

Running head: SPIRITUALITY AND FACIAL TRAUMA

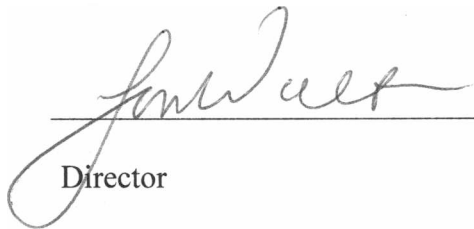
Spirituality in Individuals Recovering from Facial Trauma

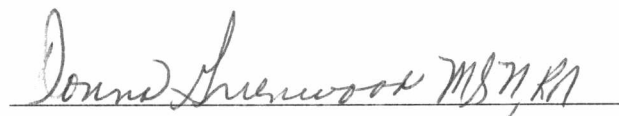
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Abstract

Trauma is the leading cause of death of individuals between the ages of one to 44 (Albertson et al., 2006). The purpose of this thesis is to gain an understanding of the role spirituality play in the recovery from traumatic facial injuries. Participants were English-speaking individuals who were recovering from a disfiguring trauma. All individuals were over the age of 18. The individuals live in the Western states. The sample size of the study was four individuals who had experienced physical trauma requiring surgical repair. Participation was based on a voluntary basis. Interviews took place in a private setting suggested by the interviewee. Data was analyzed by use of classic Grounded Theory. Data collection was complete when there was no new data to be collected and a sense of closure occurred. Using grounded theory methodology, spirituality has been defined by participants in three major categories: Family and true friends as a source of strength, finding meaning and purpose (God, nature, prayer, etc), and emotional reactions to injury (public, self, and family). Through grounded theory constant comparison the researcher has found the understanding of what spirituality means to a person who is recovering from a facial trauma and how it impacts their lives.

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To: Dr. Joni Walton and my Mother, Alyce Streich

In Loving Memory of my Father, Eldon Streich

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CHAPTER I

Spirituality and Recovering from Facial Trauma

Trauma is the leading cause of death of individuals between the ages of one to 44 (Albertson et al., 2006). Facial fractures and soft tissue injuries are a result of trauma acquired by activities, play, sports, assault, and auto crashes (Gassner, Tuli, Hächl, Rudisch, & Ulmer, 2003). Recovery from facial trauma is often a long involved, painful process that includes multiple surgeries and long periods of wound healing. Altered body image is often found in individuals who have experienced these disfiguring traumas (Horton, Renooy, & Forrest, 2000). In addition, individuals with facial trauma have a higher incidence of post traumatic stress disorder (PTSD) and social adjustment (Levine, Degutis, Pruzinsky, Shin, & Persing, 2005). The ability to understand one's view about spirituality may help to serve individuals who are recovering from trauma and has been found to enhance recovery from surgery (Puchalski, 2001). Those who experience life-threatening illnesses have reported higher stages of spiritual development (Martin & Sachse, 2002). Spirituality is a life-giving force and harmonious connection with self, divine, family and friends, community, and nature (Burkhardt, 2005). The purpose of this thesis is to gain an understanding of the role spirituality plays in the recovery from traumatic facial injuries.

Facial Trauma

Many studies suggest the causative factors for facial trauma are automobile crashes and falls; however some studies show blunt assault as the main causative factor (Zargar, Khaji, Karbakhsh, & Zarei, 2004). Individuals acquire facial trauma several ways. Injuries range from burns to lacerations to fractures. These all lead to a

disfigurement of facial features. Individuals who are recovering from a facial disfigurement report that the general public stare or will avoid them, or act differently toward them as if they are not intelligent. The individual may often withdraw from a social setting (Levine, Degutis, Pruzinsky, Shin, & Persing, 2005). Researchers have found, “The human face constitutes the first contact point in several human interactions, [sic] thus injuries and/or mutilation of the facial structures may have a disastrous influence on the affected person” (Zargar, Khaji, Karbakhsh, & Zarei, 2004, p. 110). Individuals suffer from social isolation and have increased anxiety when in social settings related to their disfigurements (Coull, 2003). The fear – avoidance model described the psychosocial difficulties following a disfigurement. Many principles make up the model, one being that those who recover efficiently are those who confront rather than avoid situations (Coull, 2003). One may cope with a facial trauma by reviewing his or her spirituality. As a nurse, encouraging individuals to express their spirituality may facilitate physical, emotional, and spiritual healing.

Spirituality

Spirituality is the core of our being; it saturates our relationships and explains who and what we are. (Burkhardt & Nagai-Jacobson, 2005). Spirituality comes from the Latin word *spiritus*, spirit. The spirit controls the mind, and the mind then controls the body, generating the force which motivates and influences one’s life (Baldacchino & Draper, 2001). The elements which make up spirituality are meaning (significance), value (belief), connection (relationship), becoming (reflection), and transcendence (beyond self) (Dyson, 1997). Walton (2007) identified spirituality as complex, involving all aspects of life, and unique to each individual. Nurses may use spirituality as part of their

holistic care. Researchers reported, “Spiritual nursing care is an intuitive, interpersonal, altruistic, and integrative expression that is contingent on the nurse’s awareness of the transcendent dimension of life but that reflects the patient’s reality” (Sawatzky & Pesut, 2005, p. 1). It may allow one to cope and understand the situation by rising above it (Adegbola, 2006). Spirituality influences our lives and is expressed through our connectedness with nature, self, others, and Higher Power (Burkhardt & Nagai-Jacobson, 2005). Exploring spirituality in the recovery from facial trauma may give nurses insight and understanding to strengthen nursing care.

CHAPTER II

Review of the Literature

Motor vehicle crashes in the United States constitute 37.9% of the reported injuries in 2007 with falls reported second at 30.2% (National Trauma Registry, 2007). An estimated 1.5 % of traumatic injuries were caused by burns which may be considered disfiguring especially if the burn involves the face (National Trauma Registry, 2007). Pathophysiology, mechanism of injury, and treatments will be reviewed, in addition to reviewing the literature related to body image, coping, and PTSD, depression, spirituality, and prayer.

Mechanism of Injury

Types of injury that cause facial trauma include blunt force, burn, and laceration and are acquired from activities of daily living, sporting events, automobile crashes, falls, and assault. A study by Gassner et al. (2003) reviewed over nine thousand individuals with cranio-maxillofacial trauma over ten years. Approximately 38% of the injuries were caused from activities of daily life. Soft tissue damage was reported the highest type of injury at 62.5%. The study showed that more males were treated than females in a ratio of two to one. Young individuals reported more dentoalveolar trauma, middle aged individuals reported higher soft-tissue injuries, and older adults are more susceptible to facial fractures. However, another study suggested that automobile crashes were reported highest along with falls and assault. Collisions that involved pedestrians were reported in 80% of the research cases. The study also examined motorcyclists, in which those who did not wear a helmet acquired more facial trauma than those who did. In vehicle crashes, front seat passengers received more facial trauma than the other occupants in the vehicle.

Seat belts were not worn in most of the vehicle crashes reported (Zargar, Khaji, Karbakhsh, & Zarei, 2004). Out of the 274 cases that were reported in the previous study, the majority of the individuals presented with open wound injuries; facial fractures reported with the next highest incidence. The most common facial fracture consisted of the mandibular bone followed by the nasal bone (Zargar, Khaji, Karbakhsh, & Zarei, 2004).

Assault. Approximately 94 % of domestic violence cases result in an injury to the face, head, and neck (Greene, Maas, Carvalho, & Raven, 1999). The estimated cost of domestic violence to the healthcare system is three to five billion dollars per year plus many individuals' lives. Domestic violence is the number one cause of trauma among women with one million cases reported in the United States. How the assault occurred was different among genders. Women are more likely to sustain injury from domestic violence such as rape and are more likely to know the individual who afflicted the injuries. Males sustain injuries to the face, constituting the majority of facial fractures which are acquired through criminal violence activity or gang association. Males are often injured by strangers and usually alcohol, gang activity, or drug related activity are a factor (Greene, Maas, Carvalho, & Raven, 1999). Zargar et al. (2004) reported that victims of assault sustained the most severe injuries to the face compared to those who had fallen or were in an automobile crash.

