

Educating Nurses on Supported Mirror Viewing for Patients After Amputation and Other Visible Disfigurements

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Abstract

Purpose: The aim of our study was to test an educational intervention to improve nurses' confidence in supporting and frequency of offering a mirror to patients who have recently suffered visible body disfigurement.

Design/Methods: Forty-eight registered nurses who worked in two acute care hospitals took part in a mixed-method one-group repeated-measures (pretest and posttest) research study. The educational intervention included a video, a presentation, and a recorded discussion.

Results: Study participants experienced a significant increase in confidence in supporting and frequency of offering mirrors to patients. An overarching theme from the qualitative analysis was that the nurse participants perceived assisting patients in viewing their changed bodies in mirrors as "an act of compassion." Four subthemes emerged: (a) seeing mirrors differently, (b) there is only one first time, (c) how can we do this better, and (d) "me too" stories of their own and patients' difficult mirror-viewing experiences.

Conclusion: Education enhances nurses' frequency of offering mirrors and supporting patients in mirror viewing after visible disfigurement because of trauma or surgery.

Clinical Relevance: Education provides nurses with the necessary skills to assist patients in adapting to an altered body image.

Keywords: Amputation; body image; disfigurement; mirrors; nursing education.

Introduction

Nurses have opportunities to impact the health and quality of life of patients in many ways; however, nursing interventions that impact emotional and psychological comfort are often missed or neglected (Jones et al., 2015). Nursing

scholars are calling for embodiment, the whole lived body, to be a central focus of patient care (Draper, 2014; Marchetti et al., 2016; Mason, 2014; Sakalys, 2006; Wolf, 2014). Likewise, a prominent healthcare approach is to focus on the unmet needs of the whole person (Snow, 2014). One intervention that is focused on embodiment and may impact the psychological well-being of patients who have suffered visible body disfigurement because of surgery or trauma is supported mirror viewing. Nurses, who are on the frontlines of patient care in hospitals and other healthcare organizations, are ideally suited to provide this intervention: supporting patients in viewing their altered bodies, including viewing the incision, injury, and/or affected/missing limb or body part in various-sized mirrors (i.e., handheld mirror, full-length mirror). This intervention is a first step toward helping patients view their altered bodies and begin the journey of accepting their new and potentially unanticipated bodies.

Shepherd and Begum (2014) found that nurses and other staff ($n = 33$) had a significant lack of confidence in helping patients look at their injuries. More than half of the staff worried that they would upset patients. Over 70% of staff never or only occasionally asked patients if

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they would like to see their injuries. Patient participants in qualitative research studies (Freysteinson et al., 2013, 2017) perceived that they had had no support in mirror viewing after bodily trauma or surgery. Patients expressed concerns that nurses and other healthcare professionals did not appear to know or care that viewing one's self in a mirror after radical injury or surgery can be a devastating experience and often accompanied by hopelessness and self-revulsion. Mirror education is lacking worldwide, leaving nurses to their own mirror experiences, best-guess practice guidelines, and personal preferences as to when to offer a mirror to patients (Freysteinson, 2009).

Why Should Nurses Help Patients Look in Mirrors?

The well-known phenomenon of the *shopping mall effect* aids in understanding the devastation a patient may feel if the initial mirror-viewing experience after a bodily injury is in a public mirror. The shopping mall effect occurs when an individual sees another person in a public space, only to discover the person is one's mirror reflection (Brandl, 2018). This mirror effect is frequently accompanied by an instantaneous uncontrollable autonomic fight or flight sympathetic nervous system *jolt* to the body, and one looks about madly in the hope that no one has seen this reaction. The bodily jolt is exponentially intensified when one accidentally views a missing limb or other radical visible body change for the first time in a public space. This unsettling, eerie experience may be one of the reasons mirrors are often associated with magic (Pendergrast, 2003) and that talking about what one has seen in a mirror is considered to be vain and taboo (Levine, 1986). Alternatively, when mirror viewing is viewed from a physiological standpoint, mirror discussions are often necessary.

