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Psychological and Physical Trauma: Treating the Whole Person

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Survivors of physically disfiguring injuries require physical, psychological, social and occupational assistance to successfully regain society.

by Patricia Blakney, Ph.D. and Daniel Creson, M.D., Ph.D.

Survivors of physically disfiguring trauma, regardless of the cause, have experienced a series of assaults on the mind as well as on the body that present extraordinary barriers to recovery and resilience. For the past 17 years, one of the authors (Dr. Blakney) has worked closely with children and adults who have experienced disfigurement. These individuals, the trauma of injury inevitably results in disfigurement, sometimes scars that can be easily hidden but often more obvious disfigurement of the body is permanent and cannot be repaired.

The physical changes in the survivor's body are permanent reminders of the fear, sadness and pain they have endured. The scars are noticeable. In fact, 20 years ago, it was generally accepted in the United States that persons with massive burns could not survive; and it was generally believed that, if such a person did survive, they would be so unattractive that they would want to die. Burn survivors were considered as the monsters of literature and film. In the last two decades, scientific work has led to greatly improved resuscitation, nutrition, management of infections and surgical techniques. Now, burn centers in the United States and in many parts of the world, people with full-thickness burns of over 90 percent of their bodies can be expected to survive, especially if they are young and healthy. That accomplishment has raised many questions about the quality of life for many survivors of the worst ordinals.

This model, which we have called a “habituation” model, not only has guided the treatment of burn survivors toward improved outcomes, but is a model we use in our work in humanization and professional development in teaching staff and in developing programs to assist people who suffer complex traumatic events of diverse types in different cultures. We have used this model now in many different parts of the world, and in the aftermath of natural disasters as well as political and military violent conflict. Although the model applies to persons who have only psychological trauma, for this article we will focus on those individuals who, in addition to a terrifying psychological event, also have experienced physical injuries that leave their bodies forever changed and disfigured, such as burn scars, amputations.

The “trauma” for the survivor is complex. The injurious event is traumatic, but there is also trauma stemming from treatment that can be excruciatingly painful, likened by many to torture. The physical changes in the survivor's body are permanent reminders of the fear, sadness and pain they have endured. The reactions of others to their changed bodies present survivors with the additional trauma of feeling rejected, isolated, unattractive, and unloved.

Persons who have been physically burned, are treated by many as “normal” and expected to function normally, no matter how young or old, must recreate themselves. They must discover new ways of moving their changed bodies in order to accomplish tasks that once they completed easily. They must find new identities to fit their new body images. The despair and anger felt 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, together accounting for most of the variance in adjustment.

What Survivors Have Taught Us

Contary to what might be expected, empirical data regarding the long-term sequelae of burn injury indicate that many burn survivors achieve a quality of life that is satisfying to them, and that most are judged by external criteria to be well-adjusted individuals. Only 50 percent of any given sample of adult burn survivors consistently demonstrate mediate to severe psychological and/or social difficulties (Anderson & Norris, 1973; Malt, 1986; Faber et al., 1987; Patterson et al., 1993). Outcome studies of pediatric burn survivors of children who have been burned adjust well, although the incidence of psychopathology may be somewhat higher than for adults (Sokoloff et al., 1989; Sokoloff et al., 1989b). In each sample studied we have found a group of 20-50 percent of the population who appear to exhibit significant functional difficulties with adjustment (Blakney et al., 1988; Blakney et al., 1990; Blakney et al., 1993; Blakney et al., 1994). The focus of our research has been to discover those factors that seem necessary or important to good recovery. In each study (reference above) we have found, somewhat surprisingly, that the extent of the injury, the presence of amputations, the depth of the burn and the area of the body burned and/or scars 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 have never included mentally retarded individuals in our studies). No other factors in the survivor's history that we have studied have been found to be significant predictors of outcome. The immediate emotional response of the patient and/or the patient's family also does not predict adjustment.

There are two important factors that we have found in repeated studies to be related to psychological and social adjustment. Firstly, these factors can be facilitated by the work of persons skilled in psychotherapy. The enduring qualities of the relationship between the patient and the willingness on the part of the patient to take social risks appear to play critical roles in the adaptation process, together accounting for most of the variance in adjustment.

The factors associated with poor psychological outcome are, in addition to social shyness of the individual, an acceptance within the family of dependence, i.e., a willingness to sacrifice and to play the role of caretaker and be given a learned helplessness. A lack of family cohesion and high conflict within the family are also important. The survivors themselves also begin to have difficulties by one year post-burn, and by two years appear, as a group, to have no more difficulties than the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups on the non-clinical reference groups.

Guidelines for Treatment

These findings yield guidelines for psychosocial interventions with physically disfigured and traumatized individuals. This patient is assumed to be a normal person and is expected to fully recover, and full recovery involves going through a difficult process over an estimated period of about two years.

1. 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. Uncomfortable symptoms may be managed with medication when available. Medication use should be kept to the minimum necessary. For example, symptoms of sleep disturbance and/or flashbacks may be treated with low doses of an antidepressant so that the patient can return to work, but in no case should the patient be made to participate and be active involved in their lives. We do not treat them as if we expect them to remain as victims of symptoms which must be medicated for a long period of time. In fact, most of our patients remain on very low doses for long periods of time.

2. The family group, however, the patient defines "family," must be included in the patient's treatment; in fact, the family is a unit that traps the family. The family becomes the patient for the psychotherapist. It is not possible to include all members of a family in actual sessions, but it is always important to remember the whole family. The needs of each member should be addressed as the family system changes from post-traumatic family to another. The family's needs are as important as the needs of the others in the family. Work with the family should promote autonomy as well as cohesion, of which it is a part, to be felt valued and supported by the others.

4. Training and practice toward self-efficacy, particularly in the domain of...
practical considerations...

in most of the countries where we have worked, professionally trained psychosocial workers have not been readily available. However, in our model, where we talk about the "psychocare" we refer to a person who is trained in the role of a therapist, i.e. onc who guides and accompanies the other through a journey. Each person must be gifted with empathy and must like people; other skills can be taught, 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.

also, many countries have a social tradition of, on the one hand, reprogramming 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 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 don't know." Thinking that perhaps he did not understand the question, Dr. Blakeney said, "You know, some people would think you were impaired by not having your arms and legs." 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

also, within the context of the "heroic survivor" concept, it is usual to see that the...