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Courage in Middle-Aged Adults with Long-Term Health Concerns

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Cette étude avait pour but de mettre au point une théorie à base empirique sur la notion de courage, chez les adultes d'âge moyen aux prises avec des problèmes de santé de longue durée. Vingt-cinq individus provenant des régions rurales et de l'extérieur des régions métropolitaines de l'Illinois central ont été sélectionnés afin de participer à cette recherche fondée sur un procédé d'échantillonnage théorique. Des entrevues d'une durée d'une à deux heures, menées sur la base de questions ouvertes, ont été enregistrées sur magnétophone et transcrites textuellement. Les données recueillies ont été analysées selon des méthodes empiriques. Chez les adultes d'âge moyen aux prises avec des problèmes de santé de longue durée, faire preuve de courage a été défini comme un processus continu marqué par des avancées et des reculs. Adopter une attitude courageuse implique que l'on devienne pleinement conscient de la menace que pose un problème de santé de longue durée et que l'on accepte ce fait; que l'on fasse preuve de discernement dans la recherche de solutions aux problèmes; et que l'on développe une sensibilité accrue à ses besoins personnels et au monde en général. Un comportement courageux signifie endosser ses responsabilités et employer son temps de façon productive. Le courage n'est pas une force illimitée; devenir courageux et faire preuve de courage dépendent de facteurs personnels et interpersonnels. Les pourvoyeuses et pourvoyeurs de soins peuvent faciliter cette démarche en se montrant compétents et en communiquant de manière efficace avec leurs patients. Adopter une attitude courageuse stimule entre autres un sentiment d'intégrité chez les individus et leur permet de s'épanouir dans l'univers de « normalité » dans lequel ils évoluent.

The purpose of this study was to develop a substantive grounded theory of courage among middle-aged adults with long-term health concerns. Twenty-five persons from rural and non-metropolitan areas of Central Illinois were selected to participate in this study based on theoretical sampling procedures. Interviews of 1 to 2 hours using open-ended questions were audiotaped and transcribed verbatim. The data were analysed using grounded theory methods. Courage among middle-aged adults with long-term health concerns was determined to consist of an ongoing progressive-regressive process of becoming and being courageous. Being courageous involves being fully aware of and accepting the threat of a long-term health concern, solving problems using discernment, and developing enhanced sensitivities to personal needs and the world in general. Courageous behaviour consists of taking responsibility and being productive. Courage is not limitless, and the process of becoming and being courageous is dependent on intrapersonal and interpersonal factors. Health-care providers facilitate this process by demonstrating competence and communicating effectively. Outcomes of being courageous include personal integrity and thriving in the midst of normality.

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Nurses frequently marvel at individuals who flourish in spite of the threat, pain, and disability of a long-term health problem. In contrast, it is sometimes difficult for them to understand why some people manage their lives but fail to thrive, or, worse yet, have difficulty carrying out very simple tasks in the face of a chronic health concern. One of the questions asked in this study was: What role does courage play in the management of persistent health concerns among middle-aged adults?

This is the fourth in a series of studies examining courage among individuals with long-term health concerns. In the first two studies, essential elements of courage were explicated (Asarian, 1981; Haase, 1985, 1987) using a phenomenological approach. In the third, a theoretical conceptualization of becoming and being courageous was delineated among a circumscribed group of chronically ill elderly individuals (Finfgeld, 1992, 1995) using a grounded theory approach. The purpose of this study was to develop a substantive grounded theory of courage among middle-aged persons with long-term health concerns.

Background

The essence of courage has been discussed, for many years, by scholars from various disciplines. Aristotle perceives courage as resulting from efforts to do the right thing (trans. 1915) and avoid extremes (trans. 1941). Walton (1986), a contemporary philosopher, views courage as an attempt to act morally and reasonably in spite of adverse circumstances. From theological and psychological perspectives, Tillich (1952), Kohut (1985), and May (1975) argue that courage involves affirming one's unique self, while Rachman (1990) concludes that soldiers learn to be courageous in circumstances in which optimism is present.

