A COMPARISON OF COPING STYLE WITH INFORMATION DESIRED BY PREOPERATIVE ABDOMINAL SURGERY PATIENTS

by

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TABLE OF CONTENTS

CHAPTER		Page
I.	INTRODUCTION	1
	Statement of the Problem	7
	Definition of Terms	7
	Hypotheses	9
II.	METHODOLOGY	11
	Criteria for Selection of Study Subjects	11
	The Study Setting	11
	Data Collecting Tools	12
	Data Collection Procedure	14
III.	RESULTS	16
	Characteristics of the Study Population	16
	Amount of Information	19
	Type of Information	25
	Coping Style	28
IV.	DISCUSSION	30
	Amount of Information and Coping Style	30
	Type of Information and Coping Style	33
V.	SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS	34
	Summary	34
	Conclusions	34
	Recommendations	35
BIBLIOGRAPHY		37

APPENDICES

		Page
A.	Face Sheet for Personal Data	40
B.	Preoperative Information Rating Scale	42
C.	Sentence Completion Test	52
D.	Patient Consent Form for Hospital A	54
E.	Summary of Raw Data	56
F.	Selected Anecdotal Notes	58

CHAPTER I

INTRODUCTION

Daily thousands of patients throughout the United States face the physiological and psychological stress of surgery with varying resources at their disposal. Some patients must rely on inner strengths and adaptations with little help from without. Others may be assisted through this experience by knowledgeable members of the health team who attempt to meet the many and varied needs of the individual patient.

Giving psychological support to the patient by offering preoperative instruction is an intervention frequently utilized by the health team. The physician is responsible for discussing with the patient the actual procedure and its possible outcome. The nurse becomes involved in interpreting expected nursing care and what it may mean to the patient, allaying his apprehensions, and assisting him to recognize and accept his role as the patient; Brant et al. (1958), Brophy (1968), Shafer et al. (1967), Smith and Gips (1966).

Principles from educational psychology clearly indicate teaching of material, not felt by the learner to be important or significant, will be useless. The psychological response of the individual to stress and the effect this may have on learning becomes an additional consideration while planning preoperative patient teaching.

As a background for the present study, it was felt a review of literature and studies related to preoperative preparation and response to psychological stress would be important.

Studies related to the amount and type of information desired by preoperative patients have been conducted by Erickson (1969), Weiler (1968), Carnevali (1961), and Couture (1961).

In Erickson's (1969) study, 21 major pulmonary surgery patients were interviewed three to five days postoperatively to determine the type of information that was and was not helpful in coping with their surgical experience. In general, four kinds of information were identified as helpful: (1) information related to expected experiences during the patients' hospital stay, (2) explanation of how their operation would affect them, (3) instruction about what the patients could do to help themselves, and (4) assurance that they were being well cared for. Fifteen patients indicated they did not wish to know everything. The patient with the most education desired the most information.

Using a rating scale, Weiler (1968) did a retrospective study of 100 open heart surgery patients to elicit what they felt should be told to patients before surgery. The responses indicated information about coughing and deep breathing, progress reports to relatives, and the meaning of "intensive care" as being most important. Some patients expressed the

view that limited instruction, especially in regard to pain and hallucinations, was important to prevent undue fear. The most general conclusion drawn emphasized the importance of individualizing care.

Dlouhy et al. (1963), in studying information needs of 96 patients having diagnostic tests, found commonalities of preferred information similar to those of surgical patients. Patients wanted to know why the test was being done, how they could help with the test, how equipment used would affect them, and finally they wanted assurance that the person performing the test was competent.

In a small study by Carnevali (1961), n = 10, supportive aspects of nursing care in the preoperative period were evaluated by postoperative surgical patients and their nurses. Decreasing the area of the unknown (information giving) was ranked sixth in importance by patients and first by nurses.

Couture (1961) conducted a study of the effect of planned preoperative teaching of early ambulation for patients having major abdominal surgery. There were 20 subjects, 10 in the experimental group and 10 controls. Planned instruction was given preoperatively to the experimental group with reinforcement the first postoperative day. The control group, if instructed, was contacted by the regular nursing staff on the hospital unit. Follow-up interviews postoperatively revealed none of the patients in either group had asked for information about early ambulation activities; 12 patients

said they did not wonder about what they would be expected to do after their operation. Four experimental and seven control patients denied receiving any definite instructions after they came to the hospital. Nineteen patients said they approved and would want to receive preoperative instruction. One control patient said he disapproved because "I wouldn't want to know everything." It is interesting to note that four experimental patients could not recall their preoperative instruction even with reinforcement the first postoperative day. One may wonder if this could possibly suggest a response to stress by implementation of avoidance defenses.

Psychological stress is aroused by an impending threat, that is, cues of impending harm. The threat may be an anticipation of death or injury, the prospect of social disgrace or moral sanctions, or the potential loss of strong interpersonal bonds.

To reduce the psychological discomfort aroused by threat, certain action tendencies are mobilized by the individual. These action tendencies are called the coping process or coping style. The choice of coping style is assumed to reside in the individual regardless of the threat stimulus according to Lazarus (1966).

Coping styles described in the literature range on a continuum from avoidance through vigilance. Avoidance involves defenses aimed at removing the threat from awareness, such as repression or denial. Vigilance refers to tendencies

designed to reduce threat by approaching the threat and clarifying the implications of the situation, such as intellectualization; Lazarus (1966) and Byrne (1964).

If avoiders tend to utilize defenses designed to keep threat from awareness, it might be predicted these individuals would resist being given information about the impending threat. Copers, because of their heightened sensitivity to threat, might be expected to welcome information and find it highly desirable.

