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THE ROLE OF THE CHILD CARE WORKER IN THE TREATMENT OF SEVERELY BURNED CHILDREN

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ABSTRACT. Experience with 57 children suggests that the physical and psychological rehabilitation of severely burned children is promoted in a positive and child-oriented environment. It has also suggested that the child care worker, functioning as an integral member of the burn team, can help establish a more peaceful relationship between the child and his environment and insulate him, by means of repeated positive encounters, from the threatening and often seemingly hostile world around him, while preparing him eventually to meet it. Thus, the child care worker can offer to the child the critical support and understanding needed throughout the long period of hospitalization by helping create a more normal and child-centered environment. *Pediatrics*, 50:617, 1972. BURNS, CHILD ABUSE, CHILD CARE, SPECIAL EDUCATION, PATIENT CARE TEAM.

THE complex problems which severely burned children must overcome and the adjustments which they and their families have to face have been described in the past 12 years by surgeons, pediatricians, psychiatrists, nurses, and social workers.[1-5] This communication deals with the experiences of a new professional, the child care worker, functioning as an integral member of a burn team in a large metropolitan teaching hospital.

The child care worker is the one member of the burn team who deals exclusively with the child as a growing youngster in a nonstructured situation rather than as a patient. However, Child Life Programs, the frame in which child care workers function, are a fairly new adjunct in the total care of pediatric patients. To date there has been, therefore, no comprehensive description of their roles in such work. Bernstein *et al.*[1] speak of the importance of play and schooling in the "middle period" of a burned child's hospitalization; but they have not advocated these functions during the acute postburn period ("immediate care"). A nurse, M. Rubin,[2] has also recognized the need for play and schooling for burned children, but does not describe the time or mechanics. On the other hand, when Vigliano[3] asked a boy when it was that he was sure that he would live he replied: "When I got to play with the other patients."

Trauma and pain, as well as the altered relationships to parents, siblings, and peers, particularly if they were involved in the incident leading up to the burn, cut children off from their normal life patterns. The most important function of the Child Life Program is to help children preserve these essential relationships and to continue with the tasks of childhood—to grow physically, emotionally, and intellectually, to remain inquisitive, to form their will.

To perform these functions effectively, the child care worker has to learn about the premorbid personality of the child, about his skills and interests, and any emotional problems present before his injury. She has to be able to differentiate between typical "burn patient behavior" and the individual's normal style of reacting to stressful situations. She must be alert to the unexpected sources of significant information which may give the other members of the burn team insights into the patient's special problems and concerns. She has to be aware of the many fantasies that may im-

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pede the child's progress and either deal with them herself or pass them on to someone more qualified.

The burn program at the Cleveland Metropolitan General Hospital opened in the Fall of 1970. Up to the time of this communication, 57 pediatric patients have been treated. The burn team consists of the Director (a general surgeon) and his house staff, a staff pediatrician, nurses, social workers, physical therapists, dietitians, a child psychologist (on call), and the child care workers. A child psychiatrist is also available for consultation but has no immediate contact with the children. Patients are admitted to the Intensive Care Unit for resuscitation and stabilization and are then transferred to either the infant division or the general pediatric unit of 24 beds. Although the lack of a single comprehensive patient care area results in a number of technical difficulties, it has allowed the burn children to become a part of the general pediatric community during their recovery in the hospital. As soon as a burn child is admitted, the members of the burn team are notified. This gives them a chance to assess the situation. Along with the surgeons, the nurses, and social worker, the child care worker establishes contact with the child and his family during the immediate postburn period.

Trauma and pain bring out regression and anger. The behavior even of older children is reminiscent of a 2-year-old who has to assert his independence in outbursts of rage. The burned child, immobilized by his injury or treatment procedures, has only a few ways available to express his resentment and anger. He can lash out verbally at those around him, he can refuse to accept treatments and medications, and he can refuse to eat. This breakdown of usual behavior is not only a trial for staff and parents but also very frightening for the child who sees himself regress. The more serious the original trauma, either because of the severity of the injury or because of the guilt the child assumes for the accident, the greater the helplessness and the anger he may feel.

One of the horrors of burned children is the constant loss of serum, which they call blood, which often stains their bandages and bedding. "I am bleeding to death," says the 12-year-old at the sight, and he is hard to convince that this is not true. The boundaries of the body are fogged by the loss of skin; some parts become distorted or even lost through the burn, radically changing the child's body image to something fearful, even monstrous. Black children are often in despair about the lack of pigmentation when the burn area starts to heal.

