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Journey Towards Recovery Following Physical Trauma

Abstract

Convalescence and recovery following illness are of central importance to nursing. These themes have been explored increasingly in the literature. The focus, however, has been primarily on the process of integrating chronic illness into one's life. Recovery from physical injury is rarely addressed. A body of work focusing on physical trauma demonstrates that recovery is often not complete after injuries that have not been viewed as disabling. To illuminate understanding of recovery following physical trauma, the purpose of our 1997 study was to describe more thoroughly the nature of recovery. A total of 63 adults, in a convenience sample, who survived serious physical trauma, were interviewed 2.5 years after injury using an open-ended semistructured interview guide. Three themes were identified: event, fallout, and moving-on. These themes provided the organizing structure for exploring the journey to recovery. This journey, as disclosed by the seriously injured, does not necessarily correspond with the views of most trauma clinicians. Traumatic events create a line of demarcation, separating lives into before and after. The event becomes the starting point of a journey to resume one's life. The event itself is more than the trauma; it is the perceptual and contextual experience that needs to be incorporated into a person's essence. Fallout from the injury is multifaceted and includes physical, psychological, social, and spiritual dimensions. Moving-on in this journey is nonlinear as survivors recognize their lives are forever different. The survivors' accounts suggest that nurses should carefully consider the question, 'What is successful recovery?'

Keywords

physical trauma; recovery; repercussions; survivorship; healing; content analysis

Disciplines

Medicine and Health Sciences | Nursing

Journey Towards Recovery Following Physical Trauma

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Abstract

Convalescence and recovery following illness are of central importance to nursing. These themes have been increasingly explored in the literature. The focus, however, has been primarily on the process of integrating chronic illness into one's life. Rarely is recovery from physical injury addressed. A body of work focusing on physical trauma demonstrates that recovery is often not complete after injuries that have not been viewed as disabling. To illuminate understanding of recovery following physical trauma, the purpose of our study was to more thoroughly describe the nature of recovery. Sixty-three adults, in a convenience sample, who survived serious physical trauma were interviewed 2.5 years postinjury using an open-ended semi-structured interview. Three themes were identified: event, fallout, and moving-on. These themes provided the organizing structure for exploring the journey to recovery. This journey, as disclosed by the seriously injured, does not necessarily correspond with the views of most trauma clinicians. Traumatic events create a line of demarcation, separating lives into before and after. The event becomes the starting point of a journey to resume one's life. The event itself is more than the trauma; it is the perceptual and contextual experience that needs to be incorporated into a person's essence. Fallout from the injury is multi-faceted and includes physical, psychological, social, and spiritual dimensions. Moving-on in this journey is non-linear as survivors recognize their lives are forever different. The survivors' accounts suggest that nurses should carefully consider the question, "What is successful recovery?"

Key Words: physical trauma, recovery, repercussions, survivorship, healing, content analysis

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Journey Towards Recovery From Physical Trauma

The theme of recovery has been found in the nursing literature since the 1970's, but rarely is recovery from physical injury addressed. This literature principally concentrates on integration of chronic illness into one's life. The psychosocial oncology literature has given a great deal of consideration to the process of recovery or survivorship. This literature concentrates on two aspects of recovery: dealing with or integrating a negative life event and finding meaning in the experience (Curbow, Legro, Baker, Wingard, & Somerfield 1993). In a literature synthesis, Lesko and Holland (1988) portrayed the consequences of surviving a hematological malignancy. These consist of a sense of physical damage, including alteration in body image; reentry into developmental life tasks; having hidden concerns and financial insecurity; and experiencing a lingering affinity with death.

