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

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## Background:

Psychosocial work on the RAH Burns Unit utilises knowledge from the recovery stages of the large burns survivor and trauma research, along with Wanganeen's[1] principles of aligning the *Seven Humanities.*

The associated ongoing physical and psychological pain can take the survivor on an experience that challenges their endurance and will to survive.[2]

From admission the survivor commonly faces changes to identity, mobility, relationships, appearance and loss of past goals and dreams, which often overlay a background of grief and trauma.[3] This can result in the patient having existential crises during their recovery stages.

Research in psychoneuroimmunology has linked stressful life events to the immune system response, which may negatively impact wound healing and trigger viral infections.[4] Integrating towards a new reality for the burns survivor requires psychosocial support that draws eclectically from a broad knowledge base in social work and psychology.

## References:

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5. Knight, C. Trauma-informed social work practice: practice considerations and challenges. *Clinical Social Work Journal*. 2015:43:25-37.
6. Sullivan, W., & Rees, J. Clean language - revealing metaphors and opening minds, Crown House Publishing, UK. 2015.

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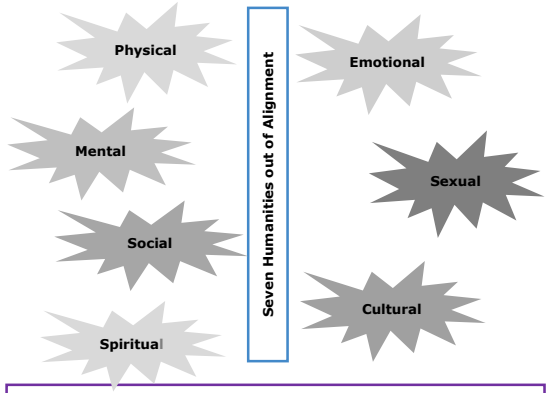
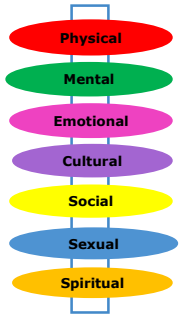



## Wanganeen's Model of Loss & Grief[1]

Created for Indigenous Australians, Wanganeen's loss and grief model has been partially adapted to trauma recovery of the large burns survivor, by the RAH Burns Unit Social Worker, in consultation with the model's author. Addressing past trauma of the burns survivor as well as *Tangible and Intangible Losses*[1] associated with a large burn injury through the *Seven Humanities*[1] supports holistic reintegration towards a new reality and identity for the burns survivor.




**Aligned Humanities Towards Reintegration of New Reality**

## Stages of Burn Injury Recovery

### CRISIS STAGE

| Typical Symptoms and Presentations | Typical Treatment and Approaches |
|---|---|
| • Pain*<br>• Limited cognition and ability to engage<br>• Dissociation<br>• Depersonalisation<br>• Shock, fear, terror<br>• Sadness, guilt*<br>• Grief*<br>• Anxiety* | • Analgesic medication*<br>• Psychopharmacological intervention*<br>• Psychosocial intervention<br>  ○ Information<br>  ○ Normalisation*<br>  ○ Validation*<br>  ○ Reassurance<br>• Pain management & relaxation strategies<br>• Supporting family/loved ones<br>• Psychosocial screen*/ Risk assessment* |

### ACUTE STAGE

| Typical Symptoms and Presentations | Typical Treatment and Approaches |
|---|---|
| • Changes in pain<br>• Sleep disturbance*<br>• Rapid emotional shifting & behavioural regression<br>• Depression*<br>• Anger<br>• Identity changes<br>• Re-emergence of premorbid trauma and psychopathology | • Team liaison and education*<br>• Focus on maintaining pre-established coping mechanisms & strengths*<br>• Psycho-education, Psychotherapy<br>• Sleep hygiene, focused attention, values work<br>• Occupational/increasing independence<br>• Connection to social systems<br>  ○ Finances, legal, practical, community<br>• Preparation for rehabilitation/discharge |

### RECOVERY/REINTEGRATION

| Typical Symptoms and Presentations | Typical Treatment and Approaches |
|---|---|
| • Adjustment difficulties<br>• Body image concerns<br>• Helplessness<br>• Anxiety – relating to avoidance and phobic responses<br>• PTSD | • Goals based and future directive work<br>• Psychotherapy<br>  ○ Trauma focused therapies<br>  ○ Skills work<br>  ○ Body image and social interaction<br>• Family/relationship focused intervention<br>• Peer support from burns survivors<br>• Referral to external agencies |

NB: * = continuous importance/presence in all stages

## Case Studies Integrating Psychosocial Approaches

**Middle aged male > 50% TBSA, injury resulting in amputation, resistive to medical advice due to upbringing and past traumas**

**Patient ideology to be understood in the context of past trauma**

- Working alliance built on rapport through understanding patient's trauma background[5]
- 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 masculine identity**

- Redefining masculinity was necessary 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 psychosocial needs, and the 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-immolation injuries, cross cultural background**

**For this family the word *disability* represented to be 'hidden away' and to be 'shunned'**

- Crucial to not assume meaning behind words or fill gaps with personal conceptions[6]
- To gain consent for a referral to disability services 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*[6] exposes alternative understandings

**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 evidence and experience
- Being realistic is essential while maintaining hope at same time - shift the focus to what is achievable

**Middle aged male > 75% TBSA, house fire, very lengthy admission**

**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 in a crisis

**Father /child relationship impacted by child's fear of the naso-gastric feeding tube**

- A 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 validate and normalise anger as an expected part of recovery
- Attending to practical matters in preparation for discharge strengthened rapport enabling conversation about expression of anger and redirecting anger away from staff therefore keeping them safe
- 'Focused Attention' utilising a sunrise metaphor of a new day, seeded ideas and suggested opportunities for a fresh start without guilt[6]

[Wanganeen's Seven Humanities[1]]

## 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 Wanganeen's model of Loss & Grief [1], *Clean Language*[6] 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 injury survivor as the extent of human resilience is unknown[2], and it is the team that must carry hope for the survivor when they cannot.

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