Using a phenomenological approach, Asarian (1981) identified key elements of courage among three individuals, one a middle-aged person diagnosed with cancer. Haase (1985) used phenomenology to examine courage among chronically ill adolescents. Asarian's (1981) and Haase's (1985) research resulted in identification of constructs such as dignified acceptance, taking responsibility, and getting on with life that are associated with courage and the management of long-term health concerns. These researchers did not, however, explicate a theoretical framework.

Asarian (1981) and Haase (1985) suggest that becoming and being courageous involve a process. For this reason, Finfgeld (1995) chose grounded theory to study courage among elderly adults with a chronic illness, and concluded that becoming and being courageous among the

chronically ill elderly involve lifelong efforts to problem-solve and transform struggles into challenges. Courageous behaviours were identified to include quiet acceptance, engaging in self-care, and getting on with life in spite of difficulties. It was determined that courage is learned over time and eventually becomes part of a person's lifestyle. Factors found to promote and maintain courage included expectations of others, role models, values, significant others, input from health-care providers, and hope. Personal integrity and a sense of equanimity about one's life were identified as outcomes of being courageous. Finfgeld's (1995) work is important to understanding courage among the chronically ill elderly, but little has been done regarding this phenomenon in middle-aged individuals with persistent health concerns.

Method

Grounded Theory

Based on evidence (Asarian, 1981; Finfgeld, 1995; Haase, 1985) that becoming and being courageous involve a process, grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990) principles were used for this study. Grounded theory is based on the interpretive tradition of symbolic interactionism and provides a philosophical perspective as well as methodological guidelines for carrying out investigations (Annells, 1996). The aim of grounded theory research is to explicate common life patterns within the context of change, social interactions, factors that affect adaptation, and the social environment (Benoliel, 1996).

Sample

Ten men and 15 women, ranging in age from 40 to 64, took part in the study. They represented a wide variety of educational and occupational backgrounds and reflected the predominately Caucasian population of rural and non-metropolitan areas of Central Illinois. Their long-term health concerns comprised cancer, heart disease, diabetes, chronic fatigue syndrome, hard-to-control seizure disorders, multiple sclerosis, and residual effects from head injuries. At the time of data collection, all respondents were managing their health problems at home.

Participants for this investigation were identified in two ways. First, the researcher scanned local newspapers for announcements of support-group meetings, contacted the organizers of the meetings, described the study, and was granted permission to attend. At the meetings, the researcher identified 15 individuals who demonstrated courageous behaviours and invited them to participate. Second, 10

additional participants were located through recommendations by colleagues and acquaintances familiar with the study. All of the individuals who were asked to participate agreed to do so.

Respondents were invited to take part based on theoretical sampling criteria. Initially, characteristics of courage that were used as sampling criteria were derived from research conducted by Asarian (1981), Haase (1985), and Finfgeld (1995). These characteristics included dignified acceptance, taking responsibility, and getting on with life in spite of difficulties. Later, individuals were also selected based on courageous behaviours identified and substantiated by data from this study. Included among these behaviours were pushing oneself and taking risks in order to remain a productive member of society.

Procedure

Written informed consent was acquired from each respondent. Audiotaped interviews lasting 1 to 2 hours were conducted on an intermittent basis to allow for ongoing data analysis (Strauss & Corbin, 1990). Data collection usually took place in respondents' homes, but in a few instances it took place in private offices. An interview schedule was used as a guide. Open-ended questions focused on respondents' definitions and descriptions of courage, their perspectives of how courage helped them manage their lives in the face of long-term health concerns, and ways to promote and maintain courage. Throughout the interview process, respondents were also encouraged to describe outcomes of being courageous.