BACKGROUND

The process of finding meaning in a negative life event has been depicted by Welsh-McCaffrey, Hoffman, Leigh, Loescher, and Meyskens (1989) who described positive changes following a cancer diagnosis. These results were obtained from a content analysis of the oncology literature. Documentary analysis of case reports, retrospective studies, and legal overviews was conducted, yielding characteristics of long-term cancer survivorship. Themes included a strengthened family, a greater appreciation for life, increased life satisfaction, improved self-acceptance, and a renewed spirituality or religiosity. McCaffrey et al. note that the resulting positive changes may "overshadow the physical compromise that may accompany cure" (p. 520). Curbow et al. (1993) interviewed long-term survivors of bone marrow transplant and acknowledged loss and recovery themes. A number of these themes echo the work of Lesko

and Holland (1988) and Welch-McCaffrey et al. (1989). Similar themes were financial security and disfigurement. Other themes depicted by Curbow et al. (1993) included interrupted life, physical disability, pain, physical limitations, and loss of family and friends. New themes included redirected life, compassion, new perspective, and taking better care of self (Curbow et al. 1993).

In a case study, Norris (1990) revealed the convalescence process and identified multiple psychosocial adaptations that take place following injury. These included reassessing life goals, reintegrating a changed body image, dealing with dependence and independence, and coping with role failures and heightened emotions. These observations should not be generalized, but do contribute a foundation for further study.

Welch (1990) studied the lived experience of 30 adults recovering from serious injury over 14 months and identified three phases of recovery: crisis, stabilization, and healing. At the study conclusion, patients self-identified themselves as “recovered” or “not recovered”. Factors common to those considered “not recovered” included depression, permanent physical injury, and disfiguring scars. Those considered “recovered” had shorter hospital length of stay, full physical recovery, and were able to return to work. This study identified two health source related factors that influenced recovery: the sense of abandonment after (early) discharge and poor pain management.

Janoff-Bulman (1992) provides a theoretical context for exploring the effects of injury, proposing that some individuals assume they are indestructible. An injury event challenges this inherent assumption and forces one to face his or her vulnerability. Additionally, the psychological distress that arises from the injury has been shown to compromise recovery

following injury, independent of the severity of injury or baseline status (Michaels, Michaels, Moon, Smith, Zimmerman, Taheri, & Peterson, 1999).

Richmond (1997) and Richmond, Kauder, and Schwab (1998) investigated short-term postinjury disability following serious injury. At three months post-discharge, data revealed significant levels of postinjury disability. Factors contributing to disability included functional limitations, psychological distress, age, pre-injury disability and limited social networks. The seriously injured without central nervous system involvement were not expected to have residual disability. Based on our findings, further investigations into the cause of this disability were instituted, with the original participants contacted at 2.5 years after injury. In addition to assessing disability quantitatively, an open-ended semi-structured interview was used to develop a broader and more descriptive portrait of peoples' journey towards recovery. The purpose of our study was to more thoroughly describe the nature of the recovery trajectory following physical trauma.

METHODS

Sixty-three survivors of serious trauma were interviewed 2.5 years postinjury, as part of a larger investigation examining factors contributing to postinjury disability. Data for this study were collected in 1997. Sample size was determined by a power analysis for the quantitative component. A descriptive mode of inquiry was used to more fully illuminate the nature of postinjury disability (Artinian, 1988). Inclusion criteria required an injury of sufficient severity to require operative intervention, intensive care, or hospitalization that exceeded 72 hours. Exclusion criteria included self-inflicted injury, a pre-existing, active psychiatric diagnosis not injury-related, and coexisting central nervous system injury. Participants were identified during

acute care hospitalization, at which point informed consent was obtained. A semi-structured telephone interview, which was part of a larger quantitative study was done.

Sample characteristics are in Table 1. This sample had moderate to severe injuries as measured by the injury severity score (ISS), which is an anatomic system of rating the severity of injury across body regions for a mixed group of injuries (Baker & O'Neill 1976). The possible range of ISS is 1 (minor) to 75 (lethal). The mean ISS was 13.5 (SD \pm 8.4; range 4 –35). The mean length of hospital stay was 12 days (SD \pm 13.1; range 3-95 days).

Following interview completion, participants' responses were transcribed from the data collector's field notes, then first analyzed for common themes using qualitative content analysis (Morgan 1993). Each separate thought and idea was treated as a distinct data element and reviewed by the principal investigator (PI) with the data collector and organized into three a priori principal categories: meaning, management, and injury consequences. Preliminary allocation of elements within the categories was agreed upon through consensus.

Second, the PI described each element and identified preliminary themes in an iterative process of reading the narrative element in the context of the complete narrative account. From this stage, 36 preliminary themes emerged.

