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Emotional Care of the Burned Patient

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To be burned severely is to suffer one of the most devastating and dehumanizing injuries a human can experience. Psychologically, the tasks that the burn patient has to negotiate are similar to those of every human growth process: from passivity to activity, from narcissistic withdrawal to interest in the external world, from helplessness to mastery. All stages and problems may not be seen in every patient. They do not occur in the same order for each patient, and they may recur. The problems vary depending upon the age and personality of the patient prior to the burn, the support provided by the family and the medical team, and the social and economic status of the patient and his family.

The purpose of these chapters is to address the psychological aspects involved in the care of the severely burned child and adult as well as their families. Consideration will also be given to the concept of the burn unit as an ongoing system. The material presented herein is to be used as a guide. It must be recognized that subjective processes are always present that follow the basic tenets governing the ongoing human needs of the patient, such as compassion, empathy, trust, and hope.

BIOPSYCHOSOCIAL INFORMATION

I. Acquisition of information upon which to base differential diagnostic and therapeutic procedures:

A. Obtaining and synthesizing the biopsychosocial data of a patient with a major burn is ideally begun within the first 48 hr after admission. This provides a valuable framework to help plan psychological support in an expedient and helpful manner.

B. Information is obtained by interviewing the patient, family, and any significant person within the social network and/or community.

II. Initial information to explore:

A. The burn incident: (1) where, (2) when, (3) how, (4) who was present, (5) agent involved, (6) others injured or killed?

B. When self-inflicted or inflicted by another person, ascertain the precipitating event.

C. When obtaining the information, it is important to note: (1) the degree of difficulty remembering, (2) obvious gaps in information and content, (3) affect (i.e., angry, frightened, resigned, sad) that is connected to general presentation of content, as well as to various parts of content.

III. Biopsychosocial areas to explore with emphasis on life change events during the previous year:

A. Medical: The physician has usually obtained a complete, detailed medical history. It is important for the mental health professional to be aware of: (1) acute and chronic physical conditions of the patient; (2) past hospitalizations of the patient. The emphasis should be on the exploration of the patient's family's attitude and experience in coping with past illnesses and hospitalizations.

B. Environmental: Pertinent information includes: (1) housing, (2) financial: source of support (i.e., public assistance, employment, family), approximate income/month, (3) type of employment (union), (4) education, (5) hospital insurance.

1. Explore significant change or loss in socioeconomic status.

2. When indicated, or requested, explore, advise and refer for appropriate financial and medical social services (i.e., medicaid disability, union benefits).

C. Social: This includes primary relationships (spouse, children, parents), friends (more significant in relation to adolescents), neighbors, and extended family.

1. In acquiring the above information it is helpful to obtain specific dates and time sequences of significant normative developmental landmarks as well as crises (i.e., length of marriage, birth of children, siblings, change, promotion, loss of jobs, graduation, retirement, separation, divorce, illness or death of significant others). Within this context, explore the possibility of the "anniversary phenomenon."

2. Exploration of the qualitative, subjective nature of significant relationships should be considered to have equal importance with the factual aspects of the situation (i.e., marital relationship, sexual relationship, parental role, parent—child relationship, job satisfaction, etc).

D. Cultural/community sectors: Variables within the patient's subculture are valuable information for anticipating patient/family reactions. These include: (1) informal code of justice (attitude toward retaliations), (2) range of crisis as a level of functioning, (3) role of religion, (4) sexual roles. Values, attitudes and informal "codes" of behavior within the patient's culture/community function as his "norms."

E. Psychological: Emphasis is on recent data. However, tentative differential diagnosis of premorbid personality diagnosis is formulated to guide treatment approaches. The following should be considered:

1. Alcohol and drug abuse
2. Organic mental syndrome or senility
3. History of or symptoms of affective disorder
4. History of or symptoms of acute psychotic behavior
5. Suicidal attempts or severe depression

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6. Impulsive behavior
7. Poor judgment with or without mental retardation
8. Life crisis
9. Past psychiatric hospitalization
10. School- or family-reported behavioral problems
11. Conduct disorders
12. Diagnosis of attention deficit disorder (hyperkinetic syndrome) IV. Utilization of biopsychosocial information:

A. Base for initial contact with patient and family.

B. Participation and teaching of other members of the burn team to foster a more comprehensive understanding of the patient and family.