Burns. More burn-injured individuals suffer emotional difficulties than reconstructive surgery and trauma patients (Wisely & Tarrier, 2001). A quantitative study showed that the medical staff were able to identify the presence of psychological difficulties in more than half of the cases. The need for psychological care in follow-up

services for burn-injured individuals was examined in the Wisely & Tarrier study. The hospital where the research was conducted administered the depression and anxiety scale to help facilitate the research. Burn-injured individuals reported a lack of psychological support and said that this would have been beneficial. The information listed is valuable information, but the number of burn-injury study participants was higher than the reconstructive surgery and trauma patient participants. This could allow room for error. The sample size was large with a total of 100 participants. Nurses could intervene by actively listening and by using presence, touch, meaning of life, and reminiscence. Promoting spiritual support, nurses could intervene by use of forgiveness, instilling hope, and prayer (Gaskemp et al, 2004). For example, an individual was burned at the age of five affecting 97 % of her body. As the individual grew older, perseverance shined through the numerous operations, including facial restructuring and skin grafts. The individual once reported that one of the hardest things was to accept, "why do I look like this when I feel just the same inside" (Coull, 2003, p. 256). The individual is currently happily married which she never envisioned and stated that it is hard for those who are disfigured to look in the mirror every day and know it will not change. Emphasis was put on the importance of nurses and doctors to encourage patients to look into the future because those with facial traumas only know what they look like at that moment.

Pathophysiology

The body's normal reaction to a facial trauma is inflammation and pain. Depending on the type of injury, the duration of the inflammation and pain varies (Porth, 2007). Pain, however, is often described as an individual experience, happening when and where the individual says it does.

Inflammation. This is a protective process the body undergoes in order to respond to cell injury. The process involves destroying harmful agents so that the site of injury can heal and become reconstructed. When repairing the tissue, the body regenerates the damaged cells or fills in the defect with scar tissue (Porth, 2007). The healing process depends on the type of injury. According to Porth (2007), "Tissue healing is regulated by the action of chemical mediators and growth factors that mediate the healing process as well as orchestrate the interactions between the extracellular and cell matrix" (p. 210). Burns may lead to many local and systemic problems such as fluid and protein losses, sepsis, and changes in metabolic, endocrine, respiratory, cardiac, hematologic, and immune functioning (Coffee, 2006).

Pain. Burned individuals experience cutaneous sensitivity depending upon the degree and location of the burn (Malenfant et al., 1996). Tactile, thermal, and pain thresholds were tested in 121 patients with healed burns and matched with 121 healthy control subjects 18 months after a burn injury. This was a quantitative study to examine cutaneous sensitivity in burned individuals. Burn patients had a higher pain threshold than the control individuals (Malenfant et al., 1996). Deep burn wounds that required skin graft were more affected than the superficial wounds that healed more spontaneously. Sensory losses were not only found in the burned areas but also in the non-injured areas as well, suggesting central nervous system changes. Significant deficits in tactile modality were observed when comparing symptomatic and asymptomatic sites. The depth of the burn and age of the participant were other factors that were taken into consideration when considering chronic sensory problems. This study examined burns only of the upper extremities, and healed burns, then divided them into symptomatic or

asymptomatic sites depending on the site of the pain or parasthesia and then compared to its counterpart. The findings of this study provided useful information for nursing intervention. Education may include pain management and possible loss of function of the extremity due to the severity of the burn, which in turn could affect a person's quality of life.

Treatment

Certainly there are several different therapies for individuals with facial trauma. Surgery may be one of the most invasive therapies, but it may also be the most rewarding. The type of injury, size, and extent of the injury will determine what type of treatment the individual will receive (American Society of Plastic Surgeons, 2008). Surgeons are the primary physicians for trauma patients (Angelos, 2002). Surgeons are often the first to introduce new technologies and treatments (Angelos, 2002). Plastic surgery may be able to improve the appearance of the face resulting in a more positive body image for that individual. Dr. Pulchalski distinguished the different ways in which one sees life and what each represents:

Helping, fixing, and serving represent three different ways of seeing life. When you help, you see life as weak. When you fix, you see life as broken. When you serve, you see life as whole. Fixing and helping may be the work of the ego, and service the work of the soul. (2001, p. 352)

Reconstructive surgery. An estimated 5.2 million reconstructive procedures were done in 2007 (American Society of Plastic Surgeons [ASPS], 2008). The top five procedures done were the following: tumor removal (3.9 million), laceration repair (286,000), scar revision (150,000), hand surgery (142,000), and breast reduction

(106,000) (ASPS, 2008). The goal of reconstructive surgery, as stated by the ASPS (2008), is performed on abnormal structures of the body to improve function. Each surgery is unique and depends on the circumstances of that individual. The surgeries are done based on two different categories depending on if the abnormality was acquired such as burns, lacerations, or growths, or a congenital abnormality, meaning developmental birth defects. Individuals are unique and their healing ability may differ; therefore, their outcome is not always predictable. Complications that occur are complications that can occur with any surgery which include the following: infection, excessive bleeding, wound-healing difficulties, and problems with anesthesia. Reconstructive surgery requires extensive planning, and many procedures are done in stages to obtain maximal results. Different types of surgery include the following: skin grafts, tissue expansion, flap surgery/microsurgery, and several forms of laser surgery (ASPS, 2008).

Complementary treatments. Complementary alternative medicine may be used with modern medicine. These complementary therapies may include transpersonal caring, therapeutic touch and prayer. Therapeutic Touch (TT) is a meditative healing technique that was developed by Dolores Krieger and Dora Kunz (Straneva, 2000). It was developed in the 1970s and is adopted from the ancient practice of “laying on of hands.” Therapeutic Touch is a therapy in which energy is transferred from the healer to the healee all in the purpose of helping others. This form of therapy is not a basis of miracles but is conducive to self-healing (Straneva, 2000). Straneva (2000) reported studies that were conducted in the early 1970 by Krieger and Kunz. These research studies involved the study of hemoglobin. The reason to study hemoglobin was simply because in Eastern

philosophy one who has excess "prana" or breath is healthy, and those who have a deficit experience a disruption in their vital energy. Through many trials of research, Krieger & Kunz had positive results indicating that those who experienced Therapeutic Touch therapy had a higher level of hemoglobin than those who received no treatment. Krieger and Kunz then proceeded to teach Therapeutic Touch primarily to nurses. They concluded the difference between the laying on of hands and Therapeutic Touch to be as follows: TT does not require religious affiliation, there is no physical contact, human potential is accessed through instruction, and no faith is required in the practitioner or for the therapy to work. Over 90% of individuals who received TT experienced physical symptoms of relaxation as evidenced by peripheral flushing indicated by vasodilation, decreased and deep respirations, and subdued voice level (Straneva, 2000). Straneva (2000) concluded that TT has been efficacious in many circumstances such as the following: increased hemoglobin levels, reduced pain, increased quality of sleep, decreased anxiety, and accelerated wound healing. Daley (1997) pointed out that TT increased emotional, physical, and spiritual well-being of individuals. Daley (1997) explained that Therapeutic Touch, although created entirely in the field of nursing, can be learned by anyone who is empowered by compassion and motivated to help others. Therapeutic Touch is based on four principles: (a) centering, utilized by the practitioner by deep breathing to become focused; (b) assessment, scanning the body 2-6 inches away from the individuals attuning to any blockages in the energy field; (c) treatment, redirecting the congested energy to even out the energy field; and (d) evaluation, reassessment of the individuals energy field to assure balance (Krieger, 1979).

Body Image

Altered perception of body image is found in most individuals recovering from disfiguring traumas (Levine, Degutis, Pruzinsky, Shin, & Persing, 2005). Body image is how one may view his or her body in the mind or how one appears to himself or herself, which makes body image a personal view of oneself (Atkinson, 2002). Body image is something learned early on in life and continues to grow as individuals grow and develop with life experiences (Atkinson, 2002).

Body image model. Price's (1990) model of body image is made up of three components: body ideal, body reality, and body presentation which, together, make up our self image (cited in Atkinson, 2002). Body ideal is how an individual wants to appear whereas body reality is how the individual actually appears. Body presentation deals with the public aspect of body image. Studies have shown that attractiveness is correlated with goodness, and if one falls out of this area of attractiveness, because of a disfigurement or wound, then he or she is thought to be less attractive, resulting in low self esteem (Atkinson, 2002). Altered body image is defined by the individual as personal distress, appearing dysfunctional to individuals, and being unable to partake in social settings with others because of fear of social stigma (Atkinson, 2002). Factors that may lead to alteration in body image include disrupted reality (unpredictable), uncertainty (implications for one's lifestyle), and restructuring of reality (acceptance of a new body image) (Atkinson, 2002). Nurses play a vital role by assessing body image, coping strategies, and spirituality in individuals who have experienced a disfiguring trauma.

Social adjustment. Individuals who experience disfiguring trauma may report a feeling of rejection, unworthiness, and humiliation. The injury is a permanent reminder of

the sadness and fear they experienced (Blakeney & Creson, 2002). Individuals have reported a fall-out in marital status and increased binge drinking and a higher incidence of posttraumatic stress disorder (Levine, Degutis, Pruzinsky, Shin, Persing, 2005).

