

Psychosocial Care of Persons with Burn Injuries

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Introduction: Why Psychosocial Care Is Important

Treatment of people with burn injuries includes recovery of optimal function for survivors to fully participate in society, psychologically and physically. Increased likelihood of physical survival has led to greater concern for potential psychological morbidity for the burn survivor. Surgical and medical technology has improved to such an extent that now, in most cases, burn care providers must assume that the patient will live. They must be aware, even in the first moments of treatment, of what will be important to the surviving patient.

Burn survivors experience a series of traumatic assaults to the body and mind which present extraordinary challenges to psychological resilience. Contrary to what might be expected, empirical data regarding the long-term sequelae of burn injury indicate that many burn survivors do achieve a satisfying quality of life and that most are judged to be well-adjusted individuals. However, thirty percent of any given sample of adult burn survivors consistently demonstrate moderate to severe psychological and/or social difficulties.^{1,2} Similarly, most pediatric burn survivors, even those with the most extensive and disfiguring injuries, adjust well.³⁻⁵ Empirical studies, as well as clinical observations and patient self-reports, suggest that burn care of the whole person, including early and continued attention to psychosocial aspects of the patient's life, can facilitate positive psychological adaptation to the challenges of traumatic injury, painful treatment, and permanent disfigurement.

Who Provides Psychosocial Care

Ideally, clinicians who specialize in human behavior (psychiatrists, psychologists, social workers, psychiatric nurses or others with similar expertise) can be involved in treatment programs for all burned patients throughout the recovery process, beginning as soon as possible and continuing throughout rehabilitation.⁶ However, there are many locations in the world where fully trained mental health experts are not readily available. Where we talk about the "psychotherapist" we refer to a person who guides and accompanies the other (in this case, the burn survivor) through a journey. Such a person must be gifted with empathy and must like people; other skills can be learned, regardless of educational background. However, it is most helpful if ongoing consultation and supervision can be arranged to be provided by a well-trained expert.

It must be remembered that every person who interacts with a patient impacts the psychosocial world of the patient. Any caregiver, including the patient's family, may be the instrument of psychotherapeutic intervention. An important role of the psychotherapist is to consult with caregivers about psychological and social issues and to suggest therapeutic interventions that any or all can act upon. Furthermore, psychotherapists on a burn team provide direct treatment to patients as appropriate to changing concerns. As needs of the patient evolve, the intensity of direct psychotherapeutic intervention varies accordingly.

Cultural Sensitivity

Burn patients come from diverse cultures, and care providers must be sensitive to how cultural issues can affect patients and families in all the phases of the recovery process. "Culture" refers to the socially transmitted expectations, beliefs, traditions, and behavioral patterns typical of a given community at a point in time. It is influenced by many factors such as geographical location, ethnicity, and socioeconomic background. Care providers must also be aware of their own biases, values and assumptions that stem from their cultures. Individuals' concepts of time and space, appropriate hospitality, importance of greetings, how non-verbal gestures are interpreted, and ways of expressing gratitude may differ greatly among cultures.

Acculturation is the process in which individuals from one culture embrace patterns, customs, beliefs, values, and the language of the dominant culture. Patients and their families on first arriving at a burn care facility must rapidly adapt to the culture of the hospital environment. Even if the hospital is within their own community, they experience some level of culture shock and acculturation. This process is even more complicated for those who are transported for care to communities far removed from their homes and perhaps in another country.

Coping with a multitude of unfamiliar experiences in a situation that is traumatic under the best of circumstances presents extraordinary stress that can inhibit a patient's or family's ability to participate in the recovery process. Such difficulties correctly recognized can be addressed by the burn team so that cultural differences are not impediments to recovery. Cultural traditions can be incorporated into treatment plans to enhance participation toward recovery. It is not necessary for providers to know the beliefs and expectations of every culture, but what is necessary are sensitivity and willingness to learn about cultural differences. Staff can acknowledge their lack of familiarity and pose a question to the patient/family of whether there is anything the team can do to help meet their cultural, spiritual and religious needs. The question conveys respect for cultural differences and a desire to help through the acculturation process.

