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Getting back to normal: parents' perception of hospitalized children undergoing painful abdominal surgery

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Getting back to normal: parents' perception of hospitalized children undergoing painful abdominal surgery
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Abstract:

The purpose of this study was to gain a better understanding of parents' perception of their child undergoing postoperative acute abdominal pain. Grounded theory method was used to systematically collect and analyze data. Data were obtained from 17 parents (12 mothers and 5 fathers) by interview and observation. A substantive theory "getting back to normal" was developed while parents were engaged in the process of taking care of their child undergoing a painful abdominal surgical procedure. This process had 5 phases: (a) taking action, (b) waiting, (c) developing a sense of safety, (d) managing, and (e) returning to normal. The major task was that parents were addressing the process of normalizing and that giving information and preparing parents for effectively taking care of their child might be expected to greatly contribute to pain reduction. Nurses need to devote energy to working with parents so that they can be considered a partner in the care.

Key words: *grounded theory method, getting back to normal, parents' perception, surgical pain, Thailand*

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บทคัดย่อ:

การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อให้ได้มาซึ่งความเข้าใจอย่างลึกซึ้งถึงการรับรู้ของบิดามารดาของเด็กที่ได้รับความปวดอย่างเฉียบพลันจากการผ่าตัดช่องท้อง วิธีการ grounded theory ถูกนำมาใช้ในการเก็บรวบรวมและวิเคราะห์ข้อมูลอย่างเป็นระบบ ข้อมูลได้จากการสัมภาษณ์และการสังเกตบิดามารดาจำนวน 17 คน (มารดา 12 คน บิดา 5 คน) ผลการศึกษาพบแนวคิดหลักของการรับรู้ของบิดามารดาในขณะที่กำลังอยู่ในกระบวนการการดูแลเด็กขณะที่มีความปวดจากการผ่าตัดช่องท้องที่เรียกว่า "การกลับสู่ภาวะปกติ" ซึ่งกระบวนการกลับสู่ภาวะปกติมี 5 ระยะ: 1) ระยะปฏิบัติการ/ลงมือกระทำ, 2) ระยะรอคอย, 3) ระยะการพัฒนาความคิดเพื่อให้เกิดความรู้สึกปลอดภัย, 4) ระยะการจัดการ, และ 5) ระยะการกลับสู่ภาวะปกติ ดังนั้นการให้ข้อมูลและการเตรียมบิดามารดาเพื่อบิดามารดาจะได้ให้การดูแลเด็กอย่างมีประสิทธิภาพเป็นหน้าที่ที่จำเป็นและสำคัญมากที่จะให้ในขณะที่บิดามารดากำลังอยู่ในกระบวนการดูแลเด็กซึ่งอาจก่อให้เกิดการช่วยลดความปวดที่เกิดจากการผ่าตัดให้กับเด็กได้ ดังนั้นพยาบาลจะต้องทำงานร่วมกับบิดามารดาในลักษณะเสมือนผู้ร่วมให้การพยาบาลดูแลเด็ก

คำสำคัญ: *วิธีการ grounded theory, การกลับสู่ภาวะปกติ, การรับรู้ของบิดามารดา, ความปวดจากการผ่าตัด, ประเทศไทย*

Introduction

Surgical pain is stressful for children and their parents. Parents have been reported to feel stress, guilt, anxiety, distress, and anger while they are observing and involved in their child's pain[1-2] but they cannot help them reduce surgical pain. The inability to help a child from surgical pain may contribute to increased anxiety. As a result, current nursing philosophy encourages parents to collaborate with the health care team in assessing and managing their child's postoperative pain.[3-4] However, health care providers appear not to rely on parental input when assessing a child's pain and find it hard to work with parents to relieve children's pain.[5] Some nurses also feel they are the main authorities to assess and evaluate the child's pain.[6] This may lead to a misinterpretation and misunderstanding of the child's pain if health care providers assess young children without asking about their parents' perception of their child's pain.

To date, there have been very few systematic studies examining parents' perception of their child's pain experience after surgery.[7-9] Those studies have focused largely on cues parents used to assess their child's pain. The researchers suggested that parents can rate the intensity of their child's pain and easily identify cues to assess their child when they are in acute pain. Parents use both verbal and non-verbal cues to determine how their child feel during postoperative pain. In addition, parents' ratings of their child's pain intensity after surgery have been reported to correlate significantly with those of the children.[10-12] The researchers suggest that parents could have an important role in assessment their child's pain experiences. As a result, pain assessment tools have been developed for parents to use in assessing children's pain such as the post-operative pain measure for parents.[11] However, these scales are based on the Western culture and context. Therefore, these scales may not be appropriate for use in other cultures, particularly that of the Thai family. Understanding Thai parents' perception of their child undergoing postoperative abdominal pain requires more exploration.