It is essential to make the children aware that their feelings are respected and accepted sympathetically. At the same time, it is valuable to set limits and not to allow the child to manipulate staff or family beyond reason.[4] It is particularly useful to help children manage their anger, frustration, pain, and despair by giving them a better grip on reality through their intellect. Learning has to bring its rewards to the child through visible results. These may be quite varied; e.g., following skin grafting a 3-year-old had to have both arms immobilized to his chest. Activities were set up for him on the floor so that his feet and legs could substitute for his hands. He became triumphantly happy playing ball, playing with water, crayoning and painting with his feet.

It is necessary to be aware of the most common situations in which burns occur (some of these catagories have been used by previous authors[5]):

1. Accidents resulting from a lack of caution or supervision on the part of a responsible family member.
2. Self-provoked injuries, either intentional or unintentional.
3. Child abuse.
4. Catastrophic accidents beyond the control of any individual.

The function of the Child Life Program can best be described by reviewing cases which illustrate these categories.

ILLUSTRATION, CATEGORY 1

The following case is reviewed in detail as a general paradigm of the worker's role.

Laura was a 7-year-old girl who sustained 65% body surface area third degree burns and died five months after admission. Her burns resulted from a freak accident. Her 5-year-old brother was playing with a frog that wet on his hand. He pushed the frog away and, to punish the animal, he threw a burning match at it. This match ignited some gasoline that was nearby and the flash fire severely burned Laura.

The Child Life staff was informed immediately after the child's admission and saw her on her second hospital day in the Intensive Care Unit. One child care worker visited with her and her relatives, reviewed the hospital chart, and talked with the nurses for further information. Regular short visits, about twice a day, were arranged in which the worker read stories or played the recorder at the child's request. In spite of her discomfort and pain, Laura was attentive in these sessions and asked that songs and stories she liked be repeated. Arrangements were made for Laura to be tutored by the same child care worker. Laura had been a very poor student and was repeating first grade; nevertheless the child had a strong interest in activities involving her whole self. She exhibited little evidence of regression. She cursed colorfully, showing her spirited independence, which could be tapped for more constructive purposes later.

Both Laura and her mother were prepared for the transfer from the Intensive Care Unit to the Pediatric Ward. They were relieved that the same physician and child care worker would care for them in the new location. Laura had to be flat on her back during this period of her illness. Nevertheless, she responded well to her visits to the playroom although her ability to participate in activities with other children was almost nil. Laura's room was brightened with colorful posters and ribbons were placed in her hair since she could wear no clothing. A sweet potato and lentils were planted so that she could watch them grow, and a calendar was made for her bedside where she could tear off a leaf for each passing day. Whenever other children made things like fancy hats for a party, Laura enjoyed having them fastened to her bed. As soon as she could use her hands, her many drawings were put on the walls.

Although Laura's basic skills were very poor, she was quite interested when tutored. She insisted on using the school books for her age level even though the material was at least one grade beyond her ability. Some remedial teaching was used, but sensitivity to her needs seemed more important. For instance, when she noticed some shells that were in the schoolroom, the worker gave her an illustrated report on sea shells in the *National Geographic* which fascinated her though it was quite removed from her own experience. School activities were also used to help Laura express feelings about her burns and hospitalization. Denial was respected and her great emphasis on ego activities was supported. Bernstein reported similar experiences: ". . . probing or any effort to explore reactions at the outset is not advisable."[1] This lack of pressure encouraged Laura to start to talk about the accident in her own time. She sporadically made brief statements about the circumstances of her burn, her fears, and her family. These episodes occurred at unexpected moments in the middle of work or play. A self-made dictionary and dictated stories gave Laura a chance to read what she had formulated earlier.

Her mother, quite exhausted by her faithful visiting and under a trying family situation, often joined Laura in the classroom and took books that the child had selected back to her room to read to her. This was one of the many ways her mother was encouraged to become involved in the child's living experiences. When food intake became a critical issue, an electric frying pan was moved from the playroom into Laura's room and the mother could prepare meals at the bedside. It became very apparent that Laura's mother became an important part of therapeutic interaction.

In the beginning it was necessary for the Child Life staff to plan contacts between

Laura and the other children on the pediatric floor. Gradually she asked to be in the playroom with a group of children and her favorite worker. She also wanted to have her bed close to other children who sat around the table at mealtime.