C. Identification of physical, psychological, and social resources for recovery and rehabilitation should be utilized to predict and hence initiate appropriate intervention.

D. Epidemiological data are needed for research on prevention, education and medical/social/policy planning.

EMOTIONAL CARE OF THE BURNED ADULT

This section will more directly address the continuous emotional care of the adult patient with a major burn. It is suggested as basic underlying tenets that: (1) The patient should be able to identify the primary physician responsible for his medical/burn management throughout his hospital stay. This serves to enhance the patient's sense of confidence and faith that he is

receiving optimum medical care. It is particularly important in a teaching hospital, where numerous physicians are involved in direct and indirect medical care. (2) One "no-needle" mental health professional should be designated to work with the patient's emotional needs. This should be someone on whom the patient does not depend for direct medical care, and therefore to whom it is easier for the patient to express a range of feelings, including opposition and anger. (3) Mental-health-focused contact with patient should be constructed to be frequent and for short periods of time. This can be renegotiated as indicated. -

I. Physiological crisis stage.

A. External factors and internal psychological processes:

1. Patient is experiencing total dependency on the medical staff, and in many incidences artificial life support equipment for survival. Hence, the issue of dependency is very heightened at this stage.

a. Respect and accept defense mechanisms, such as denial and projections, which serve to protect the patient from the full impact of the injury.

b. Based on verbal as well as nonverbal clues, attempt to verbalize and respond to the patient's present subjective feelings

(e.g., all the machines, i.v.'s etc. are frightening; bodily exposure may be demeaning).

2. In response to isolation procedures, bodily exposure, and aseptic restrictions, the patient could be experiencing a range of feelings of isolation, violation of body, loss of differentiation of self, and weakening ego boundaries. Helpful steps:

a. Introduce yourself: state name, role in relation to the patient's care, and indicate availability of help.

b. When indicated, utilize verbal as well as nonverbal means (e.g., tone of voice, eye contact) to obtain and maintain emotional contact with the patient at the level that he can sustain.

c. When medically feasible provide for some privacy when speaking to the patient. For example, draw the curtains around the bed.

B. Delirium:

1. The main emotional complication during this stage is characterized by a global but reversible impairment of thinking, memory, and perception.

2. Delirious patients are helped most by the following orienting procedures:

a. Regular interpersonal contact

b. Reminding patient of place and time

c. Keeping complex, interesting objects in the patient's visual field

d. Keeping some light on

3. Inform the patient that he is indeed temporarily delirious but reassure him that he will recover and is not "losing his mind." Patients are aware of their own change in mental function and often fear going mad.

4. Medication: Treat agitation associated with delirium with anti- psychotic medication in low doses: e.g., fluphenazine HCl 1-2 mg, p.o. or i.m. q 4 hr pm. Increase dose slowly to 5 mg/dose if needed. Decrease and discontinue medication as delirium improves. Low doses at regular standing intervals are preferable to pm dosage schedules.

Medication will not treat the delirium itself, but will diminish the associated agitation. At times, this medication can worsen the delirium and must be discontinued. Observe for Parkinsonian and anticholinergic side effects which can occur even at low doses and can increase patient's sense of distress (e.g., akathisia, akinesia).

II. Recuperation and recovery stages:

This period is marked by many surgical procedures, painful dressing changes, and active physical and occupational therapy. The patient's

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mechanisms of coping and the extent to which the burn patient's psychological strengths and deficits will enhance or impede compliance with medical treatment and rehabilitation become more apparent. Hence, this stage is also marked by continual assessment, evaluation, and alteration of treatment approaches to help the patient toward his highest potential level of rehabilitation.

The following is offered as a general guideline to help the patient to integrate psychologically the trauma of the burn incident, as well as the trauma endured during the hospitalization:

A. To facilitate compartmentalization and desensitization, encourage verbalization of events and feelings associated with the burn incident.

