Burned - Banished or Burnished:

A pilot study of a school reintegration programme

A thesis submitted in partial fulfillment of the requirements for the degree of

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Ula Nadine Horwitz

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ABSTRACT

It is the aim of this research to create a manual and programme for the reintegration of burn-injured primary-school learners in order to assist in their re-socialisation, and to act as a buffer against depression, conduct disorders, and academic lag. Additional aims of the programme included being resource-efficient, flexible, and compatible with Outcomes-Based Education (OBE) principles evidenced in Curriculum 2005. The final aim of the research involved designing the programme in order for teachers to be able to facilitate it. The manual and programme were evaluated through an embedded case study, encompassing a mildly disfigured burn-injured learner, his family, and his school environment by way of his class and teacher. The programme was found to be efficient in its use of resources, congruent with OBE principles, and engaging of the learners and teacher. Participation in the intervention seemed to afford the burn-injured learner with a buffer against depression, but did not prevent academic lag. Minimal teasing was encountered after the programme was implemented, which is contrary to the expected outcomes based on the literature available. Teacher facilitation was not achieved, however, numerous benefits were derived from the intervention for the majority of the participants.

Acknowledgments and Thanks

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To Hassiem, his family and school community - my gratitude for allowing me into your lives. I feel privileged to have been a part of the process. May you go from strength to strength.

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To you the reader, for taking the time and effort to open this thesis - please take the plight of our burned children to heart. They desperately need additional voices to take up the call.

Thanks again,

Ula

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INTRODUCTION

The burns ... destroy the soul's clothing and leave the frail self in naked agony. Then, God willing, the soul begins to grow a new self. The surgeon may be competent to graft skin, but ... skill alone will not avail to re-clothe the soul.

(May, 1991, in Carter & Petro, 1998, p. 81).

For children who have experienced and survived severe burn injuries, "re-growing a self" is as painful and difficult as the many surgical procedures they endure. For people who have never encountered the aftermath of a burn injury, the appearance of a burn survivor who has been disfigured or disabled can be disturbing. The visual impact tends to bring with it a visceral fear, and a realisation that human beings are not impregnable fortresses, unassailed by the elements. The most typical reaction involves the rejection of the disturbing input in an attempt to preserve the illusion of immortality. Unfortunately, the burn survivor is often rejected along with his/her appearance. It is this rejection that is especially damaging to children's emergent sense of self and self-worth.

The goal of this project was to take the initial steps in developing a programme that would assist a burned child's reintegration into the school community. To evaluate the programme, an embedded case study was conducted with the focus on the child, family, and school environment. Chapter one provides an overview of the field of disability, including salient models for conceptualising disabilities and impairments. Chapter two provides an outline of the physiological and psychological impact of burns on the survivors and their families, including hospitalisation and treatment. Chapter three details the impact of the burn on the burned learners' schooling, and discusses the concept of school reintegration programmes. Chapter four presents the research aims and methodological tasks of the thesis. Chapter five discusses the implementation of the programme devised. Chapter six discusses the case study and psychological assessment of the participant. Chapter seven provides details of the applicability of the intervention, while chapter eight discusses the clinical effectiveness of the intervention. Chapter nine discusses the conclusions based on the data obtained, and recommendations for further research in the area.

CHAPTER ONE: DISABILITY - AN OVERVIEW

Burns injuries result in a variety of physical sequelae, and a number of psychological, emotional and social consequences. In children, these non-physiological consequences tend to be the most heart-wrenching, as the reactions of their communities, and wider society, can be extremely damaging.

1.1 THE NATURE OF THE BEAST

In a world without bias, prejudice or stigma, this research topic would be unnecessary. There would be no need for special programmes to reintegrate burn-injured children into the classroom or community, as they would be accepted for their abilities and not judged by arbitrary societal norms. However, in many Western-influenced societies, a high value has been placed on youth and beauty, performance and achievement. Disfigurement and disability are therefore judged by implied public standards of how people should look and what is "normal" (McGookin & Leveridge, 1991). The notion of disability thus has at its base a social construction, and not merely a medical diagnosis.

According to Ainscow, Jangira and Ahuja (1995), over 140 million children world-wide have significant disabilities. The Central Statistical Service estimates a disability prevalence of approximately five percent of South Africa's current population (White Paper on Integrated National Disability Strategy, 1997). The nature of human physiology suggests that as we get older, we are more likely to develop a disability of some type. This has led Hastings (1997, p. 9) to describe people without disabilities as "NYDs", or "Not Yet Disabled" persons.

In order to discuss disability in a meaningful manner, we need to define it, bearing in mind that we are not describing an abstract group of the population: we are quite possibly talking about our future selves.

1.2 THE MEDICAL MODEL OF DISABILITY

1.2.1 Conceptualising disability

According to the medical model of disability, a person is disabled when an organ, limb, or physiological system malfunctions. This seems to be a reasonable explanation, until one looks at the ideological underpinnings. This model asserts a 'normal', proto-typical way of being and functioning; and those who do not conform are labelled 'abnormal' and 'other'. This label of 'other' carries with it a host of negative stereotypes, so that someone is not 'differently-abled', but *dis*abled. Within this model, people are labelled as 'damaged' or 'inadequate', and are subsequently viewed almost exclusively in terms of their 'problems' or 'deficits' (Ballard, 1994). Medical personnel tend to use objectifying language, reducing individuals' identity to the sum total of their 'abnormal' parts.

By stating that it is the limb, organ or system that is defective, the model also locates the defect *within* the person, and effectively assigns sole responsibility to the individual for any difficulties experienced. The "individual personal tragedy" view of impairment shared by most professionals thus contributes to the poor self-esteem and negative self image that many young disabled people have (Zinkin, 1995). An expectation is therefore created that the disabled person will adapt him/herself to society (Ballard, 1994).

1.2.2 Management from the medical understanding

If the 'problem' is located within the individual, the solution is likewise situated within the individual realm. Management and treatment becomes either a problem-solving game of helping the 'poor disabled wretches' to fit in with society as best they can; or a 'hide them where they can't upset the rest of us' approach.

Medical interpretations achieved prominence in the administration of interventions to cater for the 'incapable' and became the *only* visible solutions. People with disabilities, like other members of society, need to make use of medical and other community services. As a result of the

that was all encompassing and they were assigned a "perpetual client or patient role" (Finkelstein & Stuart, 1996, p. 178).

1.2.3 Consequences and implications

By defining the situation as an individual problem, and asserting that only the medical and affiliated professions are capable of assisting people with disabilities, it follows that people with disabilities are placed in subservient, dependent positions, reliant on 'expert' interventions for everyday experiences and problems. 'Eating' becomes "feeding", and 'ablutions' become "toiletting" (MacFarlane, 1996, p. 17).

A widely held perspective upholds the view that people with disabilities are fundamentally incapable of being independent, and as a result tend to have no or low expectations of what disabled people can accomplish or contribute. When businesses employ disabled people it is often seen as good public relations, or as being 'charitable' to those 'less fortunate'. Disabled people, being members of society themselves, are also exposed to the negative stereotypes and expectations, and often internalise them as part of their self-identity, leading to 'self-fulfilling prophecies' (French, 1996).

As part of the 'out of sight, out of mind' strategy for dealing with people with disabilities, separate schooling was created to deal with the 'special needs' of these disabled children. These separate schools were often situated in remote areas, necessitating that the children board there, and become isolated from their families and communities as a result. The curricula in these schools, based on the predominant medical model of disability, ensured that schooling and preparation for adulthood were usually guided by a perspective of "long-term dependency on carers, permanent unemployment, and an end goal of isolation from public view" (Finkelstein & Stuart, 1996) p106.

1.3 THE SOCIAL MODEL OF DISABILITY

1.3.1 Conceptualising disability

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In the 1970's, a small group of dissatisfied disabled people concluded that their dependency was the result of disabling barriers created by a world designed by, and for, the able-bodied, rather than the result of any personal impairments, or physical or mental defects (Finkelstein & Stuart, 1996). The social model of disability views the experience of disability as largely the product of the institutional practices of society, expressed in education, health, employment, and other aspects of community life (Ballard, 1994). With this new definition, the disability becomes a social construction, as opposed to an individual's problem. Relocating the locus of control results in an entirely new way of looking at the world. Questionnaires that might have asked "Has your disability ever caused you problems in opening milk bottles?", now ask "What is it about the poor design of the milk bottle that makes it difficult for you to open?" (McConachie & Zinkin, 1995, p. 225).

Society as a whole, however, seems to be somewhat slower in adopting this new viewpoint. The quotation from Williams (1995) below, speaks of the struggle against decades of medical interpretations:

> *At best we are pitied and patronised, at worst we feared and vilified, denied education, employment, a family life, human dignity - all in the name of what is "wrong" with us... An impairment affects the way our bodies or minds work, but it is society's reaction to impairment which determines whether we may have a good quality of life. It is the way society reacts to physical, sensory and intellectual impairment which limits our possibilities.*
>
> (Williams, 1995, p.215).

1.3.2 Management from the social perspective

'Problem management' and 'interventions' acquire a very different orientation when based on the social definition of disability. For it is *society* as a whole, rather than the individual alone,

that needs to adjust and adapt. This model suggests that people with physical and mental impairments can have satisfying lifestyles *as disabled people* if the focus of attention is shifted towards the removal of disabling barriers rather than concentrating only on the rehabilitation of disabled individuals, or the 'overcoming of personal impairments' (Finkelstein & Stuart, 1996). It is the population of NYD's that need to be rehabilitated, to see beyond impairments, and to constantly bear the needs of a diverse population in mind, rather than simply adding 'special needs' concessions at the end.