The neurocognitive model of mirror viewing (Freysteinson, 2020) suggests viewing one's self in a mirror is primarily a neurocognitive function. Functional magnetic resonance imaging studies have found that self-recognition occurs in the prefrontal cortex (van Veluw & Chance, 2014). When viewing a changed body image in the mirror, there is a disruption of the neural network in the short-term memory of the prefrontal cortex. This disruption may be mild, as when one sees, for example, one's hair cut short after having had long hair. Frequent mirror viewings for a day or two return the mirror memory to normal, and mirror comfort resumes. However, when one views a radical change of one's body, as in amputation or another significant disfigurement, the neurological disruption is severe, and autonomic nervous dysregulation often occurs (Freysteinson, 2020). Two involuntary autonomic dysregulation experiences have been reported in qualitative studies of viewing self in the mirror. Participants have described a sensation of

“running out on the road and screaming” (Freysteinson, 1994, p. 126), which is a flight or fright sympathetic nervous system response. A second response has been described as “not feeling anything” (Freysteinson et al., 2017, p. 26), which is associated with a low parasympathetic response as described in polyvagal theory (Porges, 2018). These autonomic responses can trigger diminished heart rate variability and a host of psychological disorders (Gordon & Kinna, 2019; Porges, 2018). A key assumption of the neurocognitive model of mirror viewing (Freysteinson, 2020) is that supported mirror viewing mitigates autonomic nervous system dysregulation and alleviates feelings of devastation and hopelessness, leading to an improvement in comfort in mirror viewing.

Study Aim

The aim of this project was to study the effectiveness of a mirror education program on improving nurses' confidence and frequency of offering a mirror to patients with visible body disfigurement. We also sought to qualitatively understand the nurses' perceptions of integration of the intervention into nursing practice. A pilot study, which was a precursor to this study, was conducted to determine the feasibility of a mirror education program. Study methods, including recruitment, intervention, and data collection, were determined to be feasible (Thayer et al., 2020).

Design and Methods

Study Design and Setting

This mixed-method study consisted of a one-group pretest, a posttest mixed-method design, and a qualitative discussion. The study was conducted in two hospitals located in a large metropolitan city in Texas. Hospital A is a community-based, full service, acute care facility with 293 licensed beds. Hospital B is a campus of Hospital A and has 64 licensed acute care beds. These two facilities are part of a large not-for-profit health system in Texas.

Participants

An a priori power analysis was conducted using G*Power 3.1.9 (Erdfelder et al., 1996) to determine the minimum sample size required to find statistical significance using Pearson's correlation analysis. With a desired level of power set at .80, an alpha level at .05, and a moderate effect size at 0.30, it was determined that a minimum of 46 participants would be required to ensure adequate power (Cohen, 1988). All licensed nurses working on inpatient units (i.e., medicine, surgery, obstetrics, intensive care, emergency departments) in Hospital A and Hospital B

were invited to participate in the research study via a recruitment flyer, which was delivered by e-mail. No participants were excluded based on gender, race, ethnic group, or religion.

Ethical Considerations

The study had a dual institutional review board approval. The Committee for the Protection of Human Subjects at the University of Texas Health Science Center at Houston and the Texas Woman's University Institutional Review Board approved the study. The project also underwent an administrative review by the Clinical Innovation & Research Institute of Memorial Hermann Health System. No personal identifiers were collected. Computer encryption and participant-generated passwords were used to collect and store data.

Hospital Preparations

Before the study, a walk-through of the hospitals found no small handheld mirrors that were available to patients to view incisions and small injuries. There were no full-length mirrors in their rooms or in any private area of the hospital for patients with lower limb surgery, injury, or amputation to view their altered bodies. Hospital A had a full-length public mirror in the lobby and on the outer door of an elevator. Hospital B had a full-length mirror in the lobby and highly reflective full-length glass windows in the hallways. In preparation for this study, each hospital purchased rolling full-length mirrors and small medical two-sided magnifying handheld mirrors for each unit.

