

**THE LIVED EXPERIENCES OF BURN SURVIVORS' ADAPTATION
POST HOSPITAL DISCHARGE**

BY

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submitted in accordance with the requirements

for the degree of

MASTER OF ARTS

in the subject

NURSING SCIENCE

at the

UNIVERSITY OF SOUTH AFRICA

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FEBRUARY 2017

DECLARATION

I, MR LAMOLA, declare that **THE LIVED EXPERIENCES OF BURN SURVIVORS' ADAPTATION POST HOSPITAL DISCHARGE** is my own original work and that sources that I have used have been indicated and acknowledged by means of complete reference, and that this work has not been submitted for any other degree at any institution.

SIGNATURE.....

MONYAMANE REGINA LAMOLA

DATE

FEBRUARY 2017

ACKNOWLEDGEMENTS

I would like to express my gratitude to God Almighty who gave me strength and perseverance to pursue this study to the end.

My supervisor Professor J. Maritz, I thank you for being there for me, assisting me in all manners possible. I wouldn't have come this far without you.

I wish to thank Professor S.Z. Mzezewa, for instilling in me the interest for research and the confidence to present at the Burns Congress.

To my husband Lamola Anthony, you encouraged me to study and you never complained when I spent time away from you during the time of my study. Thanks for the support.

My children, Winny, Johanna, Tefroy and daughter-in law Phomolo, your support has been wonderful.

ABSTRACT

With the decrease in burn mortality following improved burn care facilities and methods, burn survivors are often left with residual physical and psychosocial consequences that they have to cope with requiring adaptation and modification of lifestyle. Burn survivors habitually receive excellent treatment for their wounds while in hospital but may experience challenges due to disruption of care and rehabilitation after discharge. This aim of the study was to explore and describe the lived experiences of burn survivors' adaptation post hospital discharge.

A qualitative, hermeneutic, phenomenological design using an interpretive framework was used. A purposeful sampling was used in the selection of nine participants who were above 18 years and had been admitted to the Limpopo Burn Unit while still undergoing reviews at the Plastic and Reconstructive Surgery Clinic.

Data were collected through face-to-face interviews using unstructured open-ended questions. Data were analysed using the Colaizzi's strategy. Three main themes emerged from the data, along with sub-themes. (a) The burn survival experience involved the person in totality with reference to their internal and external environment. (b) The process of recovery was lengthy and started in hospital and continued post discharge at home. (c) Reclaiming their life and finding new meaning was a process of adaptation. The core of the participants' needs included the need for the care and rehabilitation of the whole person in terms of their physical and psychosocial aspects, the importance of the survivor's involvement in his/her care, and the rehabilitation. Health care personnel and family support during this difficult time should be available in order to enable the survivors to cope and adapt effectively and reclaim their lives.

Key Words:

Burn injury, burn survivor, rehabilitation, adaptation, coping.

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ABBREVIATIONS

HRQoL:	HEALTH RELATED QUALITY of LIFE
PTSD:	POST TRAUMATIC STRESS DISORDER
QoL:	QUALITY of LIFE
TBSA:	TOTAL BODY SURFACE AREA
US:	UNITED STATES
WHO:	WORLD HEALTH ORGANIZATION
SASSA:	SOUTH AFRICAN SOCIAL SECURITY AGENCY

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Burn injuries are a grave and devastating experience (Calota, Nitescu, Marinescu, Critescu, Boiangul, Florescu & Lascar, 2012:703). Global statistics according to the World Health Organization (WHO) (WHO, 2008:2; WHO, 2011:1) and Agbenorku (2013:78) indicate that over 300 000 deaths occur from burn injuries each year.

Non-fatal burn injuries are the leading cause of physical and psychological morbidity and burn injuries are rated the sixth leading cause of deaths among the 5-14-year-olds and the eighth leading cause of deaths among 15-29-year-olds (WHO, 2008:9; Peck, Molnar & Swart, 2009:802). Although all income groups are affected, 90% of all burn injuries are from low to middle-income countries. According to the WHO (2008:2), most burns occur in homes, and women are at a higher risk than men because they are involved in cooking. Yet, the most recent data reveal equal risks between men and women due to the increase in workplace burns sustained by men (WHO, 2014). The survival rate for burn injuries is higher in developed countries where there are adequate and sophisticated burn-care resources as well as well-trained personnel as compared to under-developed and developing countries.

The WHO (2014) has estimated that South Africa spends approximately 26 million US dollars annually on burn care from paraffin cook stove accidents. Indirect costs such as lost wages, extended care for deformities, emotional trauma, and commitment of family resources also add to the socio-economic impact.

Due to the excellent strategies of burn management and sophisticated wound care products, more lives are being saved but millions of people are often left with disabilities and disfigurement that can be both physical and psychological. Some severely burnt survivors lose the affected limbs from the burn injury itself or the amputation thereof, while others develop severe scarring and contractures, creating

disabilities that restrict movement and functioning, or causes disfigurement (Hettiaratchy & Dziewulski, 2004:344; Hall, Kowalske & Holavanahalli, 2011:2).

Burn survivors also experience pain from the burn wounds themselves, from the burn management procedures, as well as the scars. The scar pain and itching may persist for weeks or even months beyond the wound healing.

The severity of the burn itself and the outcome thereof psychologically affect survivors in different ways. The ability of the person to adjust to the new post-burn situation is an individual issue and depends on many varied pre and post burn factors.

Surviving burn injuries can be a life-changing phenomenon which can create permanent physical and psychosocial consequences that may require modification of a person's lifestyle. Coping with the situation brought about by a burn injury requires the assistance of the health care workers through survivor preparation while the person suffering the injury is still admitted to hospital to avoid unexpected reactions that trigger emotions. Among the multi-disciplinary team, nurses have direct and prolonged contact with the survivors and should take the leading role in the coordination of the rehabilitative activities. The long-term (outpatient) care after burns is an important but often neglected phase in management of burn injuries (Allorto, 2016).

1.2 RESEARCH PROBLEM

As a health worker in the Burns Unit at Mankweng Hospital in the Limpopo Province, I have been managing patients with burn injuries for eight years. Patients' wounds were seen recovering well but the thought of what life after discharge would be like seemed to be overlooked. My interest in researching burn survivors' adaptation experiences was sparked by a 28-year-old woman in her last month of pregnancy who fell into the fire and burned during an epileptic seizure while alone at home and trying to cook. She sustained fourth-degree burns to the right arm down to the bone, as well as second and third-degree burns to the chest and part of the abdomen. I

had sleepless nights thinking about how the mother was going to cope and take care of the coming baby as her arm was to be amputated.

Literature (De Sousa, 2013:24) indicated that irrespective of the survivors' successful healing, there are often residual physical and psychosocial consequences that change their functional ability. The scars that result from burn injuries change the visual appearance of the skin and causes discomfort (Rumsey & Harcourt, 2003:83). There is an agreement among different researchers that visible scars are more stressful to the survivor than hidden ones, because of the stigmatising behaviours of others which include staring, negative remarks, social isolation and name calling (Corry, Pruzinsky & Rumsey, 2009:541; Rumsey & Harcourt, 2003:85; Hettiaratchy & Dziewulski, 2004:393; De Sousa, Sonavane & Kurvey, 2013:26).

Burn survivors also experience pain from the burn wounds themselves, from the burn management procedures, as well as the scars (Dahl, 2013:8). The persistence of pain as influenced by factors that include changes in weather conditions and itching, interferes with normal functioning, relaxation and sleep, and negatively affects the person's quality of life. This can continue for some weeks or years after the wound has healed (Summer, Puntillo, Miaskowski, Green & Levine, 2007:538). Previously, it was commonly believed that burn-related pain is proportional to the size and severity of the burn. However, recent research indicates that small and superficial burns can be very painful due to exposed nerve endings while large and deep ones may be less painful as nerve endings are destroyed (Burn Injury Model: System Consumer Information). The person may, therefore, be required to adapt physically after the burn injury as a result of the damaged nerve endings.

Burn injuries not only have physical consequences that require adaptation but also psychosocial effects. The survivor's mental functioning is influenced as they have to adapt to a new appearance and limitations which adversely affect their self-image and self-confidence (Dahl, 2013:4). The adverse reactions of the public which lower the burn survivor's self-esteem, add more psychological stress. Studies by Darton (2011:4), De Sousa, et al. (2013:26) and Rumsey and Harcourt (2003:85) indicate that the survivors of burn injuries experience a range of psychological difficulties that include Post Traumatic Stress Disorder characterised by guilt, reliving the trauma in

dreams, depression, and lack of involvement with reality. The disfigurement brought about by scarring, limited functionality and occupational performance, as well as adverse reactions of the public, creates low self-esteem and a negative self-perception of the survivor.

People with visible scars experience more difficulties in societies that value attractiveness, as reported by Calota, et al. (2012:703) and Corry, et al. (2009:539). In addition, Agbenorku (2013:85) indicates that the functional disability creates a burden on the survivor as an individual because of the economic loss which requires the state to provide a livelihood in the form of a disability pension, and on the people who take care of him/her.

Body esteem, which is defined by Corry et al. (2009:539) as relating to the person's physical appearance and the degree to which a person is satisfied or not with his/her appearance, has an effect on the survivor's physical, psychological and social adaptation. People's reactions, whether supportive or not, influence the outcomes of adaptation as reported by Agbenorku (2013:85).

While it is known that people inside and outside their families often ridicule burn survivors, evidence suggests that both ridicule and overprotection are more crippling to the individual than the physical symptoms themselves, by limiting the creativity of the individual. Dahl (2013:11) claims that people with visible scars are sometimes forced to fend for themselves by facing the reactions of others, and this may teach them how to cope with those reactions effectively. Research indicated that success and failure of adaptation also depend on several factors like a person's personality issues, and emotional and psychological status before the person was burnt (Blakeney, Rosenberg, Rosenberg & Faber, 2008:434; Dahl, 2013:15).

A study by Gonçalves, Echevarría-Guanilo, Carvalho, Miasso and Rossi (2011:627) supports the fact that people are individuals with different coping abilities and therefore blanket statements cannot be made on how burn survivors will cope with their situations and what their outcomes will be. Most studies on burn injury management focus on the strategies implemented during the period when the survivor is still admitted to hospital. However, this study is concerned with the

challenges of adaptation burn survivors experience after their hospital discharge because I believe burn survivors are usually not prepared for post-discharge challenges while they are still admitted.

Discharge from inpatient treatment does not signify that a burn survivor is well. According to Blakeney et al. (2008:436), a major concern is the facilitation of a survivor's re-entry and reintegration into life at home. Returning home means re-engaging in social interactions with the larger community of extended family, friends, and strangers. Faucher and Kowalske (2007:22) indicate that progress can be slow and frustrating. However, knowledge of what to expect helps the burn survivor and family to better prepare for the challenges ahead.

There is still limited information on research studies done on burn survivors in South Africa. The Western Cape and Gauteng Provinces, where most burn injuries occur as a result of massive fires from burning shacks are given priority, while most studies concentrate on childhood burns. There is a consensus among researchers that age, gender, poor living conditions, overcrowding, and maternal illiteracy contribute to burns, and that children of different ages are affected (Van Niekerk, 2007:10).

Many patients receive excellent treatment for their wounds while in hospital but preparing them for what to expect and how to cope after discharge is usually not done. Burn management requires a multi-disciplinary approach whereby each discipline will work towards maximising the functional ability of the burn survivor.

1.3 THE RESEARCH OBJECTIVE

The objective of the study is to:

- explore and describe the lived experiences of burn survivors post hospital discharge.

1.4 RESEARCH QUESTIONS

The study is undertaken in order to answer the following question:

- What are the lived experiences of burn survivors post hospital discharge?

1.5 SIGNIFICANCE OF THE STUDY

The study might contribute to the better understanding of the complexities that lead to burn survivors' adaptation difficulties and will help in designing management guidelines that will ultimately assist the survivors to cope with their unique adaptation challenges.

1.6 DEFINITIONS OF KEY CONCEPTS

1.6.1 Burn Injury

A burn injury according to the WHO (2011:1) is the destruction of some or all layers of the skin by heat, radiation, chemicals or electricity. The severity thereof is determined in terms of Total Body Surface Area (TBSA) calculated in percentages and depth (Collins Thesaurus of the English Language, 2002:99). Burns are also defined according to their mechanism, for example inhalation burns referring to an injury to the air passages caused by the inhalation of hot smoke, usually in an enclosed area, and epileptic burns sustained through falling into a fire during an epileptic seizure, and so forth (Wood, 2009:12). In this study, a burn injury refers to injury to the skin and deeper tissues with causes as indicated by the WHO, which can extend to the bone. The burn injury for inclusion in this study would have had to be severe enough for the patient to be referred to the Plastic and Reconstructive Surgery Clinic.

1.6.2 Survivor

A survivor is someone who has managed to get through something that could have caused severe damage or death (Kelly & Bird, 2014:8). In this study, a burn survivor refers to someone who has been through the experience of the burn injury and has survived (Abrams, 2013:8). The person lives with and has to cope with the consequences of the burn injury that may be physical and psychosocial, throughout the remainder of their life.

1.6.3 Adaptation

Adaptation is defined as an alteration or adjustment in structure or habit by which an individual improves his functional condition in relationship to his environment as defined by the Collins English Dictionary (2003:99). In this study, adaptation refers to the adjustments burn survivors make in relation to the new limitations in their daily life and conditions, caused by the burn injury (Dahl, 2013:14).

1.6.4 Post Hospital Discharge

Post hospital discharge refers to the time when the person has been released from the hospital after being admitted. In this study, post hospital discharge relates to the time following the burn survivor's release from hospital back home after complete recovery or when their condition has improved. The person is out of danger and he/she has to complete the remaining burn care management at their local health care centre. The person is given appointment dates for review in the Plastic and Reconstructive Surgery Clinic until they are fully recovered.

1.7 RESEARCH METHODOLOGY

A research methodology refers to the systematic way of solving a problem and the study of methods by which knowledge is gained (Rajasekar, Philominathan & Chinnathambi, 2013:5). It consists of techniques and research procedures, the

population, sample and sampling methods, data collection and analysis, as well as trustworthiness and ethical considerations.

1.8 RESEARCH DESIGN

A research design as defined by (Cresswell 2007:41) refers to an overall plan of obtaining answers to research questions. A qualitative, hermeneutic, phenomenological design using an interpretive framework was used in this study. The design and approach will be discussed in greater detail in Chapter 3.

1.8.1 Setting and Context of the Study

The study on the lived experiences of burn survivors' adaptation post hospital discharge was carried out at the Plastic and Reconstructive Surgery Clinic of Mankweng and Polokwane Hospitals in the Limpopo Province in South Africa. A full description of the setting is provided in Chapter 3.

1.8.2 Population and Sample

The population is the entire group of persons or objects of interest to the researcher and to which the researcher wishes to generalise or transfer the research results. The population in this study was the entire clientele who had been admitted for burn injury treatment from 2010 to 2013, which was obtained from the Limpopo Burn Unit Data Bank.

A sample is an element of the population considered for inclusion in the study. A purposive sample of all patients who had been admitted to the Burns Unit at Mankweng Hospital and Surgical Unit of Polokwane Hospital from 2010 to 2013 was used. Nine participants took part in the study.

1.8.3 Data Collection Methods and Procedures

Data were collected using in-depth, unstructured, face-to-face interviews with open-ended questions, observations and field notes, and a reflective diary. Each collection method will be further discussed in Chapter 3.

1.8.4 Data Analysis

Data analysis started at the time of data collection. Coliazzi's method of data analysis (Shosha, 2012:34) was implemented. The analysis will be offered in Chapter 3.

1.8.5 Measures of Trustworthiness

Trustworthiness, as defined by Lietz and Zayas (2010:191), refers to measures taken by the researcher to ensure that the study findings represent the perspectives of the participants. Lincoln and Guba's trustworthiness model (Elo, Kääriäinen, Kanste, Pölkki, Utriainen & Kyngäs, 2014:2), which include the five criteria for establishing trustworthiness, will be used. These criteria include credibility, dependability, conformability, transferability, and authenticity. Each will be discussed in Chapter 3.

1.19 ETHICAL CONSIDERATIONS

In order to reduce the risks of ethical violations in the research process, the researcher will maintain ethical principles. This is done to ensure that justice, the prevention of harm, respect for autonomy, and the dignity of participants are upheld as stated in Fouka and Mantzorou (2011:5), Dahl (2013:25), Gray, Grove and Burns (2013:173), and The Bill of Rights in the Constitution of the Republic of South Africa (Act No. 108 of 1996 as amended).

Ethical clearance for this study was granted by the Higher Degrees Ethical Committee of the University of South Africa (Annexure A) and the Department of Health Ethical Committee of the Limpopo Province (Annexure B). Ethical considerations will be elaborated on in Chapter 3.

1.10 OUTLINE OF THE DISSERTATION

Chapter 1: Orientation to the study

The chapter discusses the background and problem statement, the objective, research questions and significance of the study. Key concepts are defined, and the

theoretical framework, research design and methodology, and ethical considerations are briefly described.

Chapter 2: Literature review

The review of literature pertaining to the study is presented. Information sources related to burn injuries, with specific reference to the physical and psycho-social adaptation of burn survivors after hospital discharge, are discussed.

Chapter 3: Research methodology

The chapter describes the research design and methodology employed in the study. Qualitative research methods adopted in this study are described. This includes the steps that the researcher took in conducting the study and analysing the data.

Chapter 4: Findings of the study

In this chapter, an overview of the data analysis and results are presented in terms of identified themes, categories and sub-categories.

Chapter 5: Discussion of the findings

In this chapter, the findings from the analysed data are discussed.

Chapter 6: Conclusions, recommendations and limitations

This chapter summarises the research findings and makes conclusions. Limitations of the study and recommendations are presented in terms of clinical care, health care professionals' education, and further research.

1.12 SUMMARY

This chapter presented an overview of the research problem on the adaptation challenges experienced by burn survivors after being discharged from the hospital. The rationale for the study was given, indicating the need for further studies in this field for the purpose of contributing to the body of knowledge in burn care. A brief overview of the methodology was provided. The theoretical frameworks and literature review will be discussed in Chapter 2.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION AND BACKGROUND

Kiteley and Stogdon (2013:9) define the literature review as a comprehensive summary of ideas, issues and approaches of what has been published on a certain topic. It is a scrutiny of all relevant sources of information and an excellent source for selecting a topic by investigating what has already been done in a particular problem area. It can inspire research ideas by identifying gaps or inconsistencies in a body of knowledge, thus helping the researcher to determine or define research questions or hypotheses (Kiteley & Stogdon, 2013:10; Ramdhani, Ramdhani & Amin, 2014:48).

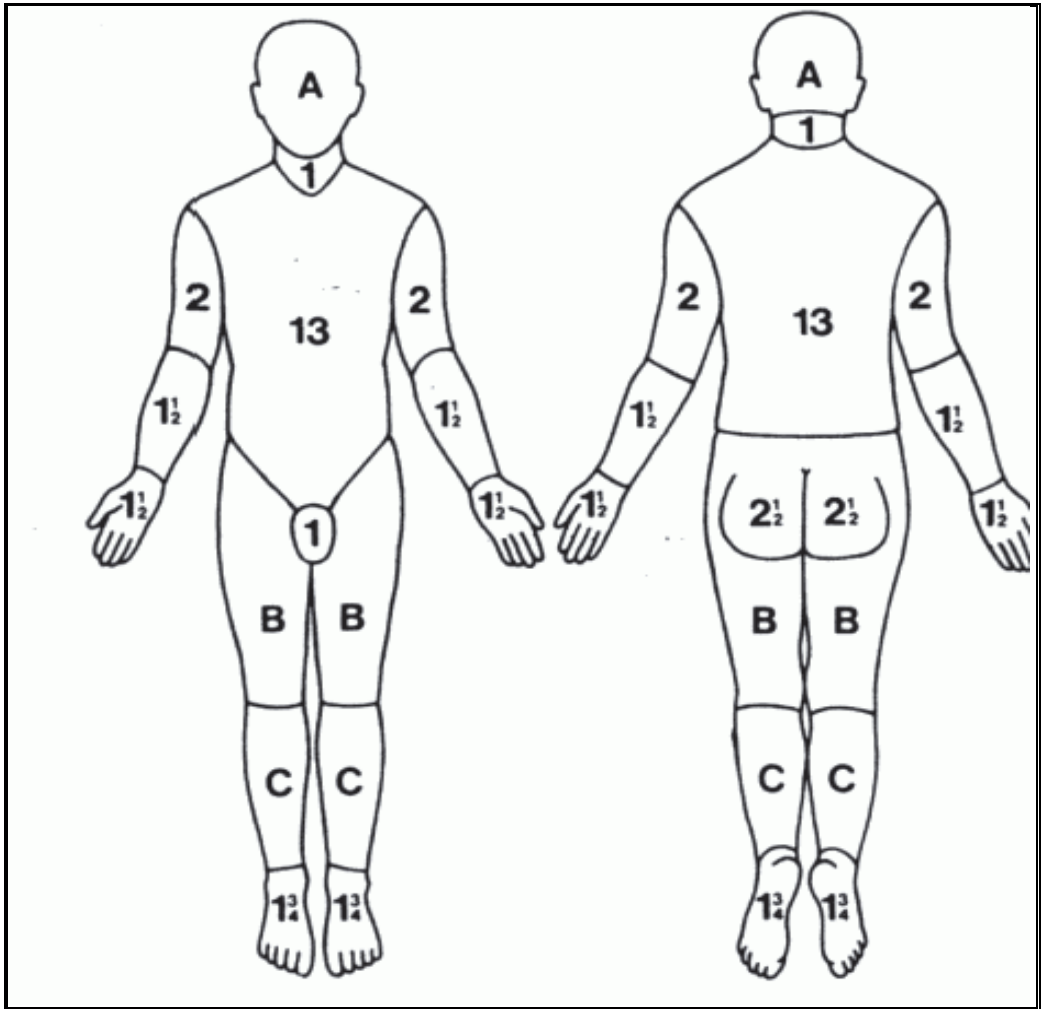
2.2 BURN INJURIES

A burn injury, according to WHO (2011:1), refers to the destruction of some or all layers of the skin by heat, radiation, chemicals or electricity. In this study, a burn injury refers to injury to the skin and deeper tissues with causes as indicated by the WHO, which can extend to the bone.