1.3.3 Consequences and implications

The suggestion that society is disabling challenges those of us who are currently able-bodied to :

> *stop thinking of the disabled as sick or helpless, as patients, or people with problems, and to recognise that often the major difficulties they have, are created by societies that fail to meet their needs or acknowledge their right to self-determination*
>
> (Ballard, 1994, p.14)

1.4 DEFINING DISABILITY

Having traced a brief history of the two major viewpoints on disability, it is now possible to move to the working definition which informs the thinking within this thesis. In 1980, the World Health Organisation (WHO) suggested a classification system that ran a spectrum from: *"impairment → disability →handicap"* (Khan & Durkin, 1995). '*Impairment*' was defined as lacking part or all of a limb, or having a defective limb, organ or mechanism of the body. '*Disability*' was described as any restriction or lack of ability to perform an activity in the manner, or within the range considered normal for a human being, this restriction or lack of ability resulting from an impairment. Lastly, '*handicap*' was considered to be the function of the relationship between disabled persons and their environment, that is, the loss or limitation of opportunities to take part in the life of the community on an equal level with others (Stopford, 1988).

1.5 ATTITUDE FORMATION AND STIGMATISATION

People's attitudes play a major role in how disability is defined and viewed. There seems to be an underlying assumption in society that if someone *looks* the same they must *be* the same (Hill, 1997). The converse expectation also holds true: if someone *looks* different, they must *be* different. In order to facilitate later discussions on societal attitudes toward burn-specific disability and disfigurement, it is necessary first to define the terms being used.

1.5.1 Definitions

According to Baron and Byrne (1991, cited in French, 1996, p. 151), attitudes are "enduring mental representations of various features of the social or physical world. They are acquired through experience and exert a direct influence on subsequent behaviour". Most definitions of attitude have three components: cognitive, affective and behavioural. *'Cognitive'* denotes our beliefs regarding the object or person to whom the attitude is directed. *'Affective'* refers to our evaluation of the person or object to whom the attitude is directed. These evaluations are based on underlying values we hold which represent ethical codes and social and cultural norms. *'Behavioural'* consists of those actions we take in response to these beliefs and values (French, 1996).

1.5.2 Cultural beliefs regarding disabilities

In the following section, historical perspectives on stigma will be examined, in order to orient the discussion. We can then proceed with a more detailed examination of how developing countries view disabilities.

Ainlay, Colman and Becker (1986, cited in Bernstein, O'Connell & Chedekel, 1992, p.5) state that:

The contemporary connotations of the word "stigma" are not really much different from its original meaning. For the Greeks, "stigma" referred to bodily signs that called attention to

some moral failing on the part of the person who bore them. Signs, often cut or burned into the body were intended to cause other people to avoid the bearer - the slave, traitor, or criminal. Today, "stigma" involves the same sense of moral disapproval, denigration and avoidance.

There appears to be a widespread belief among both ancient cultures, and those of certain developing countries, that the birth or appearance of a disabled child is linked to evil spirits and/ or parental misconduct; or may be seen as a curse resulting from sins committed by an ancestor, or by the affected person in a previous existence (McConkey, 1995). These explanations deal with the original cause of the impairment, but do not explain how this impairment is then viewed, handled or treated by these societies. Available literature on disability in developing countries tends to take the viewpoint of western education and culture, and therefore emphasises the presence of negative attitudes towards impairment and disabled people (Marfo et al., 1983, 1986, in Kisanj, 1995).

However, viewed from within communities with a high level of illiteracy and a subsistence economy, the general pattern of overt community reaction has been one of sympathy and acceptance, providing for all basic needs at an extended family level, and allowing people with impairments to participate in the community institutions and activities within the limits of their abilities (Kisanj, 1995).

1.6 THE SOUTH AFRICAN POSITION ON DISABILITY

1.6.1 The plight of children who are disabled

Having defined the general terrain, it is now necessary to examine our own 'backyard', with specific reference to the South African general view of children as disabled individuals. As children will be the focus of this study, reference to disabled individuals and burn-injured individuals should henceforth be taken to mean children who are disabled or burn-injured.

The social model of disability would insist that a child with a permanent impairment has the same basic needs as other children in terms of adequate food and water, shelter, clothing, protection, and consistent loving care (Birkett & Brümmer, 1998). However, South African

professionals are still widely influenced by the medical model, viewing children with disabilities as incapable or ill, and a burden on society. When born into poor socio-economic backgrounds, such children frequently grow up believing that their disabilities are economic and social curses, and that they are a burden to their families. These children are less likely to be exposed to opportunities that build a sense of confidence in their own abilities, making them more likely to be disempowered adults, unable to make decisions, solve problems or demonstrate initiative. They are also more likely to be illiterate, contributing to the high percentage of unemployment amongst adults with disabilities (White Paper on Integrated National Disability Strategy, 1997).

1.6.2 Implications of the models for South Africa's educational context

As a result of previous governmental policies, education in South Africa has a broad range of standards. At the lower end of the spectrum, learner:educator ratios of more than 90:1 are not uncommon (Department of Education, 1997a). Limited available resources have meant that learning environments for the vast majority of our *able-bodied* learners are often impoverished. Bearing in mind that impairments can be both physical (such as cerebral palsy, muscular dystrophy, epilepsy etc.) as well as intellectual (resulting from brain damage, foetal alcohol syndrome etc.), different sources (e.g. Donald, 1993, cited in Green, Naicker & Naudé, 1994) estimate the short-term incidence of *special educational needs* as between 40-50% of the school-going population. From this, one can conclude that the need for specialised education is as much the norm as the exception (Green et al., 1994).

The medical conceptualisation of disability has ensured the segregation of disabled children, with "special schools" devoted to their "special needs". However, the number of children requiring specialised education, and thus the corresponding number of these sorts of facilities has been grossly underestimated. In many instances, educationalists classify certain children as "too severely disabled", and exclude them from any educational opportunity. It is estimated that almost 70% of

children of school-going age with disabilities are presently out of school (Department of Education, 1997b).

The social definition of disability previously explored suggests that it is the educational system's responsibility to adapt and function in a way that can accommodate a diversity of learner needs and system needs, as opposed to expecting the learner to adapt or face exclusion from the system (Department of Education, 1997a).

Within the South African context, training has tended to be informed by the medical model, which focuses on learner deficits, rather than on the causes of learning breakdown and the meeting of a diversity of needs. The move towards Outcome Based Education (OBE) is an attempt to correct this imbalance, by examining and addressing the barriers to learning. OBE is based on the philosophy that all learners can learn, and makes provision for children with disabilities and other special education needs. It implies a flexible, accessible curriculum and teaching methodology, and support services where necessary (Department of Education, 1997c). The adaptable, creative teaching strategies make resource-efficient interventions possible, and congruent with the settings in which they would most likely be utilised.

Curriculum 2005 is the current South African model of inclusive education based on OBE principles. One of its most important objectives is to create learning environments that reflect and celebrate diversity, and create experiences that acknowledge learning rates, levels, and styles (Department of Education, 1997a). Thus the call for inclusive education is not a move to hide disability or pretend that everyone is the same, that is, it is not a policy of assimilation but rather one of valuing diversity (Ballard, 1994). Some of its more important principles include the ability of all learners to succeed and develop at their own pace, and the uniqueness and individuality of all learners. Teachers are expected to be able to recognise and attempt to understand different abilities (Department of Education, 1997a).

One of the eight critical learning areas in Curriculum 2005 is that of Life Orientation, formerly known as "lifeskills". Specific outcomes in this area include an understanding of, and

acceptance by, all learners of their uniqueness and worth as human beings; and an ability to use skills and display attitudes and values that improve relationships in family, groups and communities (Department of Education, 1997a). The vital area of attitude change towards learners who experience barriers to learning may therefore be seen as an important part of life orientation.

CHAPTER TWO: BURNS

The general definition of impairment and disabilities referred to in section **1.4** was broad enough to include any disabilities. Many of the physiological and psychological disabilities have separate societies, charities, and organisations aimed at raising public awareness, interest, and funds in service of their particular cause. This is done, not to divide public sympathy or beg for special favours, but to heighten awareness that not all disabilities are identical, and people with different disabilities may well have different needs.

An area that requires specific attention is that of burn-related injuries, as they can lead to both disfigurement and disabilities. This is an area that has been neglected or ignored in South African research.

2.1 BURN-RELATED DISABILITIES

Despite expert physical and occupational therapy, children with burn injuries are often left with burn scars, body contour deformities, reduced dexterity and loss of digits/ limbs (Moore et al., 1996). Many paediatric burn survivors must thus live with permanent disfigurement, and/ or physical disabilities (Tarnowski, Rasnake, Gavaghan-Jones, & Smith, 1991). These children, with their splints, scars, missing fingers and prescriptions for itch medication might easily be labelled handicapped and rejected by their communities (Cahners, 1979b).

The unique repercussions of a burns injury may therefore lead to aesthetic disfigurement without disability, or in conjunction with a physical disability. However, little research has been conducted to explore the impact of disfigurement by burn injuries on psycho-social development in paediatric survivors (Partridge & Robinson, 1995).

2.2 PREVALENCE OF BURNS

Various reports have indicated that more children than adults are burned (Stoddard, Stroud & Murphy, 1992). Reasons for this include children's curiosity about their physical surroundings; their lack of understanding of cause-and-effect (for example, pulling on kettle cords resulting in water scalds); and the high incidence of child abuse (both covert neglect and overt abuse). It has also been found that children from poorer backgrounds are more at risk of being burned (Stoddard et al., 1992; Cella, Perry, Poag, Amand & Goodwin, 1988). Possible reasons for this include: the use of certain heating fuels by marginalised communities; and the lack of affordable day-care facilities, which results in leaving children unattended.