Other researchers have studied strategies parents used to deal with their child's pain. Researchers reported that strategies parents use to reduce their children's pain include cuddling, distraction and entertaining their children.[8,13-14] Parents learned to manage their children's pain through trial and error by evaluating pain according to three criteria: (a) pain medication, (b) children' s behavior, and (c) verbal pain cues.[8] They manage their children's pain by trial and error without teaching from health care professionals. However, parents need to know proper interventions in helping their child reduce pain. This points to the fact that nurses need to teach parents what pharmacological and non-pharmacological techniques they can use in helping their child to reduce pain.

In Thailand, hospital rules allow one parent to room-in and stay overnight with sick children in order to support and take care of their child. However, Thai nurses rarely ask parents about their child's pain perception. In addition, nurses rarely ask children about children's pain experiences. They still evaluate and manage children's pain using their own perception.[14]

Furthermore, Thai nurses still have some misinterpretations and myths about children pain behaviors at some point.[6,14-15] Examples of incorrect perception included believing that when children sleep quietly, they do not have pain, and some nurses perceived incorrectly that parents intervening during the intervention process will not relieve a child's pain, but only deter nurses intervention. More importantly, there are no pain assessment tools developed for nurses and parents to measure Thai children's pain experiences. As little is known about parents' perception of children's pain experiences in Thailand, substantive work is needed in order to formulate a theory of pain experience.

While some researchers have recognized the importance of understanding cues parents use to assess their child's pain experience and strategies parents use to deal with their child's pain, no research has been conducted to describe Thai parent's perception of their child undergoing painful surgery within their socialization. Socialization refers to cultural experience within the context of the hospital and operative experience. Understanding Thai parents' perception of their child undergoing painful surgery within their socialization process is an important step in building the foundation of knowledge about pain in terms of parents' perception and helping nurses and health care providers create appropriate assessment tools, evaluate the tools, and develop behavioral intervention strategies. Thus, interviewing parents on their perception will facilitate answering the following question: what is it like for parents to witness their child in pain? What cues do parents use to assess or evaluate the child's pain? What do parents teach their child about pain and strategies to deal with pain?

Materials and methods

Research design

The design of this study was descriptive, using a grounded theory method to generate a substantive theory grounded in the perceptions and experiences of parents.

Sample and settings

The study was conducted at the pediatric ward of Songkla Hospital and a surgical ward of Hatyai Hospital, Songkhla, Thailand. The research proposal was approved by the Human Subjects Committee at University of Washington and Committee of the Faculty of Nursing, Prince of Songkla University. The criteria for inclusion of participants were the mother or father of a child aged 5 to 7 years who provided postoperative care for up to 72 hours but not neccessarily on a 24-hour basis, could speak Thai, was Buddhist, and whose child did not have any chronic medical condition or developmental delay. A total of 17 parents (12 mothers and 5 fathers) of 15 children were then included in the study. Parents age ranged from 28 to 41 years (mean = 34.8 years). Seven families reported a family income between 5,001-10,000 baht/month, four had 10,001-15,000 baht/month, two had 15,001-20,000 baht/month, and two had 1,000-5,000 baht/month. Subjects' education varied from grade 1 to four years of college. Four subjects had graduated with 4 years of college, one had graduated with 2 years of college, one had finished grade 12, one grade 9, six grade 6, and one each grades 1, 2, 3, 4 and 5.

A total of 15 children (10 boys and 5 girls) who had undergone abdominal surgery were included in the study. Children ranged in age from 5 to 7 years (mean, 6.4 years). Thirteen of the children (86.7%) had appendicitis including acute appendicitis and ruptured appendicitis, one (6.7%) had blunt abdominal trauma with ruptured spleen, and one (6.7%) had complete gut obstruction with moderate dehydration. All children had undergone abdominal surgical procedure.

Methods

Data collection methods primarily relied on interviews and observations. Participant focus group discussion was also included to validate data from interviews and observations.

Interview: Each parent was interviewed in depth three times to ascertain their perception. The first interview was conducted 6-12 hours after the child's surgery (day 1) and the second interview in the evening on day 2. The first and second interview focused on the parent's perception of their child's pain, cues they used to assess their child's pain and strategies they used to teach their child to deal with pain and used a written guideline. Examples of the open-ended ques-

tions are: "What is it like for you to witness your child in pain? What do you teach your child about pain and strategies to deal with pain?" The third interview was conducted in the evening of day 3. There was no question guide to use for the third interview, but the interview was based on clarifying previous interview comments and verifying the investigator's beginning conceptualizations of the data. The interviews were tape-recorded and transcribed by the investigator into written form.

Observation: Unstructured observation was used to assess parents' behaviors in relating to their child's painful events as advocated by Brink and Wood.[18] Parents' behaviors were observed for 3 hours in the pediatric ward after their child was transferred from the recovery room until no new behaviors occurred. Parents' behaviors, including verbal and nonverbal responses and interactions with their child were also observed on a daily basis during different procedures and care activities, and at various time periods. The behavior of each parent was observed for at least 20 minutes until no new behaviors occurred. Each activity was observed for a minimum of one to a maximum of four hours daily and occurred during various periods of the day and evening.