Assisting With Death

Treatment plans and programs must be based on an assumption of life beyond the hospital; however death also occurs on the burn unit, and psychosocial treatment planning includes plans for assisting patients in living to the cessation of life. As part of such a plan, the patient's family must be aided in preparing for and enduring bereavement. In this event, supporting and enhancing whatever coping strengths the family manifests is the primary task for psychotherapy. Most families initially deny the possibility of death, appearing not to hear an unwanted prognosis. Staff can allow the family to maintain hope while subtly preparing them with honest statements which pose death as an outcome which is possible to accept. Comforting the bereft and helping them to care for themselves, physically and spiritually, are essential elements of a plan that facilitates the family's ability to participate in the process. Keeping the family informed about changes in the patient's condition and actively supporting,

sometimes instructing, them in continuing their relationships with the dying patient help the patient and family through this difficult event. At the time of death, the staff can psychologically support the family by assisting them through the necessary paperwork (e.g. signing consents for release of the body or for autopsy) and in allowing them quiet, private time with the deceased loved one before the body is removed. A death occurring in the context of family acceptance is more easily accepted by staff. Nevertheless, death of a patient is always sad and may elicit a wide range of strong emotions among the members of the burn team. Structuring a time for de-briefing and validating the feelings of staff members who want to talk about their experience can be helpful in maintaining the morale of the team as a whole.

Assessment And Intervention

Our general approach to assessment and care of burn survivors is a behavioral approach based on learning principles (e.g. operant conditioning, cognitive restructuring, and social learning theories) where maladjusted behavior itself (rather than intrapsychic phenomena, for example) is the target of intervention. Assessment and treatment are integrally related and both occur simultaneously throughout the recovery and rehabilitation process.

Phases of Recovery

Psychological healing occurs across time commensurate with physical healing in a pattern which is relatively predictable and consistent.⁷ Awareness of this pattern allows caregivers to anticipate the emergence of psychosocial issues and to prepare a patient for coping with those issues. Predicting problematic issues for patients enables them to view their concerns in a context of normal reactions rather than as symptoms of psychological impairment. For convenience in describing this pattern, we have arbitrarily designated four phases of recovery: admission, critical care, in-hospital recuperation, and, finally, reintegration and rehabilitation. Table 1 outlines typical symptoms of patients at each phase and recommended treatments.

Table 1. Phases of Recovery with expected psychosocial symptoms and suggested treatments

Phase	Expected Symptoms	Recommended Treatments
Admission	<ul style="list-style-type: none"> • Anxiety, Terror • Pain • Sadness, grief 	<ul style="list-style-type: none"> • Antianxiety Medication • Analgesic Medication • Psychological Support <ul style="list-style-type: none"> Reassurance Normalization Relaxation Techniques
Critical Care Phase	<ul style="list-style-type: none"> • as at admission plus.. • Acute stress disorder 	<ul style="list-style-type: none"> • Antianxiety Medication • Analgesics • Medication targeting acute stress disorder symptoms • Continued Psychological Support
In-Hospital Recuperation	<ul style="list-style-type: none"> • Increased pain with exercise 	<ul style="list-style-type: none"> • Targeted administration of

	<ul style="list-style-type: none"> • anger, rage • grief • depressive episodes, rapid emotional shifting 	<ul style="list-style-type: none"> analgesics • Psychotherapy (Cognitive-Behavioral and Family Therapy) • Pharmacological treatment of anxiety and depression
Rehabilitation and Reintegration (may be several years)	<ul style="list-style-type: none"> • Adjustment difficulties • Post-traumatic stress disorder • Anxiety (including phobic response) • Depression 	<ul style="list-style-type: none"> • Re-entry program • Medication targeting Post-traumatic stress disorder • Psychotherapy (Cognitive-Behavioral and Family Therapy, social skills) • Anxiolytics tapered off over time • Anti-depressant medication

Admission Phase: On admission, the primary psychological tasks are to establish therapeutic rapport, diminish anxiety, and assess the psychosocial strengths and needs of the patient. The first two tasks are addressed immediately by orienting a patient, by assisting the patient to focus on immediate priorities, and by assuring the patient that the burn team is composed of knowledgeable experts who will provide excellent care. The patient's anxiety can be expected to interfere with comprehension, so it is usually wise to repeat statements of reassurance. Techniques of relaxation with focused imagery can be very helpful in quickly assisting a patient to feel more comfortable. Rapport is developed as the patient associates the voice of the therapist with increased comfort.