Data Collection

After nurse participants gave consent to be in the study, they used Psychdata to complete demographics and a survey. Shepherd and Begum's (2014) confidence and frequency survey that had been slightly adapted (i.e., references to patient burns were removed) for the feasibility study that was a precursor for this study (Thayer et al., 2020) was used to collect data before the educational intervention and at 1-month postintervention. The survey was not a validated tool; however, it was the only instrument that could be found in the literature that had been used to measure an improvement in nursing mirror confidence and frequency.

Shepherd and Begum's (2014) survey measured confidence, which was defined as the registered nurses' perceptions of their feelings of being confident in helping patients view their injuries in the mirror. Nine items were used to assess mirror confidence. Items (e.g., "I am confident that I have the skills to support patients in seeing

their injuries in a mirror") were rated on a 5-point scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The internal consistency reliability of the scores was $\alpha = .91$. Mirror frequency (see Figure 1) was assessed using nine items. Responses were given on a 5-point scale, ranging from 1 (*never*) to 5 (*always*). The internal consistency reliability of the frequency scores was $\alpha = .95$ (see Figure 1). Following the intervention, the nurse participants took part in a recorded semistructured group discussion (see Figure 2).

Intervention

A video, a PowerPoint lecture, and a discussion were used in the design and development of a 90-minute educational mirror program. Participants watched a 20-minute video titled "Assisting Individuals With Mirror Viewing After Amputation and Other Visible Disfigurements" (Freysteinson et al., 2018). The script for this video was adapted from the qualitative study of viewing self in the mirror for individuals who had an amputation (Freysteinson et al., 2017). The information offered within the video included education on why and how handheld and full-length mirrors should be offered to patients with visible bodily disfigurement.

The PowerPoint lecture briefly reviewed the phenomenology of mirroring (Freysteinson et al., 2012), where to find mirrors on the unit, how to introduce and talk to a patient about mirror viewing and handle emotions, education for family and loved ones, the implications of mirrors for physical and occupational therapists, and when to refer a patient to a psychologist (i.e., a patient has had radical extreme body disfigurement, a psychiatric or suicidal history, or relentless mirror fear and avoidance).

Data Analysis

IBM SPSS was used to analyze participant demographics, confidence, and frequency of offering mirrors. Before analyses, data were prepared to ensure that the study

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- Explicitly offer handheld mirrors so patients can view their incision sites.
 - Explicitly offer full-length mirrors so that patients can view their injuries.
 - Ask patients if they would like to see their injuries in a mirror.
 - Offer to be with patients in looking at their injuries in a mirror.
 - Try to ensure patients have viewed their injuries in at least one mirror prior to discharge.
 - Discuss mirror-viewing at multidisciplinary team meetings.

Thayer, Freysteinson, & Thomas, 2020, p.134

Figure 1. Survey question examples.

- Tell me your thoughts on the importance of this intervention.
- Tell me about any concerns you have about putting this mirror intervention into practice.
- Describe your thoughts about this learning activity.
- Is there anything else you would like to share, or are there any recommendations you

would like to make about the mirror project and intervention education?

Figure 2. Semistructured discussion questions.

variables were normally distributed and did not contain extreme outliers. Descriptive statistics were calculated for demographic variables, including gender, ethnicity, education, and years in nursing. The primary analyses included dependent samples *t* tests to examine how the sample changed in mirror confidence and frequency after receiving the educational intervention. Thus, two separate tests were used, one for each dependent variable (confidence and frequency).