The skin performs functions that include protection against loss of body fluids and drying of the inner tissues, protection against the invasion of the micro-organisms, temperature regulation, is a sensory and excretory organ, assists in the formulation of vitamin D, and is cosmetic, giving the body shape. When it is burnt, the functions it performs are usually disrupted in proportion to the extent of the destruction. The severity of the destruction thereof is determined in terms of Total Body Surface Area (TBSA) burnt, calculated in percentages, and the depth is calculated in degrees (WHO, 2007:2).

2.2.1 Total Body Surface Area (TBSA)

Various methods were used to calculate the size of the surface area burnt. Evidence from different studies suggests that other methods were not accurate and led to faulty patient care planning. The Lund and Browder Chart method (Senarath-Yapa & Enock, 2009: 42) is internationally regarded as the most appropriate method, as it assigns percentages to different parts of the body according to age. This is done because from infancy various parts of the body change in proportion to the head. In infancy the head is bigger in proportion to the body, but as the person grows the proportions are reversed (Martin, Lundy & Rickard, 2013:247).



Age	0	1	5	10	15	Adult
A – ½ of the head	9 ½	8 ½	6 ½	5 ½	4 ½	3 ½
B – ½ of the thigh	2 ¾	3 ¼	4	4 ½	4 ½	4¾
C- ½ of the lower leg	2 ½	2 ½	2 ¾	3	3 ¼	3 ¾

Figure 2.1 Lund and Browder Chart. (Adapted from Senarath – Yapa, & Enock, Management of burns in the community. Wounds)

2.2.2 Burn Depth

The severity is also determined by the depth in degrees (Figure 2.2). First-degree burns are superficial, involve the epidermis, and are severely painful as the nerve endings are exposed (WHO, 2008:79; Dahl, 2013:4). Second-degree burns involve the epidermis and part of the dermis. Structures like the skin nerve endings, blood vessels, hair follicles, sweat and sebaceous glands are embedded in the dermis and are partially destroyed.

Third-degree burns involve the full thickness of both the epidermis and the dermis. All the structures in the dermis, including the nerves, are destroyed. As a result, less pain is experienced in third-degree burns compared to the first and second degrees. Fourth-degree burns go beyond the skin to involve the subcutaneous level, the muscle, and even the bone tissues (Alharbi, Piatkowski, Dembinski, Reckort, Grieb, Kauczo & Pallua, 2012:4).

Burns are also defined according to their mechanism. Inhalation burns refer to injury to the air passages caused by the inhalation of hot smoke, usually in an enclosed area, and epileptic burns are sustained through falling into a fire during an epileptic seizure, and so forth (Wood, 2009:12).

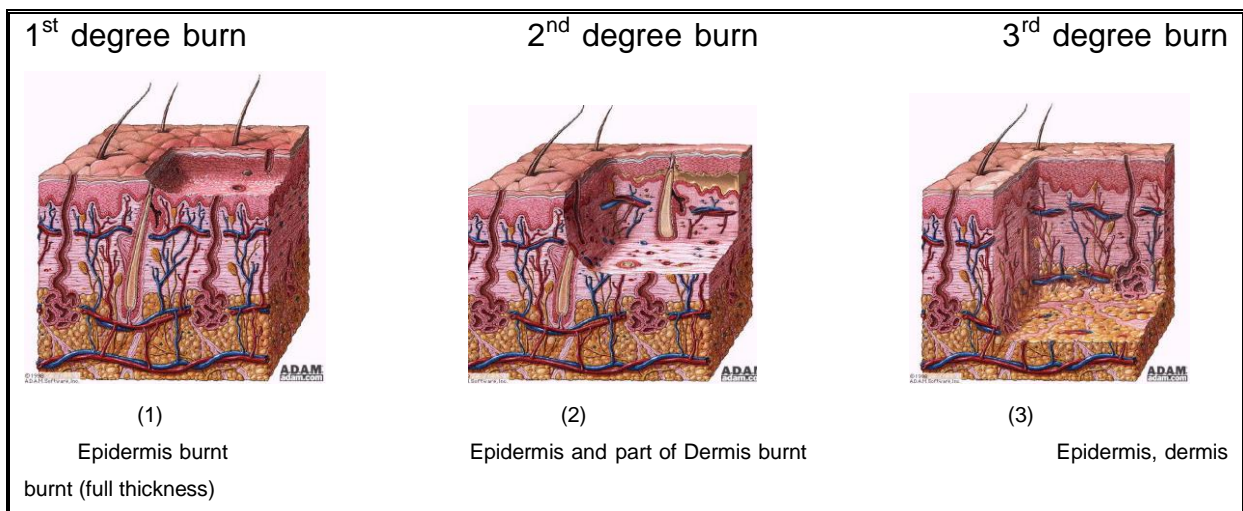


FIGURE 2.2: Burns depth in degrees (Adam) (Source: Kote, 1998)

2.3 EFFECT OF BURNS ON SURVIVORS

Burn survivors experience a series of traumatic assaults to the body and mind which present extraordinary challenges to their psychological resilience. Irrespective of the burn survivors' successful healing, there are residual physical and psychosocial consequences that change their functional ability (Dahl, 2013:3).

The person lives with and has to cope with the effects of the burn injury throughout the remainder of his/ her life, requiring adaptation and modification of their lifestyle. In his study, Agbenorku (2013:85) found family and community support or lack thereof having a direct influence on the outcomes of adaptation. Though people are individuals with different coping abilities, evidence suggests that adults are more affected by burn injuries than children, as they are more self-conscious and have roles to play in society (Hodder, Chur-Hansen & Parker 2014: 22). They also have greater difficulty to continue with their lives from where they left off before the burn injury.

According to literature, the percentage of total body surface area and the depth of the burn also have an adverse impact on the overall recovery outcomes (Harbin & Norris 2012: 430). Other factors also include the survivor's age of below two years and above sixty years, other medical conditions, and the location of the burn including the face, airways, hands, feet, and genitals. How long the adjustment period will take is seemingly an individual factor (Dahl, 2013:13).

There is a general consensus among researchers (Harbin & Norris 2012: 430; Summer et al. 2007: 535) that the effects of the burn injuries on the individual survivor depend on factors that include the severity of the injury. According to popular belief, the bigger the surface area burnt, the greater the likelihood that the person will take a long time to heal and there is a potential risk of wound infection. Deep burns also take time to heal as the granulating tissue has been destroyed. Findings of a study by Sliwa, Heinemann and Semik (2005:1920) indicated a correlation between a large surface area and deep burns and a prolonged hospital stay. However, blanket statements cannot be made as an individual's physiological status has an effect on healing e.g. tissue immunity, nutritional status, presence or

absence of other co-morbidities, to name a few. However, recent evidence showed that because of sophisticated wound care materials and interventions like skin grafting, the hospital stay time was dramatically shortened.

The scar, gender, age and the body part affected coupled with pain, can lead to bad physical, social, and psychological adjustment even years post hospital discharge (Gonçalves et al., 2011:624; Calota, et al. 2012:710; Willebrand, 2003:10; Dahl, 2013:35). Agbenorku's (2013:84) study reveals that the situation of physical adaptation will not have the same outcomes in developed and under-developed areas because of differences in burn care and reconstruction surgery resources. Sliwa, et al. (2005:1921) further stresses the correlation between premorbid emotional disorder and poor psychological adaptation.

Research has indicated that the success and failure of adaptation also depend on several factors like the individual's personality issues, and their emotional and psychological status before they were burnt (Dahl, 2013:15).

2.3.1 Physical Consequences

With the decrease in burn mortality following improved burn care facilities and methods, more survivors are left with disabilities that cause functional limitations. However, global data on the disabilities caused by burns is not readily available.

The severity of a burn injury and the part of the body burnt has a bearing on the outcome, as well as the survivor's adaptation to it. This is because the functional impairment has the potential to inhibit the employability of the individual which has a direct effect on their quality of life (QoL) (Abrams, 2013:52).

2.3.1.1 The scar tissue

Besides the lack of elasticity of the scar tissue which causes a feeling of tightness, the burnt skin experiences dryness owing to the destruction of sebaceous glands which secrete sebum responsible for lubricating the skin (Ledbetter 2010:9). This causes itching, pain and a feeling of discomfort for the burn survivor, interfering with sleep and negatively affecting the survivor's quality of life (QoL).

Empirical evidence has revealed that some of the severely burnt survivors' scars thicken and become elevated, red and delicate, causing more pain and discomfort. Scarring develops into keloids and creates contractures in the burn survivor, which causes disability by limiting movement and the performance of daily activities (Hettiaratchy & Dziewulski, 2004: 344; WHO, 2007:7).

The scars that result from burn injuries change the visual appearance of the skin, disfiguring the affected individual and creating unwarranted attention from onlookers which cause discomfort for the burn survivor (Rumsey & Harcourt, 2003:83; WHO, 2007:7).

Norman (2016) (www.faceitonline.org.uk) defines disfigurement as anything that noticeably affects someone's appearance. Though the disfigurement is visible to the observer, the effects thereof are more psychological for the survivor. Research evidence indicates that disfigurement is a primary stressor affecting the patient's social interaction with other people, adding to their psychological stress.

Researchers agree that visible scars are more stressful to the survivor than hidden ones because of the stigmatising behaviours of others. Such behaviours include staring, negative remarks, social isolation, and name calling (Corry, et al. 2009:542; Rumsey & Harcourt, 2003: 85; Hettiaratchy & Dziewulski, 2004:393 ; De Sousa, et al. 2013:25).

In his 30 year qualitative study of the social effects of disfigurement, McGregor was quoted by Freeman and Jaoude (2007:77) saying:

".....In their efforts to go about their daily affairs they are subjected to visual and verbal assaults and a level of familiarity from strangers [including] naked stares, startle reactions, double takes , whispering, remarks, furtive looks, curiosity, personal questions, advice, manifestations of pity or aversion, laughter, ridicule, and outright avoidance. Whatever forms the behaviours may take; they generate feelings of shame, impotence, anger, and humiliation in their victims."

Facial scars that affect the upper eyelids have the potential to cause an inability to close the eyes and exposing the eyes to corneal ulceration and loss of vision (Goel & Shrivastava, 2010:65). A study by Procter (2010: 103) indicates that burns of the head, neck and chest, as well as inhalation injuries, put the survivor at risk of narrowed airways from scarring, creating life-threatening respiratory complications that may require operations like tracheostomies.

2.3.1.2 Amputations

On the extreme, some survivors end up with the loss of the affected limbs from the burn injury itself or the amputation thereof. In his study, Agbenorku (2013:84) reported that amputations reduced or diminished the employability of the survivor that has an adverse impact on their Health Related Quality of Life (HRQoL) and adaptation. The limited or complete lack of ability for the survivor to do activities that he/she used to do is distressing. Evidence (Oster 2010:16) suggests that the earlier the rehabilitation of the person from the date of admission, the better the outcome of adaptation and integration.

2.3.1.3 Pain

Burn survivors experience pain from the burn wound itself, from burn management procedures, as well as the scarring. This pain can last some weeks or years after the wound has healed (Summer, et al. 2007:538). The persistence of pain as influenced by changes in weather conditions and itching interferes with normal functioning, relaxation and sleep, and negatively affects the survivor's quality of life. According to the Burn Injury Model System Consumer Information (Wiechman & Brych, 2011:3), pain is not necessarily related to the size or severity of the burn injury. Small and superficial burns can be very painful because of exposed nerve endings while large and deep burn wounds may be less painful if nerve endings have been completely destroyed. How the individual survivor copes with the situation also depends on the person's willpower and the influence of the people around them.

2.3.2 Psychological Consequences

Burn injuries also influence mental functioning as the survivor has to adapt to a new appearance and physical limitations (Blakeney, 2008: 433; De Sousa, 2013: 24; Abrams, 2013:18). Due to the excellent strategies of burn management and sophisticated wound care products, more burn survivors' lives have been saved yet millions are left with disabilities and disfigurement resulting in stigma and rejection.

For some survivors, extensive and deep burns resulting in big scars, disfigurement and disability create helplessness and a lack of acceptance by the communities they used to interact well with, while suffering from the pain of frequent audible and observable derogatory remarks and reactions. On the contrary, other burn survivors experience pity and overprotection. People with visible scars experience greater adaptation difficulties (Calota, et al. 2012:703). A study by Dahl (2013:12) indicates that women are more psychologically affected by visible scars and disfigurement than men, especially if they are from societies that value beauty. However, Blakeney, et al. (2008:439) maintains that the influence is minor, citing pre-burn emotional and psychological factors, including self-esteem, personality and coping mechanisms, as key factors influencing the survivor's adjustment outcomes and quality of life. This is attributed to the improvement in medical and surgical technology which is used to restore people's appearance. De Sousa, et al (2013:25) report that body esteem, which is defined as relating to the person's physical appearance and the degree to which a person is satisfied with his/her appearance, has an effect on the survivor's physical, psychological and social adaptation. The disfigurement brought about by scarring, limited functioning and occupational performance, as well as the negative reaction of the public, create low self-esteem and a negative self-perception in the survivor. Self-acceptance, irrespective of the new changes, improves the survivor's adaptation chances.

In their study on disfigurement perceptions and portrayal by the media, Bayat, McGrouther and Ferguson (2003:88) found that disfigured participants reported outrage at the negative portrayal of disfigurement by the public, as it is frequently linked with stigmatisation.

The age at which disfigurement occur also has a bearing on the adaptation of the survivor. Young girls who still need to have their beauty valued by the same and opposite sex and who are still looking forward to getting married, find it difficult to accept their disfigurement and their negative self-perception is remarkably high (WHO, 2004:83).

2.3.2.1 Post Traumatic Stress Disorder

Psychological manifestations of a difficult adaptation may take the form of Post-Traumatic Stress Disorder (PTSD) together with depression, substance abuse and risk of suicide. Post Traumatic Stress Disorder as defined by Dahl (2013:12) refers to an anxiety disorder that occurs following exposure to a traumatic event with a reaction of intense fear, helplessness or horror. It is characterised by intrusive thoughts and dreams, or flashbacks. The affected person is constantly in a state of alarm, that is, alert and tense with nervous excitability and difficulty in falling asleep or concentrating. The symptoms may last one to two years following the burn incident. Female survivors with visible scars are said to be prone to develop PTSD (Dahl, 2013:12; WHO, 2012; Darton, 2011:4). Though the symptoms may decrease in time, their impact seriously affect the burn survivor's adaptation.

2.3.2.2 Satisfaction with appearance

Dahl (2013:11) and Lawrence et al (2004:31) found in their studies a correlation between society's reaction to an altered physical appearance caused by burn scars and poor self- perception and lack of satisfaction with own appearance in burn survivors. Body image dissatisfaction due to disfigurement is a source of stress and has a direct bearing on the burn survivors' adaptation. Dahl discovered that burn survivors' body image-related stress will worsen over time, but they eventually develop the social skills necessary to cope with the experiences of stigmatisation (Dahl, 2013:11).

2.3.3 Social Consequences

The success of social integration in burn survivors is dependent on the level of support from their families and communities, according to studies by Gonçalves, et al. (2011:625), the WHO (2011:1), and Agbernoku (2013:78). However, Blakeny, et al.(2008:439) indicate that both ridicule and overprotection by families are more crippling to the individual than the physical symptoms themselves by limiting the creativity of the individual.

Research evidence (Dahl, 2013:11; Blakeney, et al. 2008: 440) indicate that people with disfigurement and disabilities are sometimes forced to fend for themselves by facing the reactions of others, and this may teach them how to effectively cope with those reactions. This involves creating something very good out of their unfortunate situations, like being pioneers and active in motivating other survivors and bringing them hope.

More studies need to be undertaken on this issue to assess adaptation effectiveness when comparing survivors from developed countries with good rehabilitation and reconstructive surgery resources and poor countries, as well as survivors from those countries who value appearance and those who do not. Evidence of the functional disability as a cause for the burden on the survivor as an individual, the people who take care of him/her, and economic loss requiring the state to provide a livelihood in the form of a disability pension, was indicated by Agbenorku (2013:85) in his study.

2.4 ADAPTATION

The burn injury can have serious life changing consequences that may interfere with the individual's physical and psychosocial functioning that require adaptation to the new post burn situation whereby there will be lifestyle change too (De Sousa 2013:24). Dahl (2013:14) defines adaptation as "...a behavioural process of balancing conflicting needs or needs against the obstacles in the environment". In her study findings, Dahl reports that the first year after discharge is the most difficult as the individual will be struggling with secondary stress reactions, vivid memories of the accident, and facing the reality of a changed appearance and physical

limitations. According to Lawrence et al, (2011:1) and Frota (2013: 1060) successful adaptation is attributed to the coping styles of survivors on how to approach a problem, social support and personality traits.

2.5 BURN CARE

Burn care is divided into three phases including the initial critical phase whereby most of the resuscitative activities take place. This is followed by the acute phase where wound assessment, wound care strategies, and decisions around letting the wound heal through the granulation process or intervening through procedures like skin grafting surgery, are taken. Infection control is the number one priority in order to prevent localised and systemic complications. The third phase is the rehabilitative phase which is a lengthy process and may continue for several years after wound healing and may include plastic surgery (Hettiaratchy, 2004:391; Wood, 2009:48; Blakeney, 2008:435).

Different rehabilitative approaches are taken depending on the preferences and availability of certain services like reconstruction surgery, but the overall goal is to facilitate the patient's return to life with the least possible physical and psychological stress

According to Procter, (2010:101), rehabilitation includes activities to maintain mobility and prevent disabilities and focuses on ensuring that the survivors are able to take care of themselves in the best possible manner, are able to return to their previous daily activities and work, and are capable of living with social and cosmetic changes (Dahl, 2013:6; Kornhaber 2013:146).

For the management of burns to be effective, a multidisciplinary approach is mandatory. The burn team usually consist of plastic surgeons, nurses, dieticians, physiotherapists and occupational therapists, psychologists and social workers. A burn team has clearly defined and shared goals with well-defined tasks, and each expert contributes their knowledge to the team to provide optimal care for the survivor (Dahl, 2013:7; Watt, 2011:20).

2.6 CONCLUSION

There is a deeply rooted need for rehabilitation to restore a burn survivor to a state of self-acceptance and usefulness. The issues of physical, psychological and social effects of burns and stress were examined and a strong relationship was found among them, as well as how they influence adaptation. Therefore, every attempt to care for and rehabilitate a burn survivor should be focussed on addressing their physical, psychological and social needs in order to maximise their recovery and adaptation outcomes.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter focuses on the research methodology employed in the exploration of the lived experiences of the burns survivors' adaptation after hospital discharge. The chosen design describes the research design and approach, sampling procedure, data collecting procedures, data analysis, and ethical considerations.

3.2 RESEARCH DESIGN

The design of a study refers to the plan or steps followed to collect, analyse and interpret data. It guides the planning and implementation of the study in order to achieve the objective of the study (Creswell, 2013:33). The function of a design is to ensure that the evidence obtained enables us to answer the initial research questions as explicitly as possible. A qualitative, hermeneutic, phenomenological design using an interpretive framework was used.

The study adopted a qualitative design for the purpose of exploring the lived experiences of the burn survivors' adaptation after hospital discharge. Qualitative designs make knowledge claims based on constructivist perspectives and are naturalistic, studying phenomena in their natural settings (Creswell, 2013:36). Qualitative designs focus on exploring and understanding the way individuals or groups interpret and make sense of their experiences, behaviours, interactions, and social contexts in the world in which they live (Creswell, 2013:45).

Thus, the qualitative approach is most appropriate in this study since the aim is to explore the lived experiences of the burn survivors' adaptation after hospital discharge.

3.3 RESEARCH APPROACH

A phenomenological research approach was used as it is concerned with the study of the lived experiences from the perspective of several individuals whose phenomena was being studied (Creswell, 2013:79). The phenomenological approach enabled the researcher to collect data from the persons who have experienced adaptation challenges after being discharged from the hospital. It allowed the development of a composite description of the essence of the experience for all individuals, consisting of what they experienced and how they experienced it (Creswell, 2013:76). The phenomenological paradigm provides a qualitative tool for researchers to collectively capture how individual human experiences are perceived and organised, and how individuals make sense of the experiences within their life stories.

Phenomenology is based on the belief that essential truths about a reality are grounded in everyday experiences. Phenomenological research, an approach within qualitative design, is grounded in the philosophical works of Edmund Husserl, with a primary focus on the discovery and interpretation of human experiences in the natural environment. It rests on the belief that the description of *how* an experience is understood rather than an explanation of *why*, provides the most useful data to identify and describe the essential elements of the lived experience (Abrams, 2013:74).

A researcher's epistemology, according to Groenewald (2004:7), is literally his/her theory of knowledge, which serves to decide how the social phenomena will be studied.

The study was conducted using the interpretive framework whereby it is believed that reality is socially constructed as interpreted from the subjective experiences of people (Polit & Beck 2010:104). An interpretive framework is underpinned by the need to understand information from the perspectives of those who experienced it as opposed to imposing the researcher's perspectives on the research. Therefore, in this study information was obtained from the participants who experienced the burn injuries through interview and observation.

Husserl's philosophical assumption of "epoche" was taken into consideration whereby the researcher's own prior experiences and knowledge gained from working with burn patients in the burn unit were suspended so as not to influence the study and a "fresh perspective" (Creswell, 2013:80) towards the phenomenon being studied was taken.