Pre-injury physical and psychological health, coping skills, and family/social support are closely related to the behavior, distress and recovery of a patient. Thus assessment of these factors must be begun as soon as possible following admission. Prior stressful events and coping strategies, risk factors, as well as psychosocial and economic strengths are included in a good history of a patient's premorbid lifestyle. A patient's history and position in the family as well as the family's strengths and weaknesses are often helpful pieces of information in guiding plans for treatment. Historical risk factors which may predispose individuals to burn injury and which foretell poor prognoses are physical illness, substance abuse, psychiatric illness, behavioral problems, poverty, inadequate social support, and heightened family disruption.

The psychotherapeutic tasks to be accomplished immediately with a family are similar to those for a patient (i.e. to establish a therapeutic relationship and to diminish anxiety). Both tasks can often be initiated by assisting them in orienting to the hospital and by providing relevant information about the normal responses to trauma. Explaining, for example, that people in this situation often have difficulty for a few days in eating, sleeping, and concentrating, communicates empathy and validates that their distress is acceptable and temporary. Family members are important components of the therapeutic efforts for the patient, and it is important to say this explicitly to the family. This helps to return to them a sense of purpose and control.

Critical Care Phase

From hospital admission until the majority of open wounds are covered, the emphasis in treatment of a burned patient is necessarily on intensive medical and surgical care to resolve physiologic crises. This period is psychologically critical as well. A patient experiences great anxiety during much of this time. Fear of death blends into fear of pain and fear of treatment procedures. A multitude of organic factors stemming from both the injury and its treatment, as well as premonitory conditions, can all contribute to psychological symptoms of disorientation, confusion, sleep disturbance, transient psychosis and delirium which are commonly observed among adolescent and adult patients.^{7,8} Pharmacological interventions to manage pain and anxiety should be instituted and, along with psychological interventions can diminish anxiety and confusion. Repeated statements of orientation to time, place, and person are mandatory. Objects that are familiar and comforting can be placed in the patient's view or so that the patient can touch them. The patient's environment should be as soothing as possible. A schedule which approximates a regular wake/sleep cycle helps a patient begin to feel normal. Visits from family and friends can provide familiarity and reassurance to a patient.

Staff interacting with patients during this phase must be willing to listen to patients' anxieties and reassure them that the nightmares and vivid memories are normal aspects of recovery. Staff can help patients focus on the present time in which they are safe in the hospital and are healing. When a patient is withdrawn or in a coma, staff must remember that the patient may be hearing, although not responding, and must take care to talk to the patient. They must also be discreet in what is said within a patient's hearing range. Patients are often listening to determine what will happen to them; and, in their altered mental states, they may attribute unexpected meanings to what they hear.

During the critical-care phase, family members usually become at ease with the routines of the hospital. They may, however, continue to experience some symptoms of acute traumatic stress, such as intrusive thoughts, difficulties with sleep, or avoidance behaviors. It is helpful to provide families with information about what they may expect to observe with their burned relative in the immediate future and to guide family members as they respond to the patient. Families need instruction about how they can be helpful. The staff can find ways to allow family members to nurture their relative and provide instructions so that the family can begin to become comfortable in caring for the patient's needs. Staff members of critical-care units are very busy and may, at moments, want to send the family away so that tasks can be completed more efficiently. However, these instructions encourage the family to join with the burn team in the healing and rehabilitation of the patient and are of critical importance to the future of the patient who needs the expressions of care by loved ones. Psychotherapeutic work with the family must also identify and plan for management of those family issues that may impede a patient's recovery and rehabilitation. Management plans must support, to the extent possible, the physical and emotional well-being of all the members of the family during a period of time in which the burned patient's needs place unusual and urgent demands on the family system.