Qualitative data analysis was guided by Graneheim and Lundman's (2004) qualitative content interpretative analysis and procedures to achieve trustworthiness. Two researchers did an independent analysis of the findings, the results of which were merged and further analyzed. In each separate analysis, meaning units were isolated from the text and pasted into word documents. These units were condensed, interpreted, and assigned potential subthemes. When the two interpretations and subthemes were merged, the additional analysis uncovered four key themes. Credibility was enhanced through discussion with the nurses who were in the study, all of whom were from different hospital units with a variety of nursing backgrounds and skill sets. Using two independent researchers helped to ensure that no relevant data were inadvertently excluded. The final analysis was discussed with the entire research team, which led to further analysis. An additional subtheme and a final overarching theme were uncovered during the writing of this article. One researcher was assigned to ensure that the same questions were asked in all the discussion groups that followed the intervention. This aided in the dependability of the results. Transferability is aided by the description of the nurses and the units where they worked. Ultimately, transferability is the decision of the reader.

Results

Participant Characteristics

The final sample included 48 nurses, of whom 46 were women (95.8%). Participants had been working as a

nurse for a mean of 15.65 years ($SD = 11.83$). The majority of the sample was White (66.7%), followed by Asian (18.8%) and Black or African American (10.4%). Finally, 41.7% of the sample reported having a BSN, and 25% reported having a master's degree.

Seventy-four nurses had consented to participate in the study. The nurses received an e-mail with a posttest link at 30 days. Sixty-three nurses took the posttest. The participants created an identifying code during the pretest that was required for the posttest to match pretest and posttest scores. Forty-eight pretest–posttest scores were matched, providing the data for the quantitative findings.

Quantitative Findings

Participant confidence and frequency of offering mirrors were examined using two dependent samples *t* tests. As shown in Table 1, study participants experienced a significant increase in confidence from pretest to posttest, $t(47) = 4.78, p < .001, d = 0.66$. Likewise, the participants significantly increased the frequency of offering mirrors, $t(47) = 5.58, p < .001, d = .99$. Based on the effect size of each analysis (Cohen's *d*), the improvement in confidence could be considered a moderate effect, whereas the improvement in frequency represented a large effect (see Figure 3).

Qualitative Findings

All participants took part in a semistructured postintervention discussion, which revealed an overarching theme of “an act of compassion” and four subthemes.

Table 1 Results of Dependent Samples *t* Tests Examining Changes in Mirror Confidence and Frequency

	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	<i>d</i>
Mirror confidence			–4.78	<.001	0.66
Pre	3.11	0.79			
Post	3.70	0.81			
Mirror frequency			–5.83	<.001	0.99
Pre	1.66	0.98			
Post	2.98	1.61			

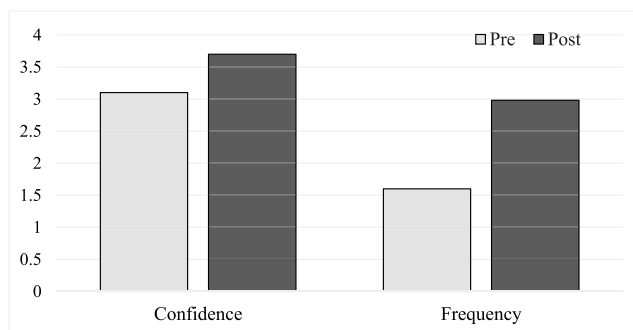


Figure 3. Mirror confidence and frequency changes ($p < .001$).

This Intervention Is an Act of Compassion

An overarching theme that was uncovered in the study was nurses perceived that offering and assisting patients in viewing their changed bodies in a mirror was “an act of compassion.” One nurse stated, “what could be more compassionate than this?” Four subthemes within this overarching theme were (a) seeing mirrors differently, (b) there is only one first time, (c) how can we do this better, and (d) “me too” stories of difficult mirror-viewing experiences.