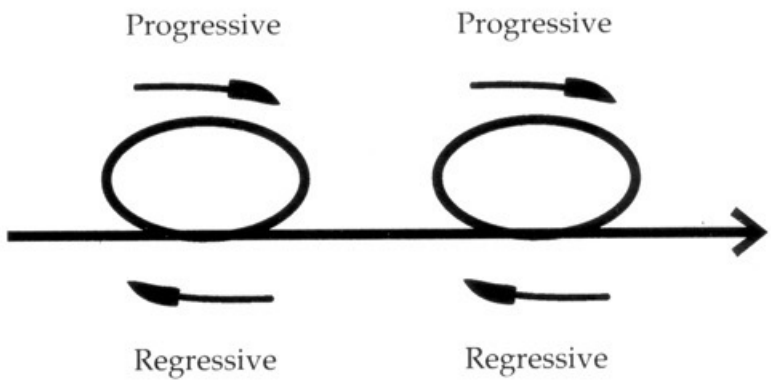
Initially, not all respondents perceived themselves as courageous. Some were unwilling to characterize themselves as such because of concerns about modesty. These participants were asked to describe what it would be like to courageously manage a long-term health problem. The researcher verbally summarized their descriptions, and respondents were then able to recount situations in which they had behaved in a courageous fashion.

The audiotapes were transcribed verbatim and data were analysed using the constant comparative method (Strauss & Corbin, 1990). *Textbase Alpha* computer software (Sommerlund, 1989) was used to initially code the transcriptions and organize similarly coded segments of the text. The coded data were then placed in subcategories, and emergent categories were identified. Placement of these categories into Strauss and Corbin's explicative paradigm consisting of causal conditions, context, antecedent conditions, action and interactional strategies,

and consequences helped delineate and verify the core category: becoming and being courageous. Continuous memo writing and efforts to develop schematic conceptualizations promoted the use of grounded theory methods and identification of an emergent substantive theory.

Two attempts were made to ensure credibility of the findings. First, midway through data collection and analysis a written summary of the preliminary findings was mailed to all participants. They were given the researcher's phone number and address and asked to reflect on the conclusions drawn to date. One participant responded that the work "appeared good" and offered no suggestions for change. Following analysis of all the data, a summary of the findings was mailed to the participants with a further invitation to share their thoughts. One woman reflected in writing that the findings appeared consistent with her own experience as well as that of her chronically ill mother. Two participants indicated verbally that the conclusions seemed congruent with their perspectives. Other than these four affirmative responses, no comments were received.

Figure 1 *Progressive-Regressive Process of Becoming and Being Courageous*



Findings

Overview: Process of Becoming and Being Courageous

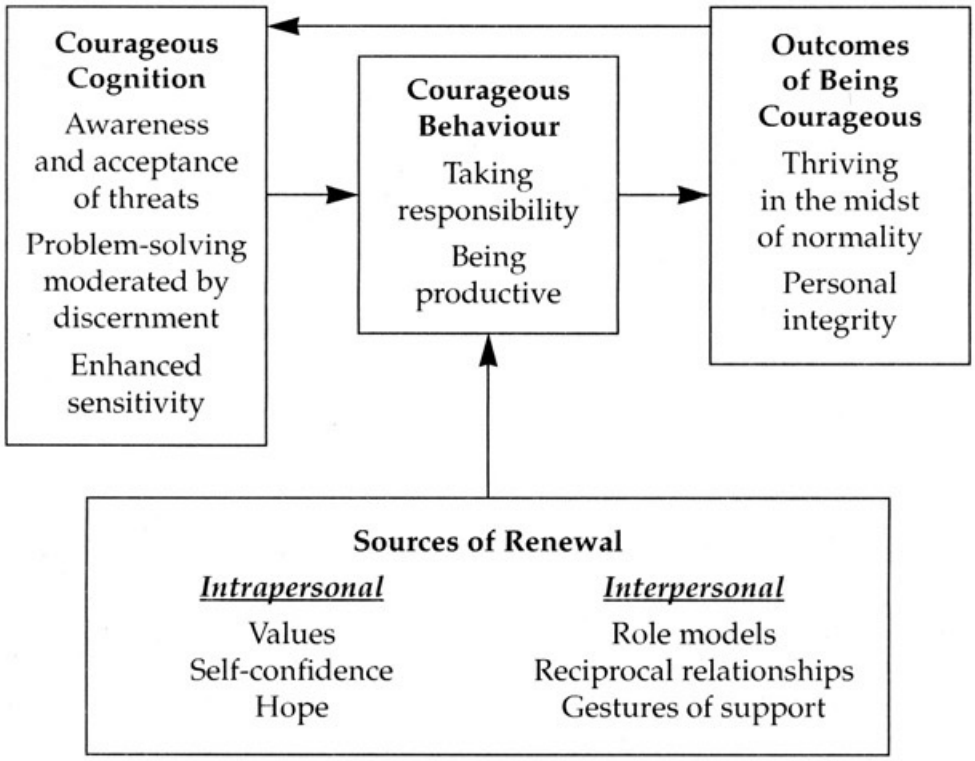
The findings support the notion that courage is not suddenly invoked. Rather, it is learned over the course of one's life and continues to emerge as people manage their lives in the face of long-term health concerns. Becoming and being courageous occur within the context of a progressive-regressive process, the essence of which is illustrated in Figure 1. It was succinctly described by one respondent as "two steps