Coping. Emotional venting, self-blame, and behavioral disengagement are three coping strategies that were identified as injury –related distress among injured adults (Victorson, Farmer, Burnett, Ouellette, Barocas, 2005). These three coping strategies were among five that were tested in a correlational study. The five coping strategies included the following: denial, substance abuse, disengagement, venting, and self-blame. The study investigated maladaptive coping strategies following a physical injury. It was conducted in 2005 with ages ranging between 18-66. The trauma system checklist – 40 (.89-.91 reliability) and brief coping orientations to problems experienced scale (.50-.90 reliability) were used. The participants' injuries ranged from burns, multiple trauma, and orthopedic injuries. The study was conducted at a level one trauma center. Nurses could implement psychosocial and educational interventions for coping after a traumatic injury which might prevent injury-related distress (Victorson, Farmer, Burnett, Ouellette, Barocas, 2005). Spirituality may be utilized when coping with disfigurement (Puchalski, 2001). According to some studies, those who are spiritual may have a more positive outlook and a better quality of life (Puchalski, 2001). Individuals feel comforted from their spiritual beliefs and more satisfied with their life (National Trauma Registry, 2007). Individuals recovering from trauma are forced to cope with pain, physical therapy, and staged reconstructive surgery and for many, time away from employment as well as the challenge of re-entering into socialization (Boyd, 2005). The impact of trauma is not only observed physically but also emotionally. Researchers reported, "Survivors of physically

disfiguring trauma, regardless of the cause, have experienced a series of assaults on the mind as well as on the body that present extraordinary challenges to human resilience” (Blakeney & Creson, 2002, ¶ 1).

Habilitation. Blakeney and Creson (2002) have developed a model called “habilitation” which was created to guide burn survivors through treatment and toward improved outcomes (Blakeney & Creson, 2002). Not only are these individuals coping and trying to accept their disfigurement, but they are also trying to heal physically. Financially these injuries become expensive to treat. The individual may experience body image alterations. The feeling of inadequacy from the loss or disfigurement of a body part is often reported (Heron Evans, 2006). Lifelong sadness and pain may remain as the reminders of the physical body changes of the person experiencing the trauma (Blakeney & Creson, 2002). According to a study done by Blankeney and Creson (2002), quality family support and the individual’s willingness to take social risks play a major role in the recovery. Family or a significant other is important during the time of recovery because of the fear of re-entering into society (Coffee, 2007).

Social support. Individuals have reported that social support provides individuals with feelings of recovering from their injuries and encouragement to live a healthy, normal life (Richie, Ferguson, Adamaly, El-khoury, & Gomez, 2002). Care giver role strain impacts individuals with traumatic injuries because of the many daily health care needs of the injured individual. Self-pay is the second leading method of pay for trauma reported at almost fifteen percent (National Trauma Registry, 2007). Medicare accounts for about thirteen percent of the trauma injury costs (National Trauma Registry, 2007). This particular act may have an impact on the community tax payers. The cost of

healthcare can be a financial burden because of the multiple reconstructive surgeries (ASPS, 2008). The ASPS reported that the type of reconstructive surgery then depends on the cost of the procedure as well as how long it may take the individual to heal. One study showed that individuals with a facial laceration between the ages of 18-45 had a significantly higher incidence of post trauma unemployment, marital problems, binge drinking, and jail time than those without a facial abnormality which indicates a negative social and functional impact related to facial trauma (Levine, Degutis, Pruzinsky, Shin, & Persing, 2005).

Patients with facial trauma were sent questionnaires and asked to answer for a research study. They were asked questions on their surgical experience, if it helped their psychosocial aspect of life. They were also asked questions on body image, self-concept, and social and professional situations. The results showed that interacting with new people, dating, and looking at themselves in the mirror was frequently or always difficult. Below average scores were reported on self-confidence, self-esteem, friendships, securing employment, family dynamics, fear of rejection, and other issues and concerns with their self-concept and body image, as previously stated. Their feelings of attractiveness were reported below average. Several of the participants joined in a focus group discussion. They talked about several suggestions that would help the psychosocial aspect of their healing of facial trauma. More than half of the participants agreed that information and resources about facial differences need to be more readily available for individuals. They also believed that networking with other individuals who have facial differences as well as information sessions would be of importance. Participants added that "Surgery may not change your life, like you think it might" and "Society still expects

beauty to come from outside-they will not take the time to know you from within” (Horton, Renooy, Forrest, 2000, p. 9). Participants also added that after their surgery they were able to attend school, church and social groups, but others had a hard time with their self-concept. One participant reported, “Sometimes when I look in the mirror, it’s hard to see myself, [sic] there are people staring at me and making mean comments” (Horton, Renooy, Forrest, 2000, p. 9). One participant even reported that he or she could still not find permanent employment in a public field (Horton, Renooy, Forrest, 2000). The result of this study indicates that the nonsurgical needs of individuals are not being met. Nurses can provide information for individuals such as pamphlets and support groups in the area. Nurses can do a thorough psychosocial assessment to indicate if further psychiatric intervention is needed. Complementary alternative medicine may be implemented as well such as prayer/meditation and therapeutic touch.

PTSD and Depression

Identifying post traumatic stress disorder (PTSD), depression, and anxiety symptoms soon after a traumatic injury may increase an individual’s quality of life (Wang, Tsay, Bond, & 2004). Early detection of PTSD, depression, and anxiety was researched in patients with traffic-related injuries in Taiwan. The study had an exploratory, correlational follow-up design. The research was conducted one week after the injury and again at six weeks. High levels of PTSD were reported at both week one and week six. Depression was the most important variable to predict PTSD at week six with week six being stronger than week one. These findings indicated that traffic-accidents have an impact on an individual’s psychological well-being. Nurses could intervene by assessing individuals after a traumatic injury and talk to the patient about

how it is important to communicate with the healthcare professionals about the injury.

The nurse could also refer him or her to a Psychiatrist to encourage more help.

Gender. A meta-analysis study showed that women are more likely than men to meet criteria for PTSD but less likely to meet criteria for potentially traumatic events (Tolin & Fou, 2006). The study was a quantitative study that reviewed 25 years of research related to gender differences in trauma and PTSD. Four key questions were used to diagnose their results. They used people from many different categories ranging from prisoners/homeless persons, children, adolescents, to people who were currently seeking psychiatric help. Other categories reviewed life threatening or extreme fear of accidents. The study had a vast number of categories. The articles they used ranged from 1980 to 2005. The nursing implication that arose from this study would indicate a need for gender specific interventions to diagnose PTSD.

Depression. In 2004, Tracy Watson conducted a study in South Africa titled "Body Narrative Interrupted: The Relationship between Body Disfigurement, Depression, and Self-Concept." The study focused on women who had not undergone reconstructive surgery and the disfigurement was not caused from an illness. The results showed that altered body appearance and function can result in psychological and psychosocial disturbances. The majority of the women felt they needed to join group therapy or formulate support groups to come to terms with past and current traumatic experiences. This study was limited because of the small sample group of less than 100 individuals, and men were not in the study (Watson, 2004). Many tools and scales were used in the study to determine the level of affected self-concept and depression. Nurses could implement support groups so individuals could talk about their experiences to help expel

emotions. This may help individuals talk about their spirituality and see how others cope with their recovery. A protocol from National Guidelines Clearing House was identified and found that active listening should be used to promote spirituality in individuals. This allows a trusting relationship to develop between client and nurse when the client has time to talk about his or her feelings and experiences (Gaskemp et al., 2004).

Individuals seeking plastic surgery repair for facial disfigurement often experience signs and symptoms of depression. One who has a facial disfigurement may experience stressful life events and side-effects of medications which may lead to depression. Depression has been linked to longer length of stays in hospitals and higher cost of care. Nurses can play an important role in screening, education, support, and referral. Nurses can reinforce that 80-90% of depression treatment is effective (Valente, 2004).

A trusting relationship may empower individuals to take time to talk about their spirituality with the nurse (Gakemp et al., 2004). Allowing this time for individuals to express their feelings on spirituality and how to include spirituality in one's life may help the nurse and the individual with the plan of care.

Spirituality and Prayer

Since the mid-1800 medicine was pre-occupied with mind-body dualism (Ameling, 2000). Dossey (1993) described the effects of the scientific era as a time in which antibiotics, surgeries, and other drugs were used to cure illnesses; this emphasis turned attitudes toward the importance of these scientific advances and pushed prayer out. The scientific era continued uninterrupted until the 1950s when a new mind-body medicine arose: spirituality, meditation, and prayer. Individuals reported that they were

not dissatisfied with their medical care but wanted something closer to their beliefs and life styles (Ameling, 2000). DiJoseph & Cavendish (2005) reported that in 2002 prayer was the most used therapy, noting that 43 % of Americans pray for their health, and 24 % pray for others.