Third, the elements and preliminary themes were circulated to all members of the investigative team for evaluation and validation of the match between the element with the theme and to reach consensus on the best thematic label. This process necessitated significant discussion concerning the label, more so for an accurate representation of the element than for the movement of elements to altogether different themes. The themes were decreased to 22. All elements were again examined to verify that the best match of element and label had been

achieved. The final analysis entailed reorganizing the themes and finalizing the meta-themes, which differed from the a priori three categories that had been used to organize the data.

Each of these processes increased the trustworthiness of the analysis as described by Lincoln and Guba (1985). The research team involvement throughout the process, the use of all raw data, and the progressive analytical framework increased the credibility of our findings. The audit trail established by the investigators also improved dependability.

RESULTS

Three meta-themes provided the organizing structure from which to explore the journey to recovery. These meta-themes were event, fallout, and moving-on.

Event

Given that physical trauma is an unexpected occurrence, the event itself becomes a defining moment. The event and one's perception of and response to that event, becomes a marker in the individual's life – separating the survivors' lives into two parts, before and after injury. This life-altering moment is exemplified in the following narrative.

“It has changed my life. It was the changing point. It made me have a whole new perspective on my life. Any day can be my last.”

The traumatic occurrence, as a division point in life, caused many of the survivors to revisit the meaning and purpose of their lives, as one stated.

“It has made me more conscious of what I want to do with my life. I was struck – life is sudden...have to make everyday count....do in life what [you] can before [you] no longer have it.”“

Making each day count was linked to a heightened sense of mortality. The belief that one almost died and could die at any moment had profound aftereffects.

“I made a list of things to do before I die...I had a confrontation with my overdeveloped sense of optimism.”

Confronting one’s mortality resulted in a deeper understanding of human frailty. The once safe world no longer exists. Trust is broken. Narratives supported a vulnerability in this newly unsafe world, as one noted.

“I’m more afraid to get on the road. I’m afraid I’ll get in an accident....I’m afraid I’ll die the next time.”

Coming to grips with this vulnerability affected how one lived, influencing choices made. The following narrative by a professional man who was assaulted late at night in a neighborhood to which he traveled frequently, and one in which he felt safe, gives voice to his vulnerability.

“I’m thoughtful of where I walk in the city – it’s a real part of my perception. I was walking through _____ Square at night – I was scared, my heart rate was up.”

Regardless of the cause or the severity of injury, the perception that one might have died was a stimulant for revisiting the status of one’s life.

“It’s probably made me re-evaluate my career and future. It brought me to the realization that I’m not unbreakable and I am human.”

Another survivor said the following.

“Overall, [the biggest issue was] one of confronting a near death experience...that I had a brush with death. I had a difficult time confronting that. I’m careful about how I spend my time – so I can get things completed. It’s not better or worse, but different. My options have narrowed.”

For certain survivors, this confrontation stimulated them to think about life differently.

“I decided that life is fragile, people live in a routine – the status quo and wish they had other things. My injury...live life rather than just doing stuff. It snapped me out of it.”

The traumatic event had profoundly life-altering effects as another noted.

“I’m a more proactive person. Life is the important thing. I live my life for my life. I want to make the most of it.”

Fallout

Fallout comprised the period following injury during which individuals came to an ever-increasing awareness of the effect the injury had on their lives. Fallout extended beyond physical repercussions to encompass psychosocial, economic, and legal entanglements. Return to work (RTW) was linked to a cluster of intense problems and oftentimes the painful awareness that return to previous work was impossible. RTW was problematic for the majority of participants as one stated.

“I couldn’t go back to my job – the kids I used to work with. Not being able to walk right and do the things I used to do. Just keeping up with people.”

The timing of RTW, was an issue for many survivors, taking months, often up to a year to RTW. This prolonged time to RTW was surprising and unexpected. Even for those whom RTW was early, problems were encountered.

“I tried to go back at week three, but it didn’t work at all. I took another 30 days. I finally returned to work around 45 days later.”

However, merely examining the ability to RTW misses the fact that often, the nature of the job held had to change.

