance on this, stating later that it made her feel “welcome.” Knowing the vulnerabilities associated with the operating room helps one to understand why the welcome smiles had such a positive impact. It is also important to note that most participants discussed getting a “shot in their I.V.” then everything was gone. This action was portrayed as a welcoming event.

Appraisals of Uncertainty

Uncertainty is rather inherent to the perioperative experience. Elements of the health/wellness continuum, the *spiritual journey* and the procedure itself all contain associated potential for uncertainty. It would seem to surround the experience. As anticipated, participants revealed several instances where uncertainty was confronted. What became a focus of the descriptions was their formulation of an anticipated outcome based on previous experiences and/or *spiritual resolve*. All participants entered the perioperative environment having already played out the experience in their minds. The anticipations were unique to each participant and had a wide range of outcomes. Five participants entered the experience expecting a positive outcome
while two had painted a negative, dismal picture in their minds.

This described appraisal of uncertainty seems to support the second theme of Mishel’s theory of uncertainty: appraisal (Mishel, 1988; Mishel & Clayton, 2008).

Appraisal has been described as placing a certain value on a given event or situation of uncertainty. Mishel & Clayton (2008) stated,

There are two components of appraisal: inference or illusion. Inference refers to the evaluation of uncertainty using related examples and is built on personality dispositions, general experience, knowledge, and contextual cues. Illusion refers to the construction of beliefs formed from uncertainty that have a positive outlook (p. 60).

Uncertainty is a neutral state until it is evaluated and an assignment is made. Basically, the result of appraisal leads to a view of uncertainty as either a danger or an opportunity (Mishel & Clayton, 2008).

In this study, participants’ pre-perceived outcomes truly affected their spiritual trajectory and physical trajectory -- given the next example. The patient who didn’t think she would be able to deal with going right home, ended up with an extended stay at the surgery center. The participant anticipating pain stressed that he needed a pain intervention immediately when waking from anesthesia.

As stated earlier, one element that affected the appraisal was previous experience. As described in chapter four, participant one had such a negative experience with prior surgery that it was difficult for her to have a positive outlook. In contrast, participant six had an important biogenic interaction with a provider during a previous surgery that carried over to affect her uncertainties regarding the
current experience and ultimately positively affected outcome. Lien et al. (2009) identified a similar result in their study regarding uncertainty, and cancer patients being treated with surgery. They found that anxiety related to uncertainty was significantly associated with the participants past medical experience. In another recent study, the researchers found that preoperative anxiety created by uncertainty negatively affected post operative recovery (Kagan & Bar-Tal, 2008). It was found that postoperative symptoms were related to the patients’ subjective readiness for being discharged. Finally, in another phenomenological study Worster and Holmes (2008) identified that preoperative experiences had a significant affect on their participants.

Not only were the experiences affected by the appraisals, but also the perceptions of patients as they transitioned through the perioperative theater. For example, three participants mentioned that their surgeon was late. The two participants, who primarily viewed the surgery as an opportunity, believed that the surgeon was held over working with or helping other people. The third, who was focusing on the dangers, viewed the tardiness as a lack of caring. These perceptions were greatly affected by prior experience, and ultimately, the appraisal made by the individual participants.

The whole story of this study would not be told if discussion of the appraisals of uncertainty stopped at this point. The *spiritual trajectory* was set in motion prior to arrival at the surgical center, and seemed to guide the participants through their perioperative care. Yet it was also noted that the trajectory could be modified. Chapter four was used to describe some biogenic interactions that occurred at the
surgery center which truly changed the participant’s path.

Implications for Nursing Practice

While this study, describing the meanings of the lived spiritual experiences of patients transitioning through major outpatient surgery, is a phenomenology representing a particular group of individual participants at a particular point in time, it should not end there. Though the study was not designed for theory building; there is a certain moral and ethical responsibility to ask the question, what does this mean for nursing. Munhall (2007) indicated that a narrative study does not meet its full potential without addressing consequence. She stated, “A call to action is sometimes the most appropriate conclusion” (p. 204). Several suggestions for nursing practice have been contemplated by this author and should be explored by nurses and nursing researchers in the future.

