

A Lived Experience of Injured Patient in Flames: Phenomenological Study

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Abstract: A phenomenological study to explore the lived experience of burns patient in hospital at , Puducherry. The objectives of the study were 1.To explore the feeling of the burns patient after the exposure 2.To identify the lived experiences of the and its impact with family members 3.To identify their difficulties to be faced in the future. The research approach selected for the study is qualitative approach and phenomenological research design. The study was conducted in selected hospital at puducherry ,8 samples who were selected by purposive sampling technique. The investigator used semi structured interview guide which was derived from a standardized quality of life tool to interview the samples. The interview extended up to a mean time of 40 minutes and was recorded by a digital recorder. Interviews were recorded and transcribed verbatim for thematic analysis. The findings of the study highlights The findings of the study revealed that 1.Enduring and emotional suffering 2.Eelf-perspectives after suffering eases 3.Experience of bitterguard life 4. Hating of power 5. Beyond the suffering. For the burns patient the most important factor required is to provide proper family support that made them to well cope with the situation and earlier discharge. The complication prevention is not only by the proper treatment and self care but it depend on psychological strength only.

Keywords: Burns, Emotion, Lived Experience

1. Introduction

"The Purpose Of Life Is To Live It, To Taste Experience To The Utmost, To Reach Out Eagerly And Without Fear For Newer And Richer Experience."

— Eleanor Roosevelt

Burns can be physically and psychologically devastating. Fortunately, survival and mortality rates have improved substantially as a direct result of medical advancements. These advancements include painful and sometimes life long medical procedures. With survival comes a need for support and information to cope with the emotional, mental, and spiritual issues that remain with the physical scars.

Burn injuries are characterized according to cause, type, total body surface area, depth, distribution, and inhalation injury (American Burn Association, 2010). The greater the severity of the injury, the greater the risk of associated physical, psychological, and social problems after discharge from the hospital (American Burn Association, 2010).¹

For burns covering greater than 30% of the total body surface area (TBSA), severe stress responses are initiated along with responses such as pain and fear. Systemic responses are generated by the release of inflammatory mediators and every organ system is affected and compromised. This results in cardiovascular, respiratory, metabolic, and immunological problems (Hettiaratchy & Dziejulski, 2004; Kramer, Lund, & Beckum, 2007). Further problems occur as compromised organ systems affect other systems creating a "domino effect". With massive insults to the integrity of skin and immune systems, people with burn injuries are often isolated from other people for extended periods to minimize the risk of infection (Hodle, Richter, & Thompson, 2006).²

Since social media is widely used by this population as a means of communication and socialization, it may be a way for young adult burn survivors to gain access to relationships and cope with some of the losses associated with being burned (Lenhart, Purcell, Smith, & Zickuhr, 2010).

The human body responds remarkably to any potential threat of danger with a "fight or flight" response. When this reaction is triggered, our brain sends messages to the adrenal glands, which release chemicals into the bloodstream that cause our bodies to change. These changes include increased respirations, increased blood flow to muscles and limbs, intensified awareness, enhanced impulses, and diminished pain.

Many crash victims/survivors report recognizing the need to get out or away from the fire and after doing so, remember little else about the event. Some only remember vague details such as smells and images. If you were burned as a result of a drunk driving crash you may not recall feelings of panic, fear, and anxiety often associated with burns. On the other hand, you may describe the experience as terrifying. Either way, immediately following a crash and for some time thereafter, a burn victim/survivor is faced with a potentially life threatening condition.³

2. Background of the Study

An estimated 265 000 deaths every year are caused by burns – the vast majority occur in low- and middle-income countries. Burns are among the leading causes of disability-adjusted life-years (DALYs) lost in low- and middle-income countries. In 2004, nearly 11 million people worldwide were burned severely enough to require medical attention.

In India, over 1 000 000 people are moderately or severely burnt every year. Nearly 173 000 Bangladeshi children are moderately or severely burnt every year. In Bangladesh,

Colombia, Egypt and Pakistan, 17% of children with burns have a temporary disability and 18% have a permanent disability. Burns are the second most common injury in rural Nepal, accounting for 5% of disabilities. In 2008, over 410 000 burn injuries occurred in the United States of America, with approximately 40 000 requiring hospitalization.⁴

Children under 5 in the WHO African Region have almost 3 times the incidence of burn deaths than infants worldwide. Boys under 5 years of age living in low- and middle-income countries of the WHO Eastern Mediterranean Region are almost 6 times as likely to die from burns as boys living in the WHO European Region. The incidence of burn injuries requiring medical care is nearly 20 times higher in the WHO Western Pacific Region than in the WHO Region of the Americas.⁵