“I was a bicycle messenger. Injury was on the job. I stopped being a bicycle messenger – so returned as a foot messenger.”

“When I got out, I couldn’t do anything heavy or work with patients. I needed a sedentary job.”

Delay in RTW and the modification in work brought with it financial problems. These were far from unusual occurrences and added insult to the initiating injury. Fallout extended beyond work to all aspects of life. Physiologic impairment due to organ dysfunction was the most obvious repercussion and profoundly affected daily life.

“I had trouble controlling my bowels after the injury... I couldn’t feel my bowels. It’s getting better. It ran my laundry bill up considerably.”

Even two years postinjury, physiologic impairment included pain that interfered with daily activities. The immediate effect of the physical impairment, however, was merely one facet. The physical repercussions of the injury caused concern for the future.

“It makes me fear the future. If I have difficulty walking now, what will it be like when I am fifty?”

All responses were not negative. There were positive outcomes as well. For example, one said:

“[It] made me more humble, made me appreciate the physical ability to do normal, everyday things.”

Discussions with participants revealed that the fallout of the injury came into awareness gradually. Once physical impairments were recognized and dealt with, the emotional fallout was troubling.

“My limitations after the accident and then thinking about it. More physical initially and then emotional later.”

One woman expressed the challenge living after the injury. Given that this interview transpired over two years after injury indicates that emotional fallout is profoundly significant and is not resolved easily.

“I still deal with it and it doesn’t stop me – I work towards dealing with it – when it won’t be there. At some point, it won’t be there.”

Of notable concern was the unmasking of depression in several.

“[It] dramatically changed my life to a point that I got depressed. Wanted to kill myself – I got help – and medication, different therapists, support groups.”

Not unexpectedly, depression was related to the ability to function. However, depression was usually undiagnosed, as participants believed it was the natural sequence of events. Given the effects of depression, this unrecognized health problem could have potentially devastating effects.

“...Bouts with depression. I wouldn’t get out of bed. I would only do things I had to do.”

Depression was not the only emotional fallout. The injury was extremely hurtful. It was clear in all interviews, that the emotional effects of the injury were often more problematic than the physical. One said:

“It [the traumatic event] had a sobering effect. It was emotionally draining. I’ve recovered from the physical injuries. Emotionally it has done a number on me.”

Another stated:

“Mentally, I keep thinking about it. I get scared with cars backfiring. Physically, I can’t lift nothing heavy. I was into construction and sports – it slowed me down a lot.”

As the above statement indicates, there was also loss. Loss was physical, emotional, and functional. A manifestation of loss was dependency. One observed:

“I would say immediately after the accident, I went to rehab and went home in a wheelchair. The most frustrating part of recovery – being home and not being able to do regular chores – being very dependent on someone.”

Another whose dependency did not entirely resolve said:

“It changed my life as far as driving – the freedom and independence. I’m limited now to bare necessities – I go shopping and to work – I stay home – even the rain bothers me. It has been 3 years since my accident.”

Physical impairment translated into loss of vigor and health with an effect on family.

“It limited my family in a lot of things we used to do, like going to the beach, amusements, etc. This guy took a lot away from me. I can’t play, run, or carry my grandchildren.”

Another with postinjury dependency said:

“It was very difficult, the pain alone; and my nerves were shot when I came home after the accident. I went to my mom’s for about a week then came home. I couldn’t handle the household. For example, my daughter bringing friends home – I would be frazzled. I couldn’t handle things like before the accident.”

For a third, the cascade of difficulties seemed to pervade every aspect of life.

“The lack of sex... The loss of income; the loss of credit and social security. I was getting \$20-25/hour and I had to decrease to \$6.50/hour.”

A factor exacerbating the ability of individuals to deal with the consequences was the social disconnect that surfaced for several.

“It was difficult. I felt like I was different than everyone else. First, I thought I would die, but I didn’t. It took a good 2 months to go out and even talk with anyone.”

A prolonged recovery was unanticipated and extended beyond physical recovery as this participant observed.

“It was six months before the veil lifted – both physical and psychological. It was difficult – the physical pain. Confusion – I was uncomfortable for months and very vulnerable.”