Focus group: Three to four parents were gathered for each of two focus group discussions in order to validate data and confirm codes that had emerged from interviews and observations. Parents were asked to share their experiences during taking care of their child postoperatively. This method would allow parents to hear other parents' responses and to make additional comments as they went along. Finally, at the end of the focus group, parents were asked to check the findings. The codes and the model that had been generated were shown and parents were asked if they agreed or disagreed with the identified codes and major tasks. This would allow parents to correct errors of fact, and suggested things that might not have been mentioned the first time around. Focus group discussion took place at the end of the child's hospital stay in a private room and lasted from 45 to 60 minutes. The focus groups were tape-recorded and transcribed by the investigator into written form.

Data collection and analysis

Glaser and Strauss's constant comparative data analysis was used.[19] The outcome of analysis using this methodology allows for theory building or generation of model that describes the data. Three steps in constant comparison include open coding, axial coding, and selecting coding. All data were analyzed by the researcher. Data analysis took place concurrently with data collection. The researcher started with a purposive sample of 3 parents and 2 to 3 open-ended questions. These interviews are coded by using gerund "ing" codes to capture the moving process.[16] From the analysis of data of the three initial probes, substantive codes were initially generated reflecting the parents' responses. For example, in the first two interviews, parents reported that they used non-verbal behaviors or actions utilized by children to communicate pain such as crying, moaning, or whimpering with or without tears, and showing facial expressions. In contrast, the third parent focused the discussion on verbal communication utilized by the child to communicate pain such as "jeb (hurt)." The researcher simultaneously compared each code (meaning or concepts) for similarities and differences and grouped the data into verbal and non-verbal communication categories. These codes clustered into assessing the change/observing the change axial codes. Then, theoretical sampling was followed to gain information in order to saturate the codes. For example, subsequent parents whose children utilized behaviors associated with emotional state change were interviewed. Finally, when no new information appeared, data that were not central to the major category were eliminated or set aside for future study. A conceptual paradigm of getting back to normal of parents' perception of the child undergoing a painful abdominal surgical procedure was developed.

Lincoln and Guba's criteria were used to check the establishment of trustworthiness of the data findings.[17] Member checking was conducted by verifying the data analysis (interpretation of data and emerging categories) with participants and in subsequent interview with the additional participants. Also, the information obtained from the different methods (interview, observation, and focus group) was compared to

check the credibility of data findings. Peer debriefing was accomplished by sharing the process of grounded theory method and the accuracy of data findings with a qualitative expert who worked at the University of Washington.

Results

In this study, the major task the parents appeared to be addressing was the process of attempting to support their child in "Getting back to normal." It was clear that when parents were faced with the uncertain cause of their child's abdominal pain and their child's surgery, they felt fear, worry, anger, guilt and unhappy. They tried to move through this stressful condition step-by-step in order to become strong and be able to provide support for their child during their child's surgical painful period. Getting back to normal was an important part of the parents' role in which parents acted to support their child to return to normal activities. Parents needed to choose the best methods to help their child decrease the surgical pain. The goal was to assure that their child was safe and could return to normal as soon as possible. Getting back to normal in this sense meant escaping from a life-threatening situation or danger and returning to undertake normal activities such as walking, eating and playing. The process of getting back to normal had five phases: (a) taking action, (b) waiting, (c) developing a sense of safety, (d) managing, and (e) returning to normal. The model of getting back to normal and related conditions is shown in Figure 1.

a). Taking action phase: The first phase was the period of time when parents adjusted/estimated their child's abdominal pain was abnormal and started treating him/her at home according to symptomatic treatment until they realized that the child's abdominal pain was getting worse and needed to be investigated and treated by a doctor in the hospital. Determining sickness and caring at home was the major code. At this phase, we found that most parents detected their child's abdominal pain (estimating the child's sickness), determined the cause of abdominal pain (developing the cause of illness), and made a decision to provide care (providing symptomatic treatment) according to their experience. Generally, parents thought that abdominal pain was common for the child and it was caused by not eating a meal/not eating on time, food poisoning, or abdominal distension from not having bowel movement. Parents treated their child's abdominal pain at home symptomatically. If the child's condition was getting worse, parents would bring the child to be investigated by the doctor. We found that father and mother discussed together before making the decision to bring the child to the hospital. Parents would bring the child to the hospital depending on the level of the child's sickness, family economic status, and the distance between the hospital and home. As parents said:

"I thought he had simply abdominal pain because he didn't eat and had colic in his stomach. I told him to eat and then I gave him paracetamol (Tylenol). But his pain was getting worse. Then, I brought him to see the doctor."