Goldstein (1959) studied the relationship between response to fear arousing propaganda and coping style. The subjects (Ss) were freshmen in a high school health education class. Copers, $n = 67$, and avoiders, $n = 72$, were selected on the basis of their response to the Sentence Completion Test (SCT) developed by Mainord (1956). The Ss listened to two talks about dental practices, one based on a strong fear appeal and the other on a minimal fear appeal. The superiority of the minimal fear appeal with avoiders was significant, $p < .05$. Copers did not respond particularly well to either appeal.

Andrew (1970) studied the interaction of three coping styles, stress reduction by information giving, and the relationship of postoperative recovery rate. It was hypothesized that surgical patients whose preferred coping style was categorized as sensitizers (copers) would welcome information about surgery, learn such information, and thereby reduce

their stress and hasten recovery from surgery. The population consisted of 40 hospitalized veterans who were to have hernia surgery. On the basis of the Mainord SCT, they were grouped in one of three coping styles: avoider, neutral, or sensitizer. A standardized test for recall was administered and used as covariate to equate for the learning measures. Finally, a 50 item T-F questionnaire was administered before and after the experimental subjects listened to an information tape about hernia surgery. Results showed learning did not relate to recovery. It was expected that sensitizers would profit most from instruction; however, they showed no change. Neutrals improved most, recovering in less time with fewer medications, when instructed than when not instructed. Avoiders required more medication though they had no difference in recovery time when instructed.

DeLong (1971) hypothesized that variations in coping style affect both adaptation to stress and ability to utilize stress relevant information. The subjects were 64 women expecting major abdominal surgery. Coping styles were assessed by a modified version of the SCT. Findings indicated that copers, when given specific information, recovered from surgery better on both subjective and objective indices. Avoiders recovered poorly, regardless of information, having an increased number of complaints when given specific information. Neutrals recovered best, regardless of the type of information given.

The studies by Goldstein (1959), Andrew (1970), and DeLong (1971) suggest acceptance of stress relevant information may be related to coping style and the orientation of the information.

Statement of the Problem

Do all patients desire to be fully informed about their approaching surgical experience? Do they prefer information focused on physical aspects of care or information related to patient role? Do demographic variables such as age or education influence the selection of desired information or coping style?

The main focuses of the study were to investigate (1) the type and amount of information desired by preoperative abdominal surgery patients, (2) to identify if a possible relationship exists between coping style and desired information, and (3) to study the relationship of information, coping style, and demographic variables such as age, education, number of previous hospitalizations or surgeries.

Definition of Terms

The following definitions of terms were used in the study:

1. Preoperative: that period of time beginning with the physician's decision to operate and ending when the patient enters the operating room.
2. Preoperative instruction: any information given to

the patient during the preoperative period related to activities before or after surgery, involving the patient, members of the health team, or the patient's family.

a. Amount of information: the numerical score calculated from responses to the Preoperative Information Rating Scale (PIRS).

b. Type of information:

Group I: those statements from the PIRS which designate or imply an activity performed by the patient which clarifies the patient role.

Group II: those statements from the PIRS which designate or imply a therapeutic activity performed by a member of the health team either for, to, or with the patient.

Group III: those statements from the PIRS containing general information designed to increase the patient's understanding or knowledge of events associated with his care.

3. Psychological stress: the anticipation of harm following cognitive appraisal of cues from the environment and producing a high degree of emotional

tension resulting in behavior designed to reduce tension.

4. Coping style: the action tendencies aroused by anticipation of harm.
    a. Coper: the individual whose preferred defense is that of intellectualization and vigilance, based on a score of 22-40 on the revised SCT.
    b. Avoider: the individual who seldom uses intellectualizing defenses, but relies more on denial and repression in an attempt to keep the stress stimulus from awareness, determined by a score of 0-16 on the SCT.
    c. Neutral: the individual who does not specifically implement intellectualization or avoidance defenses, and whose score ranged from 17-21 on the SCT.
5. Major abdominal surgery: a serious operation in the abdominal area which involves the separation of muscles and entrance into the peritoneal cavity.

Hypotheses

The primary null hypotheses tested in the study were as follows:

1. The coping style of the patient would not be significantly related to the amount of information desired.

2. The coping style of the patient would not be significantly related to Group I, II, or III type of information as stated in the definition of terms.

Secondary interactions to be explored included the relationship of coping style, amount and type of information desired with demographic variables of age; education; number of previous surgeries and hospitalizations; number of days from admission to interview; and the number of days the patient knew he would need surgery.

It was hoped that by clarifying what the patient actually wanted to know and what he was like, it would be possible to improve the quality of preoperative instruction. Improved preoperative instruction would facilitate reduction of psychological stress, have a beneficial influence on the patient's tolerance of surgery, and speed his postoperative recovery. Finally, a better understanding of a possible relationship between coping style and information would increase the possibility of predicting the acceptance or rejection of preoperative information.

CHAPTER II

METHODOLOGY

The primary sources of data were the responses of available patients from two selected hospitals using three data collecting tools.

The secondary sources of data were from a review of related literature and studies.

Criteria for Selection of Study Subjects

Criteria to be met for inclusion in the study were as follows: participants must be 21 years of age or over; able to read and write English; not seriously ill; admitted for major abdominal surgery (excluding those with a questionable diagnosis or who faced mutilative surgery); mentally alert with no long standing psychiatric problem; and volunteering to participate.

The Study Setting

The hospitals participating in the study were located in a city of approximately 500,000 population. Hospital A was a federal hospital with about 300 beds serving a large area of the state. Hospital B was a county hospital with about 120 operating beds at the time of the study and serving predominantly the metropolitan area where it was located.

Data Collecting Tools

The face sheet for demographic data was patterned after one used by Erickson (1969). All demographic variables were recorded on this sheet utilizing the patient or his chart as the source of infomration. See Appendix A.

