EMOTIONAL CARE OF THE BURNED CHILD 117 Evaluation of the Child

The child's dependency adds a crucial element to the determination of the events causing the child's burn. The question of whether the child's normative needs for protection have been met must be considered.

On admission, the following five items are necessary for an initial evaluation:

Precisely how was the child burned? Consider if the story suggests gross abuse or neglect. Avoid accusatory interrogation. If the parent becomes defensive simply note this reaction, and postpone further history-taking until a positive relationship with the parent can be established.

2. Has the child been chronically impulsive or hard to control? Consider if this particular child requires more than average supervision from otherwise adequate parents who are more overwhelmed than neglectful. This information will help in anticipating ward management of a difficult child.

Has the child suffered other significant injuries recently? If the recent past suggests a new pattern of injuries in a child otherwise not neglected or hard to handle, the burn may represent an ongoing life crisis for the child or the family. Such a pattern warrants a more detailed family evaluation by a mental health professional.

4. Does the physical exam suggest abuse or neglect? Suggestive signs are: poor hygiene; malnutrition; multiple bruises in unusual places and of different ages; multiple scars, cuts, or scrapes. The presence of these signs warrants a skeletal survey, which may show multiple fractures in various stages of healing and in unusual sites.

What is the child's highest developmental level achieved? This will screen for developmental delay, and help hospital staff anticipate what to expect of the child and what must be done for him.

Evaluation of the Child's Family

EMOTIONAL CARE OF THE BURNED CHILD

While most important elements of burn care already outlined apply to the care of children, the translation of the same issues into psychologically sensitive management with children requires Special consideration. Two fundamental matters summarize the main focus for this consideration:

1. The child's cognitive and emotional immaturity.

2. The child's dependency on family and staff.

These key differences underly most of the practical details described below.

Emotional Conflicts

The initial contact with the parents of a burned child commonly creates intense and disturbing feelings in the professional performing this task. A major cause for this reaction is the marked contrast between the emotional responses normally aroused as we confront the parents in the present and in the past:

1. The parents evoke sympathy for the present. Staff members routinely feel great pity for the plight of parents who are currently

suffering the tragedy of their child's injury. "How can anyone bear this?"

The parents evoke condemnation for the past. Staff members just as naturally tend to blame the child's parents for the injury their child has already suffered. "How could they let this happen?"

This difficult emotional work for staff members can be relieved appreciably by a full awareness of the contradictory nature of these normal reactions.

Family Context

During the first contacts the following items require consideration:

1. What are the parents' reactions to their child's injury? The main points elaborated regarding intervention with the family of burn victims (pp. 112-116) apply here as well. In addition, parents often experience feelings of enormous guilt. They may express their guilt directly, or may project it onto others as rage at each other, the burned child, or the hospital staff. When parents seem apathetic, the question of abuse or neglect becomes relevant for later exploration. Whatever the reactions, staff members should communicate to the parents an understanding .that all parents experience very painful feelings, and an interest in helping the parents with these feelings.

2. How competent are the child's parents?

a. Do the parents judge the child's maturity appropriately? Many abusing parents expect their children to function on a level much more mature than is possible.

b. What are the usual safety patterns at home? Assess the parents' judgment, and whether they are chronically overwhelmed and in need of concrete social service assistance.

3. Is the family undergoing important changes? Many children are burned at a time of strife, threatened or actual angry separations, or other family crises. The presence of recent injuries in other members of the family lends weight to the concept of a family crisis being enacted through "accidents." Understanding such a crisis is relevant to further family treatment as well as to the meaning of the child's injury to members of his family.

4. Does the injured child have a special role in family dynamics? Often the burned child has special emotional meaning to one or both parents, as a "parent," "lover," etc. Further specialized evaluation is warranted in treating such a family and in understanding the responses of members of the family to the child's medical care.

5. Are there siblings?

a. Siblings often suffer overwhelming emotional responses to a major injury of a brother or sister. Parents may need help in realizing the impact of the patient's injury on his siblings, especially if the parents themselves are projecting their own guilt onto their other children. All child and adolescent-aged siblings should be assessed if possible.

b. If neglect or abuse seems likely, referral to local child protective services is more urgent if other children remain at home.