Spirituality has been described by nursing theorists as a harmonious interconnection with self, Divine, others, community and nature (Burkhardt & Nagai-Jacobson, 2005). The ability to understand one's view about spirituality could help serve individuals who are recovering from trauma (Puchalski, 2001). Spirituality has also been found to enhance recovery from surgery. It is broad, encompassing physical, psychological, and social components of life. This means that being in tune with this aspect could result in a more balanced state and help an individual strive for meaning and purpose in life (Baldacchino & Draper, 2001). Those who do not believe in any God still have spirituality; therefore, spirituality is not just based on religion. However religion is a product of spirituality, but it is an individual's meaning and purpose in life or the expressions of one's spirit (Baldacchino & Draper, 2001). Spirituality applies to both the believer and nonbeliever including those from various cultural backgrounds. Defining attributes of spirituality are often unique to each individual; however, common attributes include faith, connectedness, and integration. Research shows that spiritual coping, including relationship with others and self, God, and nature, may help those with facial trauma. One may explore the meaning of life, and instill hope, which may help nurture during a time of distress (Baldacchino & Draper, 2001).

In order for one to heal, both the healer and individual must recognize the spiritual dimension, encompassing the body, mind, and spirit. The connectedness

between the caregiver and receiver is a part of spirituality (Burkhardt & Nagai-Jacobson, 2005). Spiritual issues draw individuals in to experience life at their highest levels. They include mystery, love, suffering, hope, forgiveness, peace and peacemaking, grace, and prayer (Burkhardt & Nagai-Jacobson, 2005). Meraviglia (1999) reported that spirituality can be indicated by prayer and meaning of life. She stated that a person's meaning of life may be an outcome of spirituality and prayer as one's connectedness to God.

Nurses facilitate spirituality and prayer. Prayer comes from the Latin word *precarius*, meaning "obtained by begging" and *precari*, meaning "to entreat, beseech, and implore" (Dossey, 1993). In Dossey's (1993) book *Healing Words* he discussed the two most common types of prayer: petition, a type of prayer in which one asks for something for oneself, and intercession, in which one asks for something for others. Other prayers include confession, lamentation, adorations, invocation, and thanksgiving. Prayer can be public or private, it can be done alone or in a group, it may involve words, gestures, silence or bypass our awareness emerging in dreams. Prayer is often done consciously but can also come from the unconscious. Prayer's effectiveness on healing can be supported scientifically but more importantly, the primary role prayer has on healing is deeper: "prayer says something incalculably important about who we are and what our destiny may be" (Dossey, 1993, p. 6).

Dossey (1993) identified prayer as a nonlocal event meaning that it is not confined to specific place, space, or moment in time; it is infinite. Since prayer must be initiated by a mental action, then part of the human psyche is nonlocal, meaning that something in humans is infinite, omnipresent, or eternal; in Western cultures it is called "the soul." Engagement in prayer then implies spiritual implication. Three theories

support prayer practice (DiJoseph & Cavendish, 2005). Rogers' Science of Unitary Human Beings states, "Prayer is directly related with the human energy and environmental energy fields. Energy fields are patterned; humans become patterned when prayer is used" (DiJoseph & Cavendish, 2005, p. 149). Positive change results by showing greater spirituality. Neuman's Systems Model states, "[A] person's spirit is a seed with energy potential and that, in order to grow, the spiritual seed within a person longs for interaction with a higher power or force" (DiJoseph & Cavendish, 2005, p. 149). Prayer then nourishes the soul and a basic need is fulfilled. Watson's Theory of Human Caring suggests "abandoning ego or self to achieve health through a spiritual connection" (DiJoseph & Cavendish, 2005, p. 150). Clients acquire harmony in mind, body, and spirit.

Prayer is a personal communication with one's God or higher power or belief system (Cavendish, Konecny, Kraynyak, & Lanza, 2004). It is used as a tool to exchange energies between the higher power and the petitioner. According to Cavendish, Konecny, Kraynyak, & Lanza (2004) the petitioner experiences a deep psychological and emotional change internally. This power is woven into a belief system known as faith and influences one's life. Prayer holds different meanings for each individual.

Two types of prayers that nurses use in practice are petitionary prayers and preparatory prayers. Preparatory prayers are silent and personal. They are used to prepare an individual to face a situation that will test his or her inner resolve. Preparatory prayer helps one to instill a right mindset, providing the ability to concentrate on certain ideas in times of stress, providing motivation to face a personal challenge (Cavendish, Konecny, Kraynyak, & Lanza, 2004).

Individuals often reported an increase in inner strength and used prayer to cope with hard times, also as a tool for everyday life (Walton, 2007). A study showed that 18% of nurses used prayer at work for guidance and support they needed for their professional role (Cavendish, Konecny, Kraynyak, & Lanza, 2004). Many individuals find that they pray simply to find comfort (Taylor, 2003).

Prayer takes many forms in which some follow religion and pray for specific events to occur, pray to a specific God or goddess, higher power, or Absolute. Others do not pray conventionally but live with a deep internal sense of the sacred, called the spirit of prayerfulness. Prayerfulness means being attuned with something higher (Dossey, 1993). Prayer often asks for definite outcomes, structuring the future, while prayerfulness is accepting and grateful without giving up honoring whatever happens and tolerating the unknown (Dossey, 1993). Dossey (1993) stated, "If we allow ourselves to enter the quiet, still place of prayerfulness, we can understand the co-relationship of health and illness in the natural order" (p. 25). To reach a plane of experience where illness is experienced as a natural part of life and acceptance transcends passivity is what prayerfulness allows. When illness disappears one is grateful; if it remains, this too is reason for gratitude (Dossey, 1993).

Experimental studies suggest that prayer is effective, but as far as how the individuals prayed is not controlled or specified (Dossey, 1993). In most studies, individuals are simply told to pray, not how to pray (Dossey, 1993). The process of prayer therefore is unique to each individual. Prayers can be an individual, silent act or can involve a group (Taylor, 2003). Meditation is a form of prayer in which one attempts

to quiet the mind and turn one's attention away from thoughts to a calm interior place (Ameling, 2000).

Nurses should assist clients in prayer simply because nursing has so much to do with assisting clients in coping, how to adjust emotionally, and comfort measures (Taylor, 2003). Nurses could ask the questions: "Is there anything in particular you would like to pray about?" Nurses could also implement *The Four Point Guide for Spiritual Caregiving* developed by DiJoseph and Cavendish, (2005) which includes the following: conduct a spiritual assessment, respect prayer practices, observe the positive benefits of prayer, and ensure proper use of prayer in practice.

The benefits of prayer were identified by Doctor Larry Dossey (2003) who supported the power of prayer with healing. Prayer has also been associated with feelings of relief, healing, and well-being (DiJoseph & Cavendish, 2005). A study conducted on a coronary unit split 990 clients into two groups. Half of the clients were prayed for (intercessory prayer) and the other half were not prayed for. The clients who were prayed for had increasingly positive outcomes compared to those who were not prayed for indicating that prayer can work even if clients say they do not believe in prayer (DiJoseph & Cavendish, 2005). The risks that arise out of prayer may be ethical. Some say that ethically one should not pray for someone unless that person knows that he or she is being prayed for; however, sometimes that person who is being prayed for consciously does not believe in prayer, but unconsciously the mind may be asking for some sort of healing that is needed (Dossey, 1993). There are no guidelines; perhaps the only guide is based on good intentions or the Golden Rule. Prayer must be voluntary and one should not be forced into prayer (DiJoseph & Cavendish, 2005). Clients may experience a sense

of doubt in prayer if they feel as though their prayers are not answered, leading the clients into depression and refusal of spiritual rituals (Taylor, 2003).

Nursing. If individuals believe prayer to be an effective healing intervention, then it should be integrated into a part of holistic nursing, incorporating the mind, body, and spirit (Ameling, 2000). Nurses can help clients find meaning through partnership of caring (Dijoseph & Cavendish, 2005). Nurses are not allowed to force prayer onto a client. Teaching may include discussion or assessment on what types of prayer can be used and the use of any tools such as rosary beads. Walton (2007) recognized several different considerations when developing a plan of care. They are as follows: (a) listening to clients to understand their needs, beliefs, and preferences; (b) letting them tell their stories; (c) providing privacy for prayer; and (e) encouraging other nurses to understand cultural beliefs and spirituality. Other discussion among nurses may include personal prayer beliefs compared to the client's (Taylor, 2003). Transpersonal relation happens when the nurse consciously and intentionally enters the phenomenal field of another person in which she or he can determine the person's condition of being. The nurse and the other are enriched deep in the moment and are capable of transcending the moment, thus are open to new possibilities. The two join together to search for meaning and wholeness of being and becoming to help control pain and offer comfort measures, as well as, a sense of well-being and wholeness. By using transpersonal caring, one is viewed as a whole and complete person regardless of the illness or disease; a transpersonal nurse does this by centering consciousness and intentionality on healing, wholeness, and caring instead of on the disease and pathology (Watson, 2006).