"I felt stress because I saw my son was sick. I wanted to bring him to the hospital, but I did not have enough money to pay for transportation. My house is far from the hospital. It was difficult to go. After I could borrow money from my relative, I brought him to the hospital."

b). Waiting phase: The waiting phase refers to a period of time from when the child entered the hospital and parents were waiting for the physician to determine the cause of the child's abdominal pain until the child had undergone surgery. Waiting for confirmation that something was wrong with the child, developing perspective about the diagnosis and surgery, and developing a sense of control were the major codes. Gerund subcodes in this phase included the following: talking about diagnosis, talking about surgery, consoling themselves, praying to the representative of Lord Buddha or ancestor, seeking distraction, and being comforted by others. During this period, parents felt unhappy, stress, worry and fear because they were watching their child crying from abdominal pain without knowing the child's diagnosis and were waiting for the doctor in the observation room for many hours. Some parents' concerns reflected frustration with the system such as having a physical examination with many medical students several times before meeting with the attending physician with a sick child who was in pain, being interviewed by health care staff several times, and delays in receiving laboratory test

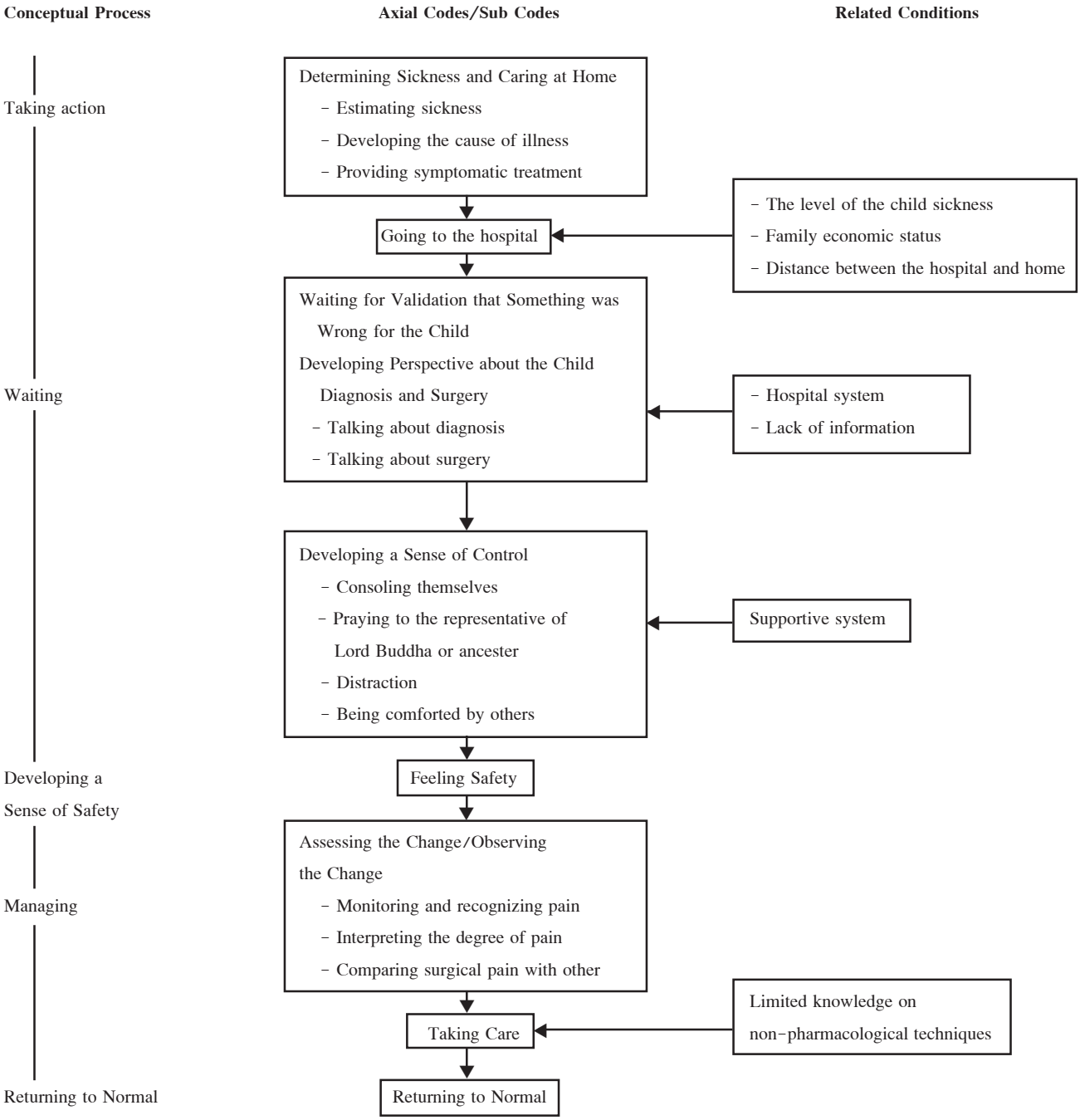

Figure 1 A summary of conceptual process, axial codes/subcodes and related conditions of the model of ″Getting back to normal: Parents′ perception of hospitalized children undergoing painful abdominal surgery.″

results. Delays in the hospital system resulted in many parents becoming angry and anxious about their child′s safety. When parents were asked what they needed during this period, they reported that they needed to meet with attending physicians immediately if their child had a critical condition rather than meeting with medical students.