Seeing Mirrors Differently

The majority of nurses had never thought of using a mirror. A common theme was that “We did not have mirrors on the unit where I worked. We did not think about offering a mirror on the floor.” Several of the nurses, in thinking back to moments at the bedside, said they realized how important the use of the mirror would have been in various circumstances (i.e., visible scarring from surgeries, facial injuries, burns).

We have amputee patients on the ortho unit.... As nurses, we tended to avoid amputation. I tell them the physical part—that they need to get up. I never thought about offering a mirror.

Participants thought the mirror education allowed them to see patient bodies from the perspective of the patient differently. One nurse felt, “I did not think I would take this personally. It is helping me grow. I’ve thought about mirrors so differently before and after (this mirror education).”

There Is Only One First Time

Perhaps one of the most salient lines in the video the nurses watched was “there is only a first time that you can look in a mirror, especially after an accident (amputation)” (Freysteinson et al., 2018, 5:05). The role of the nurse is to ensure the first time one looks in a mirror after amputation or other bodily disfigurement is to

guide the patient through this experience, beginning with the words: “Would you like to look in a mirror? I know it may be difficult. I can be here with you if you would like.” One participant stated:

In reflecting on my experience with the mirror study, one line has become my motivation as I provide care and education to patients: “There is only one first time.” The first time is a great responsibility for a nurse on any patient topic or situation. The mirror study provided us the tools/skills needed to have sensitive conversations. As I observed other participants during the video and discussions, I witnessed how they were moved by the patient’s stories in the video. I heard nurses say they felt more prepared to provide mirrors and support when assisting patients in seeing their amputations for the first time. It reminds me to stop and consider all the various patients’ “firsts” that I am privileged to support and care for each day.

How Do We Do This Better?

Time was the greatest obstacle. Nurses felt that this intervention would require time and expressed concern about having the “time to spend with a patient before being pulled into another direction.” One nurse countered that the loss of a limb was like a death. When someone on the unit dies, other nurses cover. She believed this was just as important; “I am going to get someone to cover for me while I go in and offer the mirror.”

The participants said that interdisciplinary teamwork was necessary. Physicians needed to know that nurses would be using mirrors in all units. Specialist nurses, including the diabetic educator, wound and ostomy nurses, and the lactation consultant all needed to understand and use the intervention. The occupational and physical therapists would need to know about the intervention and perhaps “partner with” nurses in discussing the mirror-viewing patient journey in team conferences. “Chaplains may need to be called in,” and “aides did not have the skills to do the intervention but did need to understand mirrors.” In some cases, a psychologist would be needed, and nurses would need additional education to support individuals with radical bodily changes in, for example, the following situation:

I had a patient that came in for something else and became septic and ended up losing her limbs. As nurses, we tended to avoid talking to her. We were not at all comfortable. We knew what medication we gave that ultimately saved her life, but that also caused this.

Ensuring the family was educated about mirror viewing was also important, especially for some cultures. One nurse stated, “Asians, Filipinos, Indian cultures have an

evil thing when it comes to the mirror.” We could “gently ask the patient if they want the family in the room.”

The nurses were concerned as to how to deal with their emotions and patient emotions during this intervention. The participants discussed that patients would be looking at the nurse for reassurance and guidance. Suggestions were shared, “We need to make sure our facial expressions show compassion, kindness, and caring.” There were a few nurses who were struggling to envision themselves offering mirrors to patients. One nurse almost cried as she said: “I will be crying as hard as my patients are if I try to help them look into a mirror.” Another nurse said, “I can talk about death, but I do not know if I can talk about mirrors.” Some nurses felt they needed more education to become comfortable with this new intervention.

We need to do a lot of education to make some nurses more comfortable. We need to take this back to our staff meetings. As experienced nurses, it is our job to teach new nurses this mirror intervention.