forward and one step back." Another participant alluded to some of the progressive-regressive dynamics involved in courageously managing her life with terminal cancer:

> Well, some days it's harder to be courageous than others. Some days, I get up; and I think what is the use? For a while, I felt like what's the use of doing anything, you know? I didn't have the desire to clean. I didn't have the desire to cook meals or.... I just didn't feel like doing anything. But now, I just feel like I can see an end to this. And, you know, that it's a good ending. So, like I do a lot of farm book work. I just couldn't bring myself to do any of that. I just thought, why should I do any of that? I probably won't be here to, you know, to finish it out anyway. But now, I feel like I am going to be here. And I'm going to do this. And I'm not going to leave anything undone, you know, if something does happen. I just feel differently than I did.

As illustrated in Figure 2, the elements of being courageous are interdependent and simultaneously impact on one another. Being courageous involves cognitively struggling to become fully aware of and comprehensively accepting the threats associated with having a

Figure 2 *Interdependent Components of Being Courageous*



long-term health concern. Problem-solving, which is moderated by discernment, ensues, accompanied by an enhanced sensitivity to the inherent goodness and pleasantness of life. Over time, courageous behaviour emerges. This involves taking responsibility for one's own welfare as well as making every effort to be productive. The capacity to be courageous is not limitless, and disappointments and frustrations make it necessary for us to have intrapersonal and interpersonal sources of renewal. Outcomes of being courageous include a sense of thriving within the context of everyday life and a sense of personal integrity, which emerges from knowing that challenges have been met in the best way possible. In keeping with the interdependent nature of the components of this phenomenon, the outcomes, and implicitly all prior components of being courageous, then affect the overall process in a circular manner.

Courageous Cognition

Awareness and acceptance of threats. One of the first steps in the process of courageously living with a long-term health concern is becoming fully aware of and accepting reality. Respondents described how they gradually gained complete awareness of the threats, risks, and struggles involved in managing their persistent health concerns. They indicated that the amount of courage needed to gain full awareness is proportional to the perceived risk involved, and that the absence of courage leads to anxiety, maladaptive avoidance, and failure to optimally handle their health problems. The following excerpt captures the sense of disbelief and fear that many respondents experienced as they began to gain full awareness of their situation:

> Well, I never had a health problem before. I'd never been in the hospital except for the few times when I had my babies, so, this was it. And I was just stunned because I had regular mammograms, and I had one less than a year, and then I discovered this little lump. Course it wasn't here, it was in Texas, but they had checked my previous mammograms and everything. It was not as if, you know, I just don't know. But I had never had health problems, and you get hit with something like this — it was a real trauma for both my husband and me. I guess it was courage that got us through because, I tell you, we were both just devastated.