The hermeneutic philosophy whose purpose is to understand experiences through stories as told by the narrators rather than to offer explanations (Kafle, 2011:191) was adopted, and results were analysed as described by the participants. Efforts were made to document those experiences to share with the reader how these might have influenced the researcher's data interpretation.

3.4 SETTING AND POPULATION OF THE STUDY

3.4.1 Setting and Context of the Study

The study on the lived experiences of burn survivors' adaptation post hospital discharge was carried out at the Plastic and Reconstructive Surgery Clinic of Mankweng and Polokwane Hospitals in the Limpopo Province in South Africa.

The Limpopo Province is situated north in South Africa with a population of 5 630 500 (Statistics SA, 2014:3) comprising mainly of the Pedi, Tsonga, Venda, English and Afrikaans ethnic groups. The Mankweng and Polokwane hospitals are located 30km apart and are two referral institutions for all the Limpopo Province hospitals. The Limpopo Burns Unit is at Mankweng Hospital where the data bank is kept, while some burn survivors are admitted to the surgical unit of Polokwane Hospital due to high volumes of patients in the Burns Unit. Burn survivors from both institutions were managed by the same plastic surgery team.

As soon as burn survivors were stabilised and their wounds had healed or were operated on, and when they were out of danger, they were either discharged home or to their local hospitals. They were given dates for review at the Plastic and

Reconstructive Surgery Clinic where their progress was monitored and appropriate decisions were taken about their care. Continuation of the physiotherapy, occupational therapy, and psychotherapy, as well as social worker services, could be recommended if the situation warranted. The reviews continued until the person was declared ready for discharge.

3.4.2 Population, Sample and Sampling Procedures

Polit and Beck (2010:1452) have referred to the population as the totality of elements or people that have common, defined characteristics, and about whom the study results are relevant. In addition, it can be denoted as the entire group of persons or objects of interest to the researcher, to which the researcher wishes to generalise or transfer the research results. However, Polit and Beck (2010:1451) further cautions that “...*the goal of most qualitative studies is not to generalise but rather to provide a rich, contextualised understanding of some aspects of human experience through the intensive study of particular cases. Yet, in an environment where evidence for improving practice is held in high esteem, generalisation in relation to knowledge claims merits careful attention...*”.

The population in this study comprised of the entire clientele who were admitted from 2010 to 2013 (609 burn survivors), which was obtained from the Limpopo Burn Unit. The date range was selected because those burn survivors who were still attending the review clinics fell within that range.

A sample is an element of the population considered for inclusion in the study. Creswell (2013:158) indicates that the phenomenon to be studied dictates the method of sampling, even including the type of participants. A purposive type of a non-probability sample was used. This type of sample is regarded suitable for qualitative studies where the researcher is interested in participants who have the best knowledge concerning the research topic (Elo, et al. 2014:4).

The sample consisted of nine burn survivors who have been admitted to the Burns Unit at Mankweng Hospital and Surgical Unit of Polokwane Hospital from 2010 to 2013. Though there were still participants booked for reviews according to the

booking diary, most of them were not reachable when an attempt was made to contact them by phone. Therefore the sample size was based on their availability. Participants who were scheduled for review at the Plastic and Reconstructive Surgery Clinic were obtained from the register in which they are booked for review. The inclusion criteria involved all males and females, 18 years and older, who were eligible to consent to the study. Participants were contacted by phone prior to the appointment date and arrangements were made with them to conduct interviews for the study. A sample of nine participants was confirmed and one participant was used for the pilot study.

3.4.3 Data Collection Methods and Procedures

The main aim of data collection methods' implementation in qualitative studies is acquiring information by asking people about their opinions and experiences (Moriarty, 2011:8). The study used qualitative data collection methods in the form of in-depth individual interviews, as well as field and observational notes to collect data on the lived experiences of burn survivors after being discharged from the hospital back to their communities.

Moriarty (2011:8) asserts that in-depth interviews offer the researcher the benefit of discovering information on issues that the researcher may not have considered. Participants become more relaxed and free to talk if it is done in the participants' natural settings or at venues that the participants have selected.

One limitation of interviews includes the power relationship problem between the researcher and the participant, whereby in the minds of the participants the researcher is in a place of authority (Das, 2010:17). It is the researcher's responsibility to make participants feel at ease.

Also according to Moriarty (2011:11), observational notes offer the researcher opportunities for the analysis of non-verbal communication and insights that are unlikely to have been gained through interviews alone. However, if people are aware that they are being observed or video-recorded, they tend to respond to questions in a way that may not reflect the actual situation (Hanckock, Ockleford & Windtidge, 2009:20).

3.4.3.1 In-depth face-to-face interviews

Jassim and Whitford (2014:4) describe in-depth face-to-face interviews as personal and intimate encounters in which open, direct and verbal questions are used to elicit detailed narratives and stories. Face-to-face in-depth interviews are well suited for the exploration of perceptions and opinions regarding complex and sensitive issues, and enable probing for more information and clarification of answers as they do not constrain participants in answering (Hancock, et al. 2009:16; Chan, Fung & Chien, 2013:5). Data were collected from burn survivors who had been discharged home following hospitalisation. Interviews were in-depth while allowing the participants to narrate freely (Chan, et al. 2013:4). Interviews were conducted after the burn survivors were through with their clinic appointment.

Interviews were unstructured to allow for greater flexibility in adapting the questions according to the participants' needs and were conducted in the participants' own languages, which was Pedi, Tsonga, Venda, English and Afrikaans. These languages are all used in the Limpopo Province, and the researcher is conversant in each. Participants were interviewed in their own language of Sepedi except one where English was used. The researcher transcribed and translated all interviews. The translations were checked by an external personal also conversant in the above languages.

The importance of making the participants at ease through rapport establishment cannot be overemphasised and this was done through self-introduction, explaining the purpose of the study, and making the participants comfortable with an attitude of acceptance and being non-judgemental. Evidence suggest that asking participants questions, and changing questions as led by their responses, place participants in control and they become relaxed (Turner, 2010:755).

Face-to-face interviews also allowed the researcher to be aware of non-verbal cues which are valuable for interpreting the participants' feelings towards certain questions and around the various responses they give. Grand tour, open-ended questions were used for the purpose of guiding the direction of the interview

sessions and allowed freedom of narration in participants' own words as indicated by Stuckey (2013:56). The question was "How was it for you to adapt after your hospital discharge?"

The conversational nature of an unstructured interview allows participants to tell their story in a natural way without feeling constrained by having to answer a list of closed-ended questions posed to them. In a way, the participants determine the flow of the discussions, with the researcher following up on their answers.

In order to encourage the participants to narrate freely (Guion, Diehl & McDonald, 2011:2), the researcher used good listenership, patience and open-mindedness while picking up subtle cues such as facial expressions, body language, and tone of voice.

When the participant had difficulty answering a question or provided only a brief response, the researcher used prompts to encourage the participant to consider the question further (Hancock, et al. 2009:17).

A digital audio recorder was used during interviews after the participants had given consent to that effect in writing. Data were gathered until no new information emerged. Saturation was reached by interview seven, two additional interviews were held to confirm saturation.

3.4.3.2 Pilot interview

Casper and Peytcheva (2011:392) describe a pilot interview as the qualitative technique and activities that allow the researcher to evaluate the data collection procedure before the commencement of the actual data collection. The main purpose of a pilot interview is to evaluate the data collection tool and procedures before data collection can actually commence as a way of ensuring the reliability of the tool. As indicated by Turner (2010:756), this involves testing the research instrument in conditions as similar as possible to the research, but not for the purpose of reporting results. Shewhart and Wilks (2014:43) and Turner (2010:757) concur on the importance of the pilot interview as a way of enabling the researcher

to identify glitches in wording of questions and lack of clarity of instructions, as well as anything that could impede the instrument's ability to collect data in a systematic way. In this study, pilot interviews were conducted with two potential participants who were not part of the study, using the same interviewing method. This allowed the researcher to test certain aspects of the questions asked, to check for possible omissions that might have been overlooked when framing questions, and to make modifications by rephrasing questions that were misunderstood. In this study, no modifications were made.

3.4.3.3 Observation and field notes

Observation notes were used in this study. According to Hancock, et al. (2009:19), observation notes refer to notes that the researcher creates in order to remember the behaviour, something observed, said and happening, during the data collection session. However, the authors (Hancock, et al. 2009:19) caution researchers to take care as valuable information can be lost when participants are interviewed, observed, and notes are written simultaneously. In this study, notes were written immediately after each interview.

3.4.3.4 Personal reflective diary

A personal reflective diary, defined by Roller (2014:7) as a diary kept by the researcher to provide personal thoughts and insights on what happened during the study, was kept to review and judge the quality of data collection and interpretation. The researcher offered a subjective account of each research event with details of the influences that may have affected the results.

The diary sensitises the researcher to his or her prejudices and subjectivities, while more fully informing the researcher on the impact of these influences on the credibility of the research outcomes. This is because distortions, preconceptions, and biases during data collection and analysis have to be addressed (Roller, 2014:8).

Qualitative research is exploratory in nature and conclusions on the data are based on commonalities, therefore, it may not be said beforehand how many participants

will be interviewed. Baker and Edwards (2012:5) suggest that the researcher considers the purpose of their research in order to decide how many qualitative interviews will be enough. Therefore, for the results to be conclusive in this study, data collection continued until saturation was reached which is the point at which no new information or themes arose from the data. A total of nine interviews were conducted.

3.5 DATA ANALYSIS

Groenewald (2004:17) describes data analysis as an investigation of the constituents of a phenomenon while keeping the context of the whole. It is also systematic procedures to identify essential features and relationships within data.

Colaizi's step-by-step data analysis process (Shosha, 2012:34) was regarded as suitable for this study. According to Lee, Landy, Wahoush, Khanlou, Liu and Li (2014:2), Chan, et al. (2013:5) and Shosha (2012:41), Coliazzi's data validated through analysis strategy ensures credibility as conclusions are member checks with participants from whom data was collected before being regarded as a true reflection of the study.

Data analysis started at the time of data collection. Coliazzi's method of data analysis as described by Shosha (2012:33) was implemented whereby all the transcripts were read and re-read to get the sense of the whole content. Critical statements were extracted from the transcripts. Meanings were formulated from the transcript statements and they were coded, classified into categories, themes and clusters, according to the derived meanings. All the themes were integrated to get the whole meaning and conclusion of the phenomenon. Finally, member checks which involved testing of data, analytic categories, interpretations, and conclusions with members of those groups from whom the data were originally obtained, were conducted (Cohen & Crabtree, 2008:334; Shosha, 2012:34; Lietz & Zayas, 2010:193). The analysis was concluded with a description of the "essence" of the experience.

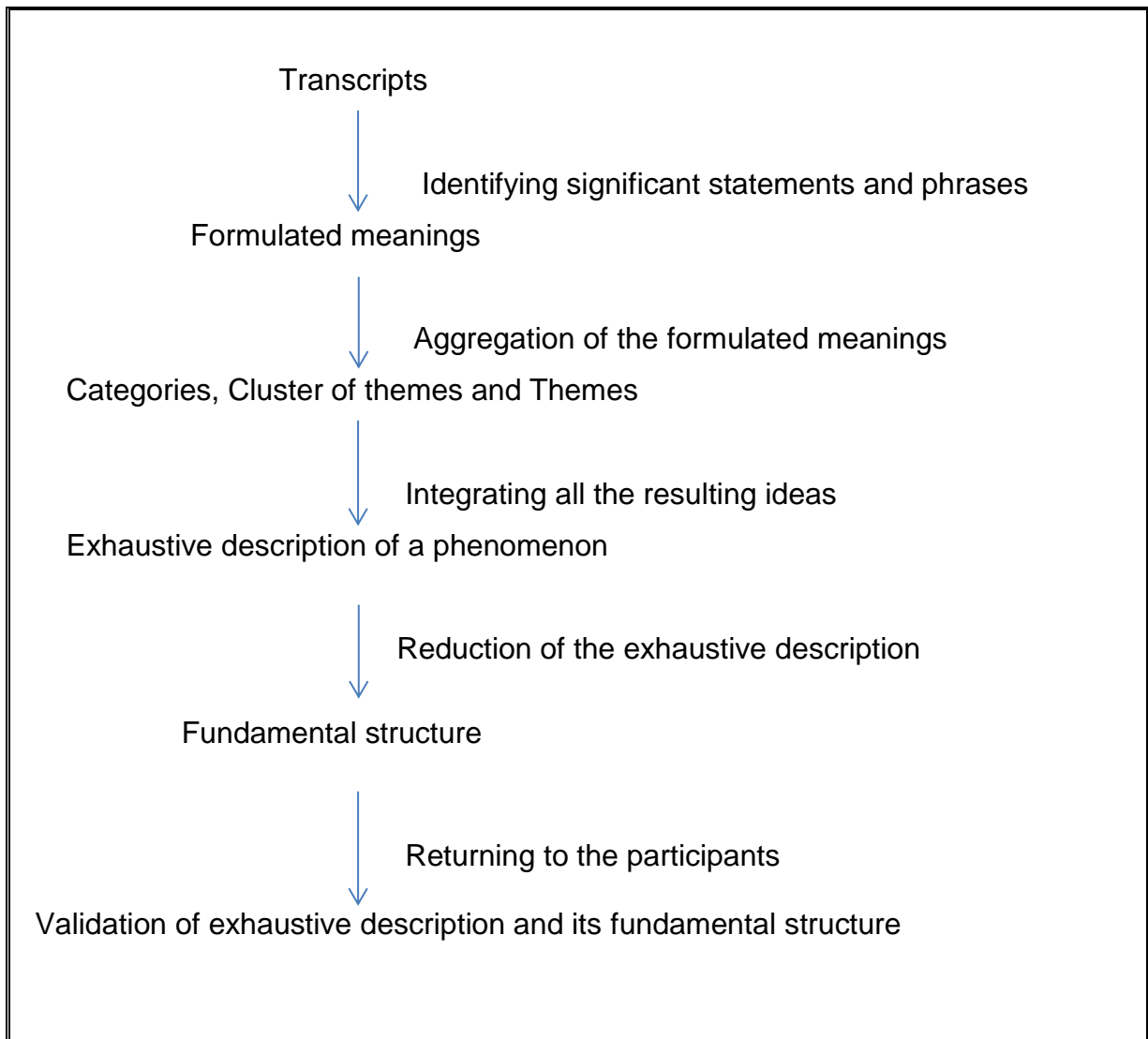


FIGURE 3.1: A summary of Colaizzi's strategy for phenomenological data analysis (Source: Shosha, 2012:34)

3.6 MEASURES OF TRUSTWORTHINESS

3.6.1 Credibility

Credibility refers to the degree to which the study findings represent the meanings of the research participants, and confidence in the truth of the data collection and interpretation in a way that enhances believability (Lietz & Zayas, 2010:189; Dahl, 2013:48). In this study, the purposive sampling and inclusion criteria ensured that all participants had experienced burn injuries and were in a position to relate their experiences. A relationship of trust, which started when participants were still

admitted whereby they knew and interacted daily with the researcher, continued during the study and allowed ease of narration and elaboration by the participants. Data collection continued until saturation of information was reached (Marshall, Cardon, Poddar & Fontenot, 2013:11; Dahl, 2013:48; Hancock, et al. 2009:22). This was achieved after nine interviews.

The researcher biases were acknowledged, stated, and kept in check so that they did not influence the results (Creswell, 2013:80; Chan, et al. 2013:1). This was done through the use of a reflective diary. The research information was summarised during the interview and after the analysis was completed, it was verified with the participants whether what was written represented their experiences as told. The research findings were exposed to a researcher who was not part of the study (Polit & Beck, 2008) and to the researcher's supervisor who reviewed and validated the analysis.

3.6.2 Confirmability

According to Lietz and Zayas (2010:197), confirmability refers to the degree to which the research results can be confirmed or corroborated by others. Confirmability involves the steps taken to ensure the research findings are the result of the ideas and experiences of the participants rather than the preferences of the researcher. In this study, information was provided to demonstrate how conclusions and interpretations were reached. An audit trail, which is defined by Lietz and Zayas (2010:196) as a transparent description of the steps taken from the start of the research project to the development and reporting of findings as well as keeping them available when needed, was done (Cohen & Crabtree, 2008:334). This included raw data, field notes and summaries, as well as recordings in the form of a digital recorder. Information was also provided on how the analytical steps were taken, how the themes were categorised, and the emergence of their relationships.

A confirmability audit is the submission of the research information to the researcher's supervisor to evaluate the study's accuracy on whether the data support the findings, interpretations, and conclusions. Triangulation was done by

comparing the researcher's findings with those of other researchers from the literature reviewed and peer reviewers, to identify similarities and differences.

3.6.3 Dependability

Crane (2014) indicates that dependability is based on the assumption of replicability or repeatability, and is concerned with whether the same results will be obtained if the study is replicated using the same tools. In this study, dependability was ensured by providing sufficient information on how data were collected and how the researcher arrived at the conclusions (Ryan, Coughlan & Cronin, 2007:742).

3.6.4 Transferability

According to Crane (2014), transferability refers to the degree to which the results of a study can be generalised or transferred to another context or setting. In this study, transferability was ensured by conducting the study with participants from two institutions, namely Mankweng and Polokwane Hospitals, as they were the only central institutions in the Limpopo Province where burn survivors from all districts of the province were being transferred, treated and reviewed. Both men and women were included in the sample.

Transferability was also guaranteed by encouraging the participants to narrate their experiences freely. Probing was done to encourage elaboration in order to get in-depth information. A thorough description of the burn injury phenomenon, research context, and field experiences, as well as the assumptions that were central to the research, was done as indicated by Cohen and Crabtree (2008:336).

3.6.5 Authenticity

Authenticity refers to the extent to which the interpretation is credible and reflects the data. To ensure authenticity, the interpretive process should be transparent and the process of arriving at the interpretation should be clearly set out in a report (Jones, 2013:402). It involves the assurance that both the conduct and evaluation of research have been genuine. In this study, authenticity was ensured by allowing the

participants to be the primary sources of data and conclusions were from the participants' perspective. Audit trails were kept as a means of verification (Lietz & Zayas, 2010:196). All sources of information were acknowledged, along with the work of previous researchers which was obtained from the literature reviewed.

3.7 ETHICAL CONSIDERATIONS

Navran (2010:6) defines ethics as moral principles that govern a person's behaviour or conduct during an activity, as well as rules of behaviour based on ideas about what is morally good or bad. Ethics deals with matters of right or wrong, good or bad, and are concerned with what one ought to do to fulfill one's moral duty. According to the Interburns Report (Potokar, 2013:3), all research involving human participants should be conducted in a manner that respects the dignity, safety, and rights of research participants. The ethical considerations adhered to in this research study is discussed below.

3.7.1 Approval and Consent

Application to undertake the research, with a research title and the reasons for conducting the study, as well as the research proposal, was submitted to the Department of Health Ethical Committee of the Limpopo Province and the Chief Executive Officers of Mankweng and Polokwane Hospitals where the study was conducted, for prior permission.

3.7.2 Self-Determination

Participants' permission to be involved in the research was secured through signing the consent form which confirmed their autonomy and self-determination. Consent from participants who were 18 years and older who were eligible to sign, was obtained after explaining the purpose of the study, the methodology to be used, any potential risks and benefits to the participants, and the participants' right to withdraw from the study at any time without prejudice (Fouka & Mantzorou, 2011:5; Dahl, 2013:25). This information was provided to enable participants to make an informed decision. Their right not to participate and to terminate their involvement at any stage

was explained to them. There would be no penalty and their future care would not be affected had they chosen not to participate (Dahl, 2013:25; Fouka & Mantzorou, 2011:6).

3.7.3 Privacy and Confidentiality

The Bill of Rights in the Constitution of the Republic of South Africa (Act No. 108 of 1996 as amended) requires the respect of every individual's privacy. The participants' privacy was protected by using a private room in the institutions for data collection.

Participants were assured of their anonymity and that their names would not be used. Instead, different codes for male and female participants were used. However, the fact that the information will be accessed by the researcher and the supervisor was disclosed. The rights of the participants who refused to divulge certain information they felt was personal, were respected (Fouka & Mantzorou, 2011:6).

3.7.4 Right to Fair Treatment

The right to fair treatment, according to Gray, et al. (2013:173), is based on the principle of justice. Participants' fair selection took place according to the reasons directly related to the study. Participants were treated equally with respect (Dahl, 2013:26), irrespective of their social, cultural and racial orientation, religion, age, and gender (Gray, et al. 2013:174).

Care was taken to avoid taking advantage of the disadvantaged groups like the poor, the old, the less educated, and preferential treatment of certain groups was avoided. All activities took place according to the agreement, and nothing was added without getting additional consent from the participants.

3.7.5 The Right to be Protected from Harm

Fouka and Mantzorou (2011:6) claim that the principle of beneficence and non-maleficence literally means "be of benefit, do not harm." According to Gray, et al.

(2013), discomfort and harm can be physiological, emotional, social and economic in nature.

Data collection was done sensitively and participants were observed for their reactions and facial expressions, which might have indicated discomfort during the data collection process. The participants' right to discontinue the research process was respected.

Fouka and Mantzourou (2011:6) suggest that if a participant experiences a high level of discomfort, they must be debriefed or referred for appropriate professional intervention which may include a psychologist or psychotherapy if necessary. Besides collecting data from the participants' narratives, observation of non-verbal behaviours that were suspicious of discomfort such as facial expressions, a change in the tone of the voice, crying and positions adopted were recorded. Even if the participants do not verbalise their discomfort, it was vital to ask if they still want to continue with the interview. As the interview was done within the hospital facility, the services of psychologists who are well trained in handling psychological and emotional issues were readily available. This was done because burn survivors sometimes go through terrible ordeals in their hospitalisation or their rehabilitation at home and asking about their experiences may have opened emotional scars. In this study, no participant required debriefing.