Burn injury is more common in our society than one might think, affecting approximately 1 percent of the population each year (Muller, Pegg, & Rule, 2001), accounting for more than 1.25 million people being burned in the United States (Centers for Disease Control and Prevention, 2011). Twenty years ago burn injuries that required hospitalization accounted for more than 100,000 patients (Muller, Pegg, & Rule, 2001) and an estimated two million yearly hospital bed days (Currerie, Luterman, Braun, & Shires, 1980). With advancing medical and transport capabilities, mortality rates from “massive” traumatic burn injury have decreased from 5.3 percent to 3.4 percent, indicating a substantial downward trend (Moi, Vindenes, & Gjengedal, 2008; Muller, Pegg, & Rule, 2001).⁶

3. Objectives of the Study

- To explore the feeling of the burns patient after the exposure
- To identify the lived experiences of the and its impact with family members
- To identify their difficulties to be faced in the future.

4. Material and Method

Method

A qualitative phenomenological approach was employed to explore the lived experience of burns patients

Sample

A purposive sample of 8 patients from the burns unit in hospital, of Puducherry.

Data Collection

The research setting is the selected at Puducherry. Semi-structured ; in depth interviews were used as an instrument for collecting required data and were devised appropriate to the objectives of the study. After establishing the communication well with the patients. Each clients was encouraged to express their experience like emotion, future, agony during the incident. The researcher was responsible for organising mutually convenient interview schedule with the client.¹⁰

Data Analysis

Table 1: Distribution of the demographic variables of the subjects in percentage (N=8)

Age	25-30	2 (25%)
	36-40	2 (25%)
	46-50	2 (25%)
	56-60	2 (25%)
Marital Status	Married	5(62.5%)
	Unmarried	2(25%)
	Widow	1(12.5%)
Education	Primary	2(25%)
	Higher level	4(50%)
	Degree/ graduate	2(25%)
Religion	Hindu	7(87.5%)
	Christian	0
	Muslim	1(12.5%)
Occupation	Gov	2(25%)
	Private	5(62.5%)
	bussiness	1(12.5%)
Family System	joint	3(37.5%)
	nuclear	5(62.5%)
INCOME	Below 20,000	6(75%)
	Above 20,000	2(25.5%)
Sex	male	1(12.5%)
	female	6(75%)

The distribution of demographic variables in percentage for the following were

Age- The patient between the age group of (25-30) 2(25%), (36-40) 2(25%) , (46-50) 2 (25%), (56-60) 2(25%) .

Marietal Status- Patient married 5(62.5%) , 1 (12.5%) unmarried, widow 1(12.5%)

Education- Patient at primary level 2(25%) , higher secondary 4(50%) , degree/graduate is 2(25%).

Religion- Patient Hindu 7 (87.5%), Christian is 0, muslim 1(12.5%).**OCCUPATION-** Patient1 in government job 2(25%) ,private job 5(62.5),business 1 (12.5%).

Family Syatem- Patient at nuclear family 5(62.5%) and joint family is 3(37.5%)**INCOME-** Patient is below 20,000 of salarywas 6(75%) and above 20,000 was 2(25.5%).

Sex- Female patient were 6(75%) and male were 1(12.5%)

Table 2: distribution of subjects as per reasonwise

Subjects	Reason For Incident	Percentage Of Burns
SUBJECT 1	carelessness	40%
SUBJECT 2	carelessness	60%
SUBJECT 3	carelessness	40%
SUBJECT 4	Suicidal attempt	70%
SUBJECT 5	Suicidal attempt	60%
SUBJECT 6	Suicidal attempt	45%
SUBJECT 7	Suicidal attempt	50%
SUBJECT 8	Suicidal attempt	45%

5. Theoretical Framework

The Health Belief Model

The Health Belief Model (HBM) was developed in the early 1950s by social scientists at the U.S. Public Health Service in order to understand the failure of people to adopt disease

prevention strategies or screening tests for the early detection of disease. Later uses of HBM were for patients' responses to symptoms and compliance with medical treatments. The HBM suggests that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behavior or action will predict the likelihood the person will adopt the behavior.

There are six constructs of the HBM. The first four constructs were developed as the original tenets of the HBM.

