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Patricia Blakeney
Daniel Creson

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Psychological and Physical Trauma: Treating the Whole Person

Survivors of physically 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 human resilience. For the past 17 years, one of the authors (Dr. Blakeney) has worked closely with children and adults who have suffered injuries to their bodies. The trauma of injury inevitably results in disfigurement, sometimes scars that can be easily hidden but more often disfiguring injuries that cannot.

The physical changes in the survivor’s body are permanent reminders of the fear, sadness and pain they have endured—scars that are visible. 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 unhappy that they would want to die. Burn survivors were construed 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 80 percent of their bodies can be expected to survive and, especially if they are young and healthy. That accomplishment has raised many questions about the quality of life among many survivors of the worst ordeals.

This model, which we have called a “libilization” model, not only has guided the treatment of burn survivors toward improved outcomes, but is a model we use in our work in humanization aid projects—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, or 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 presents survivors with the additional trauma of feeling rejected, isolated, unworthy and humiliated.

Individuals who have been physically “normal” and resolutely 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. Yet, whether the survivor is a child or an adult, this process is complex and arduous.

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What Survivors Have Taught Us

Contrary 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 30 percent of any given sample of adult burn survivors consistently demonstrate sequelae to severe psychological and/or social difficulties (Andreasons & Norris, 1973; Malt, 1986; Faber et al., 1987; Patterson et al., 1993). Outcomes studies of pediatric burn survivors who have been burned adjust well, although the incidence of psychological pathology may be somewhat higher than for adults. Immunocompromised and severely burned (Scott et al., 1980; Sokol et al., 1985). In each sample studied we have found a group of 20-50 percent of those who present unique and serious challenges to counseling. For 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 depths of the 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 later adjustment. Intelligence does not relate significantly to adjustment (although we have never included mentally retarded individuals in our data) and sex differences in adjustment are absent. There does seem to be some relationship however, to the extent that the individual was injured.

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, the length of time 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.

Factors associated with poor psychosocial adjustment include: 1) attachment to the hospitalization; 2) prolonged hospitalization; 3) continued physical pain and unavailability of others to facilitate the patient’s work; 4) the patient defined as “troubled” by others, the families of the more resilient children to be characterized by exceptionally high levels of cohesion and organization and significantly diminished conflict.

Our data also show that adaptation is a process which occurs over time. Initially, all families of traumatized persons are themselves traumatized and exhibit symptoms common to trauma survivors. Within about six months post-burn, parents of burned children begin to return to normal functioning. By two years post-burn they appear on standard measures of stress to be like the others in the family. Work with the family should promote autonomy as well as cohesion, of which the survivor should feel valued and supported by the others.

4. Training and practice toward self-efficacy, particularly in the domain of...
socia1 skills and social risk-taking, are impor­
tant components of recreation for physically dis­figured persons. They must learn to deal with predictable hurtful re­
actions from naive observers, and learn to make themselves so lovable that people will be
food of their physical differences.

5. The psychotherapist can help the patient in attaining a new self-image. In the early months or years, the patient is
encouraged to overcompensate and en­
orate that he does not know what his limitations are. And the dara and clini­
freely with the identity "hero." The psychotherapist can assist the patient in
understanding the question, Dr. Blakeney
said, "You know, some people would think you were impalied 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, liv­
ing in an apartment by himself with a
senior members of the HMD Response Interna­
tional, Medical and Technical Advisory Board. For a decade they have designed, supervised and de­
veloped training to mental health components of victim assistance programmes; addressing the sequelae of war.

Contact Information
HMD Response International
25 Pembridge Square
London W2 4DR
Tel: 440207 2207447
E-mail: hmd@hmdresponse.org
Website: http://www.hmdresponse.org

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, are no exception. High-quality prosthetic care is especially crucial to amputees who live in agrarian, non-technological soci­
eties where tillling 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, indi­
vidually fabricated to fit the residual limb. Socketless Technology for Prosthetics challenges conventional prosthetic wis­
dom 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 aca­
demic and the wearer point of view.

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.

Socketless Technology for prosthetics may revolutionize the prosthetics industry.

Socketless Option for Prosthetic Care

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.

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