The epidemiology of burns in South Africa is largely unknown, but based on American statistics of burns per number of thousand people, it is estimated that there are approximately 400 000 burns annually in South Africa, of which 4000 (1%) are admitted to hospital, and at least 400 (0.1%) die. The most current statistics available regarding admittance to Red Cross War Memorial Children's Hospital (Red Cross) are for the twelve month period from 1995-6, and they indicate that the Red Cross Burns Unit treated 430 children on an in-patient basis, and saw 2000 children as Burns Unit outpatients (Red Cross, 1998).

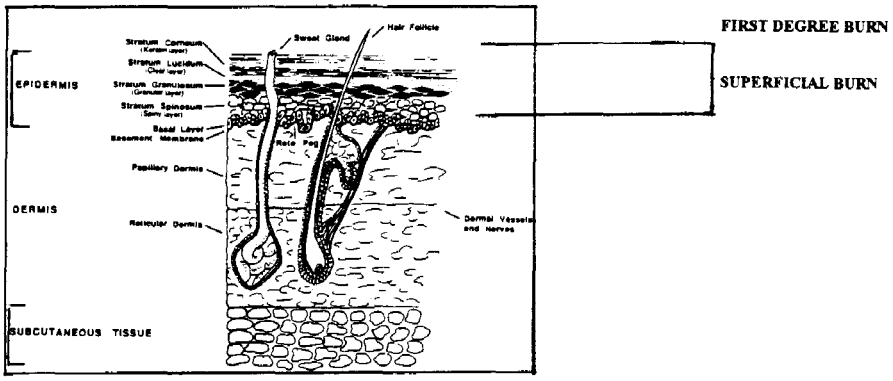
2.3 PHYSIOLOGICAL EFFECTS AND CLASSIFICATION OF BURN INJURIES

Burns or thermal injuries occur when hot liquids (scalds), hot solids (contact burns) or flames (flame burns) destroy some or all of the different layers of cells which form the human skin. Skin injuries resulting from ultraviolet radiation, radioactivity, electricity, chemicals and respiratory injuries/ damage resulting from smoke inhalation are all considered to be fire/ burn injuries (Latarjet, 1995). Burn injuries are described by medical personnel in terms of *depth*, *percent of total body surface area* (*TBSA*) affected, and the specific *location of the burn*. *Scarring* that occurs depending on burn depth and location, is another important factor.

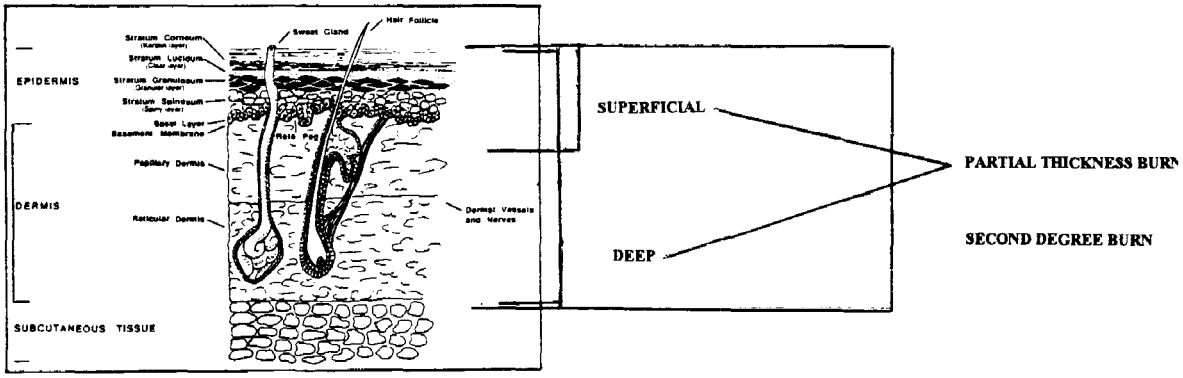
2.3.1 Depth of burn

The burn depth depends upon the amount of heat transmitted to the skin (Tarnowski et al., 1991). This depends upon two elements: the temperature of the flame, hot liquid or solid; and the duration of the exposure (Latarjet, 1995). Burn classification in terms of depth was historically categorised by the terms *first-, second,* and *third degree.* These terms have largely been replaced by *superficial, partial-thickness* (*superficial* and *deep*), and *full thickness*, as they better describe clinical findings, and imply potential healing time and subsequent scarring (Johnson, 1994).

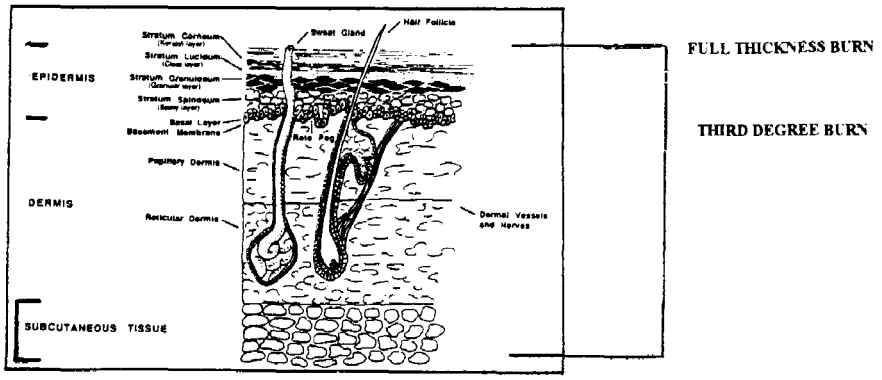
First degree burns correspond to *superficial burns*, and affect only the epidermis (Johnson, 1994).



Second degree or *partial- thickness* burns can be further subdivided into the following subcategories: *superficial* (affecting the epidermis, and some papillary dermis) and *deep* (affecting the epidermis, papillary and reticular layers of dermis, and may include some fat domes of the subcutaneous layer) (Johnson, 1994).

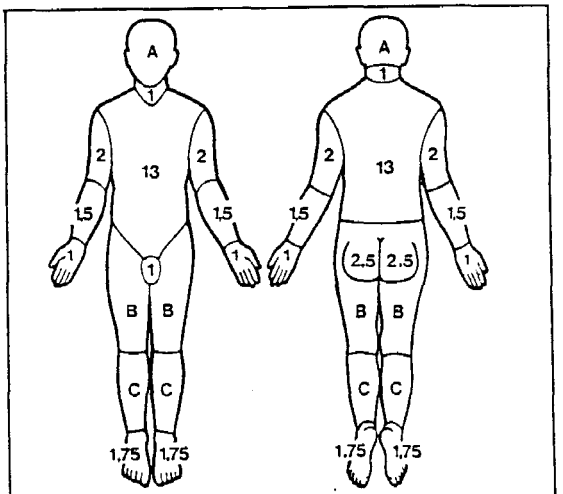


Third degree burns are currently referred to as *full-thickness* burns, in which all layers of the skin down to and including the subcutaneous tissue are destroyed. Fascia, muscle, tendon and bone may also be affected (Johnson, 1994, p. 31).



2.3.2 Total Body Surface Area (TBSA)

The larger the body surface area affected by the burn, the greater the impact of the burn on the individual, and the more severe the burn (taking into account the depth of the burn injury). The ultimate outcome of the burn injury (such as death or disfigurement) is closely related to the burn size. The Lund-Browder chart is used to calculate the relative percentage of body surface area that is affected. This system is extremely effective in calculating TBSA as it takes age and developmental rates into account (Latarjet, 1995). During the first year of life, a child's head is approximately twice as large as an adult's in proportion to the total body surface area. As the body proportions change as the child grows and develops, it is important to estimate these proportions as precisely as possible. In the table and diagram below, 'A' refers to the entire head, front or back; 'B' refers to either the back or front of a single thigh, and 'C' refers to the entire front or back of a single leg. The top row of numbers refers to the age of the child, while the numbers in rows below refer to the relative percentage of the body area affected by the burn.



AGE years	0	1	5	10	15	Adult
A=½ of head	9,5	8,5	6,5	5,5	4,5	3,5
B=½ of one thigh	2,75	3,25	4	4,25	4,5	4,75
C=½ of one leg	2,5	2,5	2,75	3	3,25	3,5

2.3.3 Location of the burn

This discussion draws on Bloch (1987), Johnson (1994), Latarjet (1995), and Richard and Staley (1994). The site of the burn injury also has major implications for the severity of the injury. Those situated on a 'functional' body region, such as the face, hands, feet, joints and perineum, may well result in disability and/or disfigurement. A burn injury on any of these areas necessitates hospitalisation as there are special medical considerations that need to be taken into account.

- The face is of particular concern as the cartilage in the nose and ears is extremely fragile, and can disintegrate in severe facial burns. If the injury occurs to the scalp, and requires grafting, the donor site will not have the same hair follicle patterns and that portion of the scalp will remain bald.
- The concerns with burn injuries to the hands are numerous. Fingers may have to be amputated, making many daily activities difficult (especially if the fingers concerned are the thumb or index fingers). The scar tissue on the hands will need intensive occupational and physical therapy, as contractures will severely restrict the range of motion (ROM). Injuries to children's hands will require operations to release the contractures as the child grows.
- Injuries involving the feet are complicated, as they are covered by very thin skin dorsally. This means that full thickness burns can severely inhibit the patient's mobility, temporarily and possibly permanently.
- Scars across joints can restrict the range of motion that that joint is capable of articulating. Contractures of these scars can prevent movement in joints entirely, if left unchecked.
- Lastly, burn injuries to the perineum and genitalia are of serious concern, as scar development in these areas can impact on urinary and sexual functions.