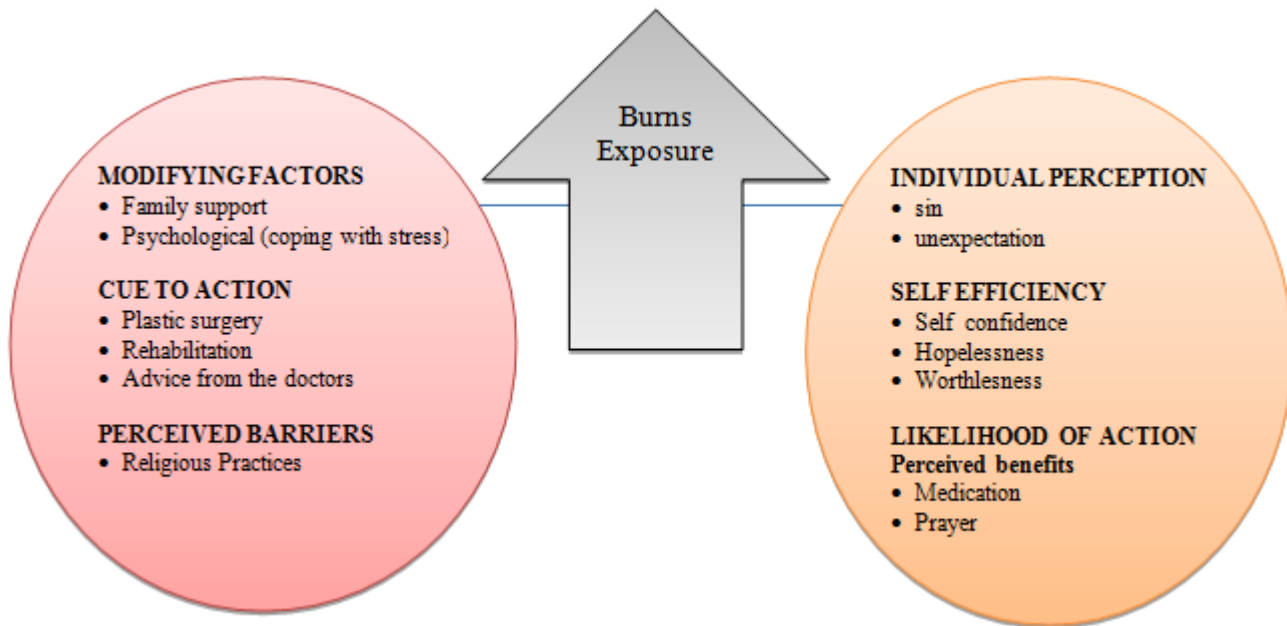
1. **Perceived susceptibility** - This refers to variation in a person's feelings of personal vulnerability to an illness or disease. Here in this model **burns wound** after exposure to burning incident.
2. **Perceived severity** - This refers to a person's feelings on the seriousness of an illness or disease. There is wide variation in a person's feelings of severity, and here the patient exposure to burns due to **sin, self intention and as unexpected incident**.
3. **Perceived benefits** - This refers to a person's perception of the effectiveness of various actions available to reduce the threat of illness or disease. The course of action a person takes in preventing (or curing) illness or disease relies on consideration here the patient mostly accepted as **medication and prayer** and evaluation of both perceived susceptibility and perceived benefit, such that the person

would accept the recommended health action if it was perceived as beneficial.

4. **Perceived barriers** - This refers to a person's feelings on the obstacles to performing a recommended health action. There is wide variation in a person's feelings of barriers, or impediments, which lead here **the spiritual beliefs lead to unacceptance**. The person weighs the effectiveness of the actions against the perceptions that it may be expensive, dangerous (e.g., side effects), unpleasant (e.g., painful), time-consuming, or inconvenient.
5. **Cue to action** - This is the stimulus needed to trigger the decision-making process to accept a recommended health action. These cues can be **internal plastic surgery or external advise from the doctors**
6. **Self-efficacy** - This refers to the level of a person's confidence in his or her ability to successfully perform a behavior. This construct was added to the model most recently in mid-1980. In this we use it as **self confidence, hopelessness, worthlessness** from the patient getting cure from the wound and for the future.⁽¹¹⁾⁽¹²⁾

It was like a see-saw model if there is any disturbances in the modifying factors, cue to action and perceived barriers it will disturb the balance in the individual perception and self-efficiency

The Health Belief Model



6. Data Analysis

Themes

ENDURING AND EMOTIONAL SUFFERING

This theme reflects putting up with something or somebody unpleasant feeling and loss of hopefulness in living the life to continue. Here in this study it was notified that most of the subjects were with the intention of putting themselves or others in unpleasant feeling like angry, tension, feeling of frustration, hopelessness. Their feeling might be a causing factor for such occurrence.