When considering the meanings of the spiritual experiences of the participants, I was drawn to reflect on my earlier publication and the concept map which was used to illustrate the spiritual experience of surgery (Griffin & Yancey, 2009). Figure 2 below is the illustration from that publication used to represent factors that might decrease spiritual well-being throughout the perioperative experience.

When considering this study and nursing practice, I was inclined to make a few alterations to the earlier illustration. First, I think it is very important to extend the visual representation of spiritual experience to appear as beginning long before the arrival to the surgical unit, and signifying different trajectories of entry. In the same fashion, it would be important to represent a relative continuation of the
Figure 2

SPIRITUAL WELLNESS

- Transitional Factors (vulnerability)
- Physical Environment Factors (unauthentic)
- Interpersonal Environment Factors (biocidal)

Figure 3: SPIRITUAL DESPAIR

Becoming aware of the spiritual issues and their potential effect on our surgical patients is an important step toward maximizing nursing care in the peri-operative experience. Surgical nurses and other providers must be willing to think beyond the operating room in order to provide holistic care. The results of this phenomenological study indicated that patients’ overall experience begins long before arrival, thus it could be important to develop an understanding of the overall appraisals well past the end of the surgery. The whole experience is then encapsulated by uncertainty. Figure 3 below represents these changes, while still inferring the potentials for decreased spiritual well-being.

Finally, I would add to the appraisals a potential for a change in trajectory related to experience along the way. This is illustrated by the final diagram, Figure 4.
experience rather than only what is taking place in the operating theater that particular day. The meaning of the whole experience lies within the patient’s story. Understanding the context is crucial to excellent care (Young & Rodriguez, 2006). In addition, it would seem important to understand the patient’s overall health goal in order to maximize the journey toward reaching that goal. While we have the patient with us in the outpatient surgery center for such a short period of time, it is a significant point in the grand picture and must be considered as such.
In addition, nurses need to be cognizant of the importance of spiritual caregiving. This study indicated that spiritual care was provided by different individuals, depending on the circumstances. Spiritual care need not always be delegated to a clergy or chaplain, nor does it seem it can be self-appointed. Participants identified people along the way to fulfill this need. Caregivers need to be ready to enter into a higher level relationship when appropriate. Caregivers must be willing to become vulnerable; be willing to listen and respond in human and personal ways, in order to provide needed care. One must also realize that the ultimate effect of such care may indeed last well beyond the surgical experience.
The vulnerability related to the operating theater identified in this study, as well as other recent surgical research, might identify an area of particular improvement opportunity in nursing and nurse anesthesia care. Efforts could be made to buffer the impact that the physical environment has on anxiety levels. While different centers of care have unique systems, perioperative flow procedures could be altered to assure that at-risk patients could receive pharmacological anxiolytics well prior to entering the operating room. Perhaps more research is needed to study the effect of early administration of anxiolytics and its outcome on anxiety levels, spiritual well-being and patient satisfaction.

Research related to the introduction of other pre-surgical non-pharmacological anxiety interventions could be addressed as well. Simple interventions, such as explaining the circulating and anesthesia nurse roles as patient advocates might prove important to patients in an arena of vulnerability. Patients need to feel that their well-being is the focus of the process.