Me Too

The participants shared stories of their own and patients’ experiences of viewing their bodies after suffering bodily disfigurement. For many, this was the first time they had shared their perceptions. One nurse said that, after her double mastectomy surgery, she looked in a mirror and thought to herself, “even though I was blessed to be here, I was sad to see what I saw.” Another nurse who worked in labor and delivery said that she “broke down and cried for hours” after she viewed her cesarean section scar in a mirror. The most difficult aspect of an accident for one participant was looking at her own body, “I was in shock when I saw my back incision. [The scar] was over a foot long. I was shocked...it was tough to see it.”

Some nurses described their experience with patients. An ostomy nurse explained how terrible she felt about making a 75-year-old patient who had emergency colostomy surgery look at his incision before he went home in preparation for self-care: “For this man, it was horrifying.” A similar story was: “My aunt had a colostomy. When she woke up and looked [in the mirror] at it, she screamed.”

Patient and nurse perceptions of body image could be different. One nurse shared a story where her perspective was different from the perspective of a patient.

I had a patient that had a wound. I was doing dressing care, and the patient asked me to take a picture with her phone. The patient said, “oh, it is getting better,” and I was thinking, “this is a horrible wound.”

Posteducation Comments

As the study was coming to an end, the research team was pleased to see that the nurses were using the handheld and

rolling full-length mirrors that were purchased for every unit. Nurses reported that, initially, they found it was a challenge to offer the mirror to patients. However, with ongoing practice, there was the realization that: “I do not understand why we have not been using mirrors all along?” Nurses on a surgical unit reported that mirrors were discussed daily in their patient care huddles. For example, the nurses found that gently helping patients look at their new colostomies in a mirror was very difficult for some patients; however, the benefit was that ostomy self-care teaching was much easier. An emergency room nurse who had taken part in the study wrote the following to be added to the discussion:

As an emergency room nurse, I have developed the confidence to offer the mirror. I have offered the mirror to patients with facial lacerations, finger amputations, and a patient with a deep tissue leg maceration injury. I even offered a mirror to a five-year-old child who had a forearm angulation dislocation closed fracture. The mirror helped the patients accept the visible disfigurement and prepared them to be ready to face the next step in the plan of treatment. Offering a mirror gave significant others/family members insight into the experience of disfigurement, which helped them support the patient emotionally. It also made the patient adhere to their follow up visits. I have greater insight on how I can teach and give patients self-care discharge instructions. Mirrors give patients a better view of their injuries, making wound assessment, and dressing care easier. The video and mirror education transformed me and the care that I give my patients.

One nurse found that, using a mirror with patients after a visible disability, there was a similar response of initial grieving and then a movement toward acceptance. Patients appeared to learn how to cope with viewing their visible disfigurements in a mirror through communication with other patients with similar disfigurements. Over time, there was an acceptance of the disfigurement.

Discussion

This study, together with the Thayer et al. (2020) feasibility study previously discussed, demonstrates that education can influence nurses’ confidence and frequency of offering mirrors and assisting patients with minor acute and permanent bodily disfigurements to view and begin to accept their changed bodies. The nurses in this study shared stories, often for the first time, of their negative personal encounters with a mirror after trauma or surgery. They also shared stories of patients who had suffered visible body disfigurements. The nurses discussed

at length their perception that supporting patients in mirror viewing was a caring, compassionate nursing intervention.

Pretesting results are similar to a study that examined how confident and how frequently burn care nurses and other healthcare professionals ($n = 33$) assisted burn victims to look in a mirror: 85% lacked practice and confidence (Shepherd & Begum, 2014). The results are somewhat similar to a study of the experience of viewing self in the mirror postmastectomy. The researchers in this study included oncology nurse navigators. One oncology nurse said she was initially concerned about allowing anyone to talk to her patients about mirrors. After the study, the oncology nurse navigators expressed feelings of frustration that they had not thought to talk to their patients about a mirror before (Freysteinson et al., 2013).