B. The patient's coping with the pain involved in the usual course of burn care, even the usage of pain medications, should never be underestimated. The mental health professional's role is to help the patient to obtain a sense of cognitive and psychological understanding, control, and mastery of his treatment by:

1. Discussing before any operation, grafting, or any procedure, the patient's expectation, understanding and feelings about the procedure.

2. Addressing the patient's questions and concerns with knowledge, simplicity, repetition, and directness.

3. Liaison with the physician as to the patient's concerns.

4. Teaching the patient self-hypnosis and relaxation techniques where feasible.

C. Support and encourage the patient's considerations of such qualitative issues such as:

1. How much longer will I have to suffer?

2. How have I changed?

3. What happened?

4. What role did I play?

5. Damage done to body part(s)?

6. How will my sexuality be affected?

7. What will I look like?

8. How will I live from now on?

9. Will spouse, children, family accept me (am I lovable)?

10. Death/extent of injury to any other person burned in incident?

D. Management of temporary regressive behavior:

1. Commonly occurs shortly after the patient's first effort (success) at being active on his own behalf.

2. Symptomatically, patient appears demanding, uncooperative, provocative, hostile, passive in self-care, and controlling.

3. Staff should accept regression as part of the recovery, as a growth process toward independence and remastery of the external world. It is important for the patient not to feel abandoned by staff and family at this time.

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4. Thrust toward independence in activities of daily living. The extent to which it is helpful for the staff/family to "encourage" the patient at this time depends on the assessment of the patient and the particular medical/rehabilitation situation.

5. Negotiate with the patient so that he can have control over any possible variables involved in burn care. For example, within reason, time of burn care, and when pain medication is to be administered.

6. Facilitate the family and staff in tolerating feelings of frustration incurred by the patient's regressive behavior.

E. Management of depression:

1. Commonly occurs as the patient is beginning to experience the impact and value of his many losses.

2. Regard depression as a normal healing process. Absence of any depressive reaction is reason for concern.

3. Help patient ventilate and express range of feelings around depression.

4. When a diagnosis of endogenous depression or affective disorder is diagnosed by a psychiatrist, appropriate medication is indicated.

F. Transition toward rehabilitation:

1. Actively involve the patient in anticipating and participating in planning for long-range rehabilitation.

2. It is important to work with the patient as part of the family in mobilizing the patient's strengths, family supports and community resources for optimum recovery.

3. Initiate referrals and follow-up for extensive use of appropriate physical/psychological and vocational resources.

III. Medication:

A. Sleep medication: Burned patients commonly suffer from insomnia, which is detrimental to their well being. Prescribe appropriate and adequate medication for all patients. Prescribe as pm at first with a specific endpoint; e.g., if not asleep by 11:00 p.m., begin with flurazepam 30 mg p. o. h. s. pm, may repeat once. If patient regularly requires second dose, prescribe standing order of flurazepam, 60 mg p.o. h.s. Use half the dose in elderly patients.

B. Antianxiety medication:

1. Prescribe appropriate and adequate doses of antianxiety medication to patients for the following indications:

a. Patient complains of significant anxiety during hospitalization. Reassure the patient that under such enormous stress, anxiety is a common symptom.

b. Nurses' report of significant anxiety. Some patients will hesitate to ask for antianxiety medication that can be of great benefit to them.

2. Discuss medication with the patient. Plan with him exact points¹¹² EMOTIONAL CARE OF THE BURNED PATIENT

for therapeutic goals. ("You tell us when you feel comfortable enough without being sleepy") and reassess the dosage regularly. It is not possible to predict the dose required for relief for a given patient.

3. Describe either chlorthalidone HCl initially 10 to 25 mg. p.o. or i.v. b.i.d. or t.i.d. or diazepam 2-5 mg. p.o. or i.v. (slow infusion) b.i.d. or t.i.d. Final necessary dose may be up to 200 mg/day of chlorthalidone HCl or 40 mg/day of diazepam. Do not administer intramuscularly; the absorption is unreliable and slower than p.o.

4. Plan to discontinue antianxiety drugs gradually as patient improves or discharge approaches and inform patient of probable temporary nature of this treatment. These medications should be considered as symptomatic treatment under conditions of enormous stress.

