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Psychological and Physical Trauma: Treating the Whole Person

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

by Patricia Blakeney, 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 challenges to personal resilience. For the past 17 years, one of the authors (Dr. Blakeney) has worked closely with children and adults who have suffered changes to their appearance. The trauma of injury inevitably results in disfigurement, sometimes scars that can be easily hidden but often more disfiguring, such as burn scars, amputations, or malformation.

The physical trauma in the survivor's body is permanent reminders of the fire, sadness and pain they have endured. The trauma is complex, the injuries are 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 endure. The reactions of others to their changed bodies persist survivors with the additional trauma of feeling rejected, isolated, unworthy and unloved. Persons who have been physically "normal" and rendered disfigured by trauma, 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 new body images. The "traumatic" 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 prosocial living, especially if the individual is young and healthy. That accomplishment has raised many questions about the quality of life of many survivors of the worst ordeals.

This model, which we have called a "humanization 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 prosocial living, especially if the individual is young and healthy. That accomplishment has raised many questions about the quality of life that survivors can expect; and consequently, research has developed around the issues of facilitating the successful adaptation of the survivors as whole persons. The cooperation and generosity of burn survivors and their families has allowed studies of their long-term psychological and social adaptation. They endured the tedious procedures of filling out standardized psychological questionnaires year after year, and they shared information with us that allowed us to discover the positive effect of different amounts of data. Analysis of these data, we have developed a "model" to help us understand what factors support the remarkable resilience of survivors.

The focus of our research has been to discover those factors that seem necessary or important to good recovery. In each study (referenced above) we have found, somewhat surprisingly, that the extent of the injury, the presence of amputations, the degree of burn and the area of the body burned and/or scarred are not determining factors of good psychosocial recovery. The age at which the individual was injured also has not been shown to relate to recovery. Intelligence does not relate significantly to adjustment (although we have never included mentally retarded individuals in our studies). The recovered and unscarred patients, however, the former with the scarred, do appear to have 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 we have found in repeated studies 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 question that survivors are faced with is how can 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 outcomes are, in addition to social risk-taking, an acceptance within the family of dependence, i.e., a willingness to help and a tolerance for being dependent on "another." A learned helplessness. A lack of family cohesion and high conflict within the family also is a risk factor. The survivors themselves also begin to have diminished problems at one year post-burn, and by two years after, a group has no more difficulties than the non-clinical reference groups on which many also indicate no significant changes. It is not that they achieve this "normal" easily, nor that they live without psychic pain. However, they learn to cope and find ways of being happy.

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Guidelines for Treatment

These findings yield guidelines for psychosocial interventions with physically disfigured and traumatized individuals. The 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.

2. 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. Otherwise, the major intervention is work, for example, symptoms of sleep disturbance and/or flashbacks may be treated with low doses of an antidepressant so that the patient will be able to function and participate and be active involved in their lives. We do not treat them as we expect them to remain victims of the survivor's distress by which symptoms which must be medicated for a long period of time. In fact, most of our patients remain on very low doses for years.

3. 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. It is not always possible to include all members of a family in actual sessions, but it is always important to remember the family. The needs of each member should be addressed as the family system changes. The adaptation process, a necessary process, includes a physically disfigured, physically injured person. The long-term well-being of the patient depends very much on the extent to which the members of the family, especially the others in the family, work with the patient's family to promote autonomy as well as cohesion, of oneself and of the family to feel valued and supported by the others. 4. Training and practice toward self-efficacy, particularly in the domain of...
social skills and social risk-taking, are important elements of competence for physically disfigured persons. They must learn to deal with predictable hurtful reactions from naïve observers, and learn to make themselves lovable so that people will be fond of their physical differences.

5. The psychotherapist can help the patient in defining a new self-image. In the early months or years, the patient is encouraged to overcompensate and enjoy the positive identification of "hero." The survivor is counseled 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 "heroic survivor." This role involves the survivor to strive to achieve expectations that are unrealistic, attempting to deny unhappiness or anger or pain. 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. Such uncomfortable human feelings must be validated. The psychotherapist can guide the patient to accept vulnerabilities and flaws without degrading from the overall positive evaluation of "self." The person who has been the "bionic traumatic survivor" can become a competent, interesting individual who also once suffered a serious injury and a terrifying experience.

Practical Considerations

In most of the countries where we have worked, professionally trained psychotherapists have not been readily available. However, in our model, where we talk about the "psychotherapist" we refer to a person who is trained in the role of a therapist, i.e. one who guides and accompanies the other through a journey. Such a 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, 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, Dr. Blakeney said, "You know, some people would think you were impaired by not having your ears and hands." He responded, "I do not know, but I don't know if I am or not.

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 held 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


Biography

Patrick Blakeney and Dan Casos are both senior members of the HMD Response International, Medical and Technical Advisory Board. For a decade they have designed, supervised and delivered training to mental health components of victim assistance programs, addressing the sequel of war.

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Dr. Chaz Holder developed Socketless Technology for prosthetics, a revolutionary approach to prosthetic care. In this article, his colleague describes this technology and its many applications.

by Ruth J. Clark, CZ Biomed

Every individual with a disability desires the three things:

1. A high quality of life
2. The freedom to pursue that life, including employment opportunities
3. Free and open access to the community in which he or she lives

Amputees, regardless of the country, society or culture in which they live, have no exception. High-quality prosthetic care is especially crucial to amputees who live in agrarian, non-technological societies where tillin the fields, grinding grain and cooking meals are all done with few or no mechanical aids.

Traditionally, artificial limbs have been constructed utilizing a socket, individually fabricated to fit the residual limb. Socketless Technology for Prosthetics challenges conventional prosthetic wisdom by bio-mechanically replicating the function of the socket without the form. This technology was conceived by the late Dr. Chaz Holder (1947-2002), himself a triple amputee, who understood all aspects of amputee care from both the academic and the wearer's point of view. Dr. Holder started developing the concept of socketless prosthetic technology in the mid 1990s. During the last one-and-a-half years of his life, he wore a socketless above-knee prosthetic, and work is continuing on the socketless below-knee and above-elbow designs.

When Socketless Technology was first created, Holder was aware of the specific needs of humanitarian prosthetic missions. The requirements of amputees around the world are the same, regardless of the political and economic conditions they live in. Key requirements to ensure successful and continued prosthetic use are:

- Comfort and light weight
- Unlimited motion
- Minimized secondary impact (heat and friction-related skin breakdown)
- Durability

Our first release, Below-Ellbow Socketless Technology, has proven to be a superb solution to these problems, par-