3.8 SUMMARY

This chapter discussed the research design and methodology in detail including the population, sample and sampling, data collection and analysis, measures of trustworthiness, as well as ethical considerations. Chapter 4 covers the findings.

CHAPTER 4

FINDINGS OF THE STUDY

4.1 INTRODUCTION

With the increase in survival rates of patients with extensive burns comes a new focus on the challenges of functionality that such people must achieve after discharge. This study has been undertaken for the purpose of exploring and describing the lived experiences of the burn survivors post hospital discharge.

4.2 DEMOGRAPHIC PROFILES OF THE PARTICIPANTS

Nine participants agreed to take part in the study. The participants' ages ranged between 19 years and 71 years at the time of the interview. One was married, one was a widow, six never married, and two were still attending school. Their average Total Body Surface Areas (TBSA) burnt ranged between 20% and 53%. Their burn injuries were thermal and chemical in nature. Three were burnt by petrol flames, two by boiling water, one by fireworks, one by a candle flame, one by a burst Primus stove's (pressurised burner paraffin stove) flames and one by acid. All the participants were from districts in the Limpopo Province and all were known to the researcher, and had a nurse-patient relationship during their time of admission in hospital.

4.3 FINDINGS

Three main themes were identified. Sub-themes were also identified from each theme (Table 4.1). The burn survival experience involved the person in totality with reference to their internal and external environment. The process of recovery was lengthy and started in hospital and continued post-discharge at home. Reclaiming their life and finding new meaning was a process of adaptation. Each theme and sub-theme will now be discussed with verbatim quotes from participants in italics.

TABLE 4.1: Central story line, themes, categories and sub-categories

CENTRAL STORY		
The burn survival experience involved the person in totality with reference to their internal and external environment. The process of recovery was lengthy, started in hospital, and continued post-discharge at home. Reclaiming their life and finding new meaning was a process of adaptation.		
THEME	CATEGORY	SUB-CATEGORY
4.3.1 The burn survival experience involved the complete person	4.3.1.1 The internal environment of the person	a) Challenges with physical wound management a.i) Encounters with pain, triggers and management a.ii) Scar tissue management a.iii) Limitation of joint movement
		b) Psychological processes of loss and coping b.i) Disfigurement b.ii) Depressive symptoms b.iii) Coping with psychological effects
	4.3.1.2 The external environment of the person	a) Social and interpersonal issues a.i) Family and friends a.ii) Neighbours and other community members
		b) Financial disruption
4.3.2 The process of recovery	4.3.2.1 The hospital environment	a) Staff competencies and attitudes a) Inadequate information and education
		4.3.2.2 Post-discharge environment
4.3.3 Reclaiming life	4.3.3.1 Finding new meaning	a) A process of adaptation

4.3.1 The Burn Survival Experience Involved the Complete Person

The burn survival experience involved the person in totality with reference to their internal and external environment. Their internal environment related to physical and psychological dimensions while the external environment referred to social,

interpersonal, and financial issues. Burn survivors' experiences were varied and involved challenges in one or more dimensions, which were often interrelated. Accumulating evidence suggests that psychological distress symptoms have an impact on health, functionality, and quality of life (Dalal, Saha & Agarwal, 2010:137).

4.3.1.1 The internal environment of the person

The internal environment of the person refers to those biological, physiological, and psychological factors that originate from within the person that determine and influence the body's status and functions. The internal environment included challenges with physical wound management and psychological processes of loss and coping.

a) Challenges with physical wound management

Physical burn wound management refers to those activities carried out on people with burn wounds in order to promote effective healing. It involves wound dressing, pain control, and management of the scar, which often results in limited joint movement.

The physical effects of burn injuries affected all aspects of the survivor's life which had a direct bearing on the person's quality of life. All participants reported being prematurely discharged when their wounds were not yet healed. Participants continued with their conventional wound management at their referring hospitals and primary care level settings, and were reviewed once a month at the Plastic and Reconstructive Surgery Clinic. Some were cared for by family members.

*"Some of the wounds were not completely healed and I attended the clinic and check-ups and waited for the complete recovery so that I can go back to school."
(Participant 2)*

*"...I came back from the hospital, while my wounds were still raw."
(Participant 4)*

*"My wife cleaned my wounds every day and dressed me."
(Participant 9)*

The premature discharge created problems for some participants who lived far from the health care centers and had to hire transport to take them for treatment and wound dressing.

“If I wanted to have my dressing changed I’d look for car to take me to Boyne [local clinic] to be dressed.” (Participant 7)

Lack of resources, such as dressing bandages and pain medication at certain primary health care centres, was problematic and one of the participants was told that there were no bandages and he was referred to the hospital. Out of frustration, he decided to buy dressing materials for himself.

“Shhh... and then she started working there. After that she told me that ‘there are no bandages’, and mind you, at that time I was naked. Ja, I had to put on my clothes on the undressed wounds and it was said I must go to the hospital where I will get bandages. I went to the nearest chemist, bought all my dressing materials and the topical cream that the pharmacist prescribed for me. My wife cleaned my wounds every day and dressed me.” (Participant 9)

“And the other difference is that at the hospital you are given the injection before your wound is exposed but at the clinic there is none. I used the tablets my mother bought and that helped me to sleep too.” (Participant 3)

While looking forward to their recovery, some of the health workers’ negative attitudes diminished the trust participants had in the care staff. They became increasingly reliant on their family to provide wound care.

“I asked the nurse who was in the ambulance to get a wheelchair for myself so that I can reach the wards where I was supposed to be seen by the doctors but she told me that I must just limp ‘till to the... I get to the wards.” (Participant 9)

“And thereafter she came and she said ‘Ooh! you did not undress (remove bandages) yourself?’. So I said to her, ‘how can I because some bandages are at my back and I can’t see them’.” (Participant 9)

According to international burn care professionals (Kornhaber, 2013:5; Procter, 2010:104), burn management and rehabilitation should start as an active continued process and not as isolated activities that are carried out at prolonged intervals. It is suggested that burn survivors should be rehabilitated within the burn units as non-burn areas are not well equipped to manage a burn-injured person. It is also indicated that nurses in those areas do not have the skills to attend to a basic wound, let alone dressing a complicated burn wound (Kornhaber, 2013:5). The Interburns Report of the World Health Organisation (2013:15) also suggests that it is a common occurrence that low and middle-income countries have a widespread shortage of both human and material resources to effectively deal with burn wounds.

a.i) Encounters with pain, triggers, and management

In addition to the challenges with physical wound management, participants also encountered other challenges, such as pain. The intensity depended on various triggers and lasted for varying durations. Participants reported having experienced pain which started while they were still admitted and continued even when they were discharged home.

“...I got discharged, got home and I was still in pain.” (Participant 8)

Participants described the pain as “continuous,” “on and off”, and “severe”, and of unpredictable onset.

“The pain is just on and off. Like now, there are times when on waking up I find my affected arm being painful.” (Participant 5)

“...I would feel it when I woke up that the pain was severe and I would feel that I was sick...” (Participant 7)

External wound healing did not signify complete clinical recovery as the participants continued to feel pain at the site of the scar. Scar pain was more pronounced when the scarred area made contact with objects.

“It took time you know, something like three months. Even after the wounds were sort of...healed I could still feel the pain, it’s like...inside or, let me say the scars.”
(Participant 3)

Factors that triggered their pain mostly included procedural pain such as wound cleaning and dressing activities, both during hospitalisation and after discharge.

“Wound management procedures like wound cleaning and dressing are the most painful times.” (Participant 6)

“Eish but I felt the most pain when I still had to get dressings, hey!... that process was painful.” (Participant 7)

Participants also referred to factors such as weather conditions, especially when it was cold and cloudy, as another pain trigger.

“A combination of things. Pain and a cold weather are not friends. I think some things or changes happen to the body when it is cold and if there is an unhealthy area it gets affected. It also happened especially when the sun was hot”. (Participant 7)

The duration of the pain was an individual issue. In some participants the pain ended when they stopped with wound dressings after wound closure, while in others it became chronic. This was often associated with the severity of the burn injury in terms of the Total Body Surface Area (TBSA) burnt and the depth. The nature of their pain was also related to the nature of their burn.

“... I took a long time on them (pain killers), something like eight months.”
(Participant 4)

“All I can say is that though it has reduced its intensity, it is sort of...chronic. Like I said, it’s situational. It depends on the type of trigger that influences it.” (Participant 5)

“The wounds... hey, my wounds were not very deep and therefore they were more painful initially”. (Participant 9)

How the participants were affected by the pain was also an individual issue as their circumstances differed. Some participants stayed alone and were forced to engage in activities of daily living that became troublesome. For these participants, activities that seemed basic and required lifting of their arms and reaching out for things that were out of reach resulted in scars stretching and breaking, which caused renewed wounds and pain.

“And also there are times when I do things like...when I hang the washed clothes on the washing line I do experience some scar breaks especially if I can overstretch myself.” (Participant 5)

In an effort to lubricate and soften their scars, participants used over-the-counter emollients.

“...I remember the other day I did that and somebody accidentally pushed me and there were some breaking in the scar creating a new wound which I started dressing again. That wound is difficult to heal and I end up applying Zambuck [over the counter emollient]...” (Participant 5)

The continuous nature of burn pain was also found to be interfering with their normal routines such as sleeping, thus causing discomfort while negatively affecting their quality of life.

“Yes contractures. Sometimes they become swollen. When they are swollen they are painful and it would be impossible even to bath and I will be forced to sit down because my arm will not be able to go down and reach other areas.” (Participant 5)

“...The quality of your sleep and life as a whole becomes negatively affected. Life becomes less interesting.” (Participant 8)

At times participants, particularly the male survivors, would endure the pain in order to look brave in front of the nursing staff for fear of being ridiculed.

“Yoh!, yoh! yoh!, the pain? It’s just that I was afraid of crying in front of the female nurses. In our culture a man doesn’t do that because people will undermine and disrespect you and they’ll never take you seriously. It’s a shameful thing and you look foolish to them.” (Participant 8)

The treatment of pain usually started with pain management in the form of narcotics that were prescribed – often in high doses – when the participant was still in hospital. Additional pharmacological treatments also included the prescription of sleeping tablets. Participants experienced the challenge of withdrawal symptoms upon discontinuing narcotics after being discharged, which included disorganised sleeping patterns characterised by the inability to sleep.

“When I got home initially I could not sleep because I was from the hospital... It was because at the hospital they gave us medication to help us sleep. So when you’re at home you just have to fall asleep on your own and you find that it took a long time to fall asleep.” (Participant 7)

Besides taking pain killers, some participants used other strategies that were found to be helpful, such as the avoidance of pain and ignoring its existence by not paying particular attention to it. Strategies included continuing with daily activities and conversations until the pain was no longer noticeable.

“...if you keep quiet and listen to it, it is always felt, but if you keep busy talking with others and not concentrating on it, it seems to disappear simply because you don’t pay attention to it.” (Participant 6)

a.ii) Scar tissue management

Scar tissue refers to fibrous tissue which is hard or leathery, having lost all or most of the features found on the normal skin, including the sweat and sebaceous glands, blood vessels, elasticity, and hair follicles (Carrougner & Meyer, 2012:1). Challenges

reported by participants regarding scars included dryness, heat sensitivity and itching. Participants also described their scars as dry and flaky with a tendency of breaking and bleeding if overstretched, causing a new wound that was difficult to heal. They reported their use of over-the-counter emollients with the purpose of lubricating and softening their scars.

“And also there are times when I do things like...when I hang the washed clothes on the washing line I do experience some scar breaks especially if I can overstretch myself. That wound is difficult to heal and I end up applying Zambuck.” (Participant 5)

Instructions were given to participants to limit sun exposure due to the sensitive nature of the scars which interfered with participants' normal activities as some of their daily activities were performed outside their homes or far from shaded areas.

“Now it becomes difficult for me because I cannot stand for two hours in the sun because my body does not allow me. When I sweat I start itching and the work stops.” (Participant 8)

Additional discomfort of localised pressure was indicated – especially where the scar had overgrown – and felt tight, creating a feeling of stiffness around the scarred area.

“...I cannot bend over completely because here (holds waist) the waist is still stiff. I cannot reach there (pointing to the feet), I can only reach my feet when I am sitting.” (Participant 8)

At times the overgrown scar would form keloids which are sharply elevated, irregularly shaped, and progressively growing scars with smooth surfaces. Those who developed keloids found the use of a pressure garment helpful as it compressed the overgrown area and suppressed further keloid growth, although it was difficult to put on. The effectiveness of the pressure garment was observed with participant 4, whose scars were still overgrown when she left the hospital but had already flattened during the time of the interview.

“Pressure garment yes. I took a long time putting it on...” (Participant 4)

Besides pain and discomfort, there were other sensations that were equally uncomfortable and these included itching, which is an irritating feeling at the surface of the skin causing the desire to scratch. The itching sensation was described by participants as unbearable, which tempted them to scratch the area affected.

“That is very uncomfortable and it was like I can press my back against the wall.” (Participant 9)

“When it itches I would just pat the area and not scratch with the nails. I would just do this gently (gently stroking the area) and not in a rough manner because I would cause another injury.” (Participant 7)

The itching sensation is said to be more pronounced during the night, and this interferes with sleeping. Sometimes participants applied oils and ointments as advised by health professionals and friends to lessen the intensity of the itching, and that proved helpful.

“They applied it at the clinic and later they advised me to buy that thing, what is it called? Err...tissue something, ah! Whatever it is called. It is an oily something like the oil of oil (meaning tissue oil).” (Participant 7)

a.iii) Limitation of joint movement

Movement of limbs is facilitated at the joint levels. A burn wound that crosses the joint causes a scarred joint that is difficult to move as the scar tissue is fibrous in nature, inelastic and stiff. Participants' joint movements were limited by the conditions of their scars and they were unable to perform daily activities. Other people, including family members, performed those duties for them. The scar that forms with the limb in a flexed or extended position – depending on the position of the burn injury – creates a contracture which forms a disability. Participants expressed their frustration at being unable to use the limbs that they used before they were burnt.

“My arm became dysfunctional, yes for a long time and I couldn’t work so I tried to use the left arm but because I’m right handed, it was a struggle.” (Participant 4)

“like wringing the clothes. I could not wring out anything because I used this (left) hand. Also I could not handle things. I struggled to get dressed.” (Participant 7)

Participants who were used to doing activities and chores for themselves at their own pace expressed the feeling that when those activities were done for them it felt like they had become burdens, even if no one told them this.

“Can you imagine, from being a free living person and all of a sudden you are dependent on other people for almost everything” (Participant 3)

In order to adapt to their situations, participants struggled to utilise their other uninjured limbs which were not naturally dominant. The need to regain their independence was the key factor that prompted the participants to engage in various activities that helped them regain their functionality. Participants reported how they worked towards their functional independence by attending physiotherapy, home activities, and exercises. They said this was a continuation of what was started while they were still admitted.

“I was exercising a lot. I’ve been attending physiotherapy in town and they gave me a certain soft ball that I used. When I was unable to do this on my own (indicating the hand squeezing action), I would use it by tightening my hold on it and throwing it and trying to catch it, lifting and lowering and so on, which strengthens the hand and arm muscles as well as ligaments. I really exercised a lot and that is why I’m like this now.” (Participant 7)

b) Psychological processes of loss and coping

Burn survivors often found themselves having to cope with situations that were stressful to them. This resulted from the psychological impact the burn injuries had on the survivors who had to adapt to their new appearance and limitations. Psychological challenges that participants were faced with resulted from their

disfigurement due to scarring, and depression. The severity of the physical effects of burns was described by participants as 'better', compared to those of psychological effects. Various strategies were used to cope with their situations.

b.i) Disfigurement

Experiencing an altered physical appearance had a significant impact on burn survivors' body image as a result of scarring. Participants went through new experiences of losing the familiarity of their bodies. How they perceived themselves and how others perceived them influenced their outlook on life and how they adapted to their physical changes.

"...He/she doesn't see the person that he/she saw yesterday. Today I am a different person with scars." (Participant 2)

Participants described how they were overwhelmed by the painful feeling of being socially isolated as they experienced different reactions from people just because they were different from others. They only wanted to be recognised as human beings like any other person, irrespective of their appearance, which was not always the case.

"Firstly I want to change the way people look at people who are different from them and... look at the person based on the fact that he or she is also human and has feelings. They must know that the other person is err... like me, can feel the pain and the issue of Ubuntu ...I mean must treat others the way I would like to be treated." (Participant 5)

Dissatisfaction with their own appearance due to disfigurement became a source of stress and maladaptation. Participants described how they were negatively affected by their inability to accept their appearance.

"I was still scarred and they didn't look good because scars are also having black dots like areas where the hair follicles grow. Imagine those on the face." (Participant 6)

“My facial scars. I was terribly deformed. Do you realise that on television sets and movies, facial scars are scary and are not associated with people but things like...err....dinosaurs and some of those other things.” (Participant 4)

“...I also think of how I was going to look had I burnt the face.” (Participant 7)

Most of the participants in this study who were still young and or who were unmarried, expressed their concerns about whether people of the opposite gender would still be attracted to them, and whether they could still hope for romantic relationships.

“...I did the skin graft and after the skin graft I got discharged but my body still worries me because I still ask myself if there’ll ever be a woman who would stand me because of my back. My back has “scotch” pattern.” (Participant 8)

b.ii) Depressive symptoms

Burn survivors often experienced depression mainly due to a lack of satisfaction with their appearance. This is because the sudden change in body appearance and functionality was drawing unnecessary attention to them, which was damaging to most of the participants’ self-esteem and diminished their confidence. Participants tried to cope with their situation, but their coping mechanisms sometimes became exhausted. One participant who had facial burns described how she found herself running out of coping options and her distress pushed her to the brink of suicide.

“The whole situation stressed me a lot and I just felt that I’ve run out of options and I only saw “red” sort of the end of the road. I think the stress level was way beyond my power to persevere. I remember at some stages I thought of committing suicide, and I always wanted to be alone.” (Participant 5)

Participants also described how traumatic it was for them to look at themselves in the mirror, and they understood what the people were seeing when they stared at them. Some reported social isolation and avoiding contact with people, while one

participant reported having felt that she was under “house arrest”. The description of how participants felt included:

“I’m still traumatised by this.”, “...In a way they lowered my self- esteem...”
(Participant 2)

and

“...I’m telling you the truth I was also afraid of myself. I remember being afraid of the mirror because each and every time I saw myself in them I was severely depressed.”
(Participant 4)

Only one participant experienced flashbacks of the burn incident.

“You know my problem was that when I was supposed to sleep, I used to see that burning incident replaying in my mind. I used to have nightmares about those flames, dreaming of seeing myself running away from them.” (Participant 4)

b.iii) Coping with psychological effects

Various strategies were used by participants with the aim of trying to cope with their post burn situations. In order to escape the attention of the public caused by visible scars, participants sought to hide their scars by wearing concealing clothes that included long dresses and skirts, as well as long sleeved garments.

“Usually, normally I was wearing normal dresses. On coming back, if I was to wear a dress it had to be a long dress or pantyhose to hide the scars, so as time went on at least..., but it took me a very long time.” (Participant 2)

Depending on the area burnt, every effort to hide the scars would be made in a way that is appropriate for that area. Participants who were burnt on the upper and lower limbs had long sleeved garments, long skirts, and pants. One participant who burnt her face and ear had to use a hairstyle that concealed the earlobe that was destroyed by the burn.

“...Now I can’t make those styles like straight back, hair by hair etc. I plait some long styles that will help me hide this side of the ear...” (Participant 5)

Contrary to common belief, not only women but also men were found to be concerned with their scars. On reviewing the study transcripts on the issue of hiding scars, it was also found that all those who were concerned were young, while the older participants were unconcerned. One older participant reported that:

“I don’t have even a single problem because I must accept myself as I am. If I can’t accept my situation I will always cry and say I’ve been burnt and I must hide the arm. I am free to put on the short sleeved clothes so that people must get used to me and know that I have been injured.” (Participant 7)

One of the leading causes of psychological trauma in burn survivors is the thought that they are being rejected by others. Participants shared their stories of how they were hurt by how unsympathetic other people were towards them. This concurs with the tones of anger and despair when participants were explaining their pain at being seen as different, during the interviews. They related their pain of being isolated and treated as different. All they wanted was to be accepted as they are, just like any other person.

“They must know that the other person is err... like me, can feel the pain and the issue of Ubuntu ...I mean must treat others the way I would like to be treated.” (Participant 5)

“You won’t believe this. How people will make you feel. (With a slightly raised voice and a change in facial expression) when I came back from the hospital, I spent a week at home before going back to school. From the first day I landed at school, I became the laughing stock of every person there.” (Participant 3)

“...when I looked at myself, I still saw that beautiful woman. I knew that people would see me in a different way. But if they were to see me by the outward appearance, they don’t know what they are missing out because they don’t know the real me because the outward is not the real me.” (Participant 2)

Participants reported how they discovered the benefits of accepting themselves and living with their situations after they did not get help from seeking public sympathy. They took the leading role of self-acceptance, expecting others to do the same. When they became comfortable with themselves, they no longer cared what other people were saying about them. This boosted their self-worth and placed them in control of their lives again.

“Hai, now to be honest, I have now accepted myself and it’s already long. It may be two years already since I started to accept and be comfortable with myself.” (Participant 2)

“Yes and it feels like I am now in control of my life again or rather I’ve regained what I had lost which is the most important aspect of my recovery. I now have direction and it’s like I’ve picked up from where I left.” (Participant 6)

Participants also described how they decided to challenge and defy their situations in order to regain their independence and exercise their rights to live their lives like any other person, irrespective of their difference in appearance. Talking about their situations assisted them in ventilating their long bottled-up inner emotions, creating a pathway to their inner healing.