Problem-solving moderated by discernment. Respondents noted that an important step in courageously managing their long-term health concerns was problem-solving moderated by discernment. Discernment emerged as a key element because of the paradoxical extremes inherent in being courageous. The paradoxes include accept-

ing reality versus minimizing problems, taking one day at a time versus having long-term determination, living day by day versus maintaining a fighting attitude, being committed to values versus being open to suggestions, taking care of oneself versus being cognizant of the needs of others, and weighing the risks versus the benefits of treatment. In the following excerpt, a cancer survivor reflects on the courageous struggle involved in realistically considering the pros and cons of treatment and its probable outcome:

> And then, sure, if you have courage you try to decide the best route. I would say, don't just stupidly do things, but you try to think what you can do that will have the highest probability of success, and you do it.

Problem-solving moderated by discernment also played an important role in transforming threatening situations into challenges. As the respondents began to perceive their situations as challenges, they were able to manage fear, grapple with struggles, and get on with living in spite of difficulties. This commitment to manage fear and get on with life is illustrated in the words of a cancer survivor:

> I think I just made up my mind that I wasn't going to let panic consume me — 'cause I think you do. Most people probably do. I just decided I wasn't going to let it bother me — just make the most of whatever.

Elements critical to the process of transforming threats into challenges include keeping a fighting attitude, remaining inspired, minimizing problems, and drawing from personal reservoirs of self-confidence and perceived control. Humour was sometimes used to reframe a situation and move it beyond the solemness of the moment.

Enhanced sensitivity. As part of the process of grappling to understand their situations, respondents described a new appreciation for nature, music, their good fortune, and the fragile nature of life. One respondent said, "I see a lot more than I saw before. It was happening before; I just didn't see it as well." They also described an enhanced sensitivity to their own needs and occasionally reported becoming more self-centred in order to care for themselves. A respondent with colon cancer expressed how he now focused more on his own needs:

> I'm being a little more selfish about taking care of my own needs. I hope I don't get too far into that, but I think I should take care of my own feelings and needs a little more quickly or put them in first place rather than in second place like I used to. I want to make the day as good as I can, and I want to feel as good as I can. I don't want to take everything away from everybody else, but I think I put myself first more than I did before.

Courageous Behaviour

Taking responsibility. Over time, courageous cognition results in the overt act of being courageous, which involves taking responsibility for one's own well-being and remaining actively engaged in self-care. One respondent said, "With cancer, you make the decisions. The doctors say 'this is the way it is,' but you have to decide what to do." Courageous individuals make assertive attempts to read, ask questions, network, and attend support-group meetings. It is sometimes necessary for them to push beyond the norm and take risks in order to endure unpleasant procedures, remain actively involved in their care, and engage in activities unrelated to their health care. A man with residual problems due to a head injury indicated his sense of personal responsibility: "The bottom line is that I have to do things myself. My wife can't go to work for me when I'm spaced out, tired, or depressed. I have to cope with that myself."

Being productive was a high priority for these middle-aged individuals. Although respondents perceived their problems as serious, they did not see them as permanent barriers to engaging in constructive pursuits. Many of them felt a responsibility to spouses and/or children, and their goal was not only to manage their health problems but also to continue to grow, better themselves, and help those around them. A respondent with lymphoma had a desire to resume her teaching career: "I didn't want to be known for just having a clean house. I wanted to have affected some lives in some way. And I don't touch as many lives when I'm home."

This does not mean that the respondents behaved in an ostentatious manner. On the contrary, they were reluctant to draw attention to themselves, and their behaviour was characterized by quiet, dignified acceptance. They placed an emphasis on unobtrusively striving to move on with their lives.

Sources of Renewal

Intrapersonal sources. The respondents alluded to the fact that sustaining courageous behaviour in the face of persistent health concerns requires commitment, determination, endurance, and continual renewal. As such, intrapersonal factors that help to continually renew courage among middle-aged individuals with long-term health concerns include values, self-confidence, and hope.

Values. Respondents indicated that values provide the foundation for personal goals, help to clarify the purpose of life, give meaning to

struggles, and serve as a beacon in challenging times. A cancer survivor stated: "Courage is being willing to do something difficult, impossible, or dangerous because you feel it ought to be done or you think the result of your doing so is a good and proper thing." Values also motivate individuals to "be there for other people" and remain strong in order to reduce stress for those around them.