Transpersonal caring is a relationship one has with another to explore a concern of the

person's inner life world as well as finding the meaning of another. Transpersonal goes deep into the connections to the spirit and the universe. By using this, one can tap into healing possibilities and potentials. Watson (2006) discovered that "transpersonal caring seeks to connect with and embrace the spirit or soul of the other through the processes of caring and healing and being in authentic relation, in the moment" (¶ 1).

There are several tools nurses can use to assess spirituality and implement spiritual care in individuals: listening, using story and metaphors, and scales such as the Howden's Spirituality Assessment scale. These assessment tools may allow individuals to review their lives and their choices going beyond and into the inner self (Burkhardt & Nagai-Jacobson, 2005). Nurses can evaluate the assessment and include the individual's unique spirituality into their plan of care. Nurses should also include tending to the spirits (encouraging discussion and reflection on spiritual concerns), touch, connectedness (relationships), rituals, mindfulness (centering, awareness), rest, and prayer (meditation) as part of the patient's spirituality care (Burkhardt & Nagai-Jacobson, 2005).

As Dossey (1993) pointed out in his book *Healing Words*, although the prayer may not be answered, the feeling of gratitude is what seems to matter. All persons have a spiritual nature and have needs; a connection with a higher power provides meaning to life and prayer may preserve the client's integrity (Dijoseph & Cavendish 2005).

Long-Term Disabilities

Long-term disability may be something that individuals may need to consider when they have experienced a trauma. Identification of risk factors can help critical care providers recognize individuals at risk for long-term disabilities (Richmond, Kauder, Hinkle, Shults, 2003). A prospective, correlational design was used to research injury-

specific information over two and one-half years. The study was to predict long term disability by using path analysis utilizing structural equation modeling. The research found that disability after an injury may be caught between physical and psychological factors that can be predicted shortly after the injury. If an individual can identify these predictors, more positive outcomes may be reached by those at risk. Several different scales were used when the data were collected. The Sickness Impact Profile was used to assess behaviors and severities of illness. The 15-item Impact of Event Scale was used to test for PTSD along with the traumatic event. The 6-item Social Support Questionnaire was used to interview the individuals on their social support before the event and two and one-half years after the event. Injuries were tested by using the Abbreviated Injury Scale which were classified as to which body system was involved. The severity of the injury was then tested by using the Injury Severity Score which worked with the Abbreviated Injury Scale to reveal the severity of all the injuries by using a numerical system. The reliability of the scales was reported as well over the acceptable range. Validity was assessed in the tools by reporting the use of the scale to obtain data. The data collected indicated that nurses should be aware of individuals' medical history if they present to the hospital with a facial trauma. By knowing individuals' past medical history, the nurse would be able to intervene more efficiently by identifying those more at risk for long-term disability which could affect the patients' quality of life.

The Role of Nursing

The nursing focus includes the North American Nursing Diagnosis Association (NANDA) nursing diagnosis, altered body image, which is of priority to the individual who has experienced a facial trauma. The use of NANDA diagnosis is important for

nurses caring for individuals with facial traumas because it provides interventions within the nurse's scope of practice (Carpenito, 2006). The evidence-based practice nursing interventions are then used to help direct individuals towards their goals. The interventions include both complementary alternative therapies as well as modern medicine therapies (Carpenito, 2006). Florence Nightingale once wrote:

Nursing is an art; and if it is to be made an art, it requires as exclusive a devotion, as hard a preparation, as any painter's or sculptor's work; for what is the having to do with dead canvas or cold marble, compared with having to do with the living spirit – the temple of God's spirit? It is one of the Fine Arts; I had almost said, the finest of Fine Arts (quoted in Burkhardt & Nagai-Jacobson, 2005, preface).

Priority diagnosis. Altered body image is the priority NANDA diagnosis for individuals experiencing facial traumas as evidenced by the disfigurement of the trauma (Carpenito, 2006). Spirituality, then, may be used to help individuals cope with their altered body image and therefore may be used as an intervention (Puchalski, 2001).

Interventions. The National Guidelines Clearing House (NGCH) offered a protocol for promoting spirituality. The interventions include active listening and spiritual support. Active listening includes the following: presence, touch, meaning of life, and reminiscence (NGCH, 2008). Presence simply means being there with the client; the nurse's attention is centered on the client. Touch conveys a sense of acceptance. Individuals receive comfort by holding a hand or someone touching his or her shoulder. Several studies have shown an increase in a person's self-esteem by using caring touch. Search for meaning can either mean the truth and significance of an illness or the spiritual concept and meaning of life. Individuals may do life reviews and remember certain

aspects of their lives to help lift their spirits and self-esteem. Reminiscence may be implemented in a support group, family, friends, or healthcare providers to help one another talk about their experience and help share emotions and feelings. There is a positive relationship between reminiscence and psychological well-being. Spiritual support can be broken into three categories: forgiveness, instilling hope, and prayer. Forgiveness entails making a commitment to no longer resent something. Nurses can help individuals in the process of forgiveness of self and others who might have caused the injury by actively listening to individuals when they are expressing guilt. Instilling hope is used to help individuals express positive orientation and a will to live. When care, hope and love are received by others, the individual may be influenced and strengthened (Gaskemp et al., 2004). Prayer has been scientifically researched and results show that along with modern medicine, prayers can heal (Dossey, 1993). Prayer is a power intervention which can be implemented in several ways such as group prayer, individual prayer, and prayer for someone else, or through meditation. Nurses could encourage individuals to meditate, pray, or even read spiritual texts (Gaskemp et al., 2004).

Psychological. Blakenly & Creson (2002) reported goals for treating the psychosocial problems of disfigured individuals. The goals are as follows: patients are assumed to be normal and recover fully; difficulties during this time are normal while these individuals are trying to develop new lives, body images, and ways of feeling about themselves; family groups are highly encouraged; training toward self-efficacy by practicing social skills may be encouraged; and the psychotherapist can help the individual identify a new-self image.

Evaluation

Research on spirituality in individuals recovering from facial trauma is limited. The need for research on spirituality and healing is, however, expanding. Many studies are related to the body image alterations in individuals with facial trauma but little on how individuals cope with their trauma and even less individuals' spirituality while recovering from their injuries. While body image is important in individuals recovering from facial trauma, how they cope with their injury and how the nurses intervene to promote spirituality should be included in the individual's plan of care. Strengths in facial trauma research fall into the psychological aspect of the trauma including PTSD, depression, body image alteration, and social impressions. After reviewing several studies, limitations remain in research regarding spirituality in individuals recovering from facial trauma.

CHAPTER III

Methodology

The purpose of this thesis was to gain an understanding of the spirituality of individuals recovering from traumatic facial injuries. Grounded theory helped answer this question by allowing the researcher to interview individuals who had experienced a disfiguring facial trauma. The researcher then obtained information related to the individual's spirituality by listening to the individual's story and how each person coped with such a traumatic injury. After interviewing and obtaining information on the spiritual nature of each person's recovery, grounded theory allowed the researcher to draw conclusions from the information obtained.

Grounded Theory

Grounded theory is a collection of data from which a theory is derived (Glaser, 1992). Glaser stated that qualitative research is done by constantly comparing but also interpreting what is emerging by asking questions that take the analyst away from what is going on (Glaser, 1992). Grounded theory is a qualitative research method that is based on human behavior and was developed by sociologists Glaser and Strauss in the 1960s (Beck, 2004). Beck (2004) described grounded theory as "the discovery of theory from data that have been systematically obtained through research (p. 266). According to Beck, grounded theory generates a theory; it does not start with a theory. The theory that is generated is used to explain a substantive area (Beck, 2004).

Grounded theory uses both inductive and deductive research. Substantive and formal theories are generated from the inductive approach. Substantive theory focuses on specific topics such as patient care, whereas formal theory is based on a conceptual area

and then deduction tests the theory empirically (Beck, 2004). Beck (2004) stated, “Symbolic interaction provides the theoretical underpinnings of grounded theory” (p. 266). Beck described symbolic interaction as the nature of social interaction among individuals. Glaser, the sociologist who invented the grounded theory method, emphasized that “grounded theory frees the researcher to discover what *is* going on rather than assume what *should* be going on” (Beck, 2004, p. 279). Grounded theory is useful in the nursing profession because “through grounded theory, the processes that underlie social experience are discovered and become the basis for nursing interventions” (Beck, 2004, p. 278).