On an open ward, children notice everything, and it is helpful to keep the children's trust by talking with them reassuringly whenever a traumatic experience such as the death of another child occurred. Laura's reaction to the death of a leukemic patient was typical of her strong need for denial. She and a burned boy of the same age were told of the death of their friend by their social worker. Laura became withdrawn, and although the boy asked questions she kept silent. As her child care worker expected, the questions came in the midst of her school work several days later. At that time she was reassured and seemed able to accept the sad event.

After 20 weeks of hospitalization, Laura's condition became critical. Intravenous hyperalimentation became necessary; however, this resulted in candida sepsis. Despite her physical decline, she insisted on coming to the playroom until two days before her death.

ILLUSTRATIONS, CATEGORY 2

Serious burns occurring through lack of caution by a parent are often the unconscious expression of unresolved conflicts of parenthood. Patients suffering burns in this manner were mostly young children with scalds or chemical burns. The parents seemed helpless; some were even unable to accept their children's accident and obstructed hospital efforts to plan realistically, while the children thrived under the care of the burn team. By reversing their passive roles as patients, through dramatic play, the children were better able to cope with their new situation and actually enjoy life in the hospital.

Accidents of preadolescents often expressed a need for the child to escape from too close parental supervision. The following two vignettes describing self-provoked accidents clearly reveal the emotional turmoil of adolescence that may predispose to such an injury.

Eleanor, 14, described her experience in a letter she wrote to a friend but never mailed. What she did not mention was that the day before her house burned down, she was caught shoplifting in a department store with a girlfriend. Although the affair was settled, it deeply shook the youngster who was just experimenting and not at all a juvenile delinquent. This is Eleanor's letter:

"Dear Judy,

How are you? I am not fine. It's a long story so have plenty of time to read this. I am writing this from the hospital a few days before I will go home. Well, I've been here for seven weeks. I'll tell you in number form. No. 1 My house burned down! No. 2 I almost died! No. 3 They (the hospital) saved my life! No. 4 Now I am all healed almost. No. 5 That's why I haven't written to you! No. 6 It happened two days before Christmas. No. 7 It happened the night I typed a letter to you! It never got mailed! Just burned! Well, anyhow, please don't cry! It was all very horrible! Boo hoo. I will send you the newspaper clippings. Thank you for your Christmas card. I spent Christmas, New Years and my birthday here. It will be good to get home now. Here's what happened!

Anyhow it was December 22. I just finished typing to you. I went to bed. About 1:30 at night I woke up. I smelled smoke. Fire, I yelled! I woke up my family! We all ran out on the upstairs back porch. We yelled for help! None came! I was choking and crying and yelling help! My ma let go of me and I ran back into the fire, but I don't remember it. Then I woke up in the hospital yelling for water. I got none!"

Did she run back into the fire to punish herself for shoplifting?

George, a 14-year-old boy, came from a motherless home and following many episodes of being "in trouble" he was brought to Juvenile Court. He was taken away from his father with whom he was living in constant conflict and placed in the custody of an older brother. A marked improvement in his performance in school ensued. Shortly thereafter he was sniffing glue in a garage with other boys and a lighted cigarette ignited the glue which exploded in the boy's

hands. He suffered a 30% body surface area third degree burn involving his face, scalp, neck, arms, hands, and thighs.

Here is the report of the first encounter of the Child Life staff with the boy:

In contrast to the experience with other children and comments in the literature (1) George immediately opened up when the child care worker introduced herself. He said, "Did you hear the story of what happened?" Then he added, "I swear I did not do it. Some other kids were sniffing glue and I picked up a can to read the label. It blew up in my face. I felt like tearing my face out. I ran out of the garage. The other boys yelled I should roll in the snow. I wish I could have taken some of them with me." His despair about his looks became apparent during the first few days of his hospitalization. Inadvertently he had seen himself in a mirror while in Physical Therapy. "All my hair is gone," he said in despair. "I don't want my girlfriend to see me this way." Even the reassurance that his hair would grow back did not relieve his dejection. It facilitated the first visit of his girlfriend, though, that the child care worker called her to tell her of the boy's concern and his frightening looks.

In spite of George's difficult past history, his guilt-ridden explosive directness helped him to concentrate most effectively on his rehabilitation.