After knowing the diagnosis and the need for surgery, most parents were still unhappy, worried, and afraid about the child′s diagnosis and surgery. In this study, the majority of children had appendicitis. Generally, appendicitis is a common disease and all parents perceived that it can be cured by surgery. However, all parents were afraid and worried that the

appendix would rupture. Thus, they talked about appendix in terms of if the appendix ruptured, their child might die from having infection. Also, surgery is a very serious situation for Thai people. Most fathers and mothers talked about surgery in terms of surgery being life-threatening, the child possibly receiving an overdose of anesthesia and not waking up from getting the overdose, possibly being allergic to anesthesia and this affecting to the child's brain, and the surgeon possibly forgetting medical equipment in the child's abdomen. Other concerns included the lack of information about their child's condition during surgery and how long the child would be in surgery. Most parents developed a sense of control in order to manage their stress during the waiting phase.

Developing a sense of control referred to whatever means parents used to strengthen and comfort themselves and to manage their stress. The main coping strategies consisted of consoling themselves, praying to the representative of Buddha or ancestors, and seeking distraction (talking with others, walking, and opening books). Most fathers and mothers said that they needed to "tumjai" (accept whatever might happen) during the time their child was in the operating room. As one mother said:

"I tried to have good thought. I thought my son was already in the hospital and the doctor was helping him."

When parents were asked what they needed from professionals during this period, they stated that they needed information about the surgical procedures and anesthesia, their child's conditions during surgery, and support from professionals in order to lessen their stress. Parents needed nurses or the surgeon to be available in the waiting room during the night shift or to occasionally come out to inform them of their child's condition. As one mother said:

"I needed a nurse or a surgeon occasionally came out to tell me a little bit about my daughter's condition and what they did for her. After my daughter went into that room, I did not hear anything about her. I felt worried because I was outside the operating room."

In addition, one father and mother needed to be with their child in the operating room. They reported that they need to see their child with their own eyes and comfort their child by holding the child's hands even though they couldn't help the child and the child was unconscious. Other parents did not need to be with their child in the operating room because they felt unhappy and worried to witness their child.

c). Developing a sense of safety phase: This period occurs when the child is out of the operating room. Immediately after their child was out of the operating room, all parents stated that they felt happy to see him/her because the surgery was over and the child was now safe. As one father said

"I felt happy and unworried because the surgery was over and I saw my son open his eyes. When I spoke to him, he responded to me."

When parents were asked to identify their needs after their child was out of the operating room, they stated that they also needed professionals, particularly the surgeon to come out to tell them about the results of surgery, including the surgical wound and their child's condition.

d). Managing phase: Managing phase refers to a period of time when the child complains and reacts to abdominal surgical pain and parents realize that their child is in pain and needs care to lessen the pain. Major codes in this phase included assessing the change/observing the change (monitoring and recognizing pain, interpreting the degree of pain, and comparing surgical pain with other), and taking care. Throughout this phase parents felt stress, which would not decrease if their child's pain would not lessen. They closely observed, evaluated and interpreted their child's pain. All parents could easily identify the early sign of pain cues (verbal and non-verbal communication) that their child used to show pain. All parents reported that their children used the word, "Jeb" to communicate their pain. Jeb means hurt or pain. Other words frequently used were "a lot of pain", "it is sore", or "sore sore heal heal." However, Jeb was the most popular word that all parents used to interpret their child's pain. Adjectives such as "a lot" or "sore sore" were used during episodes of bad pain. While adjectives such as "a little bit" and "not much" were used to represent less pain. Words used to indicate that they no longer hurt included "not hurt" or "feel good." Pain words used by children were grouped and reported in the previous study.[14]

Non-verbal behaviors used by parents to evaluate their child's pain included crying, moaning or whimpering with or without tears, showing facial expressions including no particular expression (neutral) or a sad face with sad eyes, grimacing, frowning, and clenching teeth. Non-verbal behaviors also included body movements or limb movements such as shaking the head, flexing the knee up, moving the body from left to right, rubbing the legs together or against the mattress, touching or rubbing the surgical wound or areas close to the surgical wound or guarding. Other cues associated with pain included changing sleep patterns such as not sleeping, changing skin color such as being pale, changing activity level such as not playing with toys or drawing pictures, and changing behavior related to emotional state or mood such as talking with angry voice or staying still and keeping quiet. As one mother said:

"It was difficult to figure out that he hurt because he did not show any sign of pain. He lay still, did not cry or complain and also did not talk for two days. When I talked with him, he did not respond. However, if I asked him, he would say hurt. I believed that he was in pain. He was quiet, so I think that meant he hurt. I thought he hurt so that he did not want to talk."