“In a way it was like I’ve opened an outlet valve and a build- up of steam was gradually released. What also helped me is that here at home we talk. Like when somebody hurts me in a certain way, I am unable to keep quiet about it. I’ll explain and if I end up being the wrong one, I apologise because I don’t want to go around with the baggage in my heart. My recovery was assisted by the fact that I am open with other people.” (Participant 5)

“And I used to be vocal and tell them that...I would tell them that It’s long and I had enough and so don’t resurrect the things that are already buried. And now I’m able to tell them that this and that happened.” (Participant 4)

Some of the participants used the strategy of defying their disability by just using their disabled limbs until they were fully functional. Activities were carried out gradually until they were able to attain full motion ranges.

*“Sometimes I refused because I said I must learn how to do things for myself.”
(Participant 2)*

“I actually didn’t start by bending full blast initially. I took it one step at a time until I felt I don’t have any restrictions anymore. But it took a lot of sacrifice in the form of forcing myself to bend on daily basis.” (Participant 9)

“Now I’m able to go anywhere I want and come back home without any stress. This is because now I am able to compare myself with other people. When I look at them, they are not burnt and don’t have scars but they are shabby and not lookable. When I compare myself and how I take care of my son with them I realise that this person has his own weak points.” (Participant 5)

Participants who were only stressed by the burn injury were able to focus on it and adjusted quicker than those who had other stressors. Two participants had difficulty in coping because they lost their fathers before and after the burn incidents.

“Secondly how I was transformed from a normal woman to something that cannot be described did a lot of damage to my mind. Then my father’s death added salt to the psychological wound. He was my pillar of strength at that time of serious need and now he is gone.” (Participant 4)

And:

“Like I said, my father died in a car accident and I was with him. The following year I got burnt and the year later one of the girls I was attending school with hung herself and we went to see her we found her still hanging.” (Participant 3)

4.3.1.2 The external environment

Some of the factors that had a direct bearing on the recovery and rehabilitation of the burn survivors originated from their external environments. These included social and interpersonal issues, as well as financial disruptions.

a) Social and Interpersonal Issues

Burn survivors experienced challenges that originated from the social environment in which they live. Participants in this study related how they came across different reactions by people known and unknown to them, and how this shaped their recovery and rehabilitation journey. These included family and friends, neighbours, and other community members.

a.i.) Family and friends

Participants reported how they found solace in their families which helped them cope with their disabilities. Participants were assisted with performing activities that they could not perform without complaining, until they were able to do those activities themselves. Family members went to the extent of putting the interest of the survivor above their own.

“My family is what I can say it’s a super family. There is nothing that I can want to do and they don’t come to my assistance. Some have sacrificed their time, hobbies and ... what can I say, to be with me and help me.” (Participant 5)

“...with family members, even if you were not the best of friends, when tragedy strikes it’s like it brings you together. It’s like they realise your importance and value. It’s like they realise that they can lose you and remain regretting while the failure to reconnect cannot be corrected because you would be gone.” (Participant 5)

Where the family members ran out of options in the process of assisting the survivor, cultural prescripts were also disregarded and violated in order to help the person in times of need.

“I’m telling you the truth, the issue of being exposed to your female sisters, especially younger than you are, yoh!, that is a violation of our culture and it’s humiliating. Imagine trying to hide your private parts with hands when they help you...jaa, it’s tough.” (Participant 8)

a.ii) Neighbours and other community members

Participants described how people in their neighbourhood treated them. Most reported good, sympathetic and helpful reactions. This type of response was attributed to the good relationships they had before the burn incidents. A participant who was burnt by his neighbour indicated that he found relief after forgiving the perpetrator, which also restored their relationship.

“You won’t believe if I can tell you that now I don’t have any bad feeling towards him. I now spend time with him at times. Ja, I don’t have any grudge.” (Participant 6)

However, irrespective of all the good social reports, adverse reactions were also experienced. Participants shared their experiences of how they were hurt by the negative reactions of the people they knew and used to interact with. Most were their former friends or associates. It was common for burn survivors to be frustrated by people uttering unpleasant words that may be derogatory, stigmatising, and hurtful.

“...as I tried (to go to the shops) people were talking about me and I couldn’t face them and they were laughing at me.” (Participant 5)

“...some of the things I heard. I would sit here and when passing by they would whisper about me thinking I could not hear them saying ‘that one has been burnt, don’t get close to him.’” (Participant 8)

Even if some people did not verbalise their surprise, their non-verbal communication said it all and survivors understood the meaning of their stares and felt their discomfort. This contributed to making the participants’ adaptation and integration into society difficult. Participants learned from those negative reactions that not all

the people in their lives are true friends, because on the day of trouble they abandoned them.

“First of all it taught me never to trust a person, especially a man and the people you regard as friends.” (Participant 5)

b) Financial Disruptions

Other factors related to their livelihood were also found to influence the burn survivors' adaptation process. Their earning capacity and financial security became challenged when survivors became disabled by burn wounds to their upper limbs, which took a long time to heal. Participants who were working before the burn injury found themselves financially constrained because they were unable to resume their jobs after discharge.

“No, I was unable to start (Operating the small business). I took time, something like four years. It's not long that I started again.” (Participant 4)

“It's terrible because I knew that when I went there, whatever I got at the end of the month was better because I was able to buy food for my siblings and they were able to have breakfast before they went to school.” (Participant 8)

In order to cope with the financial struggle, the local good Samaritans assisted some participants. These are sympathetic people in their local communities and churches who contributed assistance in the form of food, money or referrals to organisations that assist until the affected people were back on their feet.

“...And as for the community people...they were really supportive. I'm telling you, on coming back from hospital, I found that while we were still admitted, each and every household in our community has contributed twenty rand for our family so that those remaining at home can have food. Hai! The community was really supportive” (Participant 4)

The burn-caused disabilities also became a state-added responsibility. In order to minimise the suffering due to their disabilities which were temporary, some of the participants sought help and received temporary disability grants from the Department of Social Development until they were able to return to work or were deemed fit to do so.

“...He then wrote me the letter that he told me to take to SASSA [South African Social Security Agency] and they helped me with a disability grant.” (Participant 5)

4.3.2 The Process of Recovery

Survivors' adaption to their post burn situations depended on their internal and external circumstances and the social relationships wherever they found themselves at a given time. The impact the environmental factors had on the participants had permanent life-changing effects and enabled the participants to learn new life lessons and to have a new perspective of life.

4.3.2.1 The hospital environment

Hospitals settings can contribute to the positive recovery of burn survivors, giving them hope for recovery or adding to their stress levels with a lack of motivation through the personnel attitudes, interactions, and patient care methods of nursing staff. The public and media generally portray public hospitals as hostile areas whereby the public has developed a negative attitude towards them. When the environment is supportive, patients' adjustment is positive.

“A hospital is not always a good place to stay at but with me it was different.” (Participant 7)

a) Staff competencies and attitudes

Participants described the effect the hospital environment had on their adjustment to the stressful situation they experienced as a result of their burn injury. They explained how the Burn Unit personnel assisted them to better cope with their

situations and to look at life from another perspective. The relationship that prevailed between the burn survivors and the personnel made the participants feel that they were in a caring environment which was not much different from home.

“I still remember very well the comforting words they used to tell us. The prayer in the morning before they started working Yoh!... it brought us closer to God where we felt that irrespective of all our situations, there was some higher power that was looking after us. It feels as if you are at home and you forget that you are in the hospital.” (Participant 4)

One participant even mentioned that he regarded the staff as *“my brothers and sisters that I had never known before”* (Participant 8) while another participant likened the hospital where he was admitted to *“a five star place.”* (Participant 9)

“... we are bathed, we are given medication, we are... those that cannot feed themselves are taken care of when it comes to food. There is nobody who can say they need something and not get it. Their nurses are “top notch”. When patients complain about pain they are attended to.” (Participant 7)

b) Inadequate education and information

Burn survivors felt information about their care, wound and pain management, planned treatment and preparation for discharge education would be helpful. A lack thereof created the feeling that they are left alone to imagine what would happen.

“Err...Mm...and I don’t know this thing...err, I think should be done at the hospital is to tell the people who are injured, that are burnt, they must be told that “when you come out, there will be...” I mean, so that one must not be bothered when people stare him. I don’t know how.” (Participant 4)

4.3.2.2 Post-discharge environment

During their hospitalisation most survivors think of the comfort of their homes, being surrounded and supported by their family members. After discharge from hospital,

participants found themselves facing challenges they did not expect. Chronic post burn conditions, the need for support, and a lack of readiness to face the world were some of the problems the survivors experienced after being discharged from hospital.

a) Preparation and the home environment

Participants described how they were confronted with reality after leaving their “place of security” – the hospital. During hospitalisation, participants’ needs were attended to by the hospital personnel. This gave them a sense of security.

“To me these two places are different in terms of security. Jaa! There is a great difference. When you are in the hospital err...you are not involved in any activity by yourself except physiotherapy exercises and just walking around. You are able to tell the nursing staff of any discomfort that ‘I feel this and that’... and they will address it individually. You are given food and you can just say ‘I don’t eat this and that’... and the alternative will be brought to you.” (Participant 8)

The home environment after discharge posed challenges related to support for some participants in this study. Participants often felt alone and unsupported.

“Ei! The loneliness, yoh yoooh, can you imagine not being able to get up from the bed, you need somebody to help you and it’s a man... eish it’s just awkward. In the home I felt it. I did feel that I was alone.” (Participant 7)

“It was tough. I think it’s because I don’t have a wife and all the things I was supposed to do them myself.” (Participant 8)

Some participants felt that at the time of their discharge they were not mentally ready for the challenges they were likely to encounter. This was confirmed by one participant who experienced adaptation challenges and who felt that had she been better prepared, she would have handled her situation better.

“...err, I think what should be done at the hospital is to tell the people who are injured, that are burnt, they must be told that “when you come out, there will be...” I mean, so that one must not be bothered when people stare him. I don’t know how....maybe there must be other people like counselors who will tell people that “you are no more the same as you were before”. The person must not be reminded by other people outside. He must come out knowing that “I’m no longer the way I used to be and everywhere I go, when these people look at me I must be strong”. (Participant 4)

Although participants had positive experiences within the hospital environment, the transition from the hospital Burn Unit to other settings, including the home environment, created insecurities and negative experiences. They described situations where negative attitudes were experienced by some of the nursing staff in health care centers post discharge. Those negative and unhelpful attitudes left unpleasant marks emotionally, which diminished their recovery prospects.

“... I realised that things changed and they [nurses] were not like what I had at Mankweng Hospital. Mind you I was not so err... I was not so... I don’t know how to put it... healthy that I could walk.” (Participant 9)

“... a certain sister there said to me, ‘go into that room, it’s where I will help you’. So I went. And then I went...And there after she came and she said ‘Ooh! you did not undress (remove bandages) yourself?.... So I said to her, ‘how can I because some bandages are at my back and I can’t see them.” (Participant 9)

4.3.3 Reclaiming Life

The recovery of burn injuries is a process. Participants managed to reclaim their lives through finding a new meaning to life and participating fully in their rehabilitation process.

4.3.3.1 Finding a new meaning

After going through the challenges of recovery and rehabilitation, participants decided to defy all odds and live their lives as normal as possible. Instead of complaining about their situations which would not change overnight, some participants found their burn conditions to be life changing. They were able to cope with their lives by forgetting about the past and diverting their attention to the fact that they were lucky to survive.

“I found a new meaning in life and I’ve realised that one has to do everything to the best of his ability while there is still time as if there is no tomorrow so that he doesn’t have to regret the lost chances. Time to live is borrowed time which must be utilised before being returned to its owner.” (Participant 6)

Participants also reported how they stopped concentrating on their losses and redirected their lives to meaningful things that make their lives better. Moreover, more gratitude was directed to God who healed them. Even those who did not know Him before their injuries, started to have a relationship with Him. For some participants this happened after feeling betrayed by the people they trusted as friends, while they experienced God’s constant faithfulness.

“I only attended church when I needed prayers for certain life issues but now I’ve seen God’s help in serious terms. When you haven’t had serious problems you don’t really have a relationship with him. You just know that there is God but you don’t take him seriously. But when you see him in action like I have, now you know that really there is God and I need him always and not when it suits me.” (Participant 7)

“It (building a church) was out of thanks giving desire to the God who healed me. I will always be grateful to Him. I wanted to keep the ties with him unbroken and to have a place of worship.” (Participant 9)

Important lessons were learned by participants from their burn incidents; among them was the fact that life is dynamic and while things are well today, they may be totally different tomorrow.

“That life is not static and that when things are the way they are today don’t think tomorrow it will be the same. Accidents do happen and one’s life take a U- turn when you least expect it. Every minute of life must be lived meaningfully and fruitfully as if there is no tomorrow rather than to regret later.” (Participant 8)

Participants would advise those who have not experienced the trauma of burn injuries not to be careless and get burned, as they may not be lucky to survive. Most participants in this study found themselves feeling gratitude for the second chance to live. Their future plans included planning to positively impact on other peoples’ lives by engaging themselves in activities that would help others.

“But what is closest to my heart is to see myself being of help to the people. Remember during the incident of my burning it’s the people who helped me by stopping the process through extinguishing the fire. There is always this inner feeling of ploughing back into the community, it’s important and it’s fulfilling.” (Participant 6)

“Err... I would say thinking of the people you live with and those who have been there for you, ..or let me say all your loved ones, it’s like you don’t want to disappoint them. It’s like you have to live on so that you can pay back to them what they’ve done to you, show them appreciation or even helping them one day.” (Participant 9)

a) A process of adaptation

The degree of recovery in burn survivors is measured by the level of adaptation and independence acquired which involves all the physical, psychological and social levels. Participants described how they participated fully in their recovery process through active partaking while being supported by their significant others who impacted positively on their lives. Giving up on life was not the preferred option as some had children and families, as well as a future to live for.

“I felt overstretched but of course you just force it. If you wake up... you know I used to wake up early in the morning and start exercising and make like this (demonstrating) this way and that way and clutch the ball, then I will sit down and rest. This I did because I wanted to be well so that I can cook for the children. I must

work hard so that the contracted ligaments must be stretched and become functional.” (Participant 7)

Having gone through many challenges, most participants’ future plans included starting all over again and living self-sufficient and fulfilling lives. New priorities, which included living their lives meaningfully, were set. Others found solace in God to whom they dedicated their lives.

“They (physical and psychological effects of burns) have passed indeed, it’s just sometimes...but even if I look at the mirror I don’t consider myself to be having scars. I don’t even see them. As I mentioned before that at the hospital we were praying every day, that is where I started appreciating this God who gives us life and watch over it. I was not a religious person before but after the incident I realised that it was not yet my time to die and that I think God has a purpose with my life. I’m closer to Him more than I’ve ever been and I will never move away from Him. In fact I found a new meaning in life.” (Participant 5)

Some of the motivating factors for not giving up on life included family responsibilities, future plans, and the need to give back to those who assisted them in times of need. For others, it was the need to prove their critics wrong.

“I’m sustained by my desire to live for and take care of my remaining children...” (Participant 4)

“...But what is closest to my heart is to see myself being of help to the people. Remember during the incident of my burning it’s the people who helped me by stopping the process through extinguishing the fire. There is always this inner feeling of ploughing back into the community, it’s important and it’s fulfilling.” (Participant 6)

“A number of things. First it’s like I want to prove my critics wrong. Those who said I was dead. They must see me living on all the days that God gave me to live. You told me that my life is not dictated by what people are saying about me and I agree hundred per cent.” (Participant 8)

4.4 SUMMARY

The findings of this study were displayed from the participants' narratives of their experiences and observations. From the themes that emerged there were some commonalities in terms of wound challenges, pain, the environment and people, and how this impacted on the recovery and adaptation of the burn survivors. While their fragile bodies were in the process of recovering at home, there were some triggers that made recovery and adaptation difficult such as weather conditions, itching and being in the sun, which negatively impacting on their quality of life. Most participants were initially not satisfied with their own appearance, and this was worsened by how people reacted to their conditions. External wound healing did not correspond with the internal healing, as the scar area remained painful even once the wound looked healed.

Different emotions emerged from the participants, ranging from psychological pain and hopelessness, to self-acceptance as time went by. People coped using various mechanisms such as hiding the scars, confronting the situation, and accepting themselves as they are; the success thereof depended on the support the survivors received from their families and significant others. The duration of coping was an individual issue as people differ in personality and resilience. Looking at their burn situations and how they nearly died, participants became grateful for the second chance to be alive, and instead of complaining about their situation, they constructed new plans and a purpose for their lives and wanted to impact positively on other burn survivors like themselves, and people in general. The improvement in their body image brought growth in their self-perception and therefore self-acceptance, and this contributed to their positive and successful recovery, as well as their social integration.

CHAPTER 5

DISCUSSION OF THE FINDINGS

5.1 INTRODUCTION

The purpose of this study is to explore and describe the experiences of burn survivors post hospital discharge with the aim of preparing them for effective adaptation to their condition post hospital discharge while they are still admitted.

The burn survival experience involved the person in totality with reference to their internal and external environment. The process of recovery was lengthy, started in hospital, and continued post discharge at home. Reclaiming their life and finding new meaning was a process of adaptation. The findings will be discussed according to the main themes and categories, the theoretical model and the literature control in order to recontextualise the findings, providing a point of reference for comparing and contrasting the themes and codes of this study with those of other studies. Through the process of data analysis the following themes, categories and sub-categories emerged.

5.2 THE BURN SURVIVAL EXPERIENCE INVOLVED THE COMPLETE PERSON

In the process of recovery and rehabilitation, burn survivors experienced challenges with adaptation which started when they were still admitted and continued when they were discharged home. Challenges originated internally from within the participants themselves, or externally as influenced by circumstances around them.

5.2.1 The Internal Environment of the Person

The internal environment of the person refers to those biological, physiological and psychological factors that originate from within the person that determine and

influence their physical status and functions. The internal environment included the challenges discussed below.

5.2.1.1 Challenges with physical wound management

Adaptation challenges that originated from within the participants included those related to physical wound management and shaped the participants' recovery and adaptation outcomes.

a) Pain

The pain experienced by participants started when they were still admitted and continued when they were discharged home, creating suffering and adaptation difficulties.

According to Harbin and Norris (2012:438), Rudal and Green (2010:246), Dahl (2013:7), and Abrams (2013:129), tissue damage, exposure of nerve endings, wound management procedures, and changes in the weather were found to be major causes of pain for burn survivors. At times the survivors experienced pain without any obvious trigger. Summer, et al. (2007:536) refer to this occurrence as background pain.

The resolution of pain differs according to individuals and the circumstances around the survivor. For some, their pain ended when they completed their wound dressings, while for others the pain became chronic requiring prolonged use of analgesics. The pain intensity was often associated with the severity of the burn injury in terms of the Total Body Surface Area (TBSA) burnt and the depth. External wound healing did not signify complete clinical recovery as the participants continued to feel pain at the scar site, which was more pronounced when the scarred area made contact with objects, such as bumping the affected area.

The continuous nature of pain became incapacitating, resulting in difficulty in carrying out normal activities. How the participants were affected by the pain was also an individual issue as their circumstances differed. Some participants lived

alone and were forced to engage in activities of daily living which became troublesome. The continuous nature of burn pain was also found to interfere with their normal routines such as sleeping, thus causing discomfort while negatively affecting their quality of life. While some participants acknowledged and verbalised their pain, others, especially males, endured it and tried to look brave for fear of being undermined by female nurses.

Kornhaber (2013:137) stated that pain was found to be a difficult bodily sensation to cope with which had the potential to alter burn survivors' perspectives on life. Abrams (2013:129) indicated that the participants of her study reported chronic pain as a result of unsettled nerve endings which concurred with the findings in this study.

Although participants benefited from the use of narcotic analgesics in terms of pain control, withdrawal symptoms were problematic, leading to difficulty in falling asleep. Besides taking pain killers, some participants used other strategies that were found to be helpful, such as the avoidance of pain, ignoring its existence by not paying particular attention to it, or continuing with the daily activities and conversations until the pain was no longer noticeable.

Abrams (2013:129) concurs as the same information emerged from the participants in her study. They regarded their chronic pain as "*something that needed to be moved to the background of their thoughts and couldn't be used as an excuse not to live their lives to the fullest.*" Dahl's (2013:28) participants found the pain that was inevitably part of their rehabilitation as "*something that they had to learn to live with.*"

Resilience theory focuses on stability and healthy functioning which indicate success in adaptation after a very adverse event, as influenced by the person's coping mechanisms (Southwick, et al. 2014:2). Resilience theorists, such as Dr Bonanno, calls it "adaptive distancing and resistance" and believe that distancing oneself from the pain and ignoring its existence acts as an internal protective mechanism guarding a person's sense of self and supporting positive transformative strengths (Bernard, 2004:25; Troy & Mauss, 2011:33; Abrams, 2013:136). However, Earvolino-Ramirez (2007:76) cautions that the protective mechanism that works for one

individual may not be useful for another as people are individuals and influenced by various life circumstances.

b) Scar tissue management

The burn scar tissue challenges experienced by participants were associated with dryness, heat sensitivity, and itching. There is a general consensus among researchers that burn itching occurs mainly due to the loss of all or most of the features found on the normal skin depending on the burn depth (Goutos, Dziewulski & Richardson, 2009:221; Carrougher & Meyer, 2012:1; Hall, et al. 2011:2). Itching is regarded as a normal burn healing process, and the incidence of itching is rated at 87% in adults and 100% in children, according to Goutos, et al. (2009:221).

Most often the itching would tempt one to scratch the site, but it is also liable to break the scar, creating a new wound which is difficult to heal. In order to relieve the itching sensation while preventing scar breaks, participants would pat or stroke the area. Goutos, et al's. (2009:225) participants described the itching as distressing, which concurs with what the participants reported in this study.

The itching sensation is apparently more pronounced during the night, and this interferes with sleeping. Goutos, et al. (2009:222) concur with the scar dryness and itching issues but also suggest the involvement of the sensory nerve endings at the scar area as another cause for itching.