The Preoperative Information Rating Scale (PIRS) was a Likert-type scale containing information and describing events which might be discussed with preoperative patients. A Likert-type scale was chosen to permit quantitative analysis of the opinions expressed by the patients. Each patient was asked to respond to every item on a continuum from little detail to a great amount of detail. The five equal intervals along the continuum indicate the amount of information desired. Scores could range from one through five. The total score was the sum of weights for all items. According to Palmer (1965), this method of scoring is economical of time and yields high reliability.

The items in the tool were derived from studies done by Brant et al. (1958), Erickson (1969), Leach (1964), and Weiler (1968). Suggestions were sought from several nurses and a psychologist. The tool was administered to postoperative patients in several forms, and revisions of the items and format were made as indicated. The final tool contained 48 scoreable items and one open-ended question to allow patients the opportunity to add any information which might have been overlooked. A copy of the PIRS can be found in Appendix B.

The split-half method was used to test reliability of the instrument, n = 7. A Pearson r of .99 indicating very high reliability was obtained.

The items were categorized into Group I, II, and III type information and then submitted to another nurse for concurrence. Agreement was reached and the following categorizations used in the study. Group I consisted of items 5, 8, 10, 11, 14, 23, 24, 25, and 30. Group II included items 1, 2, 3, 6, 12, 15, 28, 31, 34, 36, and 39. The remaining 28 items were in Group III.

Coping styles were assessed by scores from the revised Sentence Completion Test (SCT) used by DeLong (1971). A copy of the tool is in Appendix C. Scores could range on a continuum from 0-40. Low scorers were considered avoiders; high scorers were copers. The sentence stems were constructed originally by Mainord (1956) to stimulate as much strong feeling as possible. The SCT attempts to separate (1) individuals who try to cope with emotionally charged stimuli from (2) individuals who characteristically avoid or evade such situations according to Pollack (1966).

The 20 scoreable items were each assigned values of zero, one, or two based on:

1. The stronger the emotion expressed, the higher the score.
2. The more personal and specific the response, the higher the score.

3. The greater the degree of personal involvement, the higher the score.
4. Items left blank, answered "I don't know," or glaringly inappropriate were scored zero.

Andrew (1970) found that use of a scoring manual increased reliability to .96, n = 10, between two raters. The scoring manual used in this study was one used by DeLong (1971).

Reliability of the tool was also assessed by DeLong. She found the test-retest correlation after two months was .78.

To assess social class, patients were categorized using Hollingshead and Redlick's (1958) Occupational Scale from their Index of Social Position.

Data Collection Procedure

After permission was obtained to carry out the study in the two participating hospitals, data collection encompassed a six week period.

Nursing personnel on each ward were contacted and recommendations of prospective patients sought. Originally, it was planned for all patients to be interviewed two days before surgery. This proved to be unworkable, and patients were contacted on the basis of availability. Patients' charts were then reviewed to ascertain if individuals met the criteria for inclusion in the study. Those patients who met the criteria were approached individually. After appropriate

introduction, the purpose of the study was explained, anonymity of the participants was assured, and voluntary cooperation of the patient was sought. Those patients in Hospital A who verbally agreed to participate also signed a consent form which was filed in the patients' permanent record; see Appendix D.

Oral instructions for completing the tools were given and clarified with each patient as needed. After completing the tools, any questions which the patient had regarding the information contained in either tool were answered. Clarification of how the patient interpreted the tool was also sought at this time if it was felt to be necessary.

Each patient was given a code number. The tools were scored and all raw data were punched on individual IBM cards. Raw data were also arrayed in tables.

Relationships between the amount of information, coping style, and all other variables were assessed by multiple correlations (R).

The Kruskal-Wallis one way analysis of variance by ranks was done to assess significant differences between types of information and other variables. Gross assessment of differences between types of information was evaluated by inspection of frequencies.

All correlations were done by computer. Nonparametric statistics were done by hand with the aid of a desk calculator.

CHAPTER III

RESULTS

Characteristics of the Study Population

Twenty-eight patients who met the criteria for inclusion in the study were contacted. Of this number, five patients failed to complete the data collection tools after beginning them. Four patients refused to participate in the study. Three of these patients were over 80 years of age and stated they knew all they wanted to know about their approaching surgery and preferred not to become involved.

The final study population consisted of 19 males admitted for major abdominal surgery who met the established criteria for inclusion in the study.

The population ranged in age from 21 to 76 years. The mean age was 53.21 years. See Table 1.

Table 1. Frequency Distribution of Patients by Age

Ages	Patients
20-29	2
30-39	2
40-49	0
50-59	8
60-69	3
70-79	4

Several patients had two years of college; none was a college graduate. The least number of grades completed was six. See Table 2. The mean number of years of education was 9.63.

Table 2. Frequency Distribution of Patients by Education.

Grade Level Completed	Patients
6-8	10
9-10	1
11-12	6
12+	2

Using Hollingshead and Redlick's (1958) Occupational Scale as an estimate of social position, patients were found to range from three through seven on the scale. Most patients were categorized in the fifth position as being skilled workers. See Table 3.

Table 3. Frequency Distribution of Patients According to Hollingshead and Redlick's Occupational Scale (1958).

Scale Position	Patients
3	2
4	3
5	7
6	3
7	4

Patients in the study were admitted with a variety of preoperative diagnoses, as shown in Table 4.

Table 4. Frequency Distribution of Patients by Preoperative Diagnosis.

Diagnosis	Patients
Inguinal Hernia	8
Peptic Ulcer	4
Gall Bladder Disease	2
Colostomy Closure	1
Diverticulitis	1
Hiatal Hernia	1
Vascular Disease	1
Ventral Hernia	1

Some patients were seen on the day of admission; one patient was hospitalized 52 days at the time of the interview. The mean number of days from admission to interview was 10.11. See Table 5.