Most parents commented that their children's behaviors were not their usual selves. They thought a change in the child's mood or personality was from being in pain and thus was the major attribute that distinguished them from being back to normal. Parents used these cues (verbal and non-verbal behaviors) that told them their children were in pain. If their child had severe pain or the condition was getting worse, parents would ask for pain medication and help from nurses. When asked about the degree of the child's abdominal surgical pain, all parents perceived that their child was in pain after surgery on both day 1 and day 2. The degree of pain decreased after day 2 and had almost gone on days close to the time of discharge. Parents also described their child's pain pattern associated with the time of day, such as more pain being experienced in the morning when they woke up. Pain waxed and waned with the child's activities, increasing during daily activities such as changing position or walking. In addition, parents' evaluation of the intensity of their child's pain corresponded well with their child's rating of the level of pain.

During this painful period, parents initially applied strategies in order to lessen or stop their child' s abdominal surgical pain. They chose the best methods to provide care for their child. Taking care referred to whatever ways parents used to lessen their child's pain during this period. Both fathers and mothers used these strategies to comfort their child during the painful period. These strategies included comforting (rubbing or touching the surgical site or massaging on other parts, telling the child to tolerate the pain, comparing with other children or objects, hugging, kissing, holding the child's hand, and psychological comforting), supporting and helping (giving assistance or supporting the child to maintain position), protecting (praying and asking a Buddha image to help and protect the child from harm), rewarding (offering lovely things such as dolls, books or clothes), and distracting (playing with toys, drawing pictures or telling stories). Most fathers and mothers commented that their children tolerated pain and felt strong if they kept telling them to tolerate the pain or cheered them up with gentle talk. Such statements parents used to comfort children were, "Boys must be strong and must not cry in front of people," "Don't cry. It is shameful," Don't cry, it disturbs the nurses," "It does not hurt. It is like ants biting," or "It hurts like ants biting." Parents also compared the child's pain with that of soldiers. Thai male children believed that soldiers were strong and tolerant. When children cried or complained of pain, parents usually kept telling them to compare themselves to soldiers with statements like "If you want to be a soldier, you must tolerate the pain." Parents commented that their children stopped complaining of hurt for a while. They also believed that their children would tolerate pain and feel strong because they wanted to be a soldier. Thus, Thai male children tend to control their behaviors that indicate pain.

Psychological strategy parents used to relieve the pain included reprimanding. Parents usually intimidated their children when children constantly cried on postoperative days. Some parents reprimanded their child when the child steadily cried and complained of pain while having the dressing changed. Parents believed that their children would be afraid, stay still

and stop crying for a while. They also believed that if they reprimanded their child while having treatment, the child would accept having the treatment quietly. However, two mothers said that they didn't want to reprimand their child because the child would feel more hurt if they reprimanded them. An associated observation was that after one mother intimidated her son, he stopped crying and stayed still. Also, a mother believed that her son would stop thinking about the pain for a while after she reprimanded him. As she said:

"Don't cry! If you cry, the surgical wound will break and it will get worse. You might have to have surgery again. If you stay still and close your eyes, you will not hurt and get better"

Rubbing or touching around the surgical site and massaging techniques were the most popular means parents used to help their child to relieve pain. Also, the child asked parents to rub around the surgical site. However, some parents did not use these techniques because they had limited knowledge about these methods. They were afraid that the child's wound might be infected or inflamed if they touched or rubbed around the surgical wound.

Another strategy was using pain medication. Using pain medication was not popular for Thai parents even though almost all parents knew that pain medication was the best method for relieving the child's surgical pain. Some fathers and mothers had limited knowledge and still misunderstood about pain medication. They believed that having pain medication was addictive or their child might not be trying to tolerate the pain and would ask for pain medication even for only slight pain in the future. This was summed up by one mother who did not want her son to receive pain medication because she was afraid that her son might become addicted with the statement.

"He might be addicted. He would not tolerate pain later and ask for analgesic medication later although he felt hurt just a little bit. I did not want him to have analgesic medication."

Some parents did not want their child to have pain medication because nurses were busy and they did not want to bother them. Some parents perceived that pain from the surgical wound was less than the pain before surgery. They felt that the pain from the surgical wound would gradually decrease by itself with time. This meant that their child could tolerate and would not require pain medication. Thus, parents rarely asked for pain medication for their child if their child was not in severe pain or could tolerate the pain. They tried to comfort their child by themselves first to help them relieve the pain. If the child was still in severe pain, then the parents would ask for pain medication from nurses.

e). *Returning to normal phase:* The final phase occurs when the child is successful in stopping pain and the parent is assured that their child is safe from life-threatening conditions from surgery and is resuming normal activities. Returning to normal was determined by the parents and cues indicating this phase were: getting up without complaining, walking more, eating more, sleeping more, playing more, and interacting more with others. For example, one mother stated that

"Today (post-operative day 2), he played with toys and games more than yesterday (post-operative day 1). He did not want to play al all and did not want to talk with anybody yesterday. I offered to tell him a story, but he rejected it".