Psychological factors play a significant role in pain and anxiety management. Scheduling of pain and anxiety assessments and the choice of assessment tools have psychological relevance. Regular, routine assessments of discomfort imply to a patient and a patient's family that the medical staff consider discomfort a valid issue that will be treated. This not only validates a patient's concerns, but sets an expectancy of relief when pain or anxiety is a problem. The use of standardized scales provides the message that to experience a range of pain and comfort responses is normal and allows the patient to participate to some degree in mastering discomfort. When staff assess comfort as routinely as vital signs and indicate that they believe the patients, patients are less likely to feel that they must complain loudly in order to convince the staff that their need for pain relief is legitimate. They also are less likely to feel hopeless and helpless and become depressed.

In-Hospital Recuperation Phase

In this phase, patients are just beginning to comprehend the extent of their injury and to realize that their bodies are changed forever. Their anxieties now are increasingly about the future and less about the past and present. Patients are confronted with new physical limitations imposed by their injuries; they experience their bodies now as incompetent and disfigured. Patients involved in this struggle shift rapidly in affective behaviors reflecting rapid shifts in cognition. Much of the time, patients experience themselves as the 'preburn self' (i.e. the 'real self'). When the body will not move as it did in the past or when the scarred skin is viewed, a patient remembers and grieves. Patients become aware of their changed appearance as they observe the responses of others and note these responses invalidate their former body image. Their pre-morbid identities no longer exist intact, and new identities must incorporate remnants of the old, as well as changed, physical body. They become easily fatigued yet must continue in a schedule of exercises and tasks determined primarily by the burn team, thus reinforcing their feelings of loss of autonomy and lack of control. In this highly emotional state, patients may be expected to act out anger and fear.

Emotional lability and cognitive and behavioral regression are typically observed in patients of all ages during this trying time. Perhaps the most difficult behavior for patient, family, and staff is the patient's expression of anger. Patients, of course, have many reasons to be angry, and they need to express that anger in order to define and direct it adaptively; however, there are significant limitations upon the availability of situations in which they can express anger. Patients have almost no privacy, nor can they relieve tension through physical activities such as running. Typically, family members and patient care staff, having devoted much time and energy to the patient, are prone to perceive the patient's angry behavior as a personal and unjust attack by an ungrateful patient. Certainly, the patient will direct rageful temper tantrums toward those who are the safest targets, usually a spouse or parent first and then a nurse or therapist. Angry attacks are best understood as necessary ventilation by the patient rather than sincere evaluations of family or staff.

Expressions of rage are not only upsetting to family and staff; they also frighten patients who themselves perceive this loss of control as evidence of potential destruction of self or others on whom they are dependent. Following an outburst, a patient typically feels guilty and fears withdrawal of love and support by those who were earlier subjugated to the angry behavior. These fears are added to the patient's fears of being rejected because of the changed appearance. Turning anger now toward self, the patient may feel overwhelmed, hopeless, depressed, and even suicidal. If the hospitalization continues over several weeks, patients experience repetitive frustrations, and tend to feel hopeless and depressed more often. Hopelessness is more likely to result when patients feel as if they have no control over aversive events and eventually give up trying to control what happens to them; such hopelessness over time can lead to chronic depression.

Psychotherapeutic work at this phase intensifies and is largely focused on working with the rest of the team to help patients combat feelings of hopelessness and helplessness. Important toward this end is structuring treatment sessions to promote patients' experience of control, achieving success, and feeling rewarded while progressing through difficult procedures. Positive feelings, generated by achieving the goals one has established, increase one's likelihood of repeating the effort. A psychotherapeutic challenge of this phase is to accept and validate the patient's emotional demonstrations as normal behaviors in the recovery process while also setting limits on the ways in which the emotional upheaval will be expressed. Early in this phase, as the patient begins to ask about the future, the psychotherapist can describe the predictable pattern of emotional vicissitudes indicating that, should such occur, they are normal; they can be endured and managed. The staff must demonstrate positive regard and acceptance of the patient while also helping the patient to exercise control over destructive behaviors. At times, they must impose external limits to protect the patient.