2.3.4 Scarring

In cases of full-thickness burns, the skin is repaired through scar formation. Two types of excessive scarring can occur: *hypertrophic* scars, characterised by an overgrowth of dermal constituents that remain within the boundaries of the wound; or *keloids*, which are scars that

extend beyond the original boundaries of the wound. The characteristics of an immature (active) hypertrophic scar can be described by the "three R's": red, raised and rigid. Keloids tend to be more swollen and whorl-like in formation, and have greater height (Staley & Richard, 1994).

2.3.5 Further physical characteristics of burn injuries

Further details regarding presentation, severity, cause, estimated healing time and treatment of the various types of burns may be found in the table below (Johnson, 1994, p.31).

Table 1

Burn Wound Classification

Severity	Cause	Surface Appearance	Color	Sensation	Histologic Depth	Healing
Superficial						
All are minor except if person is under 18 months or over 65 years or with severe loss of fluids	Sunburn Ultraviolet exposure Short flash	Dry, no blisters Edema–amount variable	Erythematous	Painful	Epidermal layers only	3–7 days with peeling No scarring May have discoloration
Partial-Thickness						
Minor Adults < 15% Children < 10%	Superficial Scald Short exposure	Blistered Weeping Moist blebs	Superficial Red	Very painful Sensitive to temperature	Superficial Epidermis, some papillary dermis	Superficial 7–21 days, no grading Rechanneal scarring Pigment changes
Moderate Adults 15–30% Children 10–30% Minor chemical or electrical < 15% but involves face, hands, feet or perineum	Deep immersion scald Flame	Blisters are large, thick-walled, will usually increase in size	Deep Mottled white (pale), pink to cherry red		Deep Epidermis, papillary and reticular layers of dermis, may include fat, denies of subcutaneous layer	Deep 21–35 days if no infection, if infected, may convert to full thickness
Severe > 30%		Normal to firm texture	Red, will blanch with pressure and refill			May develop severe hypertrophic scarring
Full-Thickness						
Minor < 2%	Chemical Electrical Flame Scald	Dry, leathery or neoplastic until debridement	Mixed white, wax, pearl,	Little or no pain Hair pulls out easily Anesthetic to temperature	Down to and includes subcutaneous tissue May include fascia, muscle, tendon, and bone	Large areas require grafting or requires many months to heal. Small areas may heal from edges after weeks
Moderate 2–10% any involvement of face, hands, feet, or perineum	Time Temperature 1 sec 158F 2 sec 150F 10 sec 140F 30 sec 130F 1 min 127F 10 min 120F	Charred, blood vessels visible under eschar If red, will not blanch with pressure	Dark black, mahogany			
Severe > 10%	Major chemical or electrical	Usually no blisters, but if present, thin-walled and will not increase in size	Charred			

From Johnson, C. Update on burn wounds. Wounds: A Compendium of Clinical Research and Practice, 4 142 1992. with permission

2.4 STAGES OF A BURN INJURY

According to Miller, Richard and Staley (1994), hospitalisation is necessary if the burn injury :

- ◈ is deeper than superficial thickness;
- ◈ is greater than 10% TBSA in children;
- ◈ is located on any of the functional body parts previously mentioned;
- ◈ is complicated by suspected smoke inhalation injuries, other pre-existing illnesses, or additional injuries;
- ◈ and/or results from electrical or chemical causes

Tucker (1986) divides hospitalisation for a burn-related injury into three different stages: *acute, intermediate,* and *convalescent stages.* These stages refer to the level of physical recuperation the burn patient is experiencing, and have corresponding links with different emotional tasks in assimilating and accepting the experience of being burned; as well as different tasks for the burns team. The duration of these stages varies from person to person depending on individual personality and temperament factors, the extent of burn injury, and the treatment environment (Moss, Everett & Patterson, 1994). A brief overview of physical, emotional and psychological features of the acute, intermediate and convalescent stages follows. More detailed examination of some of the psychological features will then be conducted.

2.5 HOSPITAL TREATMENT AND PROCEDURES

2.5.1 Acute stage of hospitalisation

The *acute stage* of hospitalisation can be defined as the interval from the onset of the burn injury to the time when fluid resuscitation (the maintenance of fluid and electrolyte balance) is complete, respiration is stable, initial burn shock is resolved, and the patient is not delirious or disoriented from sepsis or other complications (Cromes, 1984; Tarnowski et al., 1991).

(a) Physical tasks and concerns

After a serious burn, there are substantial fluid leaks throughout the body. Plasma leakage and water losses from evaporation due to the burn can lead to the body going into a state of shock, and fluid replacement is vital for survival (Latarjet, 1995).

As a result of a severe burn, the body also goes into a state of hypermetabolism, that is, the metabolism speeds up. There are increased urinary losses of nitrogen, potassium, phosphorus and other intracellular constituents, which indicate an accelerated catabolism or breakdown of compounds in the body (Johnson, 1994). If the nutritional intake is not increased sufficiently, the body resorts to breaking down muscle components, particularly protein, in order to generate energy. This leads to muscle atrophy and consequent loss of body weight. If left unaddressed, this process can lead to death (Latarjet, 1995).

The above stages of shock, as well as wound infection, sometimes lead to delirium in the burns patient during the acute phase of treatment (Latarjet, 1995; Munster, 1993). The care of burn wounds is critical because infections can be life-threatening. Because of the danger of infection, the patient is often placed in medical isolation.

(b) Burn team members' tasks and concerns

The burn wounds are covered with dressings until they heal to decrease the risk of infection, and these are often changed twice daily (Munster, 1993). To help the skin heal as quickly as possible, all dead and injured skin must be removed to prevent infection. *Debridement*, the gradual, gentle removal of loose, dead tissue, is therefore carried out by nursing staff each time dressings are changed. According to burn patients, this is often the most painful of procedures endured in the hospital (Kiecolt-Glaser & Williams, 1987; Saffle & Schnebly, 1994).

(c) Psychological tasks and concerns

Most children who are severely burned are initially hospitalised in the Intensive Care Unit (ICU), which is typically experienced as an alienating and frightening place. While in ICU, they are alternately over- and under-stimulated, that is, they either have numerous medical personnel

attending to them and requiring participation in, and co-operation with several different procedures; or they are immobilised in awkward positions, where only minimal interaction is possible (Patterson, Bombardier, Questad, Lee & Marvin, 1993). In addition, given the risk of wound infection, medical isolation tends to be enforced, leading to social isolation: the patient may be separated from family and friends. This can aggravate the emotional trauma of the burn victim, as children of all ages experience this isolation as abandonment (McLaughlin, 1990).

The experience of physical pain is greatest in the early weeks of hospitalisation, but pain threshold and tolerance are often inversely proportional to the length of hospitalisation; that is, as the length of the hospital stay increases, the patient's ability to tolerate the pain often decreases. Anxiety (for example over impending surgery) and depression tend to exacerbate the pain (Tucker, 1986). Although burn patients regularly receive pain medication, especially before the dressing change, it is not possible to eliminate the pain. Patients' compliance with dressing changes and exercises necessitates experiencing considerable pain in the process (Kiecolt-Glaser & Williams, 1987). This is never easy to explain to a child who has already suffered a traumatic experience (Knudson-Cooper, 1984).

During the acute phase, the immediate reaction to a burn of sufficient severity to require hospitalisation is typically of psychological shock: numbness and denial set in quite quickly. This response is usually short-lived, and generally resolves spontaneously, with support from staff and family. Symptoms of confusion, disorientation, and hyperactivity, often associated with delirium, are also common (Knudson-Cooper & Thomas, 1988).

It is vital to remember that the patient is struggling for survival and post-traumatic stress symptoms such as attendant anxiety, increased startle responses, disorientation, emotional lability, insomnia and nightmares of the incident are to be expected (Cromes, 1984; McLaughlin, 1990). (See section **2.8.4**).

The psychological trauma of the burn injury and the painful treatment can also lead to high levels of depression while the patient is in hospital (Pruzinsky, Rice, Himel, Morgan & Edlich, 1992). This will be dealt with in greater detail in section **2.8.5**.

The patient is usually less concerned with the long-term implications of the injury than with survival. Similarly, the family's main concern during this period of time is the survival of their child, and as a result, parents are often too distraught to hear what is being said to them, especially regarding permanent disfigurement (Knudson-Cooper & Thomas, 1988).

With the exception of massive burn injuries (in excess of 80% TBSA affected), or great delays in hospitalisation, the vast majority of patients stabilise at this point and progress to the second stage of hospitalisation.

2.5.2 The intermediate stage of hospitalisation

The *intermediate stage* begins when the patient's initial condition has stabilised, and lasts until the patient's discharge. During this time, the child is fully conscious and aware of what is going on in the environment. Adaptation to hospital routine occurs, and an intense awareness of short-term psychosocial needs, such as scheduling of treatments and family visitations, develops in both the parents and the child, as survival is no longer in question (Knudson-Cooper & Thomas, 1988).

(a) Physical tasks and concerns

Since almost all of the treatment procedures for a burns injury are painful (skin grafting, daily debridement, dressing changes, intravenous drips/ injection placements, application of topical medicines, range of motion exercises), it is especially important for the child and family to understand why treatments are being scheduled and to know what to expect (Knudson-Cooper, & Thomas, 1988; Patterson et al., 1993;Tarnowski et al., 1991). For additional information on chronic pain, please consult section **2.8.3**. A more detailed explanation of some of these procedures follows.