Researcher's bias. It was important that the researcher did not judge the participant's external injuries. It was also important that the researcher did not bring her own spirituality or push the researcher's spirituality onto the individual. The researcher could not judge the individual about how the injury happened or what interventions the individual chose to make, and had to remain nonjudgmental towards the individual.

Procedure

The sample size of the study was four individuals who had experienced physical facial trauma requiring surgical repair. Participation was based on a voluntary basis. Interviews took place in a private setting suggested by the interviewee.

Characteristics of participants. Participants were English-speaking individuals who were recovering from a disfiguring trauma. All individuals were over the age of 18. Most of the individuals live, or are from, Montana. The researcher recruited volunteers by word of mouth as well as posters with researcher's contact information at a local plastic

surgery office. Recruitment flyers were given to the office manager at the surgery office. Interested volunteers could contact the researcher via phone.

Ethical considerations. The Carroll College Institutional Review Board approval was obtained prior to initiating the study. Training for Protection of Human Subjects by the National Cancer Institute was completed prior to data collection. The data obtained, including identifiable information, were kept in a locked cabinet. The audiocassette that was used in the interview process was kept in a locked cabinet and destroyed when research was finished. No names were used; the names were coded and numbers were used. Informed consent was obtained from each individual. Interviews were conducted in a private setting.

Data collection. Data were collected by in-depth interviews. The participants were asked open-ended questions and told to elaborate on each. The researcher also asked closed ended questions. Data included age, gender, date of injury, prognosis, and psychosocial impact. The interviews were recorded on an audiocassette tape. During the interview, the researcher took notes on nonverbal communication while the individual was being recorded.

Data analysis. Data were analyzed by using the classic grounded theory by means of constant comparative method. Constant comparative method can be described in four stages: "1) comparing incidents applicable to each category, 2) integrating categories and their properties, 3) delimiting the theory, and 4) writing the theory" (Glaser & Strauss, 1967, p.101). The stages are continuously developing until the analysis is determined. Coding is done to analyze the data. Coding breaks the data up into categories that are interpreted from the incidents that are repeated. There are three types of coding in

constant comparative analysis. Open coding identifies as many categories as possible. Constant comparative coding compares the category or incident to concepts, and theoretical coding develops a relationship between the concept and its properties. The analyst writes memos on ideas about occurrences in the data. Data collection was completed when there were no new data to collect and a sense of closure occurred (Glaser & Strauss, 1967).

Limitations. The sample size of the study was small and therefore was not intended to achieve generalized results. Limitations of the study include age, healing process, and race.

The first limitation was related to the ages of the participants. The four participants were of differing ages and therefore in different developmental stages of life. This may impede results related to activities of daily life such as occupation and home life.

The second limitation was that participants were at different stages of the healing process. Each participant explained when his or her injury happened indicating how long he or she has been recovering. This creates a limitation to the study because an individual who has been recently injured may look at life a completely different way than someone that had been injured several years ago and has learned coping mechanisms that help with life challenges. For example one participant had been injured two years ago is going through the beginning stages of grief related to her injury and is careful whom she tells her story to compared to an individual who has been injured for about 17 years and is willing and ready to tell his story in classrooms and educate individuals on the street

whom he meets in passing. The time and healing stage variables influence how questions were answered.

The third limitation to this study was that all individuals were of the same race, Caucasian. This may impede results because participants of varied races may have different views on their injury. One race does not allow for variation.

CHAPTER IV

Results

The purpose of this qualitative research was to gain an understanding of spirituality in the recovery from traumatic facial injuries. Throughout the grounded theory analysis, constant comparison coding was done to identify similarities and differences. Similarities identified throughout the data analysis resulted in categories and subcategories reported the differences. The resulting categories were as follows: Family and Friends as a Source of Strength, Finding Meaning and Purpose, and Coping with the Reactions of Public.

Family and Real Friends as a Source of Strength

When the participants were confronted with a traumatic facial injury, the presence of family was the greatest source of strength during recovery. The presence of parents and friends at the hospital bedside, and their support throughout recovery, treatments, surgeries, and rehabilitation were positive forces in healing. Support of family and friends made participants feel loved, protected, and comforted. One participant woke up in the middle of the night while at the hospital shouting, "Mommy, Mommy, Mommy," because, "I needed my mom." When recovering from trauma and transitioning into everyday life, this same participant stated, "I stuck with my family and friends, people that I had already known." Participants had to rely on family during the recovery period to assist with financial matters, completion of disability paperwork, and activities of daily living due to multiple surgeries. One participant who had been involved in an alcohol-related driving accident responded, "[I]t was tough, but my family was really there for me and they were always very supportive and I got really lucky with that part." The presence

of family and close true friends provided participants with strength to endure multiple treatments, surgeries, and cope with recovery.

Real friend and not so real friends. A couple of participants stated that one finds out who one's true friends are. One participant described it as "you kind of realize who your true friends are because they are the ones that still come and see you after you have been in the hospital for weeks, and they come and see how you are doing or see if they can help." This participant told of how one of her best friends, whom she is still close to today, would come and tutor her in algebra; they would watch movies on Friday nights when she could have been out with all her other friends. One participant involved in a driving accident stated that she became depressed because "not all of my friends that I thought were my friends would come over and see me."

Finding Meaning and Purpose

Relationship with a higher power was uniquely described by each participant. Spirituality for participants included receiving hope and joy from being in nature, praying, having faith, and knowing that they are not alone. One participant stated, "I just think it reminded me that God is always there watching and He is always there watching and protecting me when I need Him." This participant made a point to explain how much God has imprinted on her life. She stated:

Religion and God are very important to me; I think they make the foundation of my life and all. Though I don't exactly follow all of the rules, it's always what I fall back on and what I, I look to for the future and it helps me with my path in life.

A participant involved with a gun accident stated the reason for the accident was, "I wasn't in contact with God." She remembered stating to her sister after one of her surgeries, "I am blessed because He wasn't ready for me." She stated, "I am not in control. God is, not me." One participant who had been burned stated:

God is still important to me, although I do not really acknowledge Him all that much anymore. Like when I am out somewhere and was to take an elk, I would say, "Thank you, God for your creation and allowing me to have it," because He created them for our pleasure.

Nature. Many participants reported that nature became more appreciable after their injury. A few viewed nature as a source of strength or energy. A participant described how she now views nature "Like when you look out at the lake, things come so much more alive again." One participant, who had stated that after his accident his priorities in life changed, expressed a compassion for nature:

The only things I can take with me when I leave this world, is the good times that I have had in the mountains. The way I explain it to people, to live in Montana and have never heard the elk bugle is like going to Hawaii and never put your foot in the water; you are just missing something. It is an awesome thing.

The same participant stated:

I always thank God that he has made the animals the way they are; I think that the elk is the most awesome animal to hunt because they are smart. I just love to hunt and fish; that is what I like to do. The two things I love to do more than anything.

Prayer. A participant used her accident as a reminder to pray more often. She stated "I used prayer a lot more after I had my accident; it reminded me that I needed to

pray more and not just when I needed Him so prayer really helped me with everything.”

One participant said that she likes to use her rosary beads, that they help her find direction when she is struggling as well to clear her mind:

When a person is feeling a down point in their life or when they are struggling or when you can't find a direction or searching for an answer, sometimes prayer helps you find an answer; it also takes my mind off things and helps me think more clearly.

Meaning of life. Each participant reported that his or her outlook on life has changed. Through the process of recovery, participants viewed their life in a more meaningful way. Several participants felt that they had a responsibility to educate the public on prevention of injury, using their injury and resulting appearance or scars to show people what can happen. One stated that materialistic things that used to mean so much don't anymore, that it is family, going out and having a good time because it is the only time that we will get and we should take advantage of it while we can. This same participant stated that his burn helped him see more clearly about a lot of things. He said that certain things that were really important to him really are not. This participant expressed his motto of life as follows:

It is a matter of knowing who you are. If you know who you are as an individual it just doesn't matter what other people think. But you need to know who you are and the way you know who you are is to know that you have done the right thing every day. You don't have skeletons in your closet type of thing. I supposed everyone has a certain amount of skeletons in their closet but knowing that you have done the best that you can do to make things right with the people around

you. When you have done that, it just doesn't matter what anyone thinks. Looking like I am, you can still go out and get yourself a wife and get married, simply because you are strong individually because you know who you are. If you don't have confidence in yourself no one else will.

