Psychosocial Practice in the Changing Context of the Larger Burns Survivor – Maximising psychosocial recovery through reintegration towards a new reality

Jenny Edge, Madeline Rowell, Rochelle Kurmis, Kathryn Heath, John E. Greenwood
Adult Burns Centre, Royal Adelaide Hospital, Port Rd, Adelaide, South Australia 5000.

Case Studies Integrating Psychosocial Approaches
Middle aged male > 50% TBSA, Injury resulting in amputation, resistive to medical advice due to upsurging and past towards
Patient ideology to be understood in the context of past trauma • Working through the patient’s trauma background• Printed information and one-on-one time with specialist disciplines to assist patient in overcoming scepticism and fear • Providing choice, including binary options, promotes self-determination and supports reintegration
Ward incidences due to patient wanting to recover his masculinity • Redefining masculinity was choice to the patient’s process of working towards reintegration of his new identity. The patient’s disregard for medical advice was recognised alongside the patient’s social circumstances, and patient/ team alliance was maintained
The alternative of a completely ruptured relationship would likely compromise total care and healing
Young adult female > 60% TBSA, self-immolations injuries, cross cultural background For this family this word disability represented to be ‘hidden away’ and to be ‘shamed’• Crucial to not assume meaning behind words or fill gaps with personal conceptions*
To gain consent for a referral to disability service essential for ongoing care, a new meaning of the word ‘disability’ had to be respectfully taught and accepted by the patient and family
Principles of Clean Language* expose alternative understanding of disability
History of family violence, unresolved complicated grief. Patient and family had unrealistic expectations of aesthetic recovery from a large burn injury • The medical team provided education based on context and experience
• Being realistic is essential while maintaining hope at some time - shift the focus to what is achievable
Middle aged male > 75% TBSA, house fire, multi tissue death
Upon admission, partner taking blame for injury due to circumstances unconnected to injury • Immediate crisis requires validation over reassurance
• Validation sends a message of belief that the individual is a crisis
Father /child relationship impacted by child’s fear of the gaseo-feeding tube • 
PEG was considered in support of fostering the father/child relationship and integrating the survivor’s changed paternal identity
• Treatment options can have many layers when consideration is given to the whole person

Periods of frustration, anger and emotional regression during time on ward • 
• Reading from a journal article helped patient understand and normalise anger as an expected part of recovery

• Attending to practical matters in preparation for discharge strengthened rapport enabling conversation

• Chronically ill patient –7 years of hospitalisation and recovery
• Housed in facility, not at home
• ‘Focused Attention’ utilising a sunshine metaphor of a new day, seeded ideas and suggested opportunities for a fresh start without guilt*

Conclusions: This review of practice and supporting literature demonstrated the need for adaptive and fluid psychosocial approaches, utilising trauma informed principles, knowledge of recovery stages, innovative use of Wagnenean’s model of Loss & Grief*. Clean Language* and using a whole team approach to facilitate reintegration towards a social world with a reformed identity. The team should not give up hope for the large burn survivor as the extent of human resilience is unknown, and it is the team that must carry hope for the survivor when they cannot

Wagnenean’s Seven Humanities*

Stages of Burn Injury Recovery

Typical Symptoms and Presentations

Typical Treatment and Approaches

CRISIS STAGE

• Pain*
• Limited cognition and ability to engage
• Dissociation
• Depersonalisation
• Shock, fear, terror
• Sadness, guilt*, grief
• Anxiety*

• Analgesic medication*
• Psychopharmacological intervention*
• Psychosocial intervention
• Information
• Non-pharmacological
• Validation*
• Reassurance
• Pain management & relaxation strategies
• Supportive family/lived ones
• Psychosocial screen? Risk assessment*

ACUTE STAGE

• Changes in pain
• Sleep disturbance*
• Rapid emotional shifting & behavioural regression
• Depression*
• Anger
• Identity changes
• Re-emergence of premorbid trauma and psychopathology

• Team liaison and education*
• Focus on maintaining pre-established coping mechanisms & strengths*
• Psycho-education, Psychotherapy
• Support group, focused attention, values work
• Occupational/increasing independence
• Connection to social systems
• Finances, legal, practical, community
• Preparation for rehabilitation/discharge

RECOVERY/REINTEGRATION

Typical Symptoms and Presentations

Typical Treatment and Approaches

• Adjustment difficulties
• Body image concerns
• Helplessness
• Anxiety – relating to avoidance and phobic responses
• PTSD

• Self-care based and future orientive work
• Psychotherapy
• Trauma focused therapies
• Skills work
• Social image and social interaction
• Family/relationship focused intervention
• Peer support from other survivors
• Referral to external agencies

References:
8. Wagnenean’s Seven Humanities*