Finally, better attempts might be made to understand the spiritual well-being of the patient prior to their entry into the actual perioperative arena. If past experience and/or spiritual resolve have led to the establishment of an appraisal of the uncertainty faced, would it not be valuable to consider the patient’s spiritual trajectory as soon as possible? If a patient is in the danger mode, maybe special attempts could be made to help the patient adjust his or her appraisal of the experience. If the patient is viewing the experience of surgery as an opportunity, then spiritual care could be focused on supporting the patient’s own coping mechanisms and resources.
Most every patient entering the surgical environment has received a preoperative anesthesia workup of some kind. In many cases registered nurses, nurse anesthetists or nurse practitioners are making the evaluation of the patient. Is it possible and feasible to include a minimal number of questions regarding the patient’s overall spiritual readiness for the procedure? How would those questions be worded; how would they be perceived and would they make a difference in overall outcome? This could be the focus of future research in this area. If we were able to identify the spiritual readiness prior to patient arrival, we might be able to maximize care in the minimal time we have.

Limitations of the Study

As with every study, limitations exist. A couple of limitations in this phenomenological study were recognized and deserve mentioning. Limitations associated with phenomenology in general are not covered here but were addressed in chapter three.

Time

The hermeneutic circle is often referred to as never-ending (Benner, 1994). While this is theoretically true, a researcher, especially one who has the ultimate goal of gaining a doctoral degree, does not work on an endless time frame. The research must come to an end at some point in time. This author believed that the research question was appropriately addressed with the participants and time conducted in this study.

Limited participant demographics

In order for the primary researcher to interview all participants in person, the
study was limited to one surgical center in the Midwest. The participant recruitment was done by the perioperative nursing staff at the surgical center. A purposeful criterion based sample was utilized and is congruent with phenomenological research (Creswell, 2007). Those criteria, along with the basic study inclusion criteria, resulted in a participant group with fairly narrow demographics. Although it was not anticipated, all participants were Caucasian. One Hispanic patient expressed interest but could not be included because she was not fluent in the English language. The participants did represent a wide range of socioeconomic classes. All participants identified themselves as Christians, although two were not involved in any particular church or religious organization.

**Conclusion**

This study was conducted to describe the meanings of the lived spiritual experiences of patients as they transition through major outpatient surgery. As discussed in chapter one, the author had two major assumptions: 1) Spirituality and the human spirit indeed exist. 2) Spiritual care is important to the total care of the perioperative patient, yet is not adequately provided in many instances. The author also believes that appropriate nursing intervention begins with a rich understanding of how a phenomenon is experienced by those living it.

The study was conducted with seven participants who experienced major outpatient surgery at the Baylis Outpatient Center of Memorial Medical Center in Springfield, Illinois. The initial interviews and follow-up interactions resulted in rich narratives representing the meanings experienced by each individual participant. These meanings were then considered as an aggregate, resulting in the illumination of
four identified themes: a) a point in time, b) holy other, c) vulnerability in the operating theater and d) appraisal of uncertainty.

A review of current literature surrounding the central themes was conducted. The results were reported within the thematic discussion. As noted, the meanings discovered in this phenomenological study were supported by current research. No significant deviation was noted.

Two general recommendations for future research were identified. Additional research is needed to study the effect of early administration of anxiolytics and/or other non-pharmacological interventions prior to the surgical theater arrival and its relationship to anxiety levels, spiritual well-being and patient satisfaction. A recommendation was also made for research related to effective ways of identifying spiritual readiness prior to surgery.
### Appendix A: Terms Associated with Husserl

<table>
<thead>
<tr>
<th>Husserlian Terms</th>
<th>Philosophical Definition</th>
<th>Methodological Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcendental</td>
<td>A state in which the phenomenon is perceived, as if for the first time or without any prior frame of reference.</td>
<td>Husserl’s transcendental phenomenology is operationalized as descriptive phenomenology.</td>
</tr>
<tr>
<td>Epoché</td>
<td>Epoché is the term to describe the suspension of presuppositions, which is necessary to view a phenomenon in the state of pure consciousness.</td>
<td>Epoché is accomplished through <em>bracketing</em> the world. The researcher must set aside all preconceptions and assumptions before addressing the phenomenon.</td>
</tr>
<tr>
<td>Bracketing</td>
<td>Essentially a term used to describe the methodological application of <em>Epoché</em>. Used to describe <em>Epoché</em> by Husserl, but more commonly used by the methodologists following his philosophy.</td>
<td>The process of phenomenological <em>reduction</em>. Effectively putting on hold all assumptions of the natural attitude.</td>
</tr>
<tr>
<td>Sedimented</td>
<td>Layers of viewpoints created by past environmental, social, and political experience.</td>
<td>Sedimented views must be realized in order to set them aside to proceed from a state of pure consciousness.</td>
</tr>
<tr>
<td>Essence</td>
<td>The basic structure, or basic parts of a phenomenon, viewed untarnished in our pure conscious.</td>
<td>The final outcome of thematic analysis of a phenomenon. With all preconceptions and assumptions of the researcher set aside, an experience or phenomenon is examined from an <em>emic</em> perspective. Takes the form of a thick description.</td>
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</table>