Based on values, there is a perceived need to preserve one's dignity and personal integrity in the face of intrusive medical and surgical procedures, declining health, and loss of control. In the context of maintaining his integrity, a respondent who had recently undergone chemotherapy rationalized that one should have the liberty to hasten one's death. "I believe that people should have the right to make the decision to end their own lives. I don't think that's cowardly. In fact, that could be brave under the right circumstances. I don't want to be kept around on machines."

Self-confidence. Self-confidence is a key intrapersonal factor in dealing with loss of control and maintaining courage. As one respondent put it, "Courage is based on a feeling inside that you can handle things pretty well without becoming too upset or unstable." Self-confidence enables courageous persons to feel comfortable with not only decisions regarding self-care but also decisions about relinquishing control over their care. They may lose tangible influence over aspects of their lives, but self-confidence allows them to comfortably and purposefully hand over control to health-care providers, family members, or a *higher power*. Their courage is fortified by the knowledge that they have made a wise decision and will receive appropriate care.

Hope. Hope promotes and maintains courage. Some individuals hope their situation will remain stable and are optimistic about the future. One man stated, "My courage comes from hoping this stuff [chemotherapy] will take care of what's in there, and it'll be in remission, and I'll be able to get back to a more normal life." People such as this man redefine normality and look forward to living a full life in spite of their health concerns. Still others anticipate a peaceful death and a gratifying afterlife.

Religious faith is an integral part of remaining hopeful, in that it fosters the perception that the world is a benevolent and safe place, one is never alone, solace can be found in the most isolating circumstance, and good will ultimately triumph over evil. Belief in a grand plan enables people who are struggling with the uncertainty of long-term health problems to envision a time when order will emerge from chaos and their experiences will be ascribed meaning. A man who had a ter-

minal illness, and whose wife had died only four months earlier, talked about his faith: "Religious faith gives me a little bit more peace of mind, something to look forward to. I know there's a better life hereafter."

Interpersonal sources. Interpersonal sources of continual renewal play an important role in promoting and maintaining courage. They include attempts by close associates to normalize the situation, expectations of courage on the part of others, gestures of support such as sending food and cards, listening to and sharing with others who have similar problems, and role models.

Role models. People who inspired courage included individuals the respondents had known as children as well as their contemporaries. Often, respondents sought to emulate the optimism and determination of family members and acquaintances who had similar health concerns. One respondent said her husband served as a positive role model:

> I look at my husband and how hard he tried to fight the cancer, and that gives me an example of courage to follow. He didn't give in to the cancer. He tried to fight it with his mind and with his body: counseling, hypnosis, vitamin therapy, and herbs.

Negative role models also affect an individual's desire to be courageous. Respondents were particularly sensitive to childhood situations in which family members had not been courageous. They described alcoholic, abusive, and irresponsible parents whose behaviour was detrimental to the welfare of the family. These experiences prompted some respondents to be courageous in order to maintain their own integrity and also to help others in stressful situations. A well-respected professional in the community described his experience with negative parental role models:

> My parents were not courageous role models for me. I knew I didn't want to grow up and be like them. All my dad wanted to do was graduate from high school, stay at home, get a job, have kids, have more kids, drink beer on the weekends — he'd drink beer all week if he wanted to, but he made sure he drank on the weekends. I had a sister that my mom and dad basically just left at the hospital. They couldn't take care of her and didn't want her. My aunt and uncle raised her. I didn't even know she was my sister until much later.

Reciprocal relationships. Some of the interpersonal factors that help to promote and maintain courage are reciprocal in nature. For example, reciprocal to being courageous for the benefit of others is the expectation of those same individuals that courageous behaviour will be demonstrated. These expectations are often covertly communicated through attempts by significant others to return life to normal or rede-

fine normality based on new parameters. Deciding to continue with daily activities or being accepted back at work are major milestones that provide an environment in which becoming and being courageous are possible. One respondent who had experienced a myocardial infarction said he was able to be courageous because his family treated him "as if nothing had happened" and "did the things they had done before."