Referral to Child Protective Services

Guidelines for making a referral to child protective services when neglect or abuse are considered:

1. Most "abused" children return to their parents. Staff require a strong alliance with the parents in assisting them in improving their home.

2. Legally, any possibility of neglect or abuse must be reported. Hospital personnel are neither judge nor jury.

3. Determine within the first few days if there is a basis for referral. Delay on the decision to make a referral tends to elevate the need for "evidence" and distort the hospital's role as "screening" agent.

4. Inform the parents promptly before the referral has been made, but after a firm decision to refer has been finalized. Referral should never be considered tentative or as a threat, but rather as a step toward treatment.

5. Explain to the parents that the referral is legally required, that its purpose is to investigate in what ways parents may need help in parenting, and that most children remain at home after the investigation. The parents, especially if they experience feelings of guilt, may worry that hospital staff are punitively taking away their child.

6. Paperwork involved in the referral should be quickly expedited. Delays in referring cause delays in evaluation, which may increase the parents' anxieties. The investigating agency will usually require a statement of facts rather than speculations.

Immediate Treatment of the Child The Mental Health Continuity Person

1. A "no-needles" person is even more vital for the child than for the adult burn patient (p. 108). This person's main function is to

provide contact for the child, uncontaminated by painful proucdures or case management authority. The person's role is more important than his or her training, and this task need not be reserved exclusively for highly trained mental health pro iss Ionals.

2. Make early contacts frequent, regular, and limited to the span of the child's attention. To a child, the concrete presence of a person communicates interest far better than words.

3. Focus first on the child's subjective experience of his environment. Since the child's thinking differs from that of the adult, we cannot assume that hospital procedures will have the same meaning to the child as they would to an adult. Children's experiences are more concrete, and by joining them in "collaborative description" of the hospital, we speak more on their level than by explaining. The strange new "here and now" will be uppermost on the child's mind and is the first opening to empathetic dialogue.

4. Early contacts should avoid aggressive questioning or interpretation. The child's initial reactions may include clear regression to behaviors long since outgrown under usual circumstances. Generally these should be accepted as temporarily necessary for the child.

5. Describe in advance unpleasant hospital procedures, such as blood tests, injections, intravenous infusions, skin grafts, debridement, and other treatments. Generally the opportunity for ventilation will be more important than the explanation offered, especially in children under 8 or 9 years old. Children often regard painful experiences as punishments and may require repeated reassurance that their medical treatments are unrelated to their guilty feelings. Such feelings of guilt are often first uncovered in reactions to painful treatments, but mandate further exploration, as some children may regard their initial burn injury in the same light. Be especially aware that some very compliant, passive children may be overly cooperative because they bear their treatments as a penance.

Physical Environment

For children of any age, especially preschool children, provide some loved objects from home in the child's room. Sterilize them if necessary. The strange hospital milieu will be more familiar to the child if his stuffed animals, dolls, posters, etc. are visible to him. Staff and visitors should be encouraged to notice these objects and use them to engage in a more personal relationship.

Medication

1. If the child becomes agitated early in his treatment, every attempt should be made to sunport and reassure the child through presence

of family, "continuity person," favorite nurses, etc. Our therapeutic "leverage" with children is much greater with interpersonal than with pharmacological interventions. Only in the unusual circumstances where these interpersonal measures are unsuccessful—or unavailable—should medication be given.

Psychoactive medication should be ordered for brief periods of time to allow staff to plan more adequate interpersonal interventions. "Standing doses" should be ordered only after several efforts to replace short term doses with interpersonal regimens have failed.