### Appendix B: Terms Associated with Heidegger

<table>
<thead>
<tr>
<th>Heideggerian Terms</th>
<th>Philosophical Definition</th>
<th>Methodological Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hermeneutics</td>
<td>The assumption that humans are social dialogical beings and that human experience can be understood from the texts they produce.</td>
<td>Hermeneutics is a process for interpreting language in text format and is described as a method of textual understanding. Transcriptions of in-depth interviews, literature, art and poetry provide the data for further analysis.</td>
</tr>
<tr>
<td>Lifeworld</td>
<td>Also <em>being-in-the-world</em>, describes how humans make meanings that cannot be separated from the world in which they live.</td>
<td>Interpretive phenomenologists take the position that the researcher cannot be separated from the world in which they are embedded, beginning from an ego-logical starting point of personal experience and then exploring a phenomena within the contextual lived experience.</td>
</tr>
<tr>
<td>Dasein</td>
<td>While the word literally means being there. Being is not that of a subjective and an objective, but is that of coherence of existence. Being engaged in the world</td>
<td>A process of phenomenological reflection by both the researcher and researched (<em>hermeneutic circle</em>), with a goal of interpretation within the complexities of the <em>lifeworld</em>.</td>
</tr>
<tr>
<td>Existentialism</td>
<td>A school of philosophy focusing on the state of existence or the experience of being.</td>
<td>It is operationalized through the same methodological process as dasein not just focusing on the participant's lived world, but their ontological view of that world as well.</td>
</tr>
<tr>
<td>Throwness</td>
<td>A phenomenon of one’s existence being not of choice. An individual is essentially placed in the world from which they make meaning.</td>
<td>The participant is an authority on the phenomenon as experienced, they must not be judged (right or wrong) concerning their ontological views as those views have been shaped by their inherited existence.</td>
</tr>
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</table>

Appendix C: Agreement to Participate Form

Agreement to Participate in
Outpatient Spiritual Experience Study

Andrew Griffin
Primary Investigator
(618) 218-0115

This research project is being conducted as a component of a dissertation for a doctoral degree. The purpose of this project is to describe the meanings of the spiritual experiences of patients transitioning through major outpatient surgery. In order to provide support for the spiritual complexities faced by patient’s undergoing major outpatient surgery, caregivers must further understand those experiences and the factors that initiate and prohibit them.

Participation in the project will consist of filling out a short form on background information about yourself, followed by an interview with the primary investigator. Interview questions will focus on spiritual encounters that occurred throughout the entire perioperative experience and their meanings to you. The primary investigator may be accompanied by a facilitator of the opposite sex if the interview is to take place in your home. The facilitator will not participate in the interview. Data from the interview will be summarized within broad categories. No personal identifying information will be included with the research results. Completion of the form containing background data should take no more than 5 minutes. The initial interview will last approximately 30 to 60 minutes. Once the data is analyzed it is hoped that you would be willing to meet for short follow-up interviews; less than 15 minutes. Interviews will be audio and video recorded for the purpose of transcription and review.