The dryness issue is also supported by literature which indicates that the fibrous tissue of the scar is hard and inelastic and lacks the sebaceous glands that secrete sebum responsible for lubricating and softening the skin making it more fragile and vulnerable (Carrougher & Meyer, 2012:1).

As a result of the scar's heat sensitivity, participants would often find it difficult to stand or work in the sun. Participants reported that over-the-counter lubricants have been helpful while limiting sun exposure was also suggested.

Abrams (2013:130) reported generalised heat intolerance. She described the inability to regulate body temperature through sweating because of lost sweat glands as causing the body to “overheat” which is unbearable for the burn survivors. However, Austin, Hansbrough, Dore, Noordenbos and Buono (2003:13) claim that overheating is not a big issue as the skin on the unburnt area compensate for the temperature regulation through increasing the sweating rate. Still, those with functional sweat glands could not stand the sensation caused by the sweat on their scars which was found to be irritating and uncomfortable.

Another discomfort of localised pressure was indicated especially where the scar had overgrown and felt tight, creating a feeling of stiffness around the scarred area. At times the overgrown scar would form keloids which are sharply elevated irregularly shaped and progressively growing scars with smooth surfaces. Those who developed keloids found the use of a pressure garment helpful as it compressed the overgrown area and suppressed further keloid growth, although it was difficult to put on (Ledbetter, 2010:9).

c) Limitation of joint movement

Participants expressed their frustration due to joint movement limitations and the inability to perform daily activities as a result of their scar conditions. Though they appreciated being assisted by family members, participants were not entirely happy as they thought they are a burden to others, even if no one made mention to that effect. The frustration was reportedly due to the fact that they used to do things at their own pace.

In order to adapt to their situations, participants struggled to utilise their uninjured limbs which were not naturally dominant. When they were still admitted, one of the rehabilitation strategies was physiotherapy which continued after discharge. The need to regain their independence was a key factor that prompted the participants to also engage in various activities that helped them regain their function. The same inner motivation in participants was found in other studies as well.

Literature reviewed support the functional rehabilitation issues and further suggest that activities to achieve functional independence should start on the first day of admission, and the burn survivor must be psychologically motivated to enhance his/her cooperation (Moore, Dewey & Richard, 2009:532; Shrivastava & Shrivastava, 2013:82). Physiotherapy, occupational therapy, exercise and the use of splints for the prevention of contractures have been recommended. Edgar and Brereton (2004:343) concur but also emphasise the importance of adequate pain control if rehabilitation activities are to be effective and render the desired results. Wound dressing techniques that prevent adhesions of parts such as the fingers, should be carried out by separating the affected fingers during wound dressing. This is also in line with the physical aspect of the biopsychosocial model of rehabilitation which focuses on assessing in the burn survivor, the disability caused by the burn injury, the adaptation ability, and strengthening the existing capacity of recovery and functionality (Gonçalves, et al. 2011:623).

5.2.1.2 Psychological processes of loss and coping

The psychological aspect of the biopsychosocial rehabilitation model focuses on psychological consequences of a burn injury which is influenced by the extent of the injury, the psychological and emotional make-up of the person, and how it influences adaptation to the new reality post burn (Wood, 2009:48; Waddell & Burton, 2004:19). The model emphasises the importance of support and preparation of the burn survivor to face the world post discharge, thus minimising the stresses and anxieties associated with life as a burn survivor.

Burn survivors experienced the loss of their normal selves in terms of their appearance and functioning (Dalal, 2010:138), which was distressing. Participants were distressed by their scars and this impacted negatively on their psychological well-being. This resulted from worrying about how people would react when they see their scars. Participants described the severity of the physical effects of burns as 'better' than the psychological effects. Various strategies were used to cope with their situations.

a) Disfigurement

Experiencing an altered physical appearance had a significant impact on burn survivors' body image as a result of scarring. Participants went through new experiences of losing the familiarity of their bodies and were negatively affected as they were unable to accept their appearance (Kornhaber, 2013: 138). This became a source of stress and maladaptation. This is in line with the research findings by Dahl (2013:35), suggesting that satisfaction or dissatisfaction with appearance is the predictor of how burn survivors will adapt.

According to the Transactional Model of Stress and Coping (Kamolz, et al. 2012:17), the way the stressful situation is perceived determines the choice of the coping strategy at the time of the stressful encounter. The success of the preferred strategy sustains the person who become resilient in times of stress .The effectiveness of the coping strategy chosen in turn determines resilience.

How burn survivors perceived themselves and how others perceived them influenced their outlook on life and how they adapted to their physical changes. Because of being different from others in terms of social standards, burn survivors often found themselves having to endure the pain of unwelcome remarks that were stigmatising and hurtful. In turn, they would often avoid going out in public and interacting with people, and they became socially isolated. Literature has also supported the social isolation issue (Kornhaber, 2013:37; Rumsey & Harcourt, 2003:90).

Burn survivors wanted to be recognised as human beings like any other person irrespective of their appearance, which was not always the case. Research has revealed that the majority of burn survivors who sustained extensive and deeper burns do not accept their new appearance (Gonçalves, et al. 2011:626; Nwashindi, Dim & Saheeb, 2014:9). In most research studies this phenomenon is associated with female survivors. This is as a result of the assumption that women are more beauty-conscious than men. This notion is attributed to current body ideals, in particular for women who are expected to be young, slim, attractive and healthy-looking as portrayed by the media (Rumsey & Harcourt, 2003:88; Dahl, 2013:11; Corry, et al. 2009:710).

In this study, both male and female participants were equally concerned about their appearance and what they feared most was facial burns. Those who did not sustain burns to their faces also indicated their relief and raised their fears of how they would feel had they burnt their faces. Hoogewerf, van Baar, Middelkoop and van Loey (2014:272) suggest that people with low self-esteem are likely to have negative evaluations of the self and might seek negative feedback from others to verify their negative self-concept.

Although several studies reported a relationship between visible scarring and body esteem as a predictor for difficult adaptation, Lawrence, Fauerbach, Heinberg and Doctor (2004:30) reported a small correlation, while social comfort was found to be a strong predictor. Hoogewerf, et al. (2014:271) further indicate that sustaining a burn to the part the person valued most, is extremely devastating. Scarring on exposed areas of the body was found to exacerbate all the attention, the stigma, name calling and staring which are severely hurtful to the survivors (Gonçalves, et al. 2011:626).

A relationship was also found between the psychological impact of burns and the age of the burn survivor, while Corry, et al. (2009:539) emphasise that burns to the part that the person values, is a strong predictor of psychological problems. Most of the participants in this study who were still young or unmarried expressed their concerns about whether people of the opposite gender would still be attracted to them and be interested in romantic relationships with them.

Even if positive comments were received, participants would sometimes interpret these comments in a negative light – as a dismissal of the burn survivor's suffering as reported by Hodder, Chur-Hansen and Parker (2014:23). In addition, reassurances that the burn is not important were not always accepted as survivors would feel "ugly." At times this resulted in the participants' rejection of support from family and friends (Hodder, et al. 2014:22).

It is thus clear that societal reactions are responsible for shaping the burn survivor's self-image. However, Dahl (2013:11) found in her study that even if burn survivors'

body image-related stress worsens over time, they end up developing coping skills necessary to cope with the negative experiences.

b) Depressive Symptoms

According to De Sousa, et al. (2013:25) and Dahl, (2013:35), burn survivors who lack of satisfaction with their own appearance develop psychological distress. The sudden change in appearance and functionality as a result of disabilities which come unexpectedly and at a time when one was looking forward to a fulfilling life brings a disruption to future plans. This leaves the burn survivor with the frustration as a result of the uncertainty of not knowing what the future holds for him as supported by Kornhaber (2013:125). Similarly, the unnecessary attention due to scarring was equally damaging to most participants and diminished their self-esteem resulting in social isolation. De Sousa (2010:155) concurs but also cautions that even those who appear to be doing well are going through the same suffering internally. Looking at themselves in the mirror was traumatic and depressing, and participants avoided mirrors until they reached the stage of self-acceptance as supported by De Sousa et al (2013:27) and Kornhaber (2013:187)

The degree of depression differed among individuals. One participant with facial burns found herself running out of coping options and was pushed to the brink of suicide as a result of depression. De Sousa,2013: 26 reports that amongst the signs of depression is re-experiencing the burn episode in the form of flashbacks, and in this study one participant related re-experiencing.

Dahl (2013:11), Nwashindi, et al. (2014:9) and Gonçalves, et al. (2011:627), emphasise that burn survivors with burns to exposed areas such as the hands and face are likely to drift into depression. De Sousa, et al. (2013:26) and Sveen (2011:13) indicate that some burn survivors are likely to develop a Post Traumatic Distress Syndrome (PTSD), characterised by intrusive thoughts, dreams and flashbacks, and they are in a constant state of alert and tense with nervous excitability and difficulty falling asleep or concentrating. Most of the participants in this study reported an inability to sleep though they attributed it to withdrawal from narcotics as well as pain.

c) Coping with psychological effects

Burn Scar, its location and the resultant body image alterations are the leading causes of psychological trauma in burn survivors as supported by De Sousa (2010: 155), Agbenorku (2013:81) and Kornhaber (2013:186). However, Lawrence et al. (2011:1) cites the thoughts of being rejected as the main reason for the psychological trauma. In order to escape the psychological effects of the burn injury, various strategies were implemented by participants to cope with their situation.

According to Willebrand (2003:5) and Kamolz (2012:17), coping involves the (a) appraisal of a threat at stake in a particular situation, and (b) identification of perceived options of what can be done about the situation. Dahl (2013:30) indicates that coping in burn survivors involved looking back and reflecting on what really happened and how it has affected their lives, while finding new perspectives and evaluating life. At the same time, while survivors are struggling to heal, they are also trying to preserve what is still normal to them. In order to minimise the effects of the unwelcome attention and comments caused by scarring, hiding the scars with concealing clothes and hairstyles became helpful to participants. Contrary to common belief, not only women were found to be concerned with their scars, but also men.

On reviewing the study transcripts, there appeared to be a link between self-image and age. Those who were image conscious tended to be younger while the older participants were less concerned.

The benefit of accepting themselves first before they can expect others to do so, and no longer caring what other people are saying about them, was discovered by burn survivors after failing to get public sympathy. This promoted psychological recovery and healing and boosted their self-worth, making them feel that they are in control of their lives again. Research (Dahl, 2013:43) suggests that burn survivors who were found to be dissatisfied with their appearance post burn had difficulty in coping.

De Sousa, et al. (2013:25) and Willebrand (2003:2) also reported that psychological healing depends on the individual's personality, pre-burn psychological status, as well as the individual's coping skills. On the other hand, Blakeney, et al. (2008:437) found that regardless of what people think, psychological healing starts with the person himself and his willingness to take critical risks in the adaptation process.

One participant who had facial burns used the same comparison strategy. She believed herself to be better than those who had not sustained burns, by using other criteria as yardsticks which helped her cope with her difficult situation. This is in agreement with what Dahl (2013:47) found in her study; when burn survivors compare themselves with those who are worse off than they are, it makes survivors feel better.

Research has confirmed that people with facial scars get more accustomed to stigmatising behaviors and learn better coping strategies than those with hidden scars (Dahl, 2013:11; Lawrence, et al. 2003:26; De Sousa, et al. 2013:27).

Some participants were crippled by negative emotions and the need to regain their independence was overwhelming. Talking about their situations and ventilating their long bottled-up inner emotions was helpful and created a pathway to their inner healing.

For others, forgiving the perpetrators of their burn injuries had an equally liberating effect. One participant found it helpful and healing to forgive those who caused his burn injuries due to neighbourhood differences, which promoted good adaptation.

Using the injured limb gradually until it was functional and achieving full motion range was another rehabilitation strategy which was prompted by the need to return to normal. The effectiveness of coping for the participants also depends on the presence or absence of other stresses, according to Orwelius, Willebrand, Gerdin, Ekselius, Fredrikson and Sjöberg (2013:231). Those who had other stressors besides the burn injuries had adaptation difficulties which required the intervention of professionals, such as psychologists, in order to cope.

5.2.2 External Environment

The external environment of the burn survivor deals with conditions outside of the person such as social and financial issues that impact on their recovery.

5.2.2.1 Social and interpersonal issues

Burn survivors experienced challenges that originated from the social environment in which they live. Their recovery and rehabilitation journey was shaped by how known and unknown people, including family and friends, reacted to their burn situations.

a) Family and friends

While still disabled by the burn injuries, burn survivors found solace in their families who assisted them in the execution of daily activities without complaining, until they were able to resume these duties themselves. In order to support their burnt family member, “helpers” sacrificed their own time and put the survivor’s interests ahead of their own. However, while the burn survivors appreciated the assistance they received, some participants felt that they are burdens to their families.

For families who previously did not care about one another, the tragedy of the burn injury became a uniting factor as family members were able to mend their differences and attend to their injured member in times of need, which affected successful adaptation. Blakeney, et al. (2008:436) and Kornhaber (2013:87) indicated that a lack of family cohesion and high conflict within the family are correlated with poor adjustment.

Most often, different cultures have a way of prescribing how people should behave towards one another. But where the family members ran out of options, cultural prescripts were also disregarded and violated with the purpose of helping the person in times of need.

According to the social aspect of the biopsychosocial theory of rehabilitation in the literature reviewed, we live in a dynamic and sociable environment where we

influence or are influenced by other people's behaviour (Gonçalves, 2011:623). The theory focuses on people's reactions, which can continue over time or be permanent, and how it can influence the survivor's adaptation. It has been found that social support is one of the most significant predictor variables for positive health outcomes for individuals suffering "massive" burn injuries (De Sousa, et al. 2013:26; Abrams, 2013:164; Kornhaber, 2013:166; Dahl, 2013:52).

While they were being assisted and supported, participants were frequently found to be over-protected. Yet, Blakeney, et al. (2008:437) indicated that over- protection, as well as ridicule by families, is as crippling to the individual as the physical symptoms themselves as their creativity become limited. While most participants had the support of their families during this time of need, there are some participants who lacked such support, leading to physical and psychological problems as well as difficulty in adaptation. In addition, Agbenorku (2013:82) revealed that burn survivors are still often excluded from external family activities by their families.

b) Neighbours and other community members

The reactions of neighbours and other community members were varied. The type of relationships they had prior to the injury influenced their post burn reactions. Those who had a good relationship prior to the burn injury were sympathetic and supportive.

However, irrespective of all the good social reports, adverse reactions were also experienced. Those reactions were experienced by people unknown and known to the burn survivors, who they had interacted with as former friends and associates in the form of unpleasant words that were derogatory, stigmatising and hurtful, as well as receiving uncomfortable stares.

Even if some people did not verbalise their surprise, their non-verbal communication said it all and survivors understood the meaning of those stares and felt their discomfort. This contributed to making the participants' adaptation and integration into society difficult. Participants learnt from those negative reactions that not

everyone are true friends because on the day of trouble they were abandoned by their “friends.”

De Sousa, et al. (2013:26) found in their study that some people reacted in the form of avoidance; avoiding coming near the person and eye contact, or hurrying past when coming across the affected person which carried the same message (Lawrence, et al. 2011:2; Corry, et al. 2009:541).

5.2.2.2 Financial disruptions

Other factors found to influence the burn survivors’ adaptation were related to the issues of livelihood. Their earning capacity and financial security became challenged when survivors were disabled by burn wounds to the upper limbs which took a long time to heal. Participants who were working before the burn injury found themselves unable to resume their jobs after discharge, and a state of uncertainty prevailed for the significant others if the burn survivor was the bread winner. The same findings emerged from Agbenorku’s (2013:82) study. According to Agbenorku (2013:83), studies are conducted on burn survivors but family members are equally affected, yet often ignored. They are supposed to take time off work in order to be with and help their affected family member or to take him/her to the clinic for dressings or reviews.

While their burn injuries still incapacitated them, some participants were unable to return to work. Factors that influenced their return to work included the length of hospitalisation, the size and depth of the burn, continuing burn care management, and the deformities incurred. Additionally, as indicated by Öster (2010:20), returning to work is also influenced by the length of hospitalisation with multiple surgeries and the psychological make-up of the person, which is estimated to start at least two years after discharge. Employer and co-workers compassion, modification of duties and working hours, as well as family support, are reported as facilitators that facilitate the return to work.

At times participants who found themselves in dire need ended up depending on handouts from sympathetic community and church members in the form of money and other commodities to sustain them.

The effects of the disability caused by the burns also became a state-added responsibility as the state maintained survivors through a grant. Some of the participants in this study sought help and received temporary disability grants from the Department of Social Development until they were able to return to work or were deemed fit to do so.

Though Social Security agencies are assisting burn-disabled individuals on a temporary and permanent basis depending on their condition, Wiechman and Brych (2011:11) encourage those who are able to return to work to do so as this is therapeutic.

5.3 THE PROCESS OF RECOVERY

Internal and external circumstances and the social relationships at the places they found themselves at any given time influenced the participants' adaptation to their post burn situations. The process of rehabilitation in burn survivors started while they were still admitted to hospital and continued post discharge.

Rehabilitation is aimed at enabling affected individuals to regain satisfactory intellectual, sensory, physical, psychological, and social health levels (Gonçalves, et al. 2011:623).

All aspects of care were carried out while keeping in mind the strengthening of the participants' existing capacity which concurs with what Abrams (2013:164) call resilient "buffering effects" or protective factors.

5.3.1 The Hospital Environment

From the interview transcripts, the hospital setting had both positive and negative effects on the participants' recovery, rehabilitation and adaptation. While there is a widespread negative public perception and media portrayal of public hospitals, participants found the Burn Unit where they were treated to be the direct opposite.

There is a general consensus among researchers that when the environment is supportive, patients' adjustment and outlook on life is positive. When the environment is hostile, every aspect of recovery and rehabilitation becomes negatively affected (Blakeney, et al. 2008:437; Wood, 2009:48; De Sousa, et al. 2013:28; Dahl, 2013:41).

Besides the issue of the environment in general, there are specific attributes in the personnel themselves that make the hospital setting regarded as positive or negative.

5.3.1.1 Staff competencies and attitudes

How the personnel interacted with the participants influenced their recovery. Participants truly appreciated it when the personnel were supportive to them and assisted them with their physical needs. De Sousa, et al. (2013:28) concur with what has been reported by participants by suggesting that patients' suffering can be reduced by timely attention from the burn treatment team.

Participants in the studies by Dahl (2013:41), and Kieft, de Brouwer, Francke and Delnoij (2014) also confirmed that when nurses showed consideration through their efforts to help them, positioning them comfortably in bed, being vigilant for expressions of pain or discomfort during dressing changes, or taking the time to sit and talk for a while or touch them, they were perceived as being very valuable. Procter (2010: 104) advocates for a combination of genuine empathy, listening, compassion, adequate information and answering questions as a key to alleviating survivors' fears. This served as a distraction from the loneliness and pain and encouraged them to get their lives back.

However, Blakeney, et al. (2008:437) cautions against over-protecting the survivors and doing everything for them as this can create "learned dependence" and limit their creativity and their remaining strengths, thereby diminishing their prospects of recovery and rehabilitation.

Through psychological and spiritual support participants were able to pay less attention to their hardships and focus on their recovery. The relationship that prevailed between staff and patients was described as healing, and one participant even mentioned that he regarded the staff as family.

5.3.1.2 Inadequate education and information

As much as the participants appreciated the good work of personnel, there were other aspects of care that participants felt were not well handled. One participant mentioned that she was not effectively prepared for the possible challenges she would come across and face out in the world, therefore her adaptation has been difficult. Research by Linebaugh (2013:21) also suggests that the health care environment also contributes to the deleterious effects on patients' stress levels.

Dahl (2013:41) indicate that the nursing staff sometimes think they understand what the survivors are going through and their patient care strategies do not meet the burn survivors' needs, and therefore their stay in hospital becomes miserable. Identified in Kornhaber (2013: 113) and Dahl's (2013:40) studies as the cause, was the lack of, or limited knowledge and education afforded to burn survivors by some of the healthcare professionals concerning therapy.

This is however justified by Martin, et al. (2013:249) and Dahl (2013:40) as resulting from the nurses' psychological involvement and inner frustration. Looking at the suffering their patients are going through make nurses feel powerless as they are unable to help the patient as they should, such as offering pain relief while they cause pain with their procedures.

5.3.2 Post Discharge Environment

After discharge from the hospital, participants found themselves facing challenges they did not anticipate. Chronic post-burn conditions, the need for support, and a lack of readiness to face the world were some of the challenges the survivors experienced after their discharge from hospital.

5.3.2.1 Preparation and the home environment

The transition from the hospital environment to their home environment and primary health care settings has not been easy for participants. While there was a sense of security at the hospital, the negative attitudes of some of the nurses at health care centres created a state of shock and diminished the trust participants had in the nurses.

Some of the participants reportedly living alone at home often felt unsupported. Other burn survivors tried to cope with their post burn situations without the help of the nurses, which they found overwhelming.

Kornhaber (2013:29) confirmed that for some of the burn survivors, leaving the “comfort zone” of the hospital where everything was done for them meant exposure to a situation that required fending for one’s self for survival. Gonçalves, et al. (2011:624) report that after hospital discharge, survivors of severe burns start to experience a chronic condition that demands permanent care, mainly associated with skin care. Acton, Mounsey and Gilyard (2007:616) described the harsh reality that some of the burn survivors faced post hospitalisation as the “bottomless nightmare” as their coping skills became tested.

Preparation of the burn survivors is thus essential prior to discharge as it enables them to adapt positively. One participant blamed her difficult adaptation on the lack of proper preparation.

This is supported by literature which indicates the necessity for preparing burn survivors both physically and psychologically to face the post-discharge challenges while they are still hospitalised as it promotes successful reintegration into society and the resumption of activities to the best of one’s ability (Blakeney, et al. 2008:435). Besides survivor preparation, Bishop, Walker and Spivak (2013:15) also suggest preparing the family who will be caring for the survivor. This is also required for facilitating cooperation of the survivor with the rehabilitation programme activities.