IV. Role of involved family members in helping the burn patient's adjustment:

Family members function in two capacities. First, they serve as auxiliaries to the burned patient. They provide the staff with much of the biopsychosocial background information. They know the patient best and can help staff to anticipate behavior and management issues such as need for visitors, effect of isolation, pain threshold, and dietary preferences. Family members often are best able to act as liaisons to the burn patient's social system. By attending to immediate concrete needs such as health insurance, housing, employment, and public assistance, they can relieve anxieties of the patient in the initial few days when he is alert. They should participate actively in expediting all stages of physical, psychological, and rehabilitative treatment. Family members gain a sense of competence and control while performing these valuable services.

Second, the burn patient's family members become, themselves, the focus of treatment. The burn injury is viewed as a trauma that has happened to the family as well as to the burned patient. Family members should be notified immediately and interviewed within 24 hours of the burned patient's admission. During this period of initial crisis, the family may feel vulnerable and may make itself especially open to professional assistance. Once rapport is established, family members are told clearly that their own reactive difficulties in adjusting to this crisis are crucial to the care of the burned patient. During the succeeding days, an assessment of the family system is made. This includes ascertaining specific members' roles, such as who is supportive, who sets limits, who can distract, and who can encourage to ventilate. Anticipatory guidance can be of great value in educating family members regarding the expected stages of the patient's course, such as regression and delirium. Careful timing is necessary in order to prepare family members adequately without overwhelming them with future problems. Throughout the patient's

treatment, family members are facilitated in expressing and working through the impact of this trauma on their lives. They can be encouraged to do this by the general formula that the better care they take of themselves, the more able they will feel to respond to the patient's needs.

A. Initial reactions: The family's first reaction on arriving at the hospital can vary from relief that the patient has not died or has been burned more severely, to wishing that the patient and they did not suffer. Guilt is a primary reaction, especially in pediatrics.

1. It is important to respect hope and needed defenses while simultaneously allowing the opportunity for any expression of grief. Usually the burn physician has discussed prognosis and extent of burn with the family.
2. Feelings of trust or mistrust toward the medical staff and hospital in general are formed.
 - a. Inquire about their previous experiences within this or other hospitals.
 - b. Relatives are concerned that by expressing angry feelings toward the staff they might jeopardize the patient's relationship with the staff.
3. Differentiate between the family complaints that are projections or displacements of their own helplessness and anger, and those that are indications of breakdown within the system.
4. Encourage communication between staff and family members. Intervene when necessary.
5. Educate, explain, and reassure about patient's change of mental status (for example, patient's confusion and disorientation that often accompanies burn trauma).
6. The magnitude of the emotional needs of the patient can deplete the emotional resources of the family members who therefore require support and acknowledgement of the value and stress of their role.
7. Provide privacy and a "space" in which they can be vulnerable (cry, be pessimistic, etc.).

B. Reactions after initial crisis

1. The family of the patient prepares itself psychologically for an extended stay in the hospital.
 - a. Assess, discuss, and facilitate with the family a system whereby their own responsibilities (job, child care) can be maintained at an equilibrium while patient's needs are being met. Include role of extended family and friends.
2. The impact on the family of the pain the patient suffers is a primary focus at this time. The family's difficulties with this matter is intensified by the patient's directing his anger, depression, and frustration toward them. 114

a. Help the family members tolerate their feelings of helpless frustration. Because main caretakers are the medical staff, the family is left with a supportive role. This enhances the family's feelings of helplessness.

b. Educate and help the family understand the principles followed in the use of pain medication. The issue of analgesics (timetables and usage) can be regarded as an issue of control as well as of different pain thresholds. This appears to be a consistent issue with patients with a history of drug abuse or alcoholism.

C. Reactions during recovery: Issues related to deformity, guilt, and transitional tasks (including separation from hospital milieu, staff, and other patients and families, reestablishment of familial equilibrium, and discharge planning) need to be addressed simultaneously during this stage of recovery.