ILLUSTRATION, CATEGORY 3

Burns associated with child abuse are often the result of scalding with hot water, boiling coffee, or cigarette burns. They commonly involve infants and toddlers and often follow excessive crying or problems with toilet training. Though concerning a somewhat older (6-year-old) boy, the case of Dick was chosen for its characteristic features. An older brother forced the boy's leg into very hot bath water, causing second and third degree burns.

Dick was a deprived and underdeveloped boy in a single-parent family of ten children. For a number of days he attempted unsuccessfully to master his anxiety and pain before going to hydrotherapy. The explanation for his anxiety became apparent when his child care worker observed him in the hydro-tank. The physical therapist, daily, had to repeat the very situation which had brought about his burn—his leg had to be immersed into warm water for debridement and dressing change. As soon as this procedure could be changed to the pediatric ward and his familiar nurse could take over and let him immerse his leg voluntarily and in his own time into a bucket of water, he became much better controlled. Though this took a long time, it was worth the effort. The physical therapist had contact with him only at the time of fear and distrust while the nurse, who had many positive encounters in addition to the inevitable negative ones, could handle him much more easily. This shows how the observations by one team member could help two others to find a better solution for treatment.

Dick started first grade while in the hospital. Though he was of below average intelligence, and burdened by his experience, he wanted very much to learn and waited eagerly for his tutor each day. Obviously, some plans had to be made before Dick could return to his family with a record of child neglect. While in the hospital, he often called his mother on the telephone and showed genuine joy when she came to visit him, particularly when she brought a younger sibling. For a period of time, he went to a convalescent hospital where both his physical care and his learning needs could be individualized. In spite of reservations about the home situation, it was decided that the boy should return there because he longed for it so very much.

ILLUSTRATION, CATEGORY 4

An illustration of the emotional difficulties arising from a catastrophic accident beyond any individual or familial control involves Sue, a 9-year-old black girl who suffered second and third degree burns of the face, arms, hands, and legs when her house burned down. She is the youngest in a stable family where grandmother and great-grandmother shared the parents' home. Not only did the family lose all their belongings in the fire, but the great-grandmother, who had in fact raised Sue while her mother worked, died from injuries sustained by jumping out of a window of the burning house. The parents, because of their own grief, were unable to tell the child the truth. The burn team felt concern about this problem, but did not have an early chance to tackle it.

When Sue went home on a short pass and naturally expected to be received by her great-grandmother, her parents told her that the old lady had gone South to visit. It was only after this that the social worker

was able to help the mother to cut through this web. They both finally talked to Sue about the death of her great-grandmother. Mother and daughter had a good cry together, and the child could be discharged from the hospital without an unresolved burden.

She then entered a school for children with physical handicaps. Even before her injury, she had been described as a slow learner; however, she made a good adjustment to her new environment. At the time of her second admission, for reconstructive surgery on the right wrist, Sue responded well to the members of the Child Life staff, with whom she had developed a strong and positive relationship during her first admission. The child care worker's notes describe graphically how this bond helped to settle a new problem:

"Although the majority of conversations with Sue on this admission followed a pattern of good-natured kidding, Sue began to verbalize her thoughts and feelings. In some instances there were situations and questions that could be immediately dealt with, while at other times she brought up certain procedures or retold something she had heard from one of the doctors but did not really understand. Many times during this admission Sue showed her trust and affection. She has been able to discuss things that she realized would not only help her but perhaps be of benefit to everyone working with other children.

Shortly after her surgery, Sue developed unexplained abdominal pains. While playing she said that her hand was now growing in her tummy. This fantasy served as a clue to explain the pain. When it was brought to her surgeon's attention, he explained to the child, more carefully than he had previously done, that her hand was not really in her tummy but attached to it by a flap of skin so that it would heal better. The pains disappeared.

She had never questioned just what kind of surgery was done on her wrist or what the purpose of the immobilizing pins was, since her doctors had very matter-of-factly but sensitively given her the necessary explanations. On the day the pins were scheduled to be removed, she first acknowledged their presence and then began to talk about them. Later the same day she asked her child care worker, "What does the word 'use' mean?" The doctors had talked about using her hand from the beginning of her hospitalization but she had not understood that they meant she would be able to write and draw again, as before her injury. After this was made clear, she talked quite openly about her previous surgical procedures. She had had surgery nine times before, she said, and she really wasn't afraid of the procedures themselves, she just hated the time she had to wait outside the operating room, because "you are still awake and no one is with you."