Moving-on

The work of moving-on was highly individual. This work entailed calling on both external and internal resources. Moving-on was active, requiring and consuming energy, but, when effective, producing energy. At first, moving-on was motivated by the need to overcome dependence, a powerful motivator.

“[It was] hard at first. I got the hang of it quick because I didn’t want to be bedridden and I didn’t want people to care for me like they were.”

Inner resilience and the ability to call up internal resources were important for moving-on. As one participant stated, assuming responsibility for oneself was important.

“I pushed myself. I pushed myself and determined if I’m breathing, I will go on.”

This internal resilience was viewed as a joint responsibility with the health care team. Much like a relay race, survivors of traumatic injury positioned themselves to accept the baton. Giving voice to this, one participant helped us see the importance of shared responsibility.

“[I] was in a wheelchair for about two years. Intensive therapy – then I took it on my own. I would work as much as I could. I would work out in the gym. The doctors did their part – it was my turn to do my part.”

Moving-on was not straightforward. It often entailed calling upon inner resources. This inner resiliency was at times constructive but, at other times, negative. This seemed to be due to a complex interaction between the individual's inner drive and a multitude of external factors. An example of the negative side of this inner drive was voiced by one participant.

“Pushing the envelope too much. I delayed full recovery by pretending I could do more than I could. It was [feelings of] invulnerability vs. macho. I would not be sick...[I would] insist that things were normal. Looking back, you know, it was not good.”

The presence of family and supportive others contributed to recovery. But it is important to note that support was characterized as both positive and negative. On the positive side, support was found to facilitate recovery. One stated:

“I think what helped me recover was the people around me. Because I had good support, I could try and get well again. Had I not had anybody, I would have to worry. I had no worries, I only had to pull myself together.”

Leaving the hospital to return home was positive. As one participant described, resuming life in one's own surroundings was exquisitely positive.

“Work. Routine. Being in extreme familiarity in my home was a ravishing sense of comfort. Being with my wife. Feeling connected.”

It was not solely family who was perceived as supportive, but also resources in the community.

“The people around me and Meals on Wheels were a big help. The home health aides are a big help. And of course, my children – a lot of people supported me.”

Having something to which to look forward was important motivation.

“My son and his wife found out they were expecting their first child – my first grandchild – and it gave me the will to keep going. I was in a hospital bed, then a wheelchair when I got home....The upcoming grandchild kept me pushing.”

Nurses, health care providers, and the health care system were perceived as both an impediment to recovery as well as supportive. Actions by health care providers that were not useful were described by several participants. One said:

“Biggest challenge deciding how much therapy/exercise is helpful versus hurting the arm? Getting conflicting information. Will this hasten arthritis, more pain etc?”

Lack of anticipatory guidance by the health care team was viewed as singularly unhelpful. Participants were entering unknown territory and wanted guideposts or a map to chart their journey. One said:

“We were not prepared for what was going to happen to us in the future. No direction or preparation for it.”

Another emphasized that providers should integrate previous survivors of injury to best provide anticipatory guidance.

“One thing – I know when I was in – someone who had gone through the same thing...could talk to me. Some sort of support/volunteers to talk to patients.”

Moving on sometimes entailed coming to the realization that life would never be the same.

“I haven’t recovered. I can’t even do my own hair.”

A major impediment to moving on was continued anger or vengeance against individuals believed to have been responsible for the traumatic event.

“I think the recovery was a state of mind. Once I stopped harping on what happened (I was angry for a while) and once I got over the anger, everything fell into place.”

DISCUSSION

The journey to recovery as disclosed by the seriously injured does not conform with the view of most clinicians. In this population of seriously injured patients, with no head or spinal cord injury, the expectation typically communicated was that surgical wounds or broken bones would heal and they would be able to return quickly to their every day lives. A growing body of quantitative studies questions the accuracy of this belief and suggests that postinjury recovery is longer than and less complete than previously appreciated (MacKenzie et al. 1986, Frutiger et al. 1991, Richmond 1997, Richmond, Kauder, & Schwab 1998).