1. Deformity

a. Usually there is a significant disappointment in the "immediate" results of grafting. Help the family members to ventilate subjectively, explore, and work through their feelings about how the patient looks and the impact it has on their feelings toward him. Offer the opportunity to discuss their questions and concerns about sexuality and sexual functioning.

b. With the burn physician, attempt to explain objectively the projected plans, alternatives and expectations that cosmetic plastic surgery can achieve in altering the particular scarring and/or deformity.

c. Be sensitive to the particular subjective meaning and role of appearance within the person's identity and self-esteem, as well as the role within primary social relationships. Do not assume that appearance is not a primary concern in an elderly person. In adolescents in particular the issue of deformity and/or scarring is highly emotionally charged, as it involves a maturational as well as situational crisis.

d. Help family members to anticipate how they will respond to the patient's questions and concerns about their appearance.

2. Guilt around what the family members feel, what they did as well as what they did not do in preventing or reacting to the burn incident.

a. Continued encouragement to help family members recognize, identify, and compartmentalize the particular issues around these feelings.

b. Facilitate the family members in sharing these feelings with the burn victim where appropriate.

3. Transitional tasks:

- a. Encourage family members to summarize their experience at the hospital and begin to separate themselves emotionally from relationships that have evolved.
- b. Help the family incorporate the postburn patient back into the family system.
- c. Actively involve the patient and family in discharge planning. Examples:

Rehabilitation facility: Encourage patient and family members to visit and work out issues of geography, insurance, etc.

Nursing home: Explore feelings, values, and attitudes attached to this decision, as well as practical considerations.

Home: Encourage sharing of anticipated impact on family, friends and community. Plan adequate home care and follow-up care for medical and psychological needs. Availability of mental health professionals should be made explicit until aftercare physical, psychological, and vocational plans have been expedited.

D. Mourning

In the severely burned patient, the process of either grieving for the death of the patient, the loss of body parts, or for the loss of a known life-style has to be dealt with. This becomes paramount, for unlike any other catastrophic illness the "normal" course of recovery of burns involves numerous life-threatening crises over an extended period of time.

1. When the family is unaware that the patient has expired, provide a private room where the physician can inform the family and where the family can react accordingly. Depending on the medical/legal circumstances surrounding the expiration of the patient, the physician will either inform or request permission for an autopsy.
 - a. Because of the infinite variations in reactions, it is important to "be there" and to be responsive to their emotional and practical needs to facilitate the family member's ability to grieve.
 - b. Give your name and telephone number in writing and convey your availability for follow-up.
2. When a patient is gravely ill over an extended period of time, encourage anticipatory mourning. On the basis of Kubler-Ross' Death and Dying, family members experience many similar stages.
3. When related to body loss, deformity, scarring and preburn status, encourage the patient and family to talk about how the person was before being burned.

- a. Family members bringing in a picture of the patient prior to the burn can be a significant catalyst in discussing the impact of body image on the patient and on the given relationship.
- b. Discuss with the patient and family the objective and subjective impact of the temporary or permanent loss of the patient's ability to function.

RESOURCES

Being aware and utilizing the full range of community resources is crucial in facilitating optimal rehabilitation. It is suggested that the worker maintain an ongoing "telephone relationship" with at least one contact person in the various resources, to keep abreast of services provided, standards of eligibility, and the informal and formal networks of obtaining these services. The following is a partial list of resources that may be helpful for the particular patient's needs:

1. Social work department of the hospital.
2. Auxiliary, volunteer department of the hospital.
3. The church/synagogue of which the patient is a member.
4. The employment union, and any fraternal organization that the patient is a member of.
5. General social service or its equivalent in any given community.
6. Visiting nurse service or its equivalent in any given community.
7. American Red Cross.
8. Long-term home health care program.
9. Social security office.
10. Public assistance office or its equivalent in any given community.
11. Medicaid and Medicare application office.
12. Family counseling agencies.
13. Outpatient psychiatric clinics.
14. Speciality rehabilitation centers.
15. Nursing homes and chronic care hospitals.
16. Bureau of Child Welfare or its equivalent in any given community.
17. Veteran's Administration and Veteran's hospitals.

FROM Manual of Burn Care

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