Staff can anticipate and assist a patient in asking questions about future disfigurement and functional abilities, including sexual activity. Without evading questions, psychotherapists give honest but hopeful appraisals that emphasize ability and minimize deformity and disability. For example, as a patient voices an unrealistic belief that time and/or plastic surgery will return the former appearance, one can state that burned skin will never look like unburned skin and that there will always be some scarring, but that appearance will change with time. Allowing patients to hope, even for unrealistic outcomes, protects them from despair and enables them to continue to believe that there are reasons to endure the pain of rehabilitation. Patients and families should be given the information that rehabilitation may require several years to achieve optimal satisfaction, but that the painful efforts usually obtain good results.

The therapeutic message to be delivered is that survivors can find ways of achieving whatever goals they set for themselves; the process is lengthy and difficult, and survivors will often feel over-whelmed and hopeless. Expressing sadness and anger is to be expected and accepted; however, such feelings can never be allowed to stop a patient from participating in the necessary regimen to

achieve full recovery. Being burned does not relieve a survivor of the responsibility of competence.

Introducing a recovered survivor to the recuperative burned patient can be a very helpful intervention at this point. The more experienced survivor can be heard as a trustworthy authority in a way the unburned professional cannot. Visual images of burn survivors telling their stories and presenting themselves in daily life activities on film or video can aid in accomplishing this purpose. Groups of patients and/or families of burned patients at varying stages of recovery and rehabilitation have been helpful in providing information, emotional validation, and support as well as reinforcing the concept that it is possible to survive burns and live acceptably happy lives.⁹

Reintegration Phase

Although plans for a patient's discharge to outpatient status are developed from the time of admission, very specific plans must be made in the final days of hospitalization. A major objective at this time is to facilitate a patient's reentry and reintegration into life at home. Returning home means re-engaging in social interactions with the larger community of extended family, friends, and strangers. Patients as well as family must prepare for those encounters.

Families and patients alike are often ambivalent about leaving the safe environment of the hospital. Patients, including very young children, fear social rejection or ridicule because of their changed abilities or appearance. Family members will probably feel a desire to protect their patient from rejection or ridicule. Family members may also express concerns about their ability to continue the time-consuming physical care of the patient while resuming their usual responsibilities. Patients may doubt their abilities to resume former activities. As discharge approaches, anxieties intensify, and patients can be expected to evidence some regressive behaviors that, in turn, can reinforce the family's doubts.

Psychotherapeutic activities of this phase involve preparation of patient and family for the difficulties that can be anticipated at discharge. Patients and families may deny that they will have problems. Rather than accepting their assurance that problems will not arise, the psychotherapist can characterize such events as normal and 'usual', and proceed, without condescending or judging, to offer suggestions for developing a repertoire of alternative behaviors to address those problems 'just in case' they do experience difficulties. Issues such as how to respond to people who stare or are rude, recurrence of symptoms of post-traumatic stress, sleep disturbance, irritability, or fear of resuming sexual activities should be discussed during the days prior to discharge. This preparatory verbal rehearsal enhances the probability that the patient/family will be less reluctant to ask for help if problems do occur; if problems do not occur, the staff has the opportunity to congratulate the patient/family on their strengths or skills in coping.

Toward the end of inpatient treatment, patients are expected to resume increased autonomy; caretakers are supported in withdrawing assistance to the degree possible. It is helpful at this point to develop with patients/families a daily

schedule to guide them in accomplishing necessary tasks. The burn team relinquishes performance of daily care so that the patient/family can assume care to the extent that they will be required to conduct it at home. The patient and family can benefit from the opportunity to rehearse out-patient care while still able to consult with the burn team for direction and support. Rehearsals are opportunities for all involved to experience difficulties in a safe environment and to plan corrective actions.

Important among these rehearsals are those of interpersonal interactions outside the hospital. Burn survivors have reported their most difficult experience at discharge involved observing the reactions of others. Patients benefit from the opportunity to experience such reactions before discharge from the hospital. They may leave the hospital for brief outings and return to the hospital for reassurance, encouragement, and praise.

James Partridge of *Changing Faces*, an organization dedicated to assisting persons with facial disfigurement, recommends a brief social skills training program called "3-2-1-GO!" The program can be provided in the hospital by staff who regularly interact with patients. The patient is asked to plan for uncomfortable social situations by thinking of 3 things to do when someone stares at them, 2 things to say when someone asks them what happened (to cause the scars), and 1 thing to think if someone turns away from them.