Injury, as noted by the survivors, is the starting point of a journey towards recovery. This event was a definitive division in the life of survivors. A line of demarcation was evident as individuals discussed their lives in terms of before and after. The injury event was not transient. Rather, it became a permanent part of one’s life – something to be incorporated into one’s essence. This is not unlike the experience of cancer survivors who have to “reconstruct” their lives after a cancer diagnosis (Curbow et al. 1993, p. 16).

Our study indicates that the perception of the injury as life-threatening heightened perceptions of vulnerability and forced many to confront their own mortality. These findings support the premises of Janoff-Bulman (1992) that trust is shattered, resulting in intense feelings of vulnerability. Injury was frequently the first time the individuals we studied faced their own death. Many eloquently shared positive aspects of confronting and coming to terms with human frailty. A renewed appreciation for life, for living life, and for making the most of life was a positive outcome. These findings support those of DeWitt (1993) who followed a group of

adolescent trauma patients through rehabilitation. These adolescents changed during their recovery, with positive changes in behavior and attitude. In particular they came to appreciate things (like walking) that had previously been taken for granted. It is possible that these positive effects generalize beyond specific populations as this renewed appreciation experienced by our sample, is similar to that described by Welch-McCaffrey et al. (1989) in adult cancer survivors.

One of our central findings is that the journey to recovery was complex and entailed recognizing difficulties over time. The fallout, once recognized, created a journey typified by detours, taking individuals to places they did not expect to nor choose to go. Recognizing problems (and thus detours), took place at varying times and often took individuals by surprise. As one set of problems was recognized and handled, new challenges ensued. The process of recognizing and dealing with the fallout differed for participants. Recovery, therefore, was not an end point or destination, but a journey in itself. Morse and Carter (1996) documented the complexity of surviving the physiologic threat of injury and serious illness noting that individuals must first endure to survive before they can progress.

It is clear that the fallout of injury extended beyond the physical to the psychological. In the quantitative portion of this study, our research team had previously reported elevated levels of psychological distress (Richmond, 1997; Richmond, Kauder, & Schwab, 1998), but we had not systematically measured depression or depressive symptomatology. In this qualitative portion of the study, participants noted their struggle with depression during recovery. The problem of postinjury depression was recently reported by the Trauma Recovery Project. In this prospective epidemiological study, postinjury depression was present at 12 and 18 months and was significantly associated with outcome (Holbrook, Anderson, Sieber, Browner, & Hoyt,

1999). Our findings, in conjunction with those of Holbrook and colleagues (1999), indicate it is important to systematically evaluate and treat the physically injured for co-morbid depressions.

Accompanying this complex journey, was the recognition by the survivors that they and their lives were forever different. The experience of recovery differed from the standard dictionary definition of recovery (regain health or a former state). Janoff-Bulman (1992) proposed that “recovery” when applied to trauma survivors is inappropriate for this very reason. For our survivors, even when health was attained, the journey did not end simply as a return to the lives once lived. For many, life was forever different. Curbow et al. (1993) in a group of bone marrow transplant survivors, noted that a new set of skills was required to move to this new place. We did not explore with our survivors the skills that helped them move to this new place in their lives, but based on the similarities to Curbow’s findings, further study in this area may be useful.

CONCLUSIONS

The survivors’ accounts suggest that nurses and health care providers should consider the question, “What is successful recovery?” These survivors bring to light the fact that they may not fit back into the world as it once was – for the injury and subsequent journey has taken them to a new place – not better or worse, but different. The challenge they experienced was how to “refit” themselves for this new world. They found that others did not understand their journey. Although the presence of supportive others was helpful, there was a limitation to this support. The availability of supportive others was found to be key to facilitating the journey towards recovery. Yet, participants identified that they and their family members needed more guidance. They needed a road map to help them anticipate the twists and turns of their journey. Nurses, by

virtue of their close relationships with patients and their families as well as their knowledge of trauma, are in a prime position to offer guidance.

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Table 1: Sample Description

Variable	%
Gender	
Male	67
Female	33
Ethnicity	
Caucasian	64
African American	33
Hispanic	3
Marital Status at Time of Injury	
Married	38
Never Married	38
Divorced/Separated	16
Injury Mechanism	
Motor Vehicle Accident	36
Violent Assault	21
Falls	16
Pedestrian	13
Other	14