This child was always dependent upon a female adult. After discharge from her second hospitalization, she started to call her child care worker on the phone regularly. They discussed the necessity of going to school, of "taking" the teasing of her sister, and similar mundane things. The mother understood that Sue needed this friendly chat with her worker and seemed to facilitate the child's calling. Since it was not always easy to reach the worker on the hospital phone, Sue wanted her home phone number. The child care worker told her to look it up herself in the phone book, which she did. This was quite an accomplishment for this rather slow-moving girl.

DISCUSSION

Severe stress on a child patient and his family, as in burns, shatters not only the physiological status of the child but also the psychological foundation of the family unit. Physical, mental, and emotional rehabilitation must be provided in unison so they can rebuild their lives. The hardest hit seem to be the preadolescents and adolescents, for whom the process of breaking away from the dependence on their families is interrupted and who find being different from others, particularly in having a damaged body, very difficult to accept. The child care worker, as a member of the burn team, can play a primary role in helping the young patients in these struggles.

Such a function is taxing. Members of the Child Life staff have felt that continuous work exclusively with burned children is too demanding, that they may become callous or irritable; therefore, two workers alternate during the day working with the most severely ill children. Experience also suggests a more general and positive aspect for consideration in planning the care of burn children. From the viewpoint of medical care and treatment, having burn children on a regular pediatric ward involves

disadvantages; but there is on the other hand the advantage of being in a child-oriented environment rather than in a burn unit where both children and adults are patients. It can be devastating for children to see adults when they are shattered and regressed while they should be the models for the children's ego ideals. It is to be hoped that a way will be found to combine the advantages of the burn unit with the opportunity of including the children into the play and work areas on a children's ward for their daily living. It has served them well.

The child care worker's objectives can be summarized as follows:

1. To break the desolate feeling of isolation from others by regular brief visits with the acutely burned child in the reverse isolation rooms on the Intensive Care Unit; having thus laid the foundation for a positive relationship, to continue work and play with the children once they are on the pediatric ward. This is often done in conjunction with physical therapy and rehabilitation. A program for continuing school work can be developed as a natural outgrowth of these early encounters.

2. Through their observations of the interactions in families, the child care workers can assist other team members in forming meaningful relationships with the patient and his family. As cited in the first case history, observing Laura and her mother and realizing the critical need for adequate nutrition, the child care worker was able to arrange that the mother cook for Laura in her own room. So meals became deinstitutionalized, the natural mother-daughter relationship reinforced.

3. To share with the nurses the oftentimes difficult preparation of the patient for repeated painful procedures and surgery. The problems in the postoperative period can also be more easily resolved when the child care worker acts as a buffer between the patient and the other members of the burn team so that they may bear the child's anger and distress without feeling the need to retaliate.

4. By encouraging and facilitating the interaction of the burned child with other children on the pediatric division, the child care worker can help the patient face the inevitable remarks about disfigurement. These remarks can be more easily handled in the controlled hospital environment where every child worries about himself than on the "outside" where the patient meets children and adults who are not so receptive to accepting him as he is. Visits from siblings and friends who can be prepared by a worker on the burn team to meet the child in a controlled setting are also important aspects in the emotional rehabilitation of a burned child.

5. To strengthen the child's hope of returning to normal life after discharge by continuing school work through imaginative tutoring. Seriously ill or damaged children can thereby realize that there is hope of returning to their previous life style. The child care worker can also use special tools to kindle interest in further learning, and facilitate the use of challenging materials such as teaching children with immobilized hands to paint and crayon with their feet; or teaching a 14-year-old to use the typewriter to express her feelings. Other children used a tape recorder to dictate examination answers when it was impossible for them to write. A child can learn many things watching plants growing from seeds or a chicken hatching in a small incubator.

SPECULATIONS

Our material points up the psychological, social, and moral human dysfunction that is so often the root cause when children get burned. Can research elucidate this and develop methods to improve functioning and to prevent such accidents? While awaiting this perhaps utopian accomplishment, how is the care of burned children to be organized? Regional burn hospitals for children exist. They are often far from the child's home, which makes it hard for parents to visit regularly. Can we instead utilize pediatric units to retain the child-oriented environment without giving up ready access to the facilities of a burn unit with its specialized treatment methods? These are needed by both adults and children; but children

need something more. Is the child care worker, as the member of the burn team who can stay detached from the strictly medical and physical care, best placed to give it?

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