Use least potent and toxic drugs first. Change empirically to the next level when required. The goal of treatment is relief of agitation or anxiety:

a. First level: antihistamines

Example: Hydroxyzine HC1 25 mg i.m. or p.o. q 6 hr for school age children (2 mg/kg/day).

b. Second level: antianxiety drugs

Example: Chlordiazepoxide HCl 5 mg p.o. or i.v. q 6 hr-12 hr for school-age child (0.5 mg/kg/day). Intramuscular doses are not well absorbed.

c. Third level: antipsychotic drugs

Example: Chlorpromazine or thioridazine 25 mg p.o. or 10 mg i.m. or iv. q 6 hr-12 hr (2 mg/kg/day). Used as general sedative more often in children than adults.

Immediate Treatment of Child's Family

The general principles of work with families of burned patients are outlined above (pp. 112-116). Because of the child's specific dependency on his parents, two areas of concern require special consideration.

Parental Activity

Enlisting parents' active involvement in their child's treatment returns to them their active role in parenting, a role that brings a sense of familiarity and comfort to the strange surroundings of a bum treatment unit. This activity can play a major role in relieving their sense of guilt.

1. Include the parents (and siblings where appropriate) as collabo-

rators in the burned child's treatment by planning with them:

a. Which objects from home will best comfort the child?

b. How often do they feel the child will need their visits and for how long?

c. What are the child's favorite hobbies, interests, and toys that staff can use to enhance their communication with the child?

2. Offer parents a clear explanation of prognosis, treatment plan,

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1. The burn treatment regimen

Encourage the child's active participation in his own management:

a. He can change his own dressings, or at least tell how he wants them changed. Example: "How many saline soaks? How fast should we pull?"

b. He can take part in decisions regarding precise doses of analgesics. The use of current school learning, such as arithmetic of doses or spelling of drug names may interest and engage the older child. Example: "How many 5 mg Demerol doses in a 15 mg shot?"

c. He can take a role in enhancing his subjective experience of relief from a given dose of analgesia. In this way children's greater suggestibility may be channeled toward mastery. Example: "See just how much relief you can make yourself get out of this dose."

d. He can make use of anticipatory guidance regarding future pain, bad dreams about the accident, procedures, etc. to engage in reporting and actively judging these experiences. Children feel less overwhelmed and alone when they participate in a task which involves reporting about themselves. Example: "When you had the bad dreams about getting hurt, was it just as scary as I told you it might be, or even worse, or not so bad?"

e. He can make use of specific preparation, through play and discussions, to actively master thoughts and feelings regarding all procedures, especially those that may cause fear or pain. Example: "Now you show me how to give this doll a shot." A clear and detailed presentation of this crucial aspect of the care of hospitalized children is described by Petrillo and Sanger (1972).

2. Interpersonal contacts

Maintain a schedule of at least twice daily, brief chats by various staff members with the child. The subject may be concrete descriptions of meals, dressing changes, etc. Encourage the child's expression of interpersonal judgments, such as if someone seemed mean or nice, rushed or calm. These informal chats maintain the child's main preserved mode of activity, that of social interaction and judgment. Children will engage in this much more if stimulated.

3. Usual developmental tasks

Encourage forward development where feasible in areas unrelated to the child's burn. This should include school work, with

parents for important information and may become anxious when his parents cannot respond to his questions.

Encourage the parents to interact with the child during engagements with the mental health continuity person. Parents can lend their good will and confidence to this person's work, make suggestions regarding special ways to communicate effectively with their child, and learn techniques they can pursue with their child on their own.

Parental Responses

The child's emotional response to his injury will be very strongly influenced by the emotional state of his parents. Express clearly to the parents that their own emotional well-being under such stress plays a crucial role in their child's recovery.

1. Responses to the burn

a. Help the parents gauge their visits on the basis of their own feelings as well as their child's needs. They may initially need to limit their visits if they find these visits too upsetting, especially when the child is not aware of their presence. Parents often need "permission" to stay away temporarily as they cope with their child's injury, or to desist from a "vigil" of constant presence that wears them out.

b. Encourage parents to consider obtaining support for themselves from their own family or friends. Parents may isolate themselves out of guilt or shame.