(b) Burn team members' tasks and concerns

One of the vital areas in which family co-operation can be essential pertains to exercise. Burn scars and contractures can result in tight skin and stiff joints. If unaddressed, they can severely restrict movement and result in further disfigurement and/or deformity, which can only be remedied by additional surgery to restore the full range of motion (ROM). All injured parts of the body must therefore be exercised as much as possible to prevent joint stiffness, loss of muscle tone and respiration function (Knudson-Cooper, 1982; Munster, 1993). Physical therapists assist patients with structured exercise procedures, typically starting 48 to 72 hours after the child has been hospitalised (Staley & Richard, 1994). Burn patients are also encouraged to be as active as possible by performing all their activities of daily living with minimal assistance, such as feeding themselves and brushing their teeth (Kiecolt-Glaser & Williams, 1987). In contrast to the mobility required in order to prevent contractures, skin grafting procedures require that the patient be immobilised for several weeks, often in uncomfortable positions (Knudson-Cooper, 1982).

(c) Psychological tasks and concerns

The patients' behaviour during this stage is energised by intense self-centred needs for safety, security, autonomy and nurturance. Their beliefs about self-control, survival, comfort and treatment procedures influence the level of fear experienced (Cromes, 1984). It is often during this time that concerns about the patients' appearance and functioning, and the effects of these on life "out there" begin to surface (Cromes, 1984; Knudson-Cooper & Thomas, 1988). Non-compliant behaviours and depression are frequent reactions when patients are faced with the task of re-appraising their identities and exploring new ways of self-evaluation in order to integrate the disability or deformity (Tucker, 1986). For more details please see section **2.8.2**.

2.5.3 Convalescent stage

This stage is one of resocialisation and rehabilitation, and ideally begins with the last part of primary hospitalisation if opportunities are provided for the patients to begin interacting with other

people in and outside of the hospital. This stage is most intense during the first year after discharge, but may last for several years (Knudson-Cooper & Thomas, 1988).

(a) Physical tasks and concerns

Upon their discharge, the majority of children must wear splints to prevent contracture across the joints which will decrease their flexibility (Hanson, 1984). In order to minimise the hypertrophic scarring, the use of uniform, controlled, continuous pressure is necessary. This commonly takes the form of pressure garments that must be worn 24 hours a day, and should only be removed during bathing. The use of these customised, elasticised pressure garments should begin as soon as the skin is healed and begins to feel dry. It should continue until the scarring process stops (until scars reach maturity) and no further raising occurs - at least one year for adults and sometimes even longer for children (Munster, 1993; Patterson et al., 1993).

Burn patients face further adjustments once the immediate burn injury has healed and they are discharged from the hospital. Burned skin remains quite delicate for up to six months, and during this period burn patients cannot engage in activities that might damage the skin. Temperature extremes can also negatively impact on the fragile skin. In the case of grafts, the skin will itch severely because of the lack of oil-producing glands that assist in its elasticity, that is, the ability of the skin to flex, stretch and 'give' depending on the movement of the limbs and muscles (Kiecolt-Glaser & Williams, 1987).

Burns may sometimes warrant amputation of extremities, such as fingers and/or toes, and plastic surgery is usually necessary to "normalise" the scar as much as possible. Repeated hospitalisation may be required for these reconstructive surgeries (Munster, 1993; Patterson et al., 1993). Similarly, cosmetic corrections (to decrease the negative effect scarring has on appearance) may often be deferred until functional corrections (such as reconstruction of body parts, or relief of contractures that inhibit range of motion in joints) are made, and cosmetic recovery may take from one to many years after the burn (Rivlin, 1988). The full impact of the changed appearance may not be experienced until long after the event (Rivlin, 1988).

(b) Burn Team members' tasks and concerns

Many children and their families feel that when they are discharged from hospital, they are 'all better' and therefore find it hard to understand that splinting, exercise and pressure therapy may be necessary for several more months, if not years, after discharge (Hanson, 1984). Occupational therapists, physio-therapists, as well as the doctors and nursing team all share the responsibility of explaining to, and convincing the family of the necessity of these measures. Preparing the family and child for discharge is another vital task of the burns team during this stage of hospitalisation.

(c) Psychological tasks and concerns

Both the children and their families may build up anxiety regarding the children's appearance and physical functioning. They also tend to be concerned about explaining the situation to friends and relatives. Anxiety about returning to school and acceptance by peers is especially intense, as disfigured children are restricted in their social and school experiences due to the frequently prolonged medical treatment (Rivlin, 1988). It is important not to underestimate the fear that children and their families may experience leaving the protective environment of the hospital, the parents' doubts about the children's needs being met, or their apprehension about the responsibility of home care (Alexander & Quay, 1988).

2.6 PROGNOSIS

The implications of the burn injury do not dissolve as the patient is discharged from hospital. As the convalescent stage implies, healing from a burn wound is a lengthy and painstaking process. It has frequently been said that a severe burn lasts forever, even if the patient is considered healed by ordinary standards. Severe burns are therefore life-changing events, and the psychological sequelae of burns may thus be viewed as a continuum, commencing with the onset of the injury, and continuing for decades (Carter & Petro, 1998; Rivlin, 1988).

Despite the wide-ranging and far-reaching effects of burn injuries on the development, social adjustment and vocational aspirations of countless children world-wide, the research in the

field has been marred by methodological weaknesses. These include sample groups that are too small, a lack of controls, and in many cases the use of non-standardised assessment tools (Tarnowski et al., 1991). A brief overview of the various components that influence the prognosis of paediatric survivors of burns, is included within this section. Detailed discussions of each component follow in subsequent sections **(2.6 - 2.10)**.

2.6.1 The family system

Childhood burn injury must be viewed as a crisis for the children and their families, as the repercussions and implications for all concerned are extensive (Blakeney et al, 1993). In providing emotional care for the children, it is therefore vital to regard *both* the children *and* their families as the targets of treatment (Knudson-Cooper & Thomas, 1988). When families are given the support they need, they are more capable of responding to the needs of their burn-injured children, and help them feel more secure, loved and supported. Those individuals too entangled in their own emotions are unable to minister to the children's needs as efficiently. These family members may also communicate their distress, concerns and fears to the patients, exacerbating their pain, distress and misery (Knudson-Cooper, 1984). For a more detailed exploration of these issues, please refer to section **2.7**.

2.6.2 The child's emotional and psychological state

The emotional, psychological and behavioural responses of burn-injured children are to some extent age-dependent and age appropriate. Toddlers, therefore, have very different responses to adolescents; and primary-school aged children's needs differ from those of infants.

Studies indicate a high incidence of psychological disorder after burn injury, estimated at between 10% and 44% (Blakeney et al., 1993; Patterson et al., 1993). The list of psychological responses to the trauma of a burn injury includes, but is not limited to:

- psychological disorders or states, such as depression; and Post-Traumatic Stress Disorder (PTSD); (Blumenfield & Schoeps, 1993; Knudson-Cooper & Thomas, 1988; Partridge & Robinson, 1995).
- cognitive and motivational distortions, such as paranoia; powerlessness; loss of self-esteem and motivation; depersonalisation; dependency;
- emotions, such as anger; shame; guilt; anxiety about self-image; depression; and despair; fear of rejection, fear of the loss of body parts or functions; desire for revenge; and a desire for others to experience the mutilation.

About 50% of children experience social withdrawal, especially those older than three or four years of age (Cromes, 1984). In fact, depression, aggression and social withdrawal have been observed 2 - 11 years after burns (de Wet, Cywes, Davies & van der Riet, 1979), and even later (Rivlin, 1983, cited in Rivlin, 1988). It should, therefore be evident that the emotional and psychological state of the individual has tremendous impact on the prognosis and long-term adjustment. For a more extensive discussion on the topic, please consult section **2.8**.

2.6.3 The societal reactions

Burn-disfigured people have their own attitudes towards body image with which to deal, as well as the attitude of the people and culture around them (Wallace, 1993). In our modern, westernised society, the responses can range from name-calling, to fear, The loss of cosmetic appearance and pleasure-pain sensations, as well as the change in body image can complicate their re-adjustment to society (Jones, Feller & Richards, 1979).

The importance of preparing the children who has been disfigured for the possible cruel responses of other children and adults, who may well be rejecting and critical because they fail to understand the nature of the problem, must not be underestimated (Cresci, 1982). Preparation for their return to society and their communities, and an awareness of the probable responses may well

decrease the suspected number of suicides due to social isolation (Albertyn, private communications, 1998). For further discussion on this topic, refer to section **2.9**.

2.6.4 The impact on self-esteem and body-image

Children do not depend on glass mirrors; they see themselves as they are reflected in other people's eyes, and they feel the shocks of social rejection as they grow up and encounter new people and new experiences (Cahners, 1979a). Peer group opinions are vital to children as they grow and develop, and while in-group and out-group bonding happens relatively quickly, it is also somewhat fluid. However, children with disfigurements or disabilities are still extremely vulnerable to the internalisation of negative stereotypes and feedback mentioned in **(1.2.1)**, and require a great deal of positive reinforcement and opportunities to re-discover their abilities and strengths, so that they do not define themselves solely by their burns. See section **2.10** for an in-depth discussion.

2.6.5 Positive adjustment

According to Stoddard et al. (1992), although stigmatisation, isolation and depression are experienced by many children and adolescents with burns, many also succeed in overcoming these difficulties with:

- appropriate treatment;
- help from their families;
- and by using their own coping skills.