Another stated, "Things that I thought before my accident I could never do I went out and said in my mind I will do these things." One female participant was confronted with many medical issues after her injury and she was told she was not going to be able to have children but she did: "I think that she is a blessing and I think that I look at her every day and I'm like it is a miracle that you are here from what I went through and what I have gone through in my whole life." This participant described her purpose of life as unconditionally loving her daughter:

Bad things do happen to good people, and we are never prepared for them, but when they do happen it definitely makes you look at things as in the ways of I am truly glad I am here; there is a reason why I am here and somewhere God, you know, obviously had a path for me that I would be here and carry on with my life and have a daughter and a career.

Emotional Reactions to Injury

Each participant expressed varied emotions similar to a grieving process that was uniquely his or her own. These reactions varied according to the influencing factors involved in the injury (alcohol, self-inflicted, or poor judgment). Reactions varied from no reaction, disbelief, joking around, guilt, anger, self-forgiveness or lack of forgiveness. One participant who was burned over 60 percent of his body described the different stages of healing he went through:

So the first stage you are thinking that was really stupid. Then you go through a stage where you are really depressed thinking about what you are going to do now. I was in a wheel chair and the only exciting thing I had was my brother in-law now, friend then; he was pushing me down through the whole hospital and I was thinking I am never going to walk. You bet I did! But you can really get depressed in a hurry. Then you get to a stage where you start feeling like you can forgive yourself for what you did. The ultimate healing in anything you do, whether you are a drug addict or alcoholic, gambling or obesity, whatever you do in your life, the complete healing, absolute healing is when you can sit one on one with someone else and look them in the eye and say I know what you are going through. None of you can relate to a burn victim because you haven't been there. You can try but you will have a whole lot better understanding now. They will understand that you don't understand and now you can relate to them a whole lot better. The healing is most complete when you can stand before a group of people such as yourselves and talk about what happened.

The participant commented on how his injury changed his view on life: "It changes what is really important to you, your family rather than materialistic things; it is going out and having that good time." The need for perfection was explained by one participant: "trying to be an overachiever at everything, trying to be just perfect more than anything . . . I think after my wreck, I felt like there had to be perfection in there." This same individual made a point to do the things that she never thought she could do.

Anger. Anger was expressed by a participant who was hit by a drunk driver, anger towards the bar for continuing to serve alcohol to the driver as well as anger towards the

driver. During the interview much anger was expressed over the long-lasting physical, emotional effects of the injury, multiple surgeries throughout the past seven years.

Guilt. Guilt was expressed by a participant who was involved in an alcohol related auto crash. This participant was very upset and felt remorse that she made her father cry: she said, "I made my daddy cry; that was the most traumatic part about it for me; I actually made my dad cry, and I couldn't forgive myself for that because I made a bad choice." This participant was involved in a drunken driving accident and rejected the option of reconstructive surgery related to her belief that they were reminders of the choice she made as a way to educate individuals on what happens when one rides with a drunk driver: She stated, "I didn't feel that it was necessary, you know; I made my choices. I did what I did and I'm just going to live with it because that's what I choose to do, and people should learn from my mistake of riding with a drunk driver."

Forgiveness. Another participant who had an alcohol-related, self-inflicted injury had to forgive herself and accept forgiveness from a Higher Power. She stated, "to commit this horrible act and yet to be forgiven and saved." The process of forgiveness for all participants but one was a process that occurred over time and involved personal spiritual growth.

Depression. A few years after the traumatic injury, one participant experienced PTSD. The participant described fear of going into the hospital. Anxiety, depression, and panic overcame her. She stated, "There were nights when I was sleeping and I would hear an ambulance . . . I would wake up panicking and screaming." Another participant reported feeling depressed related to not being able to do the things she used to do:

I was depressed because...everyone would be out doing something like out in the hills or something that I couldn't be involved in, so I was just really felt uninvolved with all of my friends, and it got really hard because I was 19 and had huge gashes on my forehead.

This same participant reported that because she could not do anything for two months, "all I did was sit around and be depressed and eat."

Family reaction. The family responds to the injury of the participant in numerous ways particularly assisting with activities of daily living. One participant stated that she was embarrassed because her sister had to help her bathe; she described this as "it was pretty humiliating being 19 years old and your middle sister is standing over you washing your hair in the tub because you can't do it." This same participant described a close relationship with her sister and stated that:

I think she was more traumatized by the accident than me . . . ; she just about passed out at the hospital . . . ; she was really upset and missed like a week of school to stay at home with me because she was so worried.

She also reported that her baby sister stayed home for a few days as well stating that "it was pretty upsetting." Another participant described how his mother felt after the accident: "It was really mentally draining to my mother to try to get everything straightened out in my life so that I could be ok when I did get back to point A again where I am up and moving." He went on to describe how it is hard on all the people around the patient: "My mother took care of me the whole way." One participant who was involved in a drunken driving accident stated, "My mother never left my side."

Public reactions. After an injury to the face, the public reaction added additional stress to participants recovering from their trauma. Participants address the situation differently. Some participants see it as a chance to educate the public, some use humor, and some dislike expressing what happened. One participant who addresses the situation in a humorous way described a story when he first returned home from the hospital. This participant had 66% of his body burned.

A 3-year-old girl was with her mother; the little girl looked at me and gasped. The mom was trying to drag her away sheepishly, looking like the little girl is embarrassing the hell out of her, and then the little girl looked up at me with these huge eyes, and asks if I was Spiderman. I said, "Yes I am."

He stated that he really liked children because they are so honest. He said it gives him a chance to educate:

They will just stare at you, and I will ask them what they think about my ears, and they say, "Uh huh," and then I ask, "Do you know what that is from," and I say, "That is from playing with matches and I got burned."

He continued to say, "The more normal you can treat people with disabilities the better it will be." This participant described the initial reaction of the public when he first returned home as people would say, "Look at that freak, look at the whatever; you really will hear a lot of that, be around a lot of that." A participant involved in a drunken driving accident had gone to a plastic surgeon to have her stitches removed:

This is the worst stitching job I have ever seen, and I started to bawl; he is telling me that my face looks like crap, and I am like, thank you; that really helps me out a lot with my personal look.

This participant went on to describe how horrible it made her feel as well as depressed.

This participant worked in a grocery store; when she returned back to work, people would ask what had happened to her which would embarrass her but she looked at it as a chance to educate:

It would get really embarrassing to have to deal with it, but if parents have kids, it was kind of a good time for me to, you know, educate their kids and say that I rode with a drunk driver, and this is what happened to me, so some parts of it were good.

A participant involved in a gun accident stated, "If I can live by example for someone else in some way, my life does make a difference." However when she is confronted by the public she stated, "they just kind of look at me like they don't know what I did; anymore I just don't go into it."

CHAPTER V

Discussion

The purpose of this qualitative research was to gain an understanding of spirituality in the recovery from traumatic facial injuries. Spirituality was described by the participants in the following categories: Family and Friends as a Source of Strength, Finding Meaning and Purpose, and Coping with Reactions.

Family and Friends as a Source of Strength

Several participants were comforted by their family presence in their hospital rooms. One participant described waking up in the middle of the night crying for her mother while she was in the hospital; she stated that this relationship grew throughout her recovery process. A participant described the help he received from his mother to help him through with his healing process. Participants needed this continuing relationship to grow and continue on their healing paths. Likewise Persson and Ryden (2006) reported the importance of supportive relationships with family and friends which one participant stated helped him talk freely about his feelings and not have to pretend. A similar finding, found in a research study showed that individuals recovering from spinal cord and/or brain injury became much closer with their families (McColl, Bickenbach, Johnston, Nishihama, Schumaker, Smith, & Yealland, 2000).

The importance of true friendship was reflected on by participants throughout the study. Some individuals stated that they found out who their true friends were. Participants felt that some friends came to the hospital only to see what was going on; they never called or came over when the participants felt that they needed a friend. Likewise McColl et al, 2000 found in their research that one participant stated that a

friend was embarrassed by her wheelchair and would never take her outside. Participants found that helpful friends were those who came over and helped with school work and called on the phone to follow up with recovery.

A few participants revealed other psychological diagnoses that they endured through their recovery. One participant stated that she was diagnosed with PTSD. Wiechman and Patterson (2004) reported social support as a vital component against psychological difficulty. Likewise, Levine and colleagues (2005) identified a high incidence of PTSD as well as depression among people with facial injuries; however, Rumsey, Clarke, White, Wyn-Williams, and Garlick reported when looking at the varying severity of each injury that there was not a significant difference in psychosocial distress (2004). All participants were involved in a traumatic accident; however each facial injury was different in character.