Table 5. Frequency Distribution of Patients by Number of Days from Admission to Interview.

Hospital Day	Patients
Admission	3
1-5	7
6-10	3
11-15	2
16-20	1
21-25	0
26-30	1
31-35	1
35+	1

The length of time the patient knew he would need surgery varied from one week to an extreme of one year.

Amount of Information

The amount of information desired by patients preoperatively (score from PIRS, mean = 110.74, standard deviation = 45.25) was analyzed in relation to seven independent variables. Multiple correlations (R) were done. The .05 confidence level (R = .455) was chosen for testing significant differences.

The patient's coping style, determined by SCT score, was not significantly related to the amount of information desired. Raw scores for the SCT ranged from a low of 12 to a high of 26, n = 19. The mean = 19.63, standard deviation = 4.21, and R = 0.04. Using cut off scores designated by DeLong (1971) for the SCT, Avoiders = 0-16, Neutrals = 17-21, and Copers = 22-40, revealed a dispersion of high and low PIRS scores within each coping style. See Table 6.

Age as a predictor of desire for information appeared inversely or negatively related. As the patient's age increased, desire for information decreased, mean = 53.21 years, standard deviation = 16.78, and R = -0.44. Of those patients below the mean age, n = 10, seven had scores on the PIRS above the mean. Of the patients above the mean age, n = 9, six had scores below the mean PIRS. See Table 7. All three patients below the mean age who scored below the mean PIRS expressed the preference for little information because they did not wish to know about the approaching

Table 6. Comparison of SCT and PIRS Scores Ranked as Copers, Neutrals, and Avoiders.

Patient	SCT Score	PIRS Score
14	26	74
07	25	87
19	25	51
04	24	182
12	24	78
05	23	169
17	23	123
01	22	167
06	20	113
09	20	138
18	18	53
10	17	54
11	17	127
16	17	141
15	16	134
03	15	183
08	15	94
13	15	81
02	12	55

Coping Style Determined by SCT Score
Coper = 40-22
Neutral = 21-17
Avoider = 16-0

PIRS Mean Score = 110.74
SCT Mean Score = 19.63

Table 7. Comparison of PIRS Score and Age of Patients Above or Below the Mean of 53.21 Years.

Age Above Mean	PIRS Score	Age Below Mean	PIRS Score
76	87	52	183
76	53	52	123
74	138	51	141
72	113	50	127
64	54	50	94
62	74	50	55
61	167	39	81
57	51	30	169
53	78	21	183
		21	134

Mean PIRS Score = 110.74

experience. Of the six over the mean age, four felt they required little information because they were already aware of the information. The other two patients affirmed that they preferred not to be given information. Patient 19, who was 57 years of age, stated, "I figure the less I know the better off I'll be." Patient 18, whose age was 76, verbalized anxiety about his approaching surgery, but rejected information because ". . . can't do anything about what will happen; we'll just take it as it comes."

The third variable, education, revealed no significant relationship to desire for information, mean = 9.63, standard deviation = 2.61, and R = 0.03. The range of educational level was limited, from sixth grade to two years of college. Both patients with two years of college scored above the mean on the PIRS. Patients with a high school education or less

showed a wide variability of PIRS scores.

Previous hospitalization which included both medical and surgical experiences, mean = 2.16, standard deviation = 1.07, and R = 0.08, was not significantly related to desire for information. See Table 8.

Having had previous surgery was not significantly related to desire for information, mean = 1.37, standard deviation = 1.16, and R = -0.18. Inspection of the raw data does reveal that of those patients who had no previous surgery, n = 5, four patients scored above the mean on the PIRS. However, of those patients having had three or more surgeries, n = 5, three of these patients also had scores above the mean on the PIRS. See Table 8.

The number of days from admission to time of interview had a significant relationship to desire for information, mean = 10.11, standard deviation = 14.50, and R = -0.61, $p < .01$. The longer the patient was hospitalized, the less information was desired. Days from admission to interview ranged from 0-52. Of the patients hospitalized one day or less, n = 10, eight patients had PIRS scores above the mean. Of those patients hospitalized from 6-52 days, n = 9, seven patients had PIRS scores below the mean as shown in Table 9.

How long the patient knew that he would be having surgery was not significant for predicting desire for information, mean = 60.16 days, standard deviation = 108.03, and R = 0.19.

Table 8. Comparison of PIRS Score and Number of Previous Hospitalizations and Surgeries Ranked by PIRS Score.

Patient	PIRS Score	Previous Hospitalization	Previous Surgery
03	183	2	0
04	182	3	3
05	169	2	0
01	167	3	1
16	141	3	3
09	138	3	0
15	134	0	0
11	127	1	1
17	123	2	2
06	113	3	3
08	94	1	1
07	84	3	1
13	81	1	0
12	78	3	1
14	74	3	3
02	55	1	1
10	54	2	2
18	53	3	3
19	51	3	1

PIRS Mean Score = 110.74
Previous Hospitalization Mean = 2.16
Previous Surgery Mean = 1.37

Table 9. Comparison of Days from Admission to Interview and PIRS Score Ranked by Days.

Patient	Days	PIRS Score
19	52	51
10	35	54
07	30	87
18	19	53
11	15	127
12	11	78
15	9	134
13	8	81
02	6	55
01	1	167
03	1	183
05	1	169
06	1	113
08	1	94
09	1	138
16	1	141
04	0	182
14	0	74
17	0	123

PIRS Mean Score = 110.74

A multiple R = 0.80, $p < .05$, was obtained when amount of information desired was correlated with the independent variables of coping style; age; education; previous hospitalization and surgery; and the number of days from admission to interview. Variables of age (R = -0.44) and days from admission to interview (R = -0.61) accounted for 55% of the variance. Therefore, the best predictor of desire for information was not one variable, but a group of variables. Included in this group of variables was coping style. The question of how much, and in combination with what other

variables coping style contributes to information seeking, still needs to be answered.