Moore et al. (1996) found in their study that survivors of massive burn injuries greater than 80% of TBSA judged themselves, and were judged by their parents, to be competent at school and interpersonal relationships. Those children with greater physical impairments did not participate in athletic teams, clubs or organisations as often as their less-impaired cohorts; however, in no other domain do they seem - as assessed by standardised instruments (such as the Child Behaviour Checklist and Youth Self-Report) - to be less competent than unburned children.

2.7 EFFECTS ON THE FAMILY SYSTEM

2.7.1 Concerns

The number of concerns that a family faces when one of the children is burned is completely overwhelming. Emotional upheaval as well as disturbance of the daily routine leaves a lasting impression on *all* family members, not only the one hospitalised. Our interest in the family's response to the crisis is two-fold, firstly, as individuals themselves, and the psychological and emotional distress they experience in their individual capacities; and secondly, as a support system for the burn-injured child. The discussion below is drawn from the following sources: Cella et al., (1988) Knudson-Cooper and Thomas, (1988); McGookin and Leveridge, (1991); McLaughlin, (1990); and Munster, (1993).

(a) The family's distress

- One of the main sources of emotional distress for parents and other family members is guilt. Regardless of whether or not they are actively responsible for the burn injury, parents often feel guilty for their children's injuries, as it may have occurred as a result of covert or overt neglect. If the injury resulted from overt abuse, the parent(s) may be filled with remorse, shame and guilt.
- The family may have intense problems because of their needs, attitudes and beliefs about family, child-rearing, the future, and circumstances surrounding the burn injury. All of the aforementioned principles, ideas and practices are called into question by the crisis, and most parents do a great deal of 'soul-searching' during this time.
- Normal family functioning may be disrupted when one or both parents spends a great deal of time at the hospital. The prolonged hospitalisation of the burn patient frequently requires role readjustments of the family members at home and at work . This can also result in distress for the siblings. Priorities shift, and the family becomes preoccupied with the burn-injured child, possibly to the extent that they neglect or ignore the other children

- Siblings of the burn-injured child may get 'farmed out' to friends and/or other relatives, and this may cause them to feel anxious, insecure and worried. They may create all sorts of conjectures regarding the implications of these actions.
- Studies have shown that parents of burned children showed some specificity in the nature of their distress, and were significantly more depressed and hopeless than parents whose children were in hospital for other medical procedures.
- For parents, depression may be a reaction to the multiple losses which can occur when children suffer from burn injuries, including: loss of the parents' physical image of their children; loss of the parents' self-image as a 'good parent'; or loss of future potential and/ or possibilities for their children.
- The anxiety and depression that parents experience may also compromise their ability to provide care for their children after discharge. They may feel guilty about insisting that the child comply with ROM exercises, or capitulate to the child's demands as a result of remorse or pity.

(b) The family as support system

According to Bernstein et al., (1992), significant relationships play an important role in the child's ability to cope with the pain associated with serious illness. Children's responses to hospitalisation and medical care are directly influenced by parental emotional states. The extent to which children adapt and recover depends largely on the strength and security of those caring for them.

2.7.2 Interventions to address the concerns

Short and long-term psychosocial interventions are necessary for the family and the children in order to alleviate guilt, establish healthier home environments, and assist in the children's responses to hospitalisation and rehabilitation (Artz, Moncrief & Pruitt, 1979). Issues regarding child-rearing practices, and beliefs and styles of coping must be explored in as sensitive a manner as

possible in order to support positive styles of coping and child-rearing, and weaken or discourage inappropriate discipline styles and unhelpful negative assumptions (Cromes, 1984).

The siblings of the burn-injured child need reassurance that their parents still care for them, even though they are presently distracted. They may also need 'absolution' if they were party to, or in any way responsible for, the burn injury - whether it be through neglect or action. The parents will have experienced disillusionment, and may well have had expectations for their child crushed as a result of the burn injury and attendant complications that can arise. They must therefore be given "permission" to grieve for the loss of physically perfect children (McGookin & Leveridge, 1991).

By designing and implementing interventions that target the entire family, the burns team can strengthen the system, and by so doing, improve and enhance the quality of support that the family is able to provide the burn-injured child.

2.8 THE EMOTIONAL IMPACT OF THE BURN INJURY ON THE CHILD

The list of behaviours engaged in, and emotions experienced by burn-injured children may appear at first glance to reflect a random, unending list of problems and symptoms. For this reason, a brief overview will be presented, before a more detailed examination of certain key features, such as depression- and anxiety-related behaviours and emotional responses, will be conducted.

It is vital to be aware of developmental issues and how these changes manifest in the child, as these will impact on the children's responses to chronic pain and hospitalisation.

- Babies and toddlers (from birth to two years) often experience separation anxiety when separated from their caregivers during hospitalisation.
- The major concern of children in the pre-school age group (three to five or six years of age) seems to be the physical changes in their bodies (Munster, 1993). According to Erickson, children between the ages of three and five years of age are learning to trust others outside the family, separate from the family, and develop their own self-concept. The people the child has

been entrusted to for care (while in hospital) are consequently seen as monsters, constantly hurting the child, and the developing self-concept is often severely disrupted (Kibbee, 1981).

- Primary school-aged children (seven to eleven or twelve years of age) more typically experience difficulties with agitation and anger, and often attempt to assert control over the situation in whichever way they can. They tend to worry a great deal about missing school and the loss of interaction with their peers. They are mainly concerned with the restriction of their behaviour and activity (Munster, 1993).
- Adolescents tend to be sensitive to issues regarding their autonomy and independence, and may respond with either non-compliance or withdrawal (Moss et al., 1994; Wallace, 1993).

For ease of reference, various behaviours and emotional responses will be classified under a number of different headings.

2.8.1 An overview of reactions and behaviours

It is important to note that the psycho-social reaction of an individual may *not* be directly proportional to the severity of the injury. The distress may be related to the experience of severe pain or threat to the patient's sense of identity and perceived worth (McLaughlin, 1990). In a burn injured patient, the pain of the injury is one of the few constants in hospital. Coupled with this, is often fear of the unknown: for example, patients are unsure of their physical status and worry that they are going to die, or that they will remain 'ugly forever'. Because no guarantees can be issued about physical and/or aesthetic rehabilitation, the patients have no idea how they will look, and how people will respond to their changed appearances. The only certainty is the *lack* of certainty (Artz et al., 1979).

Stressors during this time of hospitalisation usually include: separation from a loved one, isolation from family and friends, and a loss of independence. In addition, the pain from the burn itself, as well as the variety of medical procedures, and the forced inactivity tend to exacerbate

many of the reactions, and can often lead to stress responses such as shock; confusion; and delirium (McLaughlin, 1990).

To explore all of the reactions in detail is beyond the scope of this study, so focus will only be placed upon the most common and most significant responses.

2.8.2 Oppositional and non-compliant behaviours

In a Burn Unit, where the patient has no control over decision-making or procedures and is entirely reliant on others, it should not be surprising that the combination of pain, fear, dependency and feelings of powerlessness result in the oppositional behaviour seen (Partridge & Robinson, 1995; Tarnowski et al., 1991). Common responses and behaviours include: refusal to eat, take medication, exercise, or have dressings changed. Children may also exhibit violent behaviour when dressing change is mentioned, may be verbally abusive, ignore family visitors, and impose self-isolation, refusing to see friends (Moss et al., 1994; McLaughlin, 1990). They may also exhibit a denial of reality, temper tantrums, and low frustration tolerance (Blumenfield & Schoeps, 1993).

Another possible explanation for the non-compliant behaviour manifested by burns patients, can be found by examining defensive reactions to grief. Many of the patients, unable to tolerate or express their grief, react in an oppositional manner as a defence against feelings of sadness or loss (Kübler-Ross, 1975). This tends to be expressed as overt hostility, withdrawal and/or resistance to treatment, manifested by a refusal to co-operate with nurses who need to change bandages, debride the wounds, and feed the children (Cromes, 1984).

2.8.3 Chronic pain

As previously mentioned, pain is a perpetual presence in a burn patient's world. Some of the pain is caused by the trauma itself: superficial to deep partial thickness burns cause pain, whereas full thickness burns are often not experienced as painful, as the nerves are often destroyed, and therefore cannot relay pain impulses to the brain (see section **2.3.1**). Other causes of pain may

include the debridement of the skin tissue, and the various other medical procedures (**2.5.2. (a)**) that are necessary to ensure survival and minimal complications and scarring.

According to Artz et al. (1979) the patient may react to the pain in one of three ways: by ignoring it, by reacting to it realistically, or by overreacting to it. Albertyn (1998) insists that children are notoriously under-medicated with regard to pain medication, and concurs that staff should not make judgements as to whether the pain is appropriate or exaggerated, but should rather intervene in the patient's *reaction* to the pain.

2.8.4 Fear, Anxiety, and Post Traumatic Stress Disorder (PTSD)

Severe trauma challenges each individual's fundamental belief regarding the safety and predictability of the world. Individuals tend to respond to trauma and painful injury or stimuli with anxieties and fears, as their basic sense of invulnerability and integrity to body and personality is damaged (Munster, 1993). The fear and anxiety experienced by burn patients in the acute stage of hospitalisation often contributes to the psychological shock reaction.

Fear is often the most powerful emotion expressed by the children: fear that after the accident they are unlovable, a fear of being abandoned, and a fear of ridicule at their appearance or lack of ability to do something (Kibbee, 1981). This often leads to dependent behaviour, or withdrawal for fear of rejection.