Nurses can educate the family on the importance of the family's presence at the bedside. Friends who come to see the patient should be aware that the patient is in a vulnerable state and that those who come to visit should dedicate their friendship and support to the person and should not come just to see the effects of the injury. A study done on Chronic Illness reported that stronger friendships were developed after their diagnosis of chronic illness than prior to their illness (Walton, Craig, Derwinski-Robinson, and Weinert, 2005). A participant described a negative experience during a visit to the plastic surgeon's office. The plastic surgeon told the participant that the stitching job was the worst stitching job that he had ever seen. Other participants remembered negative comments made at the bedside. One participant who was heavily sedated heard her peers gasp and talk about how terrible she looked. Walton and

colleagues (2005) reported the importance of family coping as an intervention for individuals living with chronic illness. This would help educate the family on the healing process, as well as assess the family support systems. Nurses should also use a tool to help screen for depression and PTSD.

Finding Meaning and Purpose

Many participants referred to God as giving their life meaning and purpose. One participant responded by stating that her daughter keeps her moving forward and gives her life meaning and purpose. All participants reported that they view their lives in a new way. Some also stated that after the injury, their life is more meaningful and they now know that they are here for a purpose. McColl (2000) reported that without a meaning and purpose of life, a person would not be able to face the tasks of each day. Participants reported that their lives became more purposeful and that their meaning of life changed. Depalo (2009) reported, "It is hope and all it encompasses that a person clings to for stability. This makes it a real touchstone for existence. To hope is to acknowledge the future" (p. 74). Some participants stated that they do not look at the materialistic things in life anymore; they live life to its fullest. One participant stated that knowing who one is is one of the most important tools in recovery. Some participants reported after their accident they knew they were here for a reason; although they did not know the specific reason for why they are still here, they knew that there was a new plan for them. Persson and Ryden (2006) reported that individuals who are coping with a physical disability adapt to changing themselves and not the disability. An individual who suffers from blindness reported how restricted her life is but now she has more time to spend with her family and embraces the things she can do such as talk and listen (Persson & Ryden,

2006). McColl and colleagues (2000) also reported the same findings stating, "There is actually a reason for me being here; I have been saved."

Higher power as a source of hope. Spirituality encompasses a broad spectrum. A higher power was described by participants as a source of hope during the recovery process. Depalo (2009) reported, "Spirituality is the seat of hope, giving one a sense of meaning in the face of adversity, [sic] with hope, future recovery becomes possible" (p. 77).

Walton and colleagues (2005) reported women who are living with chronic illness reported that spirituality has transformed their despair into a positive meaning. They express their higher power as God and nature in which the use of prayer and meaning of life helped them cope with their injury. Some participants reported praying more after their trauma. One participant stated that she has always believed in prayer; however, because of her trauma she was reminded that she needed to pray more. Some stated that living through their trauma has made them feel more connected. According to Coyle (2001) spirituality empowers and provides hope: "Uncertainty produces fear, discomfort, pain and suffering. Having faith or trust in God or higher power may help to provide certainty where it is absent, where certainty is reworked to become a trust that their illness has meaning and purpose" (Coyle, 2001, p. 594). Likewise Walton and colleagues (2005) reported that God's presence gave them comfort and peace. A systematic review of literature reported by Holleywell and Walker (2008) reported that there is currently no evidence in published studies that show prayer "beneficial in the absence of any kind of faith and some evidence that certain types of prayer based on desperate pleas for help in the absence of faith are associated with poorer wellbeing and function" (p. 649).

Holleywood and Walker (2008) did however mention that in clinical practice, encouragement to pray should proceed only after proper assessment of faith and nature of prayer.

Most participants reported that nature became important in their recovery process. They stated that they spend more time admiring the beauty of nature, that it became more alive and purposeful. Spirituality influences our lives and is expressed through our connectedness with nature, self, others, and Higher Power (Burkhardt & Nagai-Jacobson, 2005). Likewise, Coyle (2001) reported, "Through my spirituality I give and receive love; I respond to and appreciate God, other people, a sunset, a symphony and spring" (p. 592). Burkhardt (2005) reported that spirituality is a life-giving force and harmonious connection with self, divine, family and friends, community, and nature.

Nurses can help people with facial trauma set attainable goals to help facilitate hope in the recovery process. By setting attainable goals, the individual accomplishes a dream he or she set to increase hope for future recovery (DePalo, 2009). Nurses should provide comfort measures such as prayer, nature, or music which can promote relaxation (Walton, Craig, Derwinski-Robinson, and Weinert, 2005). Goals however must be attainable so that if a goal is not reached the individual does not feel failure which can lead to despair and hopelessness (Depalo 2009).

Coping with the Reactions

The reaction from the public to facial injuries profoundly affected each participant differently. Some participants said that public reactions were embarrassing but gave them an opportunity to educate about prevention of injuries, while another participant, when confronted, felt as though she did not want to talk about her injury. Likewise Walton and

colleagues (2005) reported that spirituality in individuals living with chronic illness “allowed participants to endure discomfort and adapt to chronic illness” (p. 167). A study done in 1982 showed that people stand farther away from a person with a facial deformity/injury than a person who has no facial disfigurement (Rumsey, Bull, & Gahagan, 1982). This was also true with individuals with facial congenital disfigurements, such as birthmarks. The study also concluded that the public stands even farther away from a person who has had a traumatic injury to the face. This study showed the similar findings that the researcher found regarding reactions from the public. The participant who sustained a burn of up to 66 % of his body experienced these reactions at first. He shared a story about going into the local pharmacy and encountering a young mother and daughter; the mother was trying to pull her daughter away because the daughter was staring at him.

Not only did participants face emotional frustrations with the public but also encountered emotions (guilt, forgiveness, anger, and depression), regarding appearance of self. Participants learned to adapt to their appearance and had to find inner strength to help cope with the disfigurement. Likewise, those who acknowledge there is no cure and adapt to the chronic illness move forward to make positive lifestyle changes (Walton, Craig, Derwinski-Robinson, and Weinert, 2005). Similar findings by McColl and colleagues (2000) reported that finding inner strength helped individuals to cope with initial reactions.

Emotions were recalled when participants were confronted by family and friends. Some participants reported the strain on family members. Participants had to learn to trust their family in helping with normal activities of daily living during the recovery phase,

which made one participant express feelings of embarrassment. McColl and colleagues (2001) reported the importance of the awareness of self, knowing that one may need to trust individuals and ask for help, when prior to the injury no help was needed. A study on effective coping and physical disability reported the importance of one's abilities to master challenges (Persson & Ryden, 2006). Persson and Ryden (2006) also discussed the importance of independence to reduce the feelings of helplessness.

Nurses should educate the patient on public reactions, reactions from family and friends, and reaction from self to help gain strength through the healing process. Counseling should be provided before and after the initial reaction to educate and help the individual deal with emotions. According to Walton and colleagues (2005) expressing understanding and compassion could help individuals cope with frustrations they may have regarding their injury. Family and friends should also be educated on the impact that their reactions have on the patient. Education could also be conducted by individuals who have had a facial trauma. Mellott, Sharp, and Anderson (2008) reported on the importance of a healing environment in a critical setting. According to Mellott and colleagues (2008) biological, behavioral, and social variables were examined, and they found that in a stressful environment, such as that in a critical-care unit, the body releases enkephalins; these increase heart rate, blood pressure, and glucose which provides poor healing abilities (Mellot, Sharp, & Anderson, 2008). Participants stated that they now use their facial deformities as a way of educating the youth. For example a woman who was involved in a motor vehicle crash tells children that this is what happens when one rides with drunk drivers. Another example from a man who was burned tells children that this is what happens when one plays with matches.

Future Research

There is little research related to the spirituality aspect of individuals recovering from facial trauma. Many participants expressed their concern about how spirituality is not addressed enough while in the hospital. Further research on the subject would help individuals understand how spirituality can affect recovery from facial trauma and therefore promote care. Future research should include adolescents, multiple cultures, and specific gender. Quantitative research could include the different types of injuries such as self-inflicted or motor-vehicle accidents. Spirituality is not linear in nature and requires the individual to face each day anew. Future research should include individualized interventions that could be used to help strengthen their spirituality and further facilitate healing.

Summary

The purpose of this qualitative research was to gain an understanding of spirituality in the recovery from traumatic facial injuries. Throughout the grounded theory analysis, constant comparison coding was done to identify similarities and differences. Due to the small sample size, the results were not meant to be generalized, but create areas to build on for further research. Using grounded theory methodology, spirituality of persons with facial trauma has been understood in three major categories: family and true friends as a source of strength, finding meaning and purpose, and emotional reactions to coping with the injury. Through these categories, the researcher identified that the meaning of spirituality for the participants includes the importance of family presence at the bedside, the emotional support of a true friend, the impression of a higher power (God, nature, etc.), related to the inner self and hope, and coping with the reactions from

the public, family and self. Spirituality is influential and all encompassing. As each participant faces each day anew, spirituality helps guide him or her through each day and is a continuous circle that allows him or her to refine spirituality.

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