Getting back to normal depended on how successfully parents and children worked together in order to stop the child's pain. If the parents gave good care to the child, the child would return to participate more in normal daily activities and interact more with others. If parents did not give good care to the child, the child would participate less in daily activities and would not want to interact with others. Good care included giving non-pharmacological care and providing good general care such as giving food, taking a bath, or helping when the child undertook activities.

In the process of getting back to normal in terms of parents' perception, parents need to move through the 5 phases step-by-step in order to become strong and be able to provide support to their child during their child's painful period. Moving through this process, parents had to deal with stressful conditions including the hospital system, uncertainty about their child's condition, and lack of information about non-pharmacological strategies, surgical procedure, and pain medication. Parents need to cope with these stressful conditions and make themselves strong enough in order to create strategies for helping their child deal with surgical pain.

Discussion and implication

In summary, during the painful period, the parents' ability to assess pain and make appropriate decision in the beginning is crucial for the child's appropriate care. Thus, providers need to do more work in helping parents know when to seek immediate hospital care. Failure can cost the child him/her life. The parent has skill in observing and simple management strategies that the nurses need to use and work with the parent in a team fashion. This may be expected to contribute to a faster recovery and return to normal.

The initial theory which has emerged from this study is "getting back to normal or normalizing." Normalizing in this study is developed from the perspective of parents, who are the primary caregivers of children who have acute short-term and are illness undergoing a painful abdominal surgical procedure. Previously, normalizing/getting back to normal has been defined from the perspective of children themselves having acute short-term postoperative pain experiences.[20] Normalizing is also defined from the perspective of adults who have acute short-term postoperative coronary artery bypass surgery experiences.[21] These studies have focused on the process that the patients themselves use to move forward in order to return to normal life activities. In addition, the concept of normalizing has been defined from the perspective of families with chronically ill children.[22] These studies have focused on the extensive process the child and family members must engage in to redefine the family and family relationships to renormalize, by using strategies to minimize the effects of the impairment[23] or to fit into the family and society.[24] This study extends the knowledge of the process of normalizing from a limited focus on patients themselves to the perspective of the family, which is the primary caregiver for acute short-term postoperative pain experience of the child.

"Normalizing" is described from the perspective of parents who are the primary caregivers of the child who has acute short term pain experiences undergoing a painful abdominal surgical procedure as "the process whereby the parent applies strategies to help the child return to normal daily activity." The goal of normalizing after surgery was to help the child stop surgical pain, to ensure that the child is safe, and to support the child in the return to resumption of normal daily activities. Thus, parents develop strategies to help stop the pain. In this process, parents must choose the best strategies to provide care for their child in order to ensure that their child is safe and resume normal activity. Normalizing in this sense was interpreted in a physical sense of the child returning to undertake daily activities such as eating, walking, or playing which is consistent with previous findings based on the children's perspective.[20] However, parents focus much more on the safety aspects of the methods they choose for providing care for their child.

The findings provide some information about parents' perception of their child undergoing acute painful surgical experiences which highlights the importance of cues parents use to assess their child dealing with pain, and strategies parents use to help their child get rid of pain. Parents viewed surgical pain as a serious situation. They felt unhappy, stressful, fearful, angry, and worried as they witnessed the child in pain, which is consistent with previous studies.[4] The study also found that parents very readily identified their child's pain behaviors, including verbal and non-verbal behaviors, as cues to assess pain in their child. Verbal and non-verbal behaviors found in this study were mostly similar to those identified in previous studies.[7-9, 25-26] The main cues parents reported using to assess their child's pain was complaining of pain, crying, being quiet, showing facial expression, changing body position, changing sleep pattern, changing daily activity, changing skin color, and changing mood. This finding suggests that parents' rating of the children's pain intensity is based on behavioral observation, verbal expression and mood. In addition, parents' rating of their child's degree of pain corresponded with the children's own rating. This meant that parents were the key persons who identified and evaluated their children's pain accurately. Since Thai parents routinely monitor and interpret their child's pain during hospitalization, parents could play an important role in the evaluation of their child's pain. A checklist structure for parents to use to evaluate the child's pain should also be created to teach parents and better support the assessment. Also, the various cues that parents use to determine their child's pain provide a foundation for developing a valid post-operative pain measure for Thai parents in the future.