Type of Information

The Kruskal-Wallis one way analysis of variance by ranks was done to determine if the various types of information significantly varied with respect to averages among the five independent variables. The data were corrected for ties, and the following significant differences were found:

Group I information had a significant relationship, $H = -6.91$, $p < .05$, $df = 2$, with SCT score. Avoiders rejected information about patient role more frequently than either neutrals or copers. A significant relationship was found between Group I information and the number of days from admission to interview, $H = 5.17$, $p < .05$, $df = 1$. Patients hospitalized less than the mean of 10.11 days preferred information about patient role more often than those hospitalized more than the mean.

There were no significant differences for Group II information.

Group III, general information which would increase the patient's understanding or knowledge of events associated with his care, was found to be significantly different when compared with days from admission to interview, $H = 5.59$, $p < .05$, $df = 1$. Those patients hospitalized less than the mean of 10.11 days, more frequently preferred Group III information than those hospitalized more than the mean. See Table 10.

Table 10. The Kruskal-Wallis One Way Analysis of Variance Applied to Group I, II, and III Information with Five Independent Variables Within Each Group.

Variable	Group I	Group II	Group III
SCT df = 2	-6.91*	-2.97	-5.19
Age df = 1	1.22	-0.08	-0.34
Education df = 2	-0.59	-0.38	-5.88
Previous Surgery df = 2	-3.28	0.78	0.88
Days from Admission to Interview df = 1	5.17*	-0.82	5.59*

*$p < .05$

It was felt some determination of global differences between the Groups should be assessed to determine if a preference for one type of information existed. The mean for each Group was determined and found to be 2.4 for Groups I and II and 2.2 for Group III. Any item scored three or above was considered to be an indication that the patient desired more than an average amount of information. The items in each Group were inspected and a count made of the items scored three or above by each patient.

In Group I there were nine items. Arbitrarily it was decided each patient, n = 19, would have to score at least

five of the nine items three or above to indicate more than an average preference for the information in the Group. Only six of the 19 patients scored five of the items three or above.

Similar frequency counts were done for items in Groups II and III.

Group II had 11 items; therefore, six or more items had to be scored three or above to indicate preference for this type of information. Of the 19 patients, eight scored six or more items three or above.

In Group III there were 28 items. It was decided at least 15 items had to be scored three or above. Ten of the 19 patients scored 15 or more items three or above. Only in Group III did at least 50% of the patients express more than average preference for the information.

The one factor common to a majority of the patients indicating a preference for information in each group is the length of time from admission to interview. There were ten patients who were interviewed within one day of admission to the hospital. For Group I information, all six of the patients indicating more than average desire for information had been hospitalized one day or less. Of the nine patients indicating preference for Group II information, eight fell in this category. Similarly, the information in Group III was preferred by eight out of ten patients having one day or less of hospitalization.

In all three Groups, patients 01, 04, 05, 09, 16, and 17 consistently marked a majority of items three or above, as can be seen in Table 11.

Table 11. Number of Items Rated Three or More by Individual Patients, Showing More Than Average Preference for the Information in a Particular Group.

Patient	Group I	%	Group II	%	Group III	%
01*	9	100	11	100	26	93
03*	0	0	7	64	18	64
04*	9	100	10	91	21	78
05*	6	67	7	64	24	86
06*	0	0	7	64	18	64
09*	6	67	8	83	25	89
11	0	0	7	64	16	57
15	0	0	0	0	17	61
16*	8	89	7	64	22	75
17*	6	67	7	64	15	54

*Indicates those patients who had been hospitalized one day or less at the time of interview.

Coping Style

Coping style was treated as a dependent variable and assessed in relation to amount of information desired and demographic variables. The SCT score used as a continuous variable had a mean of 19.63, standard deviation of 4.2. Intercorrelations of all variables revealed coping style to be significantly related to the number of times patients were hospitalized. The multiple $R = 0.694$, $p < .01$, indicates the patient with more hospitalizations tends to be a coper.

Correlations with age, education, and desire for information were not significantly related to coping style.

Table 12 shows the correlation matrix resulting from all multiple correlations.

Table 12. Intercorrelations for Seven Variables (N = 19)

Variables	1	2	3	4	5	6	7
1 Amount of Information	-	0.04	-0.44	0.03	0.08	-0.18	-0.61**
2 SCT		-	0.33	-0.21	0.69**	0.29	0.18
3 Age			-	-0.69**	0.60**	0.53*	0.28
4 Education				-	-0.52*	-0.61**	0.23
5 Previous Hospitalization					-	0.48*	0.12
6 Previous Surgery						-	0.04
7 Days from Admission to Interview							-

*p < .05
**p < .01

Interpretation of Table 12 indicates the longer the patient was hospitalized, the less preoperative information he desired. Those patients with more hospitalizations tended to be copers. It would appear the older patients had less education. The older patients had more hospitalizations and previous surgeries.

CHAPTER IV

DISCUSSION

Amount of Information and Coping Style

The amount of information desired was not significantly related to coping style. Therefore, the null hypothesis was accepted.

In similar studies, information and coping were compared on the basis of learning and recovery from surgery (Andrew, 1970) or coping, recovery, anxiety, and specific versus general information (DeLong, 1971).

Andrew (1970) found preparation was helpful only for neutrals in her study. Both avoiders and sensitizers who received instruction had either an increased number of post-operative recovery days or an increased need for medication.

DeLong (1971) found stress relevant information was helpful for copers, but potentially harmful to those classified as avoiders.

Lazarus and Alfert (1964), Piorkowski (1967), and Speisman et al. (1964) experimented with two coping styles (sensitizers and avoiders) and suggested stress reducing information should harmonize with a subject's coping style.