The pain induced by wound cleansing or physical rehabilitation can also engender strong fear reactions to staff members or certain places in the hospital (Moss et al., 1994). These conditioned responses may be evident at times when the specific pain-inducing activity is not being conducted. These fear reactions may manifest themselves as oppositional or non-complaint behaviours; or as tearful, depressive responses.

Among the most typical of anxiety-related responses is Post-Traumatic Stress Disorder (PTSD), which refers to the experience of intrusive recollections, nightmares, and anxiety that is focused on the events surrounding a traumatic experience, beyond the scope of normal human

experience. Patients with burns in the acute-care setting frequently experience these symptoms within hours of the injury. However, for these symptoms to be technically diagnosed as PTSD, they need to last for a period of one month after the injury (Hurren, 1995; Pruzinsky et al., 1992).

According to Jiminez, Bajo, Castillo, Salvador-Robert and Torres (1994), PTSD is apt to be missed by the medical staff of burns units because physical markers, such as severity and type of burns injuries, were not good indicators or predictors of PTSD. Because the symptoms may be misdiagnosed or attributed to another anxiety-related disorder, the prevalence has been grossly underestimated. In a study by Stoddard, Norman and Murphy (1989, cited in Tarnowski et al., 1991), 53,3% of the children assessed showed evidence of PTSD. This finding was reiterated in a study by Stoddard et al. (1992) where 50% of the children assessed were diagnosed with PTSD. The implications of this are that many children leave the hospital with flashbacks and intrusive thoughts regarding the accident, and family members and teachers are left to cope with the aftermath.

2.8.5 Depression-related emotions and behaviours

In the acute hospitalisation period, it is especially critical to assess depression. Some burn-injured patients have displayed a tendency to "give up" before dying (Pruzinsky et al., 1992). In such situations, patients lose the will to live and do nothing to secure their own survival, acting as passive observers to the medical scene played out above and around them. Behaviours associated with depression can include: withdrawal, crying, anhedonia, staring aimlessly, showing disinterest and a lack of involvement in treatment (passive and incurious about procedures, and unwilling to attempt various ROM exercises), disinterest in eating (anorexia), and sad facial expressions (Cromes, 1984).

(a) Despair and grief

Once patients have moved into the intermediate and convalescent stages, it is probable that feelings of despair and grief will surface. Many patients have to come to terms with changes in physical appearance, possible changes in levels of functioning, and, in certain instances, loss of limbs or extremities due to amputation. There is an overpowering sense that things will never be the same as before, and the losses incurred may be too overwhelming for some individuals. Feelings of inadequacy and worthlessness are prominent (Moss et al, 1994).

The experience of grief is largely dependent on the age of the burn-injured child. While all children have the capacity to 'read' their parents' faces for emotional cues, in the younger age groups there is a limited capacity to process the implications of this, leading to a simplistic understanding of the situation: 'my parents are worried and that means something bad has happened'. It is widely accepted that children only develop the capacity for reflexive reflection as adolescents (Kibbee, 1981). Thus, although they might understand that they have undergone a change in appearance, they may not be able to extrapolate the implications thereof. This does not imply that children do not experience grief at the loss of limbs, possibilities, innocence, trust in the world, trust in their parents to protect them from harm, and appearance. Rather, their grief at these losses may be manifested as anger and aggression (see section **2.8.2** for further details).

(b) Guilt

It is vital to bear in mind that the burn victim is an accident victim. The patient will often have guilt feelings regarding the accident (especially if it results from the use of 'forbidden' materials, such as petrol or matches), and may have a fear of death or punishment. They therefore need repeated reassurance from their parents that they are not angry with them for getting burned, and that their parents still love them (Carter & Petro, 1998; Knudson-Cooper, 1982). Failure to receive this reassurance can exacerbate the fears and depression previously mentioned. Behavioural manifestations of guilt may include: self-recriminating remarks, comments regarding what should or should not have been done, self-defeating behaviour, or poor compliance with treatment (Cromes, 1984).

(c) Helplessness and hopelessness

Depression in children has been shown to be a serious problem that is highly under-recognised (Shafii & Shafii, 1992, in Poznanski & Makros, 1992). Estimates suggest that 15% of children who suffer from a Major Depressive Episode during their lifetime will eventually commit suicide, and that suicide is now the second highest leading cause of death amongst adolescents (Mateu & Hernandez, 1996; Poznanski & Makros, 1991).

According to Albertyn (private communications, 1998), many of the children treated at Red Cross War Memorial Children's Hospital Burns Unit commit suicide as a result of the social isolation and abuse that occurs as a result of their vulnerability due to severe disfigurement and/or disability and loss of function.

2.9 STIGMATISATION

As previously discussed, this stigmatisation often denies individuals full social acceptance, and women are particularly at risk because physical attractiveness is central to their appraisal by society (Tucker, 1986).

2.9.1"SCARED"

The acronym SCARED, was devised to describe the typical reactions of others to burn survivors' scars (Partridge & Robinson, 1995). The various letters denote the following feelings and responses: **S**taring; **C**uriosity; **A**nguish; **R**ecoil; **E**mbarrassment; and **D**read. These categories will be used to detail the majority of responses with which disfigured burn survivors are greeted.

(a) Staring

Most people are unsure of how to respond when meeting someone who is disfigured. There is usually a desire *not* to stare, as we teach children that staring is socially unacceptable. However,

there is often a difficulty in estimating the correct or normal level of eye contact. As a result, people tend to stare and disfigured persons are powerless to prevent this.

(b) Curiosity

This difficulty is compounded by a curiosity concerning the abnormality and a desire to look at it, which may well result in staring. Sometimes, having a visible disability, deformity or disfigurement is interpreted as 'open season', and people abandon or suspend the normal, 'polite' rules of engagement in social situations. Privacy is one of the first rights of which disfigured people are disenfranchised. They may also be subjected to questions about their deformity, and may be obliged to volunteer more information about themselves than non-disfigured persons (Hurren, 1995; Munster, 1993).

(c) Anguish

In referring to anguish, Partridge and Robinson (1995) discuss the painful emotional distress that many individuals feel as a result of identifying with the burn-injured individual. Pity is a very common response that disfigured persons have to endure when meeting NYDs in public. This sympathy often leaves both parties in the interaction feeling awkward and uncomfortable. It reminds the disfigured individual that people still respond primarily to what they see, and that the external appearance has great impact. The sympathetic individuals may feel helpless, and be unable to express their feelings of sorrow.

(d) Recoil

Unfortunately, another common response is rejection and withdrawal. Many people express feelings of revulsion, horror, and disgust upon seeing a burn-injured person. Facing the victim of a burn with a deformity forces a person to confront his/her own vulnerability, which sometimes leads to rejection of disfigured people (Hurren, 1995). Many disfigured people experience loneliness and isolation, as a result of being "shunned" and excluded from everyday social interactions. There is a tendency for people to avoid eye contact or at least minimise it when addressing someone who is facially disfigured. When eye contact is made, it is usually more distant and less personal. At its

worst, isolation may take the form of what MacGregor referred to as a 'Social Death', where burn-injured individuals withdraw and disappear socially. (Bernstein et al., 1992). This may culminate in suicide (Hurren, 1995).

Another interpretation of 'recoil' is to 'rebound' or 'fly back', and refers to the aggressive rebuff or personal attack that is sometimes directed at burn-injured individuals. In adults, this may take the form of mocking, while children typically resort to name-calling and rudeness (Partridge & Robinson, 1995).

(e) Embarrassment

In children, the typical response when they feel embarrassed is giggling. The conflicting impulses of curiosity and an attempt to maintain appropriate social customs often results in a sense of embarrassment and awkwardness (Munster, 1993).

(f) Dread

In Western cultures, to be less than physically attractive is a cause for social embarrassment, according to the cultural norms we seem to uphold. Within popular culture (movies, horror stories, cartoons and comic books), the villain or 'defective' individual is often portrayed as facially scarred (Carter & Petro, 1998). Possibly for this reason, many individuals fear people who are disfigured, suspecting them of matching their physical appearance with an internal deformity.

2.9.2 Children as the peer group, children as the stigmatisers

It is clear that children express negative attitudes towards disfigurement and disabilities. Negative attitudes to disfigurement and disabled people develop at a young age. It has been demonstrated that by the age of five years, children were able to discriminate between disabled and non-disabled peers and developed negative feelings towards disabled peers (Hurren, 1995). Even after prolonged exposure, it has been shown that children with amputations are more likely to be

named by their able-bodied classmates as the saddest, least liked, least nice looking, and least fun in class (Bull & Ramsey, 1988, in Hurren, 1995).

2.10 SELF-ESTEEM AND BODY IMAGE

2.10.1 "SCARED" too

According to Partridge (1993, cited in Partridge & Robinson, 1995), in being confronted by others' reactions to their burn scars, survivors may feel a range of responses that can also be captured by the acronym "SCARED": **S**elf-conscious; **C**onspicuous; **A**ngry; **R**eluctant; **E**mbarrassed and "**D**ifferent". Since some of these categories overlap, they will be combined for the purpose of the discussion below.

(a) Self-conscious and "Different"

Children's perception of themselves with different body images will dictate their ability to adapt to the behaviour norms of their peer groups (McGookin & Leveridge, 1991). They are acutely aware of their body image and are very concerned about the acceptance of their peers. Someone growing up with a disability is vulnerable to peer pressure about appearance, and what is 'cool', and may internalise the rejections and humiliations that accompany perceived difference (McLaughlin, 1990).