In addition to preparing a patient and family for discharge, the burn team may also prepare the 'community' to which a patient will return. The 'community' may include extended family, neighbors, church groups, social clubs, a patient's workplace or, in the case of a school-age pediatric patient, the school. Instructing those unfamiliar with burns in what to say or do to ease a survivor's reentry may facilitate reintegration.

Reintegration programs for adults and children educate the community in a developmentally sensitive fashion. They address both the intellectual and emotional aspects of burn injury, provide generic information about burn injuries and burn treatment, and emphasize a survivor's abilities as well as clarify the ways in which a survivor may need assistance. Homemade videotapes can be sent to target groups ahead of a patient, thus allowing a community the opportunity to see and hear the burn survivor, to anticipate difficulties, and to plan coping responses. Educational information presented in pamphlets or letters can be directed to those who will play key roles in facilitating a patient's transition from hospital to home community. If possible, one or more members of a burn team may visit the home community and speak to targeted groups, answering questions which people may be reluctant to ask of the patient or family.

Rehabilitation Phase, Post-discharge

Discharge from acute inpatient treatment does not signify that a patient is well. A burn survivor's wounds are covered with sensitive and fragile skin which is vulnerable to breakdown and requires special care. Dressing changes, exercises, and application of special splints and pressure garments continue. Patients must confront anew their losses and may experience a delayed grief reaction. Upon leaving the protective hospital environment, symptoms of post-

traumatic stress that had remitted in the hospital may recur. A survivor must continue the arduous process of tedious, uncomfortable physical treatments while struggling to comprehend and incorporate the multitude of changes into an image of 'self' which the survivor can accept and value.

During this time (which may continue for many months) patients need a great deal of support and encouragement. They need to feel that the difficulties involved in rehabilitation will eventually lead to greater comfort and satisfaction. They must be reminded of the strengths they have already demonstrated in surviving in order to encourage their continued belief in themselves. And they need someone to help them appreciate even small successes.

Summary

Outcomes studies not only report status of patients post-treatment, but also can provide indicators of those factors that seem necessary or important to good recovery. Outcomes studies of burn survivors have found, somewhat surprisingly, that the extent of the injury, the depth of the burn, and the area of the body burned and/or scarred or even amputations are not determining factors of good psychosocial recovery. The age at which the individual was injured also has not been shown to relate to later adjustment. Intelligence does not relate significantly to adjustment (although we mentally retarded individuals have not been included in these studies, and it seems likely that, at that level there would be some effect). The immediate emotional response of the patient and/or the patient's family also does not predict adjustment.

There are two important factors that have been found consistently to be related to psychological and social adjustment. Fortunately, these two factors can be facilitated by the work of persons skilled in psychotherapy. The enduring quality of family and social support received by the patient and the willingness on the part of the patient to take social risks appear to play critical roles in the adaptation process. The factors associated with poor prognoses for psychosocial adjustment are, in addition to social shyness of the individual, an acceptance within the family of dependence, i.e. a willingness to wait for "others" to provide what is needed, a learned helplessness. A lack of family cohesion and high conflict within the family are correlated with poor adjustment. These findings plus clinical experience have led us to develop the following guidelines for psychosocial care of burned persons.

Guidelines for Treatment

- The patient is assumed to be a **normal person** and is expected to fully recover. Full recovery involves going through a difficult process over an estimated period of about 2 years.
- Difficulties during the adaptation process are **normal experiences of persons** struggling to develop new lives, new body images, new ways of feeling good about themselves.
- **The family group, however the patient defines "family", must be included in the patient's treatment;** in fact, the family (as a unit including the individual) becomes the patient for the psychotherapist. Work