This study attempted to identify the preference of the study patient for information on the basis of three coping

styles. No measures of recovery were made in the study. Factors which may have influenced the patients' expressed desire for information include: the timing of the interview; the attitude of the patient toward information giving by the nurse; and the sensitivity of the PIRS for determining desire for information.

The patients interviewed on the day of admission or on the first hospital day as a general rule received a higher score on the PIRS, indicating more desire for information. This might suggest that the patients hospitalized for a longer time had an opportunity to make direct observations in the patient unit and ask questions of hospital personnel or other patients, thereby reducing the need for information.

Patients frequently stated they preferred to ask the doctor questions, but were reluctant to do so because the doctors seemed very busy. This finding was consistent with Brant et al. (1958). They also questioned if information giving was an appropriate role for the nurse in the study setting.

Interpretation of items in the PIRS may have differed among the patients. Although an attempt was made to use a consistent approach to all patients, a similar response set may not have been achieved.

As found by Meyers (1964), this study did seem to support that simple, specific instructions are most desired by patients. Rarely did patients rate items in the PIRS

above three, indicating a fair amount of detail.

It was also observed that those patients rating items as no detail, frequently stated they already knew the information and felt no need for further instruction. Occasionally patients rejected information because they really preferred not to know what was going to happen. Selected anecdotal notes on various patients can be found in Appendix F.

Age was a factor in predicting desire for information. Older patients desired less information. This could have been due to several factors. Older patients in the study tended to have had more surgeries. They may have already learned about many items in the PIRS and therefore not felt the need for further explanation. It was also possible that some of the patients had begun the process of disengagement and preferred not to be burdened with knowledge about an experience over which they felt powerless. This was particularly evidenced by the three 80 year old patients contacted in the course of the study. All three were delighted to discuss experiences associated with their past life or immediate problems not related to their present illness. When asked to participate in the study, however, all three reiterated they felt they had ". . . lived a good life and would prefer not to be involved." They devaluated their opinions as being unimportant. All three mentioned feeling lack of control over the outcome of surgery and acceptance of whatever resulted.

Type of Information and Coping Style

Coping style was significantly related to Group I information ($H = 0.691$, $p < .05$, $df = 2$). No patient categorized as an avoider scored items in Group I three or above frequently enough to indicate a preference for this type of information. Avoiders rejected information about patient role (Group I) more frequently than either neutrals or copers.

The number of days from admission to interview was significant for determining preference for information. Patients who had been hospitalized less than the mean of ten days preferred information designed to increase understanding or knowledge of events associated with their care and information which defined patient role (Groups III and I). Patients hospitalized longer than the mean of ten days more frequently rejected all three types of information.

Limitations of the study included the small size of the sample, the uncontrolled variables pertaining to the timing of the interview, and the selection of patients having had varying past experiences with surgery.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The null hypothesis of no significant relationship between coping style and the amount of information desired was accepted.

The null hypothesis of no relationship between Group I type of information and coping style was rejected. Avoiders rejected information related to patient role more frequently than copers or neutrals.

The null hypotheses of no significant relationships between coping style and Groups II and III types of information were accepted.

A significant secondary interaction proved to be the negative effect of the number of days from admission to interview on the desire for information. Increased days resulted in a decreased desire for information.

Conclusions

In a study of this size, it must be recognized that generalized conclusions cannot be made. Acceptable inferences drawn from the study include:

1. Those patients hospitalized the day or evening before surgery will probably need the most detailed explanation.

2. Information giving should be tailored to the individual patient's needs.

3. Short, specific instructions would appear more desirable than those containing unnecessary details.

4. Some patients in the study setting did not identify information giving as an acceptable role for nurses to assume. They more often perceived the doctor as fulfilling the role of information giver.

Recommendations

As a result of the study, it is recommended that the following areas be considered for further study:

1. It would seem valuable to repeat the present study in another setting, such as a private hospital. Criteria related to subjects should be tightened, either to eliminate patients having had past experience with surgery or to place them in a separate group when analyzing data. The items contained in the PIRS might yield more information if asked as open ended questions. The timing of the interview should be standardized for all patients.

2. It would seem important to continue to investigate the effects of various types of stress relevant information on recovery rates of surgical patients.

3. Exploration and clarification of the patient's perceptions of the nurse's role as an information giver could have important bearing on acceptance or rejection of patient teaching offered by nurses.

4. It would be of interest to investigate if a relationship exists between observable behavior and coping style of patients in a stressful clinical setting.

5. Finally, it would seem important to investigate the question of how much, and in what combination with other variables, coping style contributes to information seeking.

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APPENDICES

APPENDIX A

Face Sheet for Personal Data

Code # _____

PERSONAL DATA

Hospital number _____
Interview time _____
date _____
Age _____
Sex _____
Marital status
S M Sep. W D
Religion
Protestant _____
Roman Catholic _____
Jewish _____
Other _____
Education _____
Occupation _____

Admission date _____
Diagnosis _____
Surgery _____
Previous hospitalization
none _____
1 _____
2 _____
more than 2 _____
Previous surgery
none _____
1 _____
2 _____
more than 2 _____

Surgical procedure year
_____ _____
_____ _____
_____ _____

When were you told it would be necessary to have surgery?

Additional comments:

APPENDIX B

Preoperative Information Rating Scale

Code # _____

PREOPERATIVE INFORMATION RATING SCALE

The following statements describe events or contain information often discussed with patients before surgery. Some patients want very detailed explanations about these events and information. Some patients want explanations containing very little or no details.

Read each statement carefully and decide how much of a detailed explanation <u>you</u> would want before your surgery.

Indicate the amount of detail you want by placing an X anywhere on the line following each statement which most closely indicates how you feel.