The investigator believes there is little or no risk to participating in this research project. However, there may be a small risk that you will experience psychological pain when closely examining personal experiences associated with the surgery. The primary researcher, an Advanced Practice Nurse, will facilitate referral to additional psychological counseling if needed. The primary researcher will also facilitate notification of your primary care provider if a surgical complication is noted during the interview.

Participating in this research may be of no direct benefit to you. It is believed, however, this study will contribute to the understanding of spiritual experiences of outpatients as they transition through the perioperative arena. The descriptions could potentially benefit many diverse populations facing outpatient surgery, as appropriate intervention begins with a rich understanding.

As compensation for time spent participating in the research project, you will receive a small gift card ($25.00) valid at a local merchant.

Research data will be confidential to the extent allowed by law. Agencies with research
oversight, such as the University of Hawaii at Manoa’s (UH) Committee on Human Studies, have the authority to review research data. All research records will be stored in a locked file in the primary investigators’ office for the duration of the research project. Audio tapes will be destroyed immediately following verification of transcription. All other research records and video will be destroyed upon completion of the project.

Participation in this research project is completely voluntary. You are free to withdraw from participation at any time during the duration of the project with no penalty, or loss of benefit to which you would otherwise be entitled.

If you have any questions regarding this research project, please contact the researcher, Andrew Griffin, at (618) 218-0115 or andrewtg@hawaii.edu.

If you have any questions regarding your rights as a research participant, please contact the UH Committee on Human Studies at (808)956-5007, or uhirb@hawaii.edu

**Participant:**
I have read and understand the above information, and agree to participate in this research project.

_______________________________  _______________________________
Name (printed)
Appendix D: Research Questions and Answers for Participants Pamphlet

What does “spiritual experiences” mean?

In the context of this study, “spiritual experiences” are not just referring to religion or specific religious practices, although this can be a big part of it. The researcher’s working definition of spirituality is; a uniquely human, uniquely individual experience, transcending self, seeking to find a greater purpose and meaning by connections with others, self-value, nature and/or a higher being.

The surgery setting is not considered by most as being an environment conducive to spiritual well-being, yet surgery often presents obstacles which require spiritual support to overcome. The connections made by patients throughout the total surgery experience, how they are facilitated and what they mean are what we are looking to describe.

What is the research about?

Many cases that use to require an extended stay at the hospital are now accomplished in just a few hours. While surgery is dramatically changing, the basic nursing needs of surgical patients remain constant. It is widely accepted that patients face the same spiritual issues of coping, hope, inner-peace and a sense of emotional and physical well-being which have long been associated with the surgical experience, yet the newer processes force patients to adapt at an accelerated rate.

As patients move through their outpatient surgery, this study is designed to describe the meanings of their experiences. Hopefully the descriptions will help to improve future surgical encounters.
Who is participating in the research?

Those who know the most about the experience are those who have recently had outpatient surgery. We need people who:

- have just completed major outpatient surgery, defined as surgery requiring general anesthesia with an operating room time in excess of one and a half hours.
- are over the age of twenty-one and are fluent in English.
- desire to participate in an in-depth interview and are available for potential future consults.

The participants’ personal definition of spirituality does not affect the ability to take part in the research.

What must participants do?

Participants will be contacted by the primary researcher for setting up an initial meeting. This meeting will consist of:

- a short review of the study goals with the primary researcher. (5 minutes)
- signing a consent form to participate in the research. (5 minutes)
- filling out a short form on background information about yourself. (5 minutes)
- an interview with the primary investigator. Interview questions will focus on encounters that occurred throughout the entire experience and their meanings to you. (30-60 minutes)

Once the data is analyzed there is the potential for short follow-up interviews; less than 15 minutes. Interviews will be audio and video recorded for the purpose of transcription and review. Data will be secured and your full name will not appear on any published documents.

Why is this research important?

This researcher believes there is a close relationship between spiritual and emotional wellbeing and immune system function. Thus, spiritual wellness is related to positive health outcomes.