2. Responses to each other

Anticipate the possible discord between parents that the stress of a burned child sometimes precipitates or exacerbates, and communicate this to them. Ask their judgment of when and if such a change is occurring and offer the assistance of the mental health staff should the parents desire this help.

Secondary Management of the Child

The Child's Activity

Development is an active process. Children learn and grow by doing, especially physical activities. During bum treatment bodily motion is often severely restricted. A major challenge in the treatment of children with burns is the restoration to the child of a sense of activity and thereby of developmental progress. In adolescence, where activity and independence assume a central emotional importance, maintaining this sense of activity is especially vital. 124

individualized instruction, and an activity program involving hobbies, arts and crafts, etc. The "premorbid status quo" for children is one in motion. Children require—and accept—further developing as part of normal life activity.

Emotional Milieu

1. Primary care nurse

Assign a primary care nurse on at least one shift who will continue to care for the child throughout his hospitalization. Children require continuous close contact with a particular individual to establish a nonverbal reciprocal relationship similar to that with the mother.

2. Mental health continuity person

Maintain a regular schedule of visits with this person. Older children will be able to hold their feelings for these visits once it is clear that they can depend on them with regularity.

3. Identity

Encourage frequent visits by volunteers for reading or talking, stressing use of the child's own name repeatedly. For a child, much more than for an adult, identity while in a strange place is maintained by regular specifically personal activities and by being referred to as a specific, unique person, i.e., by name.

4. Intimate experiences

Special plans are needed for those childhood experiences that normally involve intimate connection with parents. Children need to experience warm and intimate closeness while attending to vital functions of the body. Planning to foster "regression" and dependency at these times can allow the child more independence and collaboration during other parts of his hospital regimen. Parents are a vital resource for their child's very special habits and preferences.

a. Feeding should be planned to include games, special names for utensils and foods, special treats.

b. Bathing should include specific toys, rituals, or stories familiar from home.

c. Play should be planned and encouraged. If the child is immobilized, an adult should regularly engage in some play sequences for the child.

5. Visitors

Encourage visits from peers as soon as feasible for and desired by the child. The hospital may be the ideal "laboratory" to test with the child his newly changed experiences in interacting with his peers. Visitors who are children may benefit from preparation

through play or talk to cope with their injured playmate. Plan to share the child's reactions to his reexposure to his peers soon after the initial visits.

Deformity

a. The child judges the world more concretely than the adult, and is more prone to assume that current deformity or disability will never change. Discussion of healing and rehabilitation should start early. Use every opportunity of increased function or healing to teach the child that a process is slowly evolving.

b. Make clear to the child that sooner or later he will see his burns, especially facial burns, that this may be difficult, that staff members want to share his reactions with him, and that he is to take the lead in asking for mirrors or looking at his reflection on glass panes for extensive exploration of his burns. A matter-of-fact approach will dispel the frequent escalation of staff anxieties in guessing whether the child has seen his injuries yet.

c. With the success of major grafts, the child may experience a dramatic sense of well-being, and come to expect complete recovery, without scarring. This tendency to denial should be confronted, albeit gradually and gently, to protect the child from severe disappointment in the future.

Secondary Management of the Child's Family

There are four major issues staff members may encounter during more prolonged work with the families of burned children.

Mourning

Parents may experience a period of mourning for the normal child they feel they have lost before they can accept their "new" injured child. They may temporarily appear to withdraw interest from their child. Staff members should accept this reaction and resist temptations to condemn parents' "lack of interest" or push the parents to more involvement than they can tolerate. The parents' ultimate ability to fully accept their injured child depends upon the relative success of this mourning process.

Guilt

Parents often come to develop strong feelings of guilt over their child's injury. This may make them particularly sensitive or resistant to procedures that cause their child additional pain. They may also become very vulnerable to what they experience as critical attitudes from staff members or rejecting

behavior from their child. They may especially try to hide their guilty 1,ee1ln9N from staff members, equating the staff's knowledge of their guilty jciing with the staff's judgment of them as guilty. Staff members should openly state that many parents in such a situation experience feelings of guilt which are often easier to bear when openly expressed. Open acceptance of these guilty feelings tacitly removes the parents' fear of the staff's condemnation

Young children may experience any harm that befalls them as the fault of their all-powerful parents. The child may accuse, attack, or dominate his parents as expressions of his rage at them, and this may aggravate the unrealistic aspects of the parents' feelings of guilt. Such behaviors are best managed in joint sessions with the child and his parents, after the parents are prepared to understand their child's reaction.