(b) Conspicuous and Embarrassed

Psychological sequelae are especially adverse for children and adolescents who suffer visible scarring. Burned girls are more socially anxious in situations involving bodily exposure such as swimming and physical education classes (Rivlin, 1983, in Rivlin, 1988).

Children may resist the idea of going back to school if they need to wear a pressure garment that is visible; especially if the parents have expressed some sort of relief when they discover that a specific type of clothing conceals the scars. It is this sort of behaviour which influences children to think that they have something they should hide, and of which they should feel ashamed or embarrassed (Knudson-Cooper, 1982).

(c) Angry

Some children attempt to lash out at the world to compensate for, or retaliate against, the pain and distress they have experienced. Many burn-injured children wish for others, especially those who witnessed or caused their burn, to experience the same mutilation that they have endured. This will be discussed in greater detail in section **3.1.3**.

(d) Reluctant

A greater frequency of bullying, teasing, stares and rude remarks exacerbate the distress many burn-injured children experience. This decreased acceptance can lead to a decrease in activity levels, which culminates in them wanting to, or managing to withdraw from both peers and other forms of public contact (Chang & Herzog, 1976; Giljohann, 1979; Molinaro, 1978; Rivlin, 1988). Frequently, burned patients are eager to return to their homes and communities, but are afraid of rejection because of the deformities resulting from the burns (McLaughlin, 1990).

CHAPTER THREE: THE IMPACT OF BURNS ON SCHOOLING

3.1 EFFECTS OF THE BURN AND RESULTANT ABSENCE ON SCHOOLING

Despite the lengthy list of potential harmful emotional, psychological and physical sequelae of severe burns, and the knowledge that more children are burned than adults (Stoddard et al., 1992), relatively few authors have focused on the effects of a severe burn on a child's schooling (Kearney, 1977; de Wet et al., 1979; Giljohann, 1979).

The average hospital stay for primary hospitalisation of the burn (stabilising the child and doing functional corrections only), is approximately two months, depending on the depth, TBSA and location of the burn (Knudson-Cooper, 1984). Cosmetic corrections, after the scars have matured, often require additional hospitalisation. This process of being hospitalised and discharged can last up to two years or more after the initial admittance for the burn injury (Munster, 1993). A number of effects with respect to the burn-injured child's return to school, and on-going schooling, have been noted.

3.1.1 Impact on schoolwork

The implications of these absences are that children, unless tutored while in hospital, typically lag behind their cohorts and experience learning difficulties. As a result of prolonged absences from school, burn-injured children may often experience tremendous difficulty in 'catching up', and many may choose to stop attending school, rather than face this subjectively insurmountable task. This may well lead to illiteracy, as discussed in section **1.6.2**.

An additional repercussion from the lengthy absence and resultant lag in academic work, is the attendant loss of self-esteem that many children experience. Just as some adults define themselves through their work and vocational achievements, so too, do certain children define part of their identity through their academic abilities. When their prowess declines, they may feel less worthy, which then compounds their loss of self-esteem as a result of the burn injury (Knudson-

Cooper, 1984). As previously mentioned, the low self-esteem typically results from negative societal responses to the appearance of facially-disfigured burn survivors. Knudson-Cooper and Thomas, (1988), found that burned children had significantly lower self-esteem and were more likely to be behind in school, than children with congenital heart defects.

Burned teenagers often have lower career goals and vocational aspirations than their unaffected peers (Wallace, 1993). More frequent changes in jobs and a lack of confidence in success at work have also been reported in burn survivors (Chang & Herzog, 1976; Rivlin, 1988).

3.1.2 Impact on peer relations: rejection and isolation

Another complication arising from their many absences is the difficulty many burn survivors experience in being re-integrated into their peer groups. To young children, a few months can feel like a lifetime, and they can find it difficult to relate to someone who has been missing for months, and in addition whose appearance has changed (Knudson-Cooper, 1984). Some children spoke of loneliness, rejection, and exclusion, citing examples such as walking alone to school while others walked in groups, and sitting alone during breaks (Molinaro, 1978). According to Zeitlin (1997), 53.2% of her sample were asked about their scars, and 20% of the patients had experienced some difficulties in contact with the opposite gender. For further discussion, refer to section **2.10**.

3.1.3 Impact on behaviour: conduct disorders and defiant behaviour

The burn injury and resultant absence from school also has a significant impact on children's behaviour upon their return to school. Teachers have described greater behavioural problems with burned children, (especially boys) than with other children who suffer from other serious illnesses (Rivlin, 1988). Anger, aggression, and a desire for others to experience similar mutilation, is sometimes expressed through acts of defiance or oppositional behaviour. Chang and Herzog (1976) observed that conduct disorders were found more frequently in the burned sample than the Utah state average for children in similar age groups, and children in the sample did not

have a past history of conduct disorder. Children who engaged in this behaviour (post-burn) felt rejected by their peers upon returning to school and were unable to tolerate the numerous questions and teasing to which they were subjected (Chang & Herzog, 1976).

3.2 SOUTH AFRICAN RESEARCH IN THE FIELD

In the only article in South African literature on the subject, de Wet et al. (1979) echoed many of the findings from the overseas literature. They defined scholastic adjustment as unsatisfactory when it was hampered by problems such as long absences from school, and behavioural and learning difficulties. Their study showed that 60% of the burn-injured children attending normal schools were between one and three years older than their cohorts due to absence and learning difficulties. For the majority, the need was for cosmetic surgery (which was often acutely needed for psychological adjustment) which would facilitate uninterrupted schooling.

School performance of patients was compared with the average for their class, based on the exams marks of the last school standard completed by individual patients. Of those, 68% of the sample achieved below their class average. Some 52% had, at some stage, failed their end-of-year exams and had had to repeat school grades. Two of the patients needed special schooling as a consequence of the burn injury, which had resulted in disabilities. The burn-injured learners' failure rate was almost double that of the other learners'. Interviews with mothers revealed that name-calling and teasing because of visible scarring resulted in considerable reluctance to attend school. Name-calling was spontaneously mentioned by 76% of the patients as the most upsetting after effect of the burn-injury.

3.3 FEELINGS AND ATTITUDES OF TEACHERS

With the exception of the family, the school exerts the most influence on a child's normal development and social adjustment. The ease or difficulty with which a child makes this crucial

adjustment depends most significantly on the school staff and the patient's classmates (Cahners, 1979b).

Many of the same emotions that affect a patient's family (grief, fear, anger, denial), can also affect the ability of the teacher to cope with the new responsibilities and demands imposed on him/her in receiving a burn scarred child in the classroom (Cahners, 1979a). The school personnel quite likely do not have information about, or experience of, burn injuries and recovery, and are therefore susceptible to all the fears, anxieties, and failings of human beings detailed above. A teacher who has never seen a burn-scarred face, or worked with a child who has lost fingers, will need a great deal of support. Teachers, like other adults, have preconceived notions of how children should look and function. They may have very personal feelings about "looking different", about pain, hospitals, adjustment; often they have angry feelings towards the parents, blaming them for the child's burns (Cahners, 1979a,b).

Teachers and school administration may also be concerned that they will be inadequate in meeting the child's needs (Blakeney, 1995; Cahners, 1979a). It is therefore vital that the school staff be emotionally and psychologically prepared for the return of burned children, as well as have access to all relevant information about their rehabilitation and recovery. This will include information regarding their capabilities and specific details regarding their rehabilitation needs and physical limitations as they relate to the hours they will be in school (Blakeney, 1995). If they are receiving medication, the school needs to know how this will affect classroom behaviour or activities (Blakeney, 1995). It is also vital to spell out that they are not expected to give medical care and can call on the Burns Unit for support.

School personnel also worry that the other children will be insensitive to the burned children or will be frightened by their appearance (Cahners, 1979a). To address the fears of children, parents and school staff, formal programmes for school re-entry have been developed in the United States of America (Blakeney, 1995).

3.4 SCHOOL RE-ENTRY PROGRAMMES

3.4.1 The necessity of school re-entry programmes

The 'community' that dominates a child's life outside of the family is the school. The school is the domain in which the children develop academic skills, social skills, and a sense of self-worth. As the burned children struggle to develop a new self-image that incorporates their scars, they need feedback from within the school community that tells them that they are valuable and competent (Blakeney, 1995). Therefore, one of the most important crises is when the child prepares to socialise and return to school with a different physical appearance and possibly a different physical capacity, and when the parents have to cope with other people's attitudes and remarks concerning their child's disfigurement (Rivlin, 1988).

The process of acceptance into the community thus requires a mutuality that includes openness and responsiveness of the society into which the burn survivor attempts to re-enter, and mental and emotional preparedness on the part of the survivor (Doctor, 1992). Experience with burned children indicates that children who go back to school within a few weeks of discharge tend to make a positive adjustment and that children who are taught by a homebound teacher tend to become isolated, depressed and stuck in the 'sick role' (Knudson-Cooper & Thomas, 1988; Cresci, 1982).

For the remainder of this section, the bulk of the discussion will be drawn from the following central contributors to this field: Alexander and Quay (1988); Blakeney (1995); and Doctor, (1992). Where ideas and thoughts are drawn from different authors, their names will be referenced.

3.4.2 The intervention

From the time of admission, the child's return to school should be part of the treatment and discharge plans. A member of the burns team, with the parents' permission, contacts the child's school to notify them of the medical status of the child, obtains important information about the

child's academic achievements, and elicits any concerns from the school personnel's point of view. Reintegration begins with that first contact, and continues through co-operative efforts of the hospital and school.

The premise