The lack of mirrors on patient units, as noted by some of the participants, is not a new finding. Full-length mirrors to view the lower limbs and smaller hand-held magnifying mirrors to view the incision site are seldom found in hospitals (Freysteinson et al., 2017). This finding is not surprising as the facility guidelines (Facility Guidelines Institute, 2006) for mirrors that have been used for the construction or renovation of many hospitals in the United States is limited: "Mirrors shall not be installed at hand-washing stations in...scrub sinks, or other areas where asepsis control would be lessened by hair combing" (p. 111). Shatterproof handheld medical mirrors and rolling full-length mirrors are relatively inexpensive and are needed for nurses to implement this intervention.

Implications for Nursing

Hospital Administration

Education in this sensitive intervention requires the support of hospital organization administrative teams. Supporting patients in viewing their altered bodies is an intervention that requires mirrors. Hospital and healthcare organization administration is encouraged to do a walk-through of their hospitals to survey existing mirrors. The questions to consider are as follows: Are there small handheld two-sided magnifying medical mirrors available to assist patients, including those with poor eyesight, in assessing and learning to care for their incisions or small injuries? Are mirrors available for patients to view their altered bodies (i.e., burns, colostomy, amputation of a lower limb) with the support of their nurses in private and with dignity?

Education

The 20-minute video titled "Assisting Individuals With Mirror Viewing After Amputation and Other Visible Disfigurements" (Freysteinson et al., 2018) is recommended in preparing nurses for this intervention. Educators are

encouraged to review the mirror studies cited in this article to prepare educational sessions. Nurses must feel empowered to provide this sensitive intervention: Nursing administration is encouraged to take part in educational sessions to promote this intervention and review with nurses where mirrors can be found on their units.

Research

Further research is needed to determine the best educational methods to teach this intervention to hospital nurses and nurses from other healthcare settings, including schools of nursing. Of interest in this study were the nurses' perceptions of the intervention as being an act of compassion. Research that explores the long-term impact of this educational intervention on nurses' job satisfaction would be of interest.

Research is needed to explore the patient experience of supported mirror viewing. Efficacy randomized control trials are needed to discern if supported mirror viewing improves patients' mirror comfort, improves psychological well-being, and mitigates autonomic nervous system dysregulation.

Limitations

This study has several limitations. The tool used to measure self-perceived confidence and frequency of supporting mirror viewing has not been validated or tested for reliability. The poor posttest sample size is a threat to validity. The reasons why 11 nurses took the pretest and did not take the posttest are unknown. Hospital educators and administration have suggested the nurses are extremely busy and do not always view their e-mails. It is also possible that nurses who took the pretest did not have increased confidence or did not find the intervention useful. At pretest, the researchers encouraged all nurses to make a note of the pretest password to be used on the posttest. However, 14 posttests could not be matched to the pretests decreasing the sample size. The study was conducted in two hospitals in a large metropolitan area in the southern United States, and of primary concern, all results were self-perceived, which limits generalizability.

Conclusion

The findings of this study suggest that education can improve nursing confidence and frequency of supporting patients in viewing an altered body. These nurses shared their lack of mirror experience, their difficult mirror-viewing moments, the importance of "the first time" in seeing one's changed body, and the need for ongoing mirror education. The wealth of information generated by this study contributes to our understanding of educating

Key Practice Points

- When nurses learn that viewing oneself in a mirror after a visible body disfigurement because of trauma or surgery can be an emotionally painful and traumatic event, they understand the benefits of a supported mirror intervention.
- Nurses are at the frontline of patient care and ideally suited to provide the supported mirror-viewing intervention.
- Furnishing nursing units with small handheld and full-length rolling mirrors and preparing nurses to use mirrors can improve nurses' confidence and frequency of supporting patients in viewing and adapting to their altered bodies.
- Nurses perceive that supporting patients in mirror viewing is an act of compassion.

nurses in helping their patients view their altered bodies in mirrors.

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Conflict of Interest

The authors declare no conflicts of interest.

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