Surprisingly, parents were also not prepared to cope with their child's surgery and pain after surgery. Parents were not told about the surgical procedure and anesthesia; were not told the child's condition during surgery or after surgery; were not told about strategies they could use to help their children cope with pain after surgery or the expectations for recovery in relation to how long the pain would continue. This finding is consistent with the previous study.[4] Most parents felt unhappy, worried and fearful when they knew that their child would have surgery. These parents wanted to know more about their child's present condition, potential diagnostic procedure, the expectation for recovery, and support from health care providers. This is consistent with previous research and supports the need for more preparation and interaction with parents and the child. An understanding of the parents' need is necessary for nurses in order to plan for appropriately preparing parents and children to cope with surgery and pain after surgery. Written materials such as a pamphlet provided to parents in the hospital would be helpful. These could be placed in the emergency setting or wards. The pamphlet should outline surgical procedures, address the types of pain and children's reactions, misconceptions about analgesic medication, and some ways parents can help their children relieve pain and other emotions before and after surgery.

It is apparent that child rearing and cultural background influences children's response to pain. In the Thai culture, parents teach the child how to react to pain from the earliest childhood which later promotes specific forms of behavior. In this study, Thai parents taught children to tolerate pain and told them they must not cry whenever children complain that they are hurt. Particularly, Thai male children are taught by fathers and mothers to be strong, to tolerate pain, and not cry. Thai male children tend to control their behaviors and may not cry or demonstrate nonverbal behaviors that indicate pain because they believe in their parent's teaching. Some Thai parents reprimanded children when children steadily cried. In addition, some children were taught to be quiet and not to cry because it would disturb the nurses. Children displayed more relaxed behaviors and tended to complain of less pain after parents taught them. This implies the possibility that the child's rearing and teaching background may influence the child's response to pain during the postoperative painful period. The findings in this study are consistent with the findings of a previous study that Thai children are reared to be nonaggressive, be obedient, avoid expressing anger or other strong emotions and be respectful of others particularly authority figures and others who are older.[27-29] But doing this may not lead to adequate pain management following surgery.

Previous studies have reported that parents are a great source of comfort to a sick child during hospitalization, serve as distracters from things that hurt, and are great anxiety reducers.[1, 4] This research confirms those findings in that the researcher found that parents were great comforters who have numerous strategies to help their child return to normal daily activities. This study suggests that parents should be encouraged to participate in the management of their child's pain. Another important finding in this study is that parents learn to manage their child's pain through "trial and error" and from "past pain experiences" without teaching from professionals. Some parents may not have past surgical experiences, but they tried to do the best with their limited knowledge. Some parents may have had past surgical experiences and they were confident to apply some non-pharmacological techniques to help their child cope with pain. Some parents may have past surgical experiences; however; they may not try to use non-pharmacological techniques because they are afraid of complications such as infection on the surgical wound. Moreover, some parents may stop their child from rubbing or touching on the surgical wound. This points to the need for nurses to teach parents what non-pharmacological techniques they can use in helping their children to reduce pain and get back to their normal activities. This notion is supported by parents' comments, such as, "I think these techniques really help them to ameliorate pain." Also, children displayed more relaxed behaviors during the application of non-pharmacological techniques. Determining the strategies by asking the child what they do and prefer to do to relieve their pain can provide the basis of assisting the child in reducing the pain. Parents should be encouraged to participate in the management of their child's pain. Nurses need to help parents identify ways in which they can help the child

cope with pain effectively. This finding also revealed that some parents had limited knowledge and felt fearful to use some non-pharmacological techniques in helping their child's pain because they were afraid of complications such as infection and inflammation. This affects the child's pain management. This study suggests that the nurses need to support parents to feel confident about their knowledge and ability to help their children relieve pain, educate parents to understand the rationale for learning and using non-pharmacological strategies, and also work in collaboration with the parents to help the child cope with pain.

It is clear that parents' attitudes and judgment about analgesic pain medication are related to under-medicating children's pain. More information is reported in a previous study (Fongkaeo, 2002). This study suggests that parents should be given an rational understanding of the use of pain medication.

A limitation of this study was that a small sample of a selected group of parents was interviewed. All parents had resided only in Songkhla province, southern Thailand. Thus, the results can be applied only to similar populations. Larger studies are needed across populations to examine the similarities and differences. Qualitative research is still needed regarding parents' perspectives on the painful experiences of their children undergoing abdominal surgical procedures in order to develop a formal substantive theory of normalization after surgical pain.

Conclusion

Surgical pain is a serious situation for Thai parents who witness their child undergoing a painful surgical procedure. Thai parents usually play a critical role in identifying and interpreting their children's expression of pain, caring, and comforting their child's pain during hospitalization. Parents need to be prepared to more effectively support their children and nurses need greater understanding of their needs and provide information in order to help them cope with the child's pain. Parents can cope with their feeling and deal with their child's pain if nurses work with them in a team fashion. Therefore, identifying parents' needs and concerns is important in the development of effective nursing intervention that will maximize coping strategies and facilitate parental adaptation during their child's surgical pain. Nurses need to devote energy to working with parents in observing the child's symptoms and in addressing pain management.

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