This study will contribute to the understanding of experiences of outpatients as they transition through the perioperative arena. The author believes that appropriate nursing care begins here. These descriptions could potentially benefit many diverse populations facing outpatient surgery.

If you have further questions please contact the primary researcher:

Andrew Griffin
618-218-0115
andrewtg@hawaii.edu
Appendix E: Demographic Data Sheet

1. Gender
   ______________

2. Age
   ______________

3. Ethnicity
   ______________

4. Educational background
   
   □ Did Not Graduate High School
   
   □ High School Graduate
   
   □ College
   
   □ Graduate School

5. Spiritual or Religious affiliation
   ______________

6. Surgeries in the past 5 years
   ______________________________
   
   ____________________________________________________________________

7. Surgeries greater than 5 years ago
   ______________________________
   
   ____________________________________________________________________

8. Surgical procedure just completed
   ______________________________
Appendix F: Interview Prompts, Sub-questions

Please tell me about your experience of having surgery, tell me all of your thoughts and feelings and particularly those that are about things such as special connections you made or events that helped you feel you could “get through it.”

**Temporality**

a) As you think about the total experience of your surgery, did it remind you of a particular experience in the past?

b) Did the experience in any way change your view (or hope) for the future?

c) Did time seem to move fast or slow during the perioperative period?

- Could you describe specific examples?

**Spatiality**

a) Describe the rooms or surroundings you were in.

b) Were there certain rooms or places that felt different than others?

- More welcoming or more comforting

**Corporeality**

a) What thoughts did you have concerning your physical body?

b) Did you feel physically safe throughout the experience?

- Did this feeling vary throughout the experience?

**Relationality**

a) Describe an encounter that you had with a caregiver.

b) Why did this interaction stand out to you?

c) Was there something in particular you did or did not receive from your interactions with caregivers?
### Appendix G: Phrases Associated with Spirituality

<table>
<thead>
<tr>
<th>Phrases</th>
<th>Working Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spiritual Wellness</strong></td>
<td>The ability to transcend self, seeking to find a greater purpose and meaning by connections with others, self-value, nature and/or a higher being resulting in positive coping, inner-peace, emotional and physical well-being.</td>
</tr>
<tr>
<td><strong>Spiritual Trajectory</strong></td>
<td>The individual experience of moving either toward or away from self transcendence, seeking to find a greater purpose and meaning by connections with others, self-value, nature and/or a higher being.</td>
</tr>
<tr>
<td><strong>Spiritual Preparation</strong></td>
<td>The act of focusing on self-transcendence through prayer, religious activity, interpersonal interaction and/or the arts and literature in order to find greater purpose and meaning.</td>
</tr>
<tr>
<td><strong>Spiritual Journey</strong></td>
<td>The long term process of self transcendence, seeking a state of greater purpose and meaning by connections with others, self-value, nature and/or a higher being with the ultimate desire of coping, hope, empowerment, inner-peace, and a sense of emotional and physical well-being.</td>
</tr>
<tr>
<td><strong>Holy Other</strong></td>
<td>Bestowing God-extending or God-like qualities on something beyond the self, trusting that being to control or facilitate control (by a Higher Power) that which the person can not personally control.</td>
</tr>
<tr>
<td><strong>Spiritual Despair</strong></td>
<td>Inability to experience purpose and meaning by connection with others, self-value, nature and/or a higher being resulting in impaired coping, inner-peace, emotional and physical well-being.</td>
</tr>
<tr>
<td><strong>Being There</strong></td>
<td>Giving of ones time, energy and/or emotion above and beyond what is normally expected in order to facilitate a higher level interaction with a person in need.</td>
</tr>
<tr>
<td><strong>Spiritual Resolve</strong></td>
<td>A state of greater purpose and meaning by connections with others, self-value, nature and/or a higher being.</td>
</tr>
</tbody>
</table>

Note. Working definitions were derived from concept analysis (Griffin, 2007).
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