- with the family should promote **autonomy as well as cohesion**, so that each member can feel valued and supported by the others.
- **Training and practice toward self-efficacy**, particularly in the domain of social skills and social risk-taking are important elements of treatment for persons with visible physical distinctions such as burn scar disfigurement. They must learn to deal with predictable hurtful reactions from naive observers, and learn to make themselves so lovable that people will be fond of their physical differences.
 - **The psychotherapist can help the patient in defining a new self-image.** In the early months or years, the patient may be encouraged to overcompensate and enjoy a positive identification of "burn survivor". The survivor is commended for rehabilitation gains and social accomplishments. Each victory is celebrated.
 - As the patient's physical and psychological adaptation stabilizes, the psychotherapist can assist the patient in **resisting the temptation to remain satisfied** with the identity of "survivor". This role invites the survivor to strive to achieve expectations that are unrealistic, attempting to deny unhappiness or anger or pain.
 - **Finally, the task of the psychotherapist is to make explicit the expectation that each burn survivor is a human individual who can be strong and competent, optimistic and autonomous and also can have moments of sadness, despair, or rage.** The person who has been the "heroic trauma survivor" can become a competent, interesting individual who also once survived a serious injury and a terrifying experience.

A Final Thought

Many cultures have a social tradition of, on the one hand, overprotecting individuals with disfiguring conditions and, on the other hand, rejecting and ridiculing them. Both of these attitudes are more crippling to the individual than the physical condition. Human beings are remarkable in their creativity; they can devise ways of achieving their goals when they feel supported and encouraged. One young boy who recently had lost much of his hearing and had all four limbs amputated following a terrible explosion, was asked if he had any impairments. He answered "I do not know." Thinking that perhaps he did not understand the question, the psychologist said, "You know, some people would think you were impaired by not having your arms and hands." He responded, "I know, but I don't know if I am or not yet." That boy is now a grown man, living in an apartment by himself with a helper dog, driving his own truck, and attending a university. His life has been very difficult, and he is not always happy. He always wishes, at some level, that he had his old body back. And, he would be happier if he had found his dream woman. But, he has accomplished much; he is optimistic, enjoys friends, and he has hope for the future. He has always had the attitude that he does not know what his limitations are. And the data and clinical experience we have gleaned, teaches us that we also cannot define the limitations of human resilience.

REFERENCES

1. Faber A, Klasen H, Sauer E, & Vuister F. Psychological and social problems in burn patients after discharge: A follow-up study. *Scandinavian J. of Plastic and Reconstructive Surgery* 1987; 21(3): 307-309.
2. Patterson C, Everett J, Bombardier C, Questad K, Lee V, & Marvin J. Psychological effects of severe burn injuries. *Psychological Bulletin* 1993; 113(2): 362-378.
3. Blakeney P, Herndon D, Desai M, Beard S, & Wales-Sears P. Long-term psychological adjustment following burn injury. *J. of Burn Care and Rehabilitation* 1988; 9(6): 661-665.
4. Blakeney, P., Meyer, W., III, Robert, R., Desai, M., Wolf, S., and Herndon, D. Long-Term Psychosocial Adaptation of Children Who Survive Burns Involving 80% or Greater Total Body Surface Area. *J Trauma* 1998;44(4):625-32.
5. Sheridan, R. L., Hinson, M. I., Liang, M. H., Nackel, A. F., Schoenfeld, D. A., Ryan, C. M., Mulligan, J. L., and Tompkins, R. G. Long-Term Outcome of Children Surviving Massive Burns. *Jama-Journal of the American Medical Association* 1-5-2000;283(1):69-73.
6. Morris, J. and Mcfadd, A. Mental-Health Team on A Burn Unit - Multidisciplinary Approach. *Journal of Trauma-Injury Infection and Critical Care* 1978;18(9):658-64.
7. Watkins, P. N., Cook, E. L., May, S. R., and Ehleben, C. M. Psychological Stages in Adaptation Following Burn Injury: a Method for Facilitating Psychological Recovery of Burn Victims. *J Burn Care Rehabil* 1988;9(4):376-84.
8. Haynes, B. W., Jr. and Bright, R. Burn Coma: a Syndrome Associated With Severe Burn Wound Infection. *J Trauma* 1967;7(3):464-75.
9. Rivlin, E., Forshaw, A., Polowyj, G., and Woodruff, B. A Multidisciplinary Group-Approach to Counseling the Parents of Burned Children. *Burns* 1986;12(7):479-83.