For example:

The hours you can visit the hospital library.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

1. You may be visited by an anesthetist to discuss the best kind of anesthesia for your surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

2. In preparation for surgery your abdomen will be shaved.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

3. The evening before surgery, the nurse will give you an enema.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

4. The reason for the enema may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

5. Following the enema, you should shave, bathe, clean and trim your fingernails and toenails.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

6. Your doctor may order a medication for bedtime.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

7. The reason for the medication may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

8. After midnight, no food or fluids will be allowed by mouth until the doctor orders them after surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

9. The reason for stopping your food and fluids may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

10. In the morning before surgery, you should remove dentures, a hearing aide, glasses, or any other appliance.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

11. You should empty your bladder before going to surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

12. Your doctor may order other medications the morning of surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

13. The reasons medications are given before surgery may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

14. You should stay in bed after receiving any medication the morning of surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

15. You will be taken to surgery on a movable bed (stretcher).

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

16. You will be awake, but sleepy, when you go to surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

17. Equipment you might see when you arrive in surgery may be described.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

18. Following surgery, you will be taken to the recovery room.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

19. The purpose of the recovery room may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

20. The location of the recovery room may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

21. How long you might stay in the recovery room may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

22. Equipment you might see in the recovery room may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

After surgery, you will be expected to do the following exercises:

23. deep breathing and coughing;

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

24. bending and straightening your legs;

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

25. turning from side to side in bed.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

26. The reason for doing the exercises may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

27. How often you are expected to do the exercises may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

28. How to do the exercises may be demonstrated.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

29. Discomfort you might expect following surgery may be discussed.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

30. Discomfort should be reported so prescribed medication may be given.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

31. Clear fluids may be given by vein (IV's) after surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

32. How long you might have fluids by vein may be discussed.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

33. The reason for having fluids by vein may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

34. Blood may occasionally be given after surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

35. The reason for a blood transfusion may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

36. Your doctor may order passage of a tube after surgery like a catheter (a tube put into the bladder to drain urine).

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

37. The reason for the tube may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

38. How long you might have the tube may be discussed.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

39. You will have your blood pressure, temperature, and pulse checked frequently by the nurse after surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

40. The reason for the above observations may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

41. You will probably have a dressing over your incision.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

42. The expected size of the dressing may be explained.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

43. The kind of drainage to expect from your incision may be discussed.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

44. Information about where your family can wait during surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

45. When you may see your family after surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

46. Where and when your family may see the doctor after surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

47. When you may see the doctor after surgery.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

48. Information about how to contact a minister, priest, or rabbi.

no detail	a little detail	a fair amount of detail	a considerable amount of detail	a great amount of detail

Please add any information you feel would be important for <u>you</u> to know, and not covered in the above statements.

APPENDIX C

Sentence Completion Test

Code # _____

Below are beginnings of sentences. You are to finish the sentences so that they say anything you wish. Do not take too much time on any one sentence. Usually your first thought is best. Do not skip any of the sentences.

1. My favorite activity is _____
2. A crippling disease _____
3. If I am ignored _____
4. Hospitals _____
5. My greatest fear _____
6. The nicest person _____
7. Poor health is _____
8. I argue with people when _____
9. Being in an accident _____
10. A woman's body _____
11. Teachers are _____
12. Being sick is _____
13. I get most angry when _____
14. When I feel pain _____
15. I hate _____
16. Books _____
17. If I were struck _____
18. An operation is _____
19. I cannot control myself when _____
20. If I were injured _____
21. Sports are _____
22. When I think about sex _____
23. Going to the dentist _____
24. I could hit a person who _____
25. I despise _____

APPENDIX D

Patient Consent Form for Hospital A

Mrs. Phyllis Robinson, a student enrolled in the University of Oregon Graduate Department, collecting data for her thesis, requires the following consent from the patient.

Date_____ Hour_____

I freely volunteer to participate in the study designed to bring patients into the planning of preoperative nursing care. The study seeks the opinions of patients in an effort to clarify the general attitudes and information desired by preoperative patients.

The study has been discussed with me, and I have been given an opportunity to ask questions about the study.

I also understand I have the right to withdraw at any time from participation in the study.

_____

Patient's Signature

APPENDIX E

Summary of Raw Data

Patient	PIRS Score	Group I	II	III	SCT Score	Age	Education Grade	Social Status	Prev. Hosp.	Prev. Surg.	Days Adm. Int.	Days Knew About Surg.
01	167	31	39	97	22	61	7	5	3	1	1	28
02	55	11	15	29	12	50	7	5	1	1	6	21
03	183	50	42	91	15	21	12	3	2	0	1	49
04	182	41	40	101	24	52	6	6	3	3	0	365
05	169	29	32	108	23	30	14	5	2	0	1	28
06	113	17	27	69	20	72	8	5	3	3	1	42
07	87	14	22	51	25	76	8	7	3	1	30	7
08	94	15	22	57	16	50	12	7	1	1	1	28
09	138	24	32	82	18	74	7	4	3	0	1	21
10	54	9	11	34	17	64	11	5	2	2	35	21
11	127	22	29	76	17	50	12	3	1	1	15	21
12	78	11	20	47	24	53	10	5	3	1	11	28
13	81	15	10	52	15	39	12	6	1	0	8	365
14	74	17	15	42	26	62	8	7	3	3	0	7
15	134	25	30	79	16	21	14	5	0	0	9	7
16	141	28	31	82	17	51	8	4	3	3	1	14
17	123	28	31	64	23	52	8	4	2	2	0	42
18	53	9	12	32	18	76	7	5	3	3	19	21
19	51	10	11	30	25	57	12	6	3	1	52	28

Variable	Mean	Standard Deviation
PIRS Score	110.736	45.250
SCT Score	19.631	4.205
Age	53.21	16.578
Education Grade	9.631	2.607
Previous Hospitalization	2.157	1.067
Previous Surgery	1.368	1.164
Days from Admission to Interview	10.105	14.498
Days Knew About Surgery	60.157	108.034

APPENDIX F

Selected Anecdotal Notes

Patient 01 (Coper)

Concerned about health problems and past experience in the hospital. Expressed need to be told about things so he could prepare himself for what was going to happen.