Support-group members also create reciprocal relationships in which information, concerns, disappointments, and triumphs can be shared openly. Individuals listen to each other, project a sense of caring, inspire optimism, and occasionally use humour to create a sense of lightheartedness. Feelings of altruism, belonging, and hope are enhanced, which aids in the continual renewal of courage. The following comment illustrates the role that a support group can play in promoting and maintaining courage:

> I think the support group has been really good for me. It's nice to know other people in the same boat. I've learned to be courageous because of the people in that group. So many of them have done so well, and that gives me hope. I was able to face my problems after I went. You can say things in that group that you don't say to family because you don't want them to worry. Everybody just seems to listen. And sometimes people will break down and really cry. And it doesn't upset us or anything. And it's just a place where you can say anything you want to.

Gestures of support. During periods of crisis, others help to maintain and promote courage through simple gestures of support. Words of kindness and encouragement; humour; cards; and a willingness to listen, socialize, and engage in diversional activities were interpreted by participants as supportive. One respondent said the "mere presence" of his family, and their willingness to travel great distances to be with him, was extremely helpful in maintaining his ability to be courageous immediately after having a myocardial infarction.

Health-care professionals foster courage by using certain modes of communication and by demonstrating competence. When health-care providers are perceived as competent, people feel they can be less vigilant about the care they are receiving and can more comfortably relinquish some decision-making and aspects of their treatment. They are able to focus on being strong, pushing themselves, and living life to its fullest.

Health-care providers can promote courage by helping to allay anxiety and establish trust. Among the modes of communication that foster trust are availability and willingness to listen and answer ques-

tions; open, honest, straightforward exchange; and expression of respect and benevolence. Realistic optimism, words of reassurance, and occasionally humour can serve to reduce tension and allow individuals to focus their attention and energy on becoming and being courageous. Some of these communication styles are alluded to in the following excerpt.

> I think the health care people can encourage courage by being as communicative as they can be — as open to communication. Not by warning ahead of time of all the pain that can occur and so on. And then to just talk about — you got to be honest — but to talk about the successes.

Outcomes of Being Courageous

Thriving in the midst of normality. Being courageous results in a feeling of vitality, a zest for life, and the sense that one has thrived and lived life to its fullest, rather than merely gotten by. In contrast, one respondent described life without courage: "I think life would be mediocre. I think that one would really live a rather dull life. I think it would be kind of boring."

Although thriving is a theme among middle-aged people who courageously manage their lives with long-term health concerns, this zest for life appears to exist in the midst of normality and routine patterns of daily living. As such, reports of thriving echo respondents' descriptions of experiencing enhanced sensitivities to reality and becoming more acutely aware and appreciative of the rather mundane and banal aspects of life.

Personal integrity. In keeping with the notion that being courageous is virtuous, respondents in this study indicated that becoming and being courageous results in feelings of personal integrity. In spite of imperfections, they felt they had lived honest, moral, and principled lives. They were satisfied with their accomplishments and were proud of the fact that they were living in the most courageous way possible. For example, a wheelchair-dependent man who pushed himself to do volunteer work and be frugal was pleased because he had carved out a "spot for himself in society" and was going to leave a legacy for his children. Respondents also expressed few regrets about how struggles had been managed, and there was a sense of equanimity about whatever injustices they had encountered. One woman's diagnosis of cancer had been greatly delayed because of inexcusable errors made by health-care providers:

> I just wanted to know what happened. I knew those decisions weren't made maliciously, and I didn't want to blame anybody. My husband and I know that suing won't change anything, and nothing can really make up for what has happened. We just don't want the same mistake made again. We don't want it to happen to anybody else.

In summary, being courageous has several distinct components: courageous cognition, courageous behaviour, and outcomes of being courageous. The capacity to be courageous is not limitless; thus intrapersonal and interpersonal sources of renewal are needed. The elements of being courageous are interdependent, and for this reason the outcomes and all other components of being courageous affect the overall process.