In her report, Dahl (2013:31) indicates that when the survivors lack the opportunity to interact positively with the nursing staff and other burn care team members, they feel isolated and are unable to ask for help when needed. This is said to delay the adaptation process. On the other hand, when the survivors are involved in their care, informed about what to expect, and are encouraged, adaptation becomes easier (Bishop, et al. 2013:14; Blakeney, et al. 2008:435).

Faucher and Kowalske (2007:15) advocate that a well prepared and detailed discharge plan is recommended. The discharge readiness assessment of the survivor and the family should be carried out by the entire multidisciplinary team and a detailed discharge plan should be formulated (European Burn Association (2015). The plan must cover the following aspects: wound care, skin and scar care, the wearing of splints and pressure garments, mobilisation exercises and relaxation, pain and itch medications, and information on psychological problems the survivor and family might encounter upon discharge. Contact details of the relevant areas and support groups to contact in times when help is needed should be provided for the survivor and the family for assistance and support.

It was also found in this study that the same participants who were forced by their circumstances to fend for themselves were more highly motivated to engage in activities that promoted effective rehabilitation than those who had everything done for them (Kornhaber, 2013:164; Camargo-Cabulon, Maciel, Martins, Cruz-Robazzi & Cardelli, 2016 ; Dahl, 2013:46).

5.4 RECLAIMING LIFE

When realising the permanence of their situation, burn survivors found their only option was to move on with their lives, adapt from the painful memories and accept a new life which was pertinent to their present status. Participants managed to cope with the effects of their burns as they decided to put the past behind them.

Just like any other type of trauma, the effects of burn injuries create an overwhelming feeling of helplessness, powerlessness and loss of control in the survivor. However, as reported by Rosenbloom and Williams (2010:149), irrespective

of the powerless feeling, there is some power that remains, and if recognized, a sense of self-control will be regained.

5.4.1 Finding a New Meaning

The burn experience is reported by participants to be life changing for survivors as there was a difference of appearance, self-perception, how they viewed life before, and how they influenced new lifestyle changes, as well as the way of doing things. Life took a new turn and was viewed differently and had a new and deeper meaning.

More attention is directed to important things, other than casual life. Most of the participants started to regard the life that they nearly lost as more sacred and appreciated the God who healed them and gave them a second chance to live. Their spirituality deepened as they, including those who did not care about God previously, started relating more to Him after being betrayed by the people they trusted (Williams, Davey & Klock-Powell, 2003:72; Dahl, 2013:47).

Valuable lessons were learnt by participants from their burn incidents, such as the fact that life is dynamic and while things are well today, they may be entirely different tomorrow. The need to do good and impact positively on others and make up for the time lost dominated, and life took a new shape (Rosenbach & Renneberg, 2008:638; Williams, et al. 2003:67; Abrams, 2013:161).

5.4.1.1 A process of adaptation

The degree of recovery in burn survivors is measured by the level of adaptation and independence acquired which involves all the physical, psychological and social levels. With social support participants were motivated to engage in activities that facilitated speedy recovery and giving up on life was not one of the preferred options.

Some of the motivating factors for not giving up on life included family responsibilities, future plans, and the need to give back to those who assisted them in times of need. For others, it was the need to prove their critics wrong. Having gone through many challenges, most participants' future plans included starting all over

again and living self-sufficient and fulfilling lives. New priorities, which included living their lives meaningfully, were set (Zamanzadeh, Valizadeh, Lotfi & Salehi, 2014:234).

5.5 SUMMARY

This chapter discussed the findings of the burn survivors' experiences in relation to how they impacted on the survivor's adaptation in line with the biopsychosocial theory of rehabilitation. Burn recovery was found to be a long journey with some hurdles to be overcome along the way. Discoveries were made about the interrelatedness of the individual's physical, social and psychological domains of life and how they influenced each other and shaped the recovery outcomes. Varying uncomfortable sensations such as pain, itching and heat sensitivity were common in most participants and continued beyond their discharge. Different emotions also emerged from the effects of their burns and how they were handled by various stakeholders and environmental influences ranging from satisfaction, dissatisfaction, depression and appreciation. Rehabilitation strategies were aimed at restoring the burn survivors' functional independence and to promote successful adaptations looking at individual limitations. The whole burn injury incident was found to be life changing as individuals' lifestyle, worldview and self-perception changed. What is most important is the burn survivors' resilience as they rediscovered themselves and redirected their lives to live meaningfully while actively participating in their rehabilitation process.

CHAPTER 6

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

In this final chapter of the research report, the summary of the study findings together with the limitations, recommendations and conclusion of the study are presented. This qualitative study was undertaken in order to explore and understand the adaptation challenges burn survivors go through after they have been discharged from the hospital using the phenomenological approach which is grounded in the philosophical works of Edmund Husserl. The study sought to understand how the burn survivors experienced their recovery, rehabilitation and adaptation, and to identify the gaps in burn management with the objective of assisting the health care workers in preparing the burn survivors for effective adaptation while they are still admitted. Against this background the study was guided by the following research questions:

- What are the lived experiences of burn survivors' post hospital discharge?

Through face-to-face in-depth interviews with nine burn survivors aged between 19 and 71 years who have been discharged from the hospital, their experiences were identified. From the analysed data, themes that emerged included the fact that the burn survival experience involves the complete person, the process of recovery, and reclaiming life.

6.2 CONCLUSIONS ON IDENTIFIED THEMES

The burn survival experience involved the person in totality with reference to their internal and external environment. The process of recovery was lengthy, started in hospital, and continued post-discharge at home. Reclaiming their life and finding new meaning was a process of adaptation.

6.2.1 The Burn Survival Experience Involved the Complete Person

From the participants' narratives challenges of fragmentation of the total person are still evident, showing disparities in the attention given to the physical, psychological and social aspects of burn care and rehabilitation. Burn care still focuses mainly on the physical wound itself more than other aspects, thereby overlooking the interrelatedness of the physical, psychological and the social aspects and how they affect one another. The influence of the environmental factors on burn survivors' rehabilitation and adaptation was often not considered.

6.2.1.1 Internal environment

Physical, psychological and social adaptation challenges that originated from the participants' internal environment were experienced and they used different strategies to cope with those challenges.

a) Challenges with physical wound management factors

Pain is the major incapacitating physical challenge in all the burn survivors which could not be adequately eliminated due to repeated triggers such as wound management procedures, changes in weather conditions, and scar pain. Burn survivors experience high levels of pain and anxiety which may extend to weeks and months beyond their discharge. Wound closure does not guarantee the end of pain. Pharmacotherapy alone has not been effective as some survivors experienced pain without any notable trigger as it could be felt even on waking up and during rest.

Equally uncomfortable is the itching sensation due to scar dryness and nerve involvement. Itching created a dilemma as it stimulated the need to scratch while the fear of opening a new wound on the scar to some extent prevented participants from scratching. While four participants mentioned the effective use of emollients for dryness, only one participant used a medication specifically for itching. Those participants with hidden scars did not report heat sensitivity while exposed scars were sensitive, which suggest that burn scars are more sensitive to heat compared to normal skin.

Other physical challenges involved overgrown skin and two participants reported the effectiveness of a pressure garment. The overgrown skin over the joint which forms contractures had undesirable disabling effects as it limited the joint movement, thus negatively affecting the conduct of normal activities and the return to work. Irrespective of the pain and other discomfort felt, regaining physical functioning became the survivors' first priority and the fear of permanent disabilities motivated all the participants to engage in activities and exercises that eventually restored their functioning.

b) Psychological processes of loss and coping

The participants' narratives highlighted the fact that besides the physical pain experienced, there is psychological pain which is more intense than the physical pain. Participants experienced a sense of loss in terms of identity, functioning, freedom of movement, and association.

Disfigurement due to scarring has been the leading cause of emotional instability in burn survivors. Participants were bothered by the visible scars to a greater extent than the hidden ones. The young participants were sensitive about their scars while the elderly participants were less affected. This explains why the young participants tried to hide their scars by wearing concealing clothes. Their psychological damage has been influenced more by how other people perceived the participants and reacted towards their scars and disfigurement, which in turn had a direct bearing on how they perceived themselves. This generated emotions ranging from depression to feelings of suicide, social isolation and withdrawal. Those who were not yet married were more concerned about whether people of the opposite gender would still be interested in them for romantic relationships.

Participants who were not satisfied with their appearance were more likely to drift into depression and in severe cases, suicidal thoughts were felt. This is because the sudden change in body appearance and functionality was drawing unnecessary attention to them, which was damaging to most of the participants' self-esteem and

diminished their confidence. The presence of stressors other than their burns also created adaptation difficulties.

The individual differences in personality and psychological and emotional make-up, are key factors in the burn survivors' ability to cope and adapt to their situations. According to the Transactional Model of Stress, the way the stress is perceived influences the choice of coping strategy suitable for that stress.

One of the coping strategies that seemed to work for most participants was self-acceptance. After finding no relief from stressing over their appearance, participants who were no longer concerned about what people were saying about them found themselves able to accept themselves and continue with their lives; they adapted quickly.

When coping mechanisms, which included hiding the scars and social withdrawal, did not work, participants decided to confront their situations by being vocal and talking about their situations, which provided a sense of relief from built-up stress.

6.2.1.2 The external environment of the person

Factors that originated from the external environment and had a direct bearing on the participants' recovery and adaptation included social, interpersonal, and financial disruptions.

The burn tragedy had the effect of bringing families together, including those families who were previously distant, as they became concerned about the survivor's welfare. They were helpful and became protective of the burn survivor. This contributed to the effectiveness of adaptation and coping for the participants.

The neighbours' sympathetic and helpful attitudes were attributed to the positive relationships they had before the burn incidents. Participants who were stressed by adverse reactions in the form of stigmatising and derogatory remarks from people known and unknown to them, experienced difficulties in their social integration.

Participants who were employed prior to the burn injuries found their return to work delayed while some were unable to continue with their employment. Sympathetic neighbours and the state contributed to financial support until they were able to resume their work.

6.2.2 The Process of Recovery

The recovery and adaptation process started when the participants were still admitted and continued once they were discharged home.

The hospital setting had both positive and negative effects on the participants' recovery, rehabilitation, and adaptation. The positive attitudes and support of personnel towards burn survivors contributed to the participants' positive outlook on life and promoted recovery and adaptation. On the other hand, lack of information on decisions taken about their care and what to expect made participants feel left out and having to imagine what would happen next.

The transition from the "secure" hospital environment also posed challenges for participants. Lack of thorough preparation to face the post discharge challenges was viewed as a cause for difficult adaptation for some participants. Since participants were discharged while their wounds were not fully healed, some participants had challenges around the distance they lived from the health care centres and they had to hire transport to health care centres for wound dressings every second day. Lack of resources at primary health care centres also posed problems and participants were sent to other institutions for their dressings. Negative attitudes of health care personnel at other health centres became a deterrent for participants who were meant to receive treatment there.

6.2.3 Reclaiming Life

The burn incident and the challenges experienced became life changing for the participants as their lives took different turns. Putting their past behind them, adjusting their lives to their present circumstances and refocusing their attention to

their future proved helpful in adapting. By doing this, they regained control of their lives.

Because of the permanent status of the changes brought on by burn injuries in terms of appearance, functioning and self-perception, the participants' lives had new meaning. Having nearly lost their lives, participants started to view life seriously and appreciated the second chance to live as they thanked and started relating to God who saved them. Valuable lessons were learned by participants as a result of their burn incidents, such as life being unpredictable and therefore their need to do good and impact positively on others dominated.

With social support participants were motivated to engage in activities that facilitated speedy recovery and giving up on life was not one of the preferred options. Driving factors for not giving up on life included family responsibilities, future plans and the need to give back to those who assisted them in times of need, while for others it was the need to prove their critics wrong. Future plans included starting all over again and living self-sufficient and self-fulfilling lives.

6.3 LIMITATIONS OF THE STUDY

There is only one burn unit in the Limpopo Province which is situated at Mankweng Hospital. Overflow patients are admitted to Polokwane Hospital which is 30 kilometers away. The burn survivors are only exposed to the burn care conditions of the same health care area and health care team. As a result, the participant feedback lacked variety. Varied participant reports would broaden the scope of the study and would enable the generalisability of the results.

The venue for the participants' interview was centralized to Mankweng Hospital due to the renovations that were carried out at Polokwane Hospital Out Patient Clinic area at the time of data collection. At that time, the review clinic was temporarily moved to Mankweng and thus, for participants who had been admitted to Polokwane Hospital, the environment might have been unfamiliar and could have influenced the responses.

The possibility of power relations influence on how participants reported on the care received while still admitted cannot be overlooked as the researcher is the manager of the Burn Unit where the participants received their care. Negative reports might have been withheld for fear of victimisation especially because the participants were still attending review clinics.

6.4 RECOMMENDATIONS

The following recommendations are proposed:

6.4.1 Recommendations for Clinical Practice

Burn survivors' analgesic demands are often misinterpreted as addiction to narcotics. Pain assessment guidelines should be developed so that the pain management strategies implemented are appropriate for every individual's needs. The researcher recommends that since pain is the key challenge in all burns survivors, the identification of other non-pharmacological strategies are needed so that these can be used concurrently with narcotics to promote effective pain control. This is because pain medications are often only given at prescribed intervals and the pain can be stressful for burn survivors in between the treatment dosages and because of the unpredictable onset of different triggers.

Taking the initiative of activity and using the affected parts until they are functional has been found to be helpful for patients, which indicates the positive effect of exercise and activity on the affected burnt limbs. The maximisation of the residual function through self-activity and exercise should be encouraged. Not only will this restore function but it may also promote self-confidence.

Compassionate care and support by health care workers has been found to promote resilience and coping. Having someone who is able to provide a listening ear, such as health care professionals and family, is therapeutic. It is recommended that the health care personnel understand the plight of patients as individuals and support them as this would promote cooperation, a positive outlook on life, as well as positive

adaptation. This should include the families of the survivors as they are going through the same emotional turmoil as the burnt survivor. Services of a psychologist or psychiatric nurse should be part of the daily patient care routine in order to counsel survivors with or without symptoms of depression.

The individual differences in personality and psychological and emotional make-up are the key factors in the burn survivors' ability to cope and adapt to their situations. The way the stress is being perceived influences the choice of the coping strategy suitable for that stressor. Nurses should personalise their caring approach to each individual's needs and coping repertoire.

Social support from families, friends and neighbours, as well as health care workers during admission and after discharge becomes the most powerful force that effect adaptation. Nurses should enquire about the patients' support network prior to discharge as well as on follow-up visits.

6.4.2 Recommendations for Health Care Personnel Education

Continuous teaching is recommended for health care workers through in-service training programmes on the latest developments in burn management to create a knowledgeable workforce capable of addressing patients' needs. Of all the multidisciplinary team members, nurses have a continuous encounter with patients on daily basis. Since the burn survivors' experiences include psychological challenges as well, it is befitting that nurses be equipped with counseling skills and psychiatric qualifications.

6.4.3 Recommendations for caring for the caregivers

The Burn Units are stress-laden areas where pain and suffering are witnessed every day. Health care personnel deal with severe burns, uncooperative patients and death with staff shortages almost daily. Although they are expected to provide a health care service that meets all the patients' needs, their own needs seem to be

neglected. It is therefore recommended that health care personnel be taken through the debriefing sessions on a regular basis together with adequate time to rest and support, to prevent the development of a burnout syndrome.

6.4.4. Recommendations for the burn survivor information

It is recommended that burn survivors be informed of every decision to be taken in their management, including procedures and what to expect. Guidelines should be developed for the purpose of rehabilitating and preparing survivors psychologically to face the anticipated challenges when they are discharged back to their communities while they are still admitted. Psychologist services are required starting from the first day of admission to be continued as outpatient sessions post discharge as needed.

As they will be home away from the assistive environment of the health care workers, burn survivors and their families will be expected to take the leading role in their rehabilitation.

Burn survivors experience pain even beyond their discharge therefore continuing with their pain medications as prescribed is recommended. The prevention of contracture development is vital for the restoration of physical functionality, therefore, exercises and participation in self - care activities as well as physiotherapy visits as scheduled are mandatory. As the burn scar is sensitive to heat, efforts should be taken to prevent exposure to the sun as much as possible while avoiding scratching when itching to prevent a breakout of a new scar wound.

Teaching the survivor and family on wound care should start while still admitted to be continued at home or at the nearest out- patient health care facility. Burn survivors should be made aware of the resources available in their local area.

6.4.5 Recommendations for Further Research

The study should in future incorporate the health care workers experiences in the care of their burn patients in order to get a holistic view of the experiences. They identify with the stresses of their patients and share their experiences, thus becoming secondary victims themselves.

A follow-up study be undertaken to assess the participants on their experiences after returning to work. This should look at the time for returning to work, the challenges experienced, the work and working conditions, the attitudes of the colleagues and employers to mention but a few.

6.5 SUMMARY

Burn recovery is a long journey that starts on the first day the injury is incurred. This study has been an eye opener for me as researcher and practitioner since burn survivors narrated their experiences from their own perspectives. Valuable lessons were learned in terms of the suffering burn survivors are going through that health care workers are unaware of. A change of focus is required moving away from the biomedical models of burn care where the person is fragmented into parts and systems and each treated separately while neglecting others, to a holistic model of care to enhance the totality of the person.

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ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE



UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HS HDC/349/2014

Date: 26 November 2014 Student No: 680-211-7
Project Title: Experiences of burn survivors' adaptation post hospital discharge.
Researcher: Lamola Monyamane Regina
Degree: MA in Nursing Code: MPCH94
Supervisor: Prof J Maritz
Qualification: PhD
Joint Supervisor: -

DECISION OF COMMITTEE

Approved

Conditionally Approved

for Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

A. H. K. (Prop.)

Prof MM Moleki

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B

CONSENT FORM

I, Monyamane Regina Lamola am a student at the University of South Africa (UNISA). I have to conduct a research study as required by the Department of Health Studies for the degree of Masters in Nursing Science. The title of the research is “The experiences of the burn survivors ‘adaptation post hospital discharge”.

The main aim of the study is to explore and describe the experiences of burn survivors’ adaptation after discharged from the hospital. You are therefore invited to participate in the study.

The study will involve face to face interview which may take around 45 minutes to one hour. Participation in the research study is voluntary. Should you wish to participate, you will be requested to sign an agreement in the form of a consent form. Even if you have agreed, you are still free to withdraw your participation at any time during the process of the study without any repercussions.

You are assured of anonymity. Your name shall not appear in the report and no clue will be linked to your identity. Only numbers shall be allocated to individual participants and will only be known by the researcher. If you feel uncomfortable in answering some questions, feel free to express your discomfort and you will not be penalised in any way.

The data collected shall be kept confidential and will only be used for the purpose of the study. However, the supervisor, editor and the departmental and institutional ethics committees shall have access to the information during their verification and validation of the research. Your disguised information may be quoted in the research report and for subsequent publication only if you give the permission. If you choose to discontinue with the study, all the information given by you will be discarded.

There are no anticipated risks in your participation in the study unless talking about your experiences creates some discomfort. There are also no financial gains promised for participating in the study.

If you agree to participate in the study, please sign the consent form on the next page.

Should you require further information please contact me on

Telephone (work): 015 286 1622/ 015 286 1334

Cell No: 082 478 3108

Fax: 015 2670206

Email Address - lamolamr@gmail.com

I.....amyears old
and have agreed to participate in the research study by
.....on the
experiences of the burn survivors adaptation post hospital discharge.

The purpose and nature of the study including the benefits and risks have been explained to me in writing.

My participation is voluntary.

I am also giving permission for my interview with
.....to be audio recorded.

I understand that I can withdraw my participation at any time of the research process without any repercussions.

I understand that anonymity shall be ensured by the researcher. My name shall not be linked to the information I give and my identity will be disguised by using a number.

I understand that the information I give shall only be shared among the people that are concerned with the study.

I understand that disguised information from my interview may be quoted in the report and subsequent publications only if I give permission.

I understand that no financial gain will be given to me by the researcher for participating in the study.

Please tick in the appropriate box

I give permission for the quotation and publication of extracts from my interview.

I do not give permission for the quotation and publication of extracts from my interview

Signature of the participant.....

Date.....

Signature of the researcher.....

Date.....

ANNEXURE C
LETTER REQUESTING PERMISSION TO CONDUCT A STUDY

547 ZONE 1
SESHEGO
0751
20 APRIL
2015

THE DIRECTOR GENERAL
DEPARTMENT OF HEALTH
POLOKWANE
0700

Madam/ Sir

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I, Monyamane Regina Lamola, am a student at the University of South Africa (UNISA) and hereby request for the permission to conduct a research study as a requirement for the Masters in Nursing Science. The research is titled "The lived experiences of burn survivors' adaptation post hospital discharge".

I intend to conduct the study at XX hospitals and my participants will be burn survivors who have been discharged after being treated for burn injuries at those institutions as they are referral centres for burn patients.

The study will be conducted under the supervision of Professor Maritz J. The purpose of the study is to assess the lived experiences of burn survivors' adaptation after they are discharged from the hospital and to make recommendations on how to assist them for effective adaptation.

Interviews will be conducted with participants who have signed consent forms and ethical considerations will be adhered to.

Enclosed please find a copy of the research proposal.

Hope my application will be favourably considered.

Yours faithfully

.....

LAMOLA M R (Mrs.)

Contact: 0824783108

Email: lamolamr@gmail.com

547 Zone 1

Seshego

0751

Date:

Chief Executive Officer

X Hospital

Private Bag x1117

Sovenga

0727

Madam/Sir

RE: REQUEST FOR A PERMISSION TO CONDUCT A RESEARCH PROJECT

I hereby request for permission to conduct a research project at your institution as a requirement for the Masters in Nursing Science for which I am a student at the University of South Africa (UNISA).