Patient 02 (Avoider)

Expressed much concern about having a spinal anesthetic. Suggested several times he did not want to know very much about things that would happen. Commented once, "Are you worried that I am concerned about these young inexperienced guys working on me? You don't have to be. It doesn't bother me at all." Asked several times if the researcher was a "shrink."

Patient 06 (Neutral)

Was slow to respond to both SCT and PIRS. Indicated while filling out PIRS that he knew many things from previous experience with surgery. Even though he knew some things, he would still like to be told (i.e.: that he would have some kind of a tube or why it is necessary to turn from side to side.

Patient 07 (Coper)

Explained he was aware of some things (i.e.: need to be shaved, visit by anesthetist) because of previous experience with surgery.

Patient 08 (Avoider)

Marked no detail on many items in the PIRS because he already knew about them from previous surgery. Wanted more information about some things he knew (i.e.: medications before and after surgery, discomfort to expect).

Patient 10 (Neutral)

Scored PIRS no detail because he knew the information from previous experience and felt ". . . many things are just common sense." Felt nurses wouldn't tell patients much, and only those things that would be all right to tell.

Patient 11 (Neutral)

Stated, "I like to know everything. I have been asking questions ever since I got here."

Patient 14 (Coper)

Explained he marked no detail on many items in the PIRS because he knew the information from previous experience with surgery.

Patient 18 (Neutral)

Expressed a lot of anxiety about approaching surgery. He did not want information because ". . . can't do anything about what will happen. We'll just take it as it comes."

Patient 19 (Coper)

Marked no detail on most items in the PIRS. He explained, "I want a very brief statement of some things, but

very little beyond a statement of fact. I figure the less I know, the better off I'll be."

Typed by Roberta Erickson

AN ABSTRACT OF THE THESIS OF

PHYLLIS A. ROBINSON

For the MASTER OF SCIENCE in NURSING EDUCATION

Date of receiving this degree: June 9, 1972

Title: A COMPARISON OF COPING STYLE WITH INFORMATION DESIRED BY PREOPERATIVE ABDOMINAL SURGERY PATIENTS

Approved: _____

Thesis Adviser

This study was done to determine if there was a relationship between coping style and the amount or type of information desired by preoperative abdominal surgery patients. Coping style was defined as the action tendencies aroused by anticipation of harm. Patients were divided into three categories--avoiders, neutrals, or copers--on the basis of their response to the revised Sentence Completion Test (SCT). Amount of information desired was assessed by the patients' response to the 48 items in the Preoperative Information Rating Scale (PIRS). Type of information desired was determined by categorization of the items in the PIRS into Group I, II, or III information. Group I information related to patient role; Group II defined the role of

the health team members; and Group III information was designed to increase the patient's general knowledge and understanding of events associated with his care.

The study population consisted of 19 male patients admitted for major abdominal surgery. Patients meeting the established study criteria were contacted on the basis of availability during the six week data gathering period. Those patients volunteering to participate filled out the two data collecting tools at that time. Demographic data were recorded on the personal data sheet from the chart or after questioning the individual patient.

Coping style and the amount of information desired were tested using multiple correlations (R), $p < .05$, $N = 19$. Inter-correlations between seven independent variables were also run and analyzed for significant relationships.

Coping style and type of information desired were analyzed using the Kruskal-Wallis one way analysis of variance.

Secondary interactions explored included the effects of age; education; previous hospitalization or surgery; and the number of days from admission to the time of the interview with coping style, amount, and type of information desired.

Findings

Coping style was not significantly related to the amount of information desired or to Group II or III type

information. Avoiders rejected Group I information more frequently than either neutrals or copers.

Amount and type of information desired was significantly related to the number of days from admission to the interview. The longer patients were hospitalized, the less information was desired. Patients interviewed before the mean of the tenth hospital day preferred information designed to define patient role (Group I) and general information about events related to their care (Group III). Patients hospitalized more than the mean of ten days rejected all three types of information.

Conclusions

Due to the limited size of the sample, uncontrolled variables relating to previous experience with surgery, and variation in the timing of the interview, generalized conclusions cannot be made.

Logical inferences which might be drawn include:

1. Those patients hospitalized the day or evening before surgery will probably need the most detailed explanations.

2. Information giving should be tailored to the individual patient's needs.

3. Short, specific instructions would appear more desirable than those containing unnecessary details.

4. Some patients in the study setting did not identify information giving as an acceptable role for nurses to

assume. They more often perceived the doctor as fulfilling the role of information giver.

Recommendations

As a result of the study, it was recommended that the following areas be considered for further study:

1. It would seem valuable to repeat the study in another setting such as a private hospital. Criteria related to subjects should be tightened either to eliminate patients having had past experience with surgery, or to place them in a separate group when analyzing data. The items contained in the PIRS might yield more information if asked as open ended questions. The timing of the interview should be standardized for all patients.

2. It would seem important to continue to investigate the effects of various types of stress relevant information on recovery rates of surgical patients.

3. Exploration and clarification of the patient's perceptions of the nurse's role as an information giver could have important bearing on acceptance or rejection of patient teaching offered by nurses.

4. It would be of interest to investigate if a relationship exists between observable behavior and coping style of patients in a stressful clinical setting.

5. Finally, it would seem important to investigate the question of how much, and in what combination with other variables, coping style contributes to information seeking.