Discussion

Many of the findings of this study are similar to those of other analyses of courage. Becoming and being courageous appears to be a learned progressive-regressive process that is elicited by struggles. Cognitive components of being courageous involve accepting reality and transforming threats into challenges. Courageous behaviour includes taking responsibility for one's own welfare and unpretentiously getting on with life in spite of difficulties. Factors that have been reported to promote and/or maintain courage include role models, hope, and being courageous for the sake of others who may be in distress. A sense of equanimity and personal integrity have consistently been reported as outcomes of being courageous (Asarian, 1981; Finfgeld, 1995, in press; Haase, 1985).

There are differences among the findings of qualitative investigations of courage among people with long-term health concerns. In contrast with the findings of this study and others (Asarian, 1981; Finfgeld, 1995, in press), discernment can be only inferred, and not clearly identified, as an overt characteristic of courageous cognition among adolescents (Haase, 1985). Perhaps this is because discernment is a cognitive skill that not all adolescents have fully mastered. Another possibility is that because Haase's (1985) respondents were interviewed while they were hospitalized, their ability to make discerning decisions was not of paramount importance; they were probably focused on simply coping with hospital routines and getting through tests, treatments, and surgery.

Another discrepancy that relates to cognitive processes is Asarian's (1981) and Haase's (1985) inference that creativity as a component of becoming and being courageous results in enhanced perceptions.

Neither Finfgeld's work (1995, in press) nor the findings of the present study support the role of creativity in producing enhanced perceptions. Data from this investigation lend credibility to the notion that courageous individuals experience enhanced sensitivities; however, there is no indication that creativity precedes this experience. This discrepancy may relate to the manner in which the terms *creativity* and *problem-solving* have been used by the researchers; further investigation might serve to offer clarity.

Unlike the adults in this study and others (Asarian, 1981; Finfgeld, 1995, in press), the adolescents in Haase's (1985) investigation did not clearly acknowledge values as critical to becoming and being courageous. As supported by Finfgeld's (in press) work with young adults, this may be because adolescents are still in the process of formulating their values and thus their value systems are not central to their development of courage. Another possibility is that if their values are not well formulated, adolescents may be less able to articulate how they influence the emergence of courage. A clinical implication relevant to this finding is whether nurses should focus on helping adolescents assess and articulate their value systems as they struggle to make decisions and as they face the challenges presented by their persistent health problems.

Respondents in this study and several other investigations (Asarian, 1981; Finfgeld, 1995, in press; Haase, 1985) identified personal integrity and equanimity as outcomes of being courageous. Young adults (Finfgeld, in press) and the middle-aged respondents in this work and that of Asarian went further, however, emphasizing a sense of vitality, thriving, and zest for life. Among the elderly, this difference may be attributed to the fact that older individuals anticipate slowing down and have already dealt with the reality of their own mortality. Among the adolescents in Haase's (1985) study, the setting in which data were collected may explain why vitality, thriving, and zest for life were not identified as outcomes of being courageous. Many of these respondents were dealing with the immediate challenges of being in hospital, and feelings of zest and vitality may not have been present.

Findings of this and other studies support the notion that health-care providers play a role in bolstering courage (Finfgeld, 1995, in press; Haase, 1985). In particular, the present study identified professional competence and effective communication as important. Two significant implications for nursing can be inferred from these findings. First, as health care becomes more complex, nurses will need to continually expand their knowledge base so they can help individuals feel secure

in becoming and being courageous. Second, in the midst of complex and sometimes overwhelming treatment regimens, nurses must remain vigilant about their use of effective communication. Several of the communication styles identified in this study are based on clarity, civility, common courtesy, and honesty. Nurses should be prepared to use all of these communication styles in meeting the psychosocial needs of clients.

Finally, there is a need for further examination of the role that values play in influencing courage, particularly in light of the implication that ending one's life may be perceived as a courageous alternative. This is an especially important area of investigation considering the resources used to extend life, perhaps against the wishes of the patient and at the expense of human dignity and personal integrity. Also, courage should be examined across cultures to determine how alternative value systems might influence people's courageous desires and behaviours.

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