It was found that subjects who made this incident with suicidal thoughts could be exhibited of having less decision making attitude, low confident to face the problem, would have evolved their mind with "this may be the only remedy" to get rid of all.

Put up with something or somebody unpleasant feeling and loss of hopefulness in living the life to continue. Here in this study the clients mostly done purposefully with suicidal thoughts to overcome the problems faced in the life situation.

S1: mentioned that *“This happened accidentally, in my deep prayer when I came to know my back is burnt, I got fear... Screamed like anything and shouted save me, save me..”*

S2: stated that, *though it happens what I feel is I would have done a sin so that god gave me punishment*

S3: stated that *Due To My Carelessness Only I Got It...Above 3 statements revealed that “soon after the incident there was a experience of fear of life, anxiety, guilt feeling, etc”.*

S4: expressed that *why I am living in this world even after this I Don't want to live in this world. Why was I been saved, I Am the only person get all sorts of problem nobody understands me. No support gets from my husband. My mother in law torturing me both physically and mentally too.....*

S5: Verbalised that *I done a mistake, failed in my subject I was afraid and shy to face my relatives and my friends .I feel guilt..*

These two statements showed that they were emotionally disturbed and did not know the way to handle the crises. Instead their guilt feeling, angry, frustration, hopelessness and lack of support made them to undergo such incident. When unexpected event takes place normally all might have experienced shock fear anxiety worry etc..

7. Self-Perspectives after Suffering

Though this incident happened either intentionally or unexpected, all the subjects experienced “extreme pain” agitation and once they had been treated in the hospital it was notified that there was an interest and wish to have a “soon recovery” and they were able to cope up with the situation after they get discharged.

S6: Positive way of coping with the existence due to strong support from the family circle *If I am bold enough to cope and ease the with my situation. god will definitely give me a strength.....let us see...*

S8: *oh...I can't imagine the pain experienced. In tolerable pain I don't know how to describe. I don't want again, i will tell others also.*

These statements enumerate that their attitude of coping well with the existency situation, the curiosity to have a normal living activities and ready to express the experience feeling to other while fired to be appreciated.

8. Experience of Bitterguard Life

Which denotes that “there is a loss of confidence and become hopelessness and helplessness. This was been recognised by the verbalization of

S7: *I lost my hope. I never felt painful due to my wound but, my heart is heavy and paining, no more life I need, god takes my life.*

S4: *My main problem is my family life. I am worthless..... this is my own decision nothing more I want. Due to the hopelessness, uncertainty, and less social support, it was found that there was a bitter guard experience.*

9. Hating of Power

The loss of power in doing the casual work and activities that may be energy level or exposure with society to led a normal life..

S 5: Here the subject verbalised, *I am not able to do their daily activities without a support from the others my mom also facing very much difficulties but he can't able to express iam thinking so bad if minutes i think of such the difficulties ho..ho..I din't do like this idiotic decision...I am very much feeling how i will face this society...*

S2: *I was very much worried that why happened like this to me this aged period how can i tolerate this pain and difficulties to see by the others also....that God only say a solution for me or else take it to her itself that's a favour for me rather than living in this world.....*

S4: *I can't able to look after my child, I am thinking why i born in this world and why my child also born and facing this type of problems hm...hmmm, that's why I am given birth to you????????*

10. Beyond the Suffering

After care from sufferings lead to complications that faced by the subject due to lack of self care not only that the reason but also the situation able to cope among the future problems and fact of withdrawn from the life.

S 1: The subject stated that *“I am not not able to maintain the posture due to the exposure of burn injury in the back and maintaining the same posture was leading into numbness. It was an horrible thing to face oh...than also the pain an irritation due to an injury.”*

S 2: verbalis that *“ scarring and contracture proper position was not able to be maintained Oh. .. god I am not able to maintain my posture fever is coming on and off I am not able to tolerate this ma....*

S 4: *I am feeling very worthless and only from the family is my main problem . The family is the future life but main problem in my family life itself then what can i do for this is my one fine decision nothing need to me..*

Major burn injury, major wound and pustules were formed more than the healing factors very slow and also having complaints of fever due to infection and also due to lack of willingness to live in the world..

11. Conclusion

From this study the experience of the burns patient is mostly based on the surrounding environment, family support and the psychological factor and the most important causative

factor is due to carelessness and familial torture made them into suicidal tendency. Further study can be conducted based on the which is the most common factor that can lead to self burning tendency. For the burns patient the most important factor required is to provide proper family support that made them to well cope with the situation and earlier discharge. The complication prevention is not only by the proper treatment and self care psychological strength is must.

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