Crisis

In cases where a recent change in the parents' social or emotional lives involved a crisis that led to the bum injury, the parents may purposely drop their still unresolved personal crisis to focus their attention exclusively on the treatment of their burned child. The practical approach is to encourage resolution of the crisis without necessarily openly connecting the crisis to the burn. Staff members should encourage parents to proceed in tackling their own life preoccupations once their child is out of danger. For example, a couple who had been contemplating separating at the time of their child's bum should be encouraged to work toward resolution of their relationship, rather than to use their child's injury as a reason to avoid this difficult task. If a bum is allowed to produce a stalemated pseudo-resolution, the burned child and his residual disabilities may assume a special role in his parents' avoidance of further resolution.

Medical Milieu

The once foreign world of the hospital now plays a large part in the lives of the burned child's family. They may start to feel like "insiders" and should be treated as such. The parents' subjective reactions to this new experience should be elicited. They should be provided with concrete and honest explanations for schedules, regimens, and changes such as nursing or housestaff relations. Parents better accept their child's treatment when they feel included in understanding its rationale. This includes staffing shortages, financial, and other practical considerations. Realistic explanation will diminish parents' "unrealistic demands."

Emotional Scars

Once the heroic saving of life and limiting of deformity have been accomplished, a lifetime of adaptation confront the burned child and his family. Some relevant considerations follow.

Theoretical Considerations

Developmental passages

The child's initial adaptation speaks only for his ability to cope with a specific developmental period. The burned child remains vulnerable to specific difficulties related to his burn injury in later periods. Adolescence, with its increased self-reflection, sensitivity to peers, and preoccupation with the body may be especially difficult even where the child has adapted well up to that point.

2. Family role

The maladoptive responses of the burned child may come to serve special functions in the family's management of other conflicts. These functions may interfere with optimal adaptation for the child. The family may seem overly accepting of the child's behavior, or family members may complain bitterly but seem unable to make any steps towards change.

For example, a husband and wife had bickered for years over the husband's social withdrawal. After their daughter's burn, the girl became very self-conscious and shy. Father now stayed home "for her" a great deal, and both he and his wife excused his continuing social withdrawal as an altruistic sacrifice for his daughter. Thus the daughter's "response to her injury" led to a temporary solution of another conflict. The parents may seem too complacent with their daughter's withdrawal. This may be a sign of their reluctance to reactivate the old conflict between themselves.

3. Family interactions

Especially on return home, the child is faced with the loss of the illusion of his parents as all-protecting, and with the fears about his parents' acceptance of him. Children may react with a pseudo-maturity of being "suddenly grown up," a testing of parents through aggression and exaggerated dependency, or alternations between these two reactions.

4. Depression

The burned child may become chronically depressed. He may passively comply with treatments but engage only superficially in physical therapy. Many of the signs of depression may be blamed on the physical consequences of the burn: apathy as "weakness," insomnia as "pain at night," academic failure as "impaired vision, trouble writing," making recognition more difficult.

Practical Considerations

1. Anticipation

Every contact with the child and his family affords an opportunity to reemphasize that sooner or later many burned children128

can benefit from specialized mental health care. Successful adaptations should be noted and praised as adequate "for now." 2. Motivation

The parents, and, with increasing maturity, the child, should be asked to make their own assessment of their lives from time to time. They should be asked to judge how the burn injury has affected them and in what ways they might want to change their coping styles. This is the final application of the path of encouraging activity in burn patients and their families. Referral

for specialized mental health assistance becomes in this way an ongoing matter for the collaborative judgment of the burned child and his family and their medical caretakers.

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Manual of Burn Care

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