The aim of the research is to explore and describe the experiences of the burn survivors in terms of adaptation after discharge from the hospital. The project will be conducted under the supervision of Professor J Maritz and will involve interviewing some patients who have been admitted to the institution with burn injuries. Participants in my study will be survivors who have been admitted to the institution with burn injuries. Ethical considerations will be adhered to.

Participants' protection shall be ensured in terms of anonymity and confidentiality. The study is expected to benefit the institution through the development of guidelines for preparing the burn survivors for effective adaptation while they are still admitted.

You will be provided with a report on completion of the study.

I am hoping that this request will be favourably considered.

Mrs Lamola Regina

Contact : 0824783108

Email : lamolamr@gmail.com

ANNEXURE D

PERMISSION TO CONDUCT RESEARCH



PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Enquiries: Stols M.L.

Ref:4/2/2

Lamola R
547 Zone 1
SESHEGO
0751

Greetings,

RE: Experiences of burn survivors' adaptation post hospital discharge

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
 - Research must be loaded on the NHRD site (<http://nhrd.hst.org.za>) by the researcher.
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, a copy should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
 - The above approval is valid for a 3 year period.
 - If the proposal has been amended, a new approval should be sought from the Department of Health.

Your cooperation will be highly appreciated.



Head of Department

18/08/2015

Date

ANNEXURE E

SAMPLE INTERVIEW

PARTICIPANT NO. 9

Interview Duration: 44 minutes

Researcher: "Good morning."

Participant: "Mm Morning."

Researcher: "And how are you?"

Participant: "I'm fine yourself?"

Researcher: "Very fine... I'm so happy to see you."

Participant: "I'm happy too."

Researcher: "After such a long time."

Participant: "Mmm, after a long time."

Researcher: "So, err... remember when we were signing the agreement paper which is the consent form, I mentioned that you are participating in this study voluntarily.

You are not forced to do it. It's in your right."

Participant: "That's right."

Researcher: "And then I also mentioned that you can choose not to participate. And if in the middle of the conversation you feel like withdrawing from the study you are free to do that without any repercussions. And then another thing, err... even if we are continuing with the conversation and you feel along the way that err... there some questions that you don't feel like answering, err... feel free to tell me so that I can stop answering them, I mean asking them."

Participant: "Mmm."

Researcher: "Then err... I promise that the information obtained from you will be anonymous. It will not be linked with err... your name in any way. After all I'm not going to use your name. I only use numbers like I'm saying the 'participant number 1' and 'participant number 2'. On the issue of anonymity err... it's only me who will be knowing that the information comes from you. But then there are people who will have access to the information... err... those include my supervisor and then... err... and then even my editor – the person who will be editing my work."

Participant: "Mmmm."

Researcher: "So, up to this far, is it understandable and can we continue?"

Participant: "Mmmmmm. Yes' we can continue"

Researcher: "No thank you so much Mr X. Err... let me say err... I know you from the hospital, Mankweng where you were admitted with burn injuries and we treated and you were eventually discharged after you were declared I'll say healed or almost healed."

Participant: "Ja...healed."

Researcher: "Then err... you were discharged to go home and continue with the treatment. So, on going back home, I'd like to find out from you, How was it for you to adapt after your hospital discharge?"

Participant: "Haai.. It's not easy to tell."

Researcher: "Okay."

Participant: "But it was... the way you treated me at Mankweng Hospital, it was so wonderful (followed by a moment of giggling by both researcher and participant). Really I don't think there is another hospital in South Africa that can be like Mankweng as I was treated."

Researcher: "O'right, err... and thank you. But, back home?"

Participant: "Going back home, I had some problems because the very same ambulance I took from Mankweng to my, err... hospital in Warmbaths, I realised that things changed and they were not like what I had at Mankweng Hospital. Mind you I was not so err... I was not so... I don't know how to put it... healthy that I could walk..."

Researcher: "O'right."

Participant: "I asked the nurse who was in the ambulance to get a wheelchair for myself so that I can reach the wards where I was supposed to be seen by the doctors but she told me that I must just limp 'til to the... I get to the wards."

Researcher: "Ok...So err... in other words err. You experienced problems before you could get home?"

Participant: "Of course and I was shocked. From a five star place to the area where you are out- rightly neglected. (Moment of laughter from the two)."

Researcher: "Alright. Then let me hear about the home. How was it there?"

Participant: "At home, well I had a good time because my wife took care of myself. She is so caring and wonderful. I think that is why God decided to create a woman for us men."

(A shared moment of laughter by both researcher and participant).

“Haai! I had no problem when I was at home. It was good uniting with my family. But at our clinic there where I was supposed to get dressed there...”

Researcher: “Mmm!”

Participant: “... a certain sister there said to me, ‘go into that room, it’s where I will help you’. So I went. And then I went.”

Researcher: “Mmm...”

Participant: “And there after she came and she said ‘Ooh! you did not undress (remove bandages) yourself?’. So I said to her, ‘how can I because some bandages are at my back and I can’t see them’.”

Researcher: “Okay.”

Participant: “And so she said... err...I went with my wife there. I said to her: ‘Oh just because you are not at work here, go outside and call my wife and then she will undo my dressings me.”

Researcher: “Okay, and then?”

Participant: “Shhh... and then she started working there. After that she told me that ‘there are no bandages’, and mind you, at that time I was naked.”

Researcher: “Oh! And then?”

Participant: “Ja. I had to put on my clothes on the undressed wounds and it was said I must go to the hospital where I will get bandages”

Researcher: “And how many times did you go back for dressings?”

Participant: “Do you think I could go there? I went to the nearest chemist, bought all my dressing materials and the topical cream that the pharmacist prescribed for me. My wife cleaned my wounds every day and dressed me.”

Researcher: “But how did the wounds feel?”

Participant: “The wound... hey, my wounds were not very deep and therefore they were more painful initially. But as time goes by it’s like you become numb and not be sure if it’s painful or not. At the end because you don’t concentrate on it frequently it fades away.”

Researcher: “But when it was still painful, how did you manage it?”

Participant: “I took the treatment I bought from the chemist but at times you don’t feel that you need it as it has been prescribed so I just reduced the frequency.”

Researcher: “And the effect thereof?”

Participant: “It was so wonderful because I just became less and less dependent on it until eventually I stopped.”

Researcher: "And then at the clinic?"

Participant: "Do you think I could go there again? Not again."

Researcher: "So err... in other words..."

Participant: "That time I went there was my last time of going to that clinic. I did not go back because I err... what is the point of going there? They told me that there are no bandages. Apparently other medications may not be there as well."

Researcher: "Ok, so err...you told me that err, mama dressed you at home."

Participant: "Ja. She dressed me until I was healed?"

Researcher: "So who assessed the wound and decided if it was healed and did not need dressings anymore?"

Participant: "I did go for check-ups after that. I went back to Polokwane Hospital for some check-ups by your professor...the one who works with you mmm...who is that man...?"

Researcher: "Okay Professor Mzezewa."

Participant: "That's him. That's right. The only day I went for check-up he declared me healed and discharged me and that is why I did not go again for Plastic Surgery check-up."

Researcher: "And then err...how did the burnt area look like?"

Participant: "The burnt area was fine. My scars were not thick because I was burnt by the water."

Researcher: "...How did they heal?"

Participant: "They were spontaneous and did not give me any problem. And....err, the back is the one that healed first."

Researcher: "Any surgical intervention?"

Participant: "No. I did not have any operation. Remember prof was still suggesting that I be grafted but I healed before he could make his final decision."

Researcher: "O'right. So how does the scar feel as compared to your original normal skin?"

Participant: "There are not much challenges and....the only stress comes when it starts to itch. But I was told that itching indicates that the wound is healing."

Researcher: "How did you manage the itching?"

Participant: "I had Allergex both to be taken orally and for application and it did help a lot? Five minutes after the application ...and you are sorted."

Researcher: “The itching sensation requires scratching and you were burnt mostly at the back. What happened when it itched?”

Participant: “That is very uncomfortable and it was like I can press my back against the wall. But I had a reliable helping hand, my wife. She would even wake up at night to massage my back when the itch starts. Hei!...That woman! I owe my life to her.”

Researcher: “Hm! And as far as the pain sensation is concerned, it just faded and never returned?”

Participant: “Oh no. Some slight pain I could feel but not always. Yeah well I went to the chemist to buy some pain killers...And when I seem not to be feeling well Mrs X my wife would notice it immediately and would just bring them for me to take”

Researcher: “Mmmm. And what usually triggered it?”

Participant: “Initially it was the cold weather. Remember I was discharged in August when it was still cold at times. Ja, it would...err...It would, mxm! I want to say, do you remember when it is cold we develop goose bumps?”

Researcher: “Y-e-e-s (Nodding).”

Participant: “They are not problematic but on the scar they are. I don’t know whether the scar tissue contract in response to the cold weather, but it was somehow painful.”

Researcher: “If you were to rate the pain severity in terms of the scale from one to ten, how would you rate it?”

Participant: “Mmmm, something like four or five.”

Researcher: “Ok. And how did the whole pain issue affect your life quality?”

Participant: “Hai! Not that much. I think I would have felt the stress if I didn’t have someone completely dedicated to take care of me. ”

Researcher: “Mmm... and then another thing, err sometimes, I’m thinking of...you know the Sotho saying that “bolwetsi bo gola boshego’ (the illness worsens during the night). How has it been with you?”

Participant: “Aaaaaaah no. I slept just like before. I never had nightmares or whatever trouble.”

Researcher: “Mrs X was taking good care of you. What about when she was out at work or running some errands?”

Participant: “Hai, we are both pensioners and even if she runs errands, it wouldn’t be for the whole day and before you realise it she would be back.”

Researcher: "How can you describe the attention she was giving to you after the burn injury as compared to before you got burnt?"

Participant: "Very much the same. It's all I can say. She is a typical African woman who knows not only her rights but her responsibilities too. She knows how to take care of me and she does it well."

Researcher: "Nodding"

Participant: "A-n-d not because she is afraid of me but out of respect and she knows her place in the family. It is a cultural requirement and if the woman disregards her cultural demands and norms, she is disqualified."

(Both the researcher and participant share a moment of laughter).

Researcher: "Okay. So, in terms of activity and movement, is there anywhere where you were affected?"

Participant: "It didn't take me long. Within plus or minus three weeks I would say I was fully functional and I went back to normal."

Researcher: "So because movements like bending over involves the back, how did it feel when you were doing that?"

Participant: "I actually didn't start by bending full blast initially. I took it one step at a time until I felt I don't have any restrictions anymore. But it took a lot of sacrifice in the form of forcing myself to bend on daily basis."

Researcher: "A lot of sacrifice. What was the driving force behind that so much sacrifice?"

Participant: "It's something that I learnt from the hospital while I was still admitted. But the most important one is that even if I am old, I still felt that I still need to be fully functional. I don't want my old age years to be spent in disability."

Researcher: "So can we safely say that the need to be well again was the motivating factor towards the exercise sacrifice you took?"

Participant: "That is exactly how it is."

Researcher: "How did Mrs X take the whole burn incident?"

Participant: "What I know is that my wife Rachel loves me and she knows her responsibilities as far as I'm concerned. In fact we are committed to each other."

Researcher: "Mmm."(Nodding)

Participant: "Even if it was her who burnt, I would do the same (laughing)."

Researcher: "According to my observation... and of course I am subject to correction. You seem to have spent a lot of time with Mrs X. And if I may ask, who are the other family members?"

Participants: "Aowa (No)... Did you forget my two sons and a daughter? They are staying at their own houses. They visited frequently and sometimes they would sleep over, but the person I spent twenty four hours with is my wife. Hey...I don't wish to be injured or sick but I'd like to see them spending time with us because even their mother gets time to rest."

Researcher: "When all is well how often do they visit?"

Participant: "The do come during some of the weekends but not always. You know family responsibilities, err...and they are at work throughout the week."

Researcher: "But the phone has bridged the communication gap that..."

Participant: "It is the best thing because if they call and say how do you feel today, then in deed it feels good as if they visited."

Researcher: "What about other people like neighbours and relatives? How did they react to your situation?"

Participant: "Of course relatives came to visit and to wish me well. You know people would encourage you and tell you all the comforting words and really gives you courage to go on with life."

Researcher: "Yeah! Of course there are still good people out there. And what exactly were they saying."

Participant: "...err... "we thank God you are alive a-n-d... God is good all the time, He will never leave you nor forsake you, err... you have to be strong..." and all the nice words."

Researcher: "All of them wished you well...?"

Participant: "Geeeee, because I am a darling to people, people they... the village people came to see if... how I perform after such a burn."

Researcher: "Mmm, so what did... what were they actually saying?"

Participant: "Their remarks were that God is so powerful and mighty, after such kind of burn...you are still going strong."

Researcher: "I believe some of them you didn't know..."

Participant: "That's right. They were so many of them but I never heard anyone talking in a manner that was not acceptable. They were happy for me."

Researcher: "What can we attribute this kindness to?"

Participant: "I am the people's person. I am the community member, an active one. There is no one who would say he or she hates me. I live well with them and help where it is necessary."

Researcher: "I also hear that they are talking about how good God has been to you. Do you perhaps belong to the same church with them?"

Participant: "...No... no...we broke away from the church we were attending before."

Researcher: "What happened?"

Participant: "There were two divisions in the church. The church minister was accused of running the church like his own business and people were... I would say enough of him and the church was on the brink of collapse."

Researcher: "And then?"

Participant: "I built a church and some of the people who were attending with us followed us and we are worshipping without any disturbance."

Researcher: "Building a church is a massive undertaking. What prompted this?"

Participant: "It was out of thanks giving desire to the God who healed me. I will always be grateful to Him. I wanted to keep the ties with him unbroken and to have a place of worship"

Researcher: "Hm! And how is the situation now?"

Participant: "The action paid off because even the congregation, the women of the congregation...they came frequently at home bringing spiritual support. Without God you couldn't have done it."

Researcher: "And the effect thereof?"

Participant: "It strengthened me very much because as they were praying there some were talking and quoting scriptures that I felt for the first time that they were talking to my life and it gave me courage."

Researcher: "Yoh! I see. By the way, how much percentage was given to your burns?"

Participant: "I don't remember... it was 20 if I was not wrong. Seems it was about 20% of it."

Researcher: "And then err, now that your wounds have healed and you are left with scars...when you... let me say when you are bathing or when you are standing in front of the mirror and see scars. What comes to your mind?"

Participant: "Geeeee, I just think that I nearly burnt to death (chuckling), ja but otherwise thanks God because I'm back to normal."

Researcher: "Mmm. Alright... And then by the way during the time of the burn injury incident, where you working?"

Participant: "Working you mean employed somewhere?"

Researcher: "Employed... that's right, for a living, or let me say for a salary."

Participant: "I was a pensioner. For thirty four years I've been a principal of the school"

Researcher: "Oh-kay. As a pensioner, how did the whole process of hospitalisation, and treatment in and out of the hospital affect you financially?"

Participant: "Financially well, it didn't. The only time when money was involved on top of the other family requirements was when my wife booked herself at a lodge in Pietersburg so that she could be able to visit me at the hospital daily. But I can't say that it disrupted my salary and our livelihood"

Researcher: "Ok. So you were..."

Participant: "Only my wife... err... was affected because she used to come time and again at Mankweng and it is a long way to drive so I can say that we were affected... is only that petrol-wise as it was not expected."

Researcher: "But err... in terms of getting your monthly salary and so on you were not affected."

Participant: "I was not getting a monthly salary but our pension sustained us very well. It sustained us."

Researcher: "Okay. And then if I may ask, err in terms of activities, coming back from the hospital how did you cope?"

Participant: "I learnt my lessons the hard way. Remember when I was still unable to or walk the nurse refused to bring a wheelchair to me. That actually taught me not to really depend on someone. I haven't been lazy but I continued with the physiotherapy on my own."

Researcher: "About household activities?"

Participant: "Ja I started working gardening in my home as usual but initially I was slow and later on increases the pace. Ja. It worked for me."

Researcher: "Ok, and then another thing, when you look at the whole incident of burn injuries, your admission, your discharge and how you are now, ummm, what can you say, what comes to mind?"

Participant: "What comes to my mind is that really the God I'm praying, it's very wonderful. You know sometimes we...we look at ourselves now and not know what

will be happening tomorrow. And even our families err, see us today as normal people and tomorrow we are somehow.”

Researcher: “Hm! So ummm...I also want to know about Mama. When you are chatting about life and sometimes something triggers a conversation about the burn incident, what does she say about the whole burn thing?”

Participant: “She never stops telling me how thankful she is. She was talking about the fact that I went to the right hospital otherwise I might have died, and I think so too. She also thanked for the hospital I went to. She would say that really, what they have done to you is unbelievable. Mmmm.”

Researcher: “Out of the burn incident and the recovery journey what, life lessons have you learnt?”

Participant: “First of all I learnt to trust God so much because I saw that life is controlled by Him alone.

Researcher: “Mmm.”

Participant: “Secondly not to trust people because...when you think they will help you is when they don't. Then err...to appreciate and do good to the people because when you are in a desperate situation, they are the same people who will be there for you when you need them most.

Researcher: “Mmm. (Nodding).

Participant: ”And to live a fulfilling life with good values so that there are no regrets tomorrow.”

Researcher: “Mmm, okay. After burning 20% of total body surface area you still emerged strong and positive. What kept you motivated?”

Participant: “Err... I would say thinking of the people you live with and those who have been there for you, ..or let me say all your loved ones, it's like you don't want to disappoint them. It's like you have to live on so that you can pay back to them what they've done to you, show them appreciation or even helping them one day.”

Researcher: “So, if you were to give advice to the person who has just burnt and is still undergoing treatment, what would it be?”

Participant: “Ee! A lot of advices starting from eating even if you don't feel hungry so that the body can have enough storage of nutrients, exercises, and just being positive and err... lots and lots of advices. They must cooperate and trust in God for their healing and not give up on life.”

Researcher: “Mmmm. So let me say what you said to me. If that is exactly what you meant it is fine. If it is not, you will correct me. So you burnt err... and the burns affected the back and the abdomen. The hands and legs were not affected...”

Participant: “...err..., the arms were affected but it was a small burn.”

Researcher: “O’ right. Yes I can see the small scars on the wrist. Yes, you burnt and were admitted and were discharged home. But the challenges started when you were not yet home.”

Participant: “Yeah.”

Researcher: “When you were...on your way back to your own hospital you did not get the sympathetic help from the nurses that were there. They couldn’t help you the way you wanted to be helped. The other challenge as far as the nursing staff is concerned is when you were at the clinic where you also did not receive an acceptable approach from the nurses. At some stages you were told that there were no bandages and you were forced to go and buy bandages yourself as well as medications. And mama dressed you at home. But I want to find out ...where did she learn or see the dressings being done, what happened and how did she do it?”

Participant: “Aaaaah! It was just from her mind, I can’t tell much of that but it was well done.”

Researcher: “And you eventually healed.”

Participant: “Yes. And even at Polokwane city...I mean hospital I went with her and professor saw her and I told professor what happened to me and he was so pleased. He also talked to her that really it was professional, she has done it well just like a trained somebody.”

Researcher: “Oh! Okay. So finally she did it very well and you were healed. You went for check -up once and were declared discharged for the wounds”

Participant: “That’s right”

Researcher: “So as you have been discharged from the Plastic Surgery Department, what was today’s appointment for?”

Participant: “Oh! There were two appointments running concurrently because I come from far. It was that of Physiotherapy and for the Ophthalmology. But I’ve been discharged today from Physiotherapy check-up because my motion ranges have fully recovered.”

Researcher: “O’right. I’m looking at you with some scars on your hands and according to the information given by you, this did not limit the use of your hands and

it did not limit you from performing duties and activities that you used to perform when you were not burnt.”

Participant: “That’s right”

Researcher: “And at the same time, the very same scars or when they were still wounds they did not trouble you like you couldn’t sleep during the night. And they did not limit your movement.”

Participant: “Very much so.”

Researcher: “Oh-kay. And then you got the support from the family at home. And then you also got the support from the community, the people, the friends that you were living with before.”

Participant: “Exactly, and a lot of it”

Researcher: “They even spoke well of you. They spoke supportively to you and there’s no single one of them who spoke negatively about you. And apparently this is because you are the people’s person. And then this brought in you the strength to continue were you have stopped before the hospitalisation.”

Participant: “Mmmm.”

Researcher: “Oh-kay. In other words, from what I have gathered, all you are saying is you are thankful that you are alive... because you burnt and you could have died but you are still alive today.”

Participant: “I’m very much thankful.”

Researcher: “You were able to face life with courage even after the burn?”

Participant: “That’s right.”

Researcher: “And then like you said, you were not employed at that time, you were a pensioner and it did not affect your earnings at the end of the month like in terms of, it did not affect your going to work because of the sick leave because you were already a pensioner. And then it also did not affect you as a person but the only thing is that money was being used more than it was usual because there were added transport and lodging costs as Mama visited you regularly.”

Participant: “That’s right.”

Researcher: “So let me say, initially at the hospital your experiences were good and when you were out of hospital they were not good as far as the nursing staff is concerned.”

Participant: “Mmm”

Researcher: “So what do you think about those differences?”

Participant: "I feel that people don't just go to seek health services for nothing. There is a need that must be fulfilled by somebody who is hired and paid a salary for that. This negative attitude thing is annoying and has to be addressed at the right platforms so that people can understand their responsibilities. Those going an extra mile in doing good must be honoured as well"

Researcher: Thank you for participating."

Participant: "You're welcome. Actually it's I who thanks the hospital the way they treated me. I'll never forget the way the hospital treated me like...I was just like a king (laughing)... really. That's why even now I'm missing you people. I was just in good hands. Some moments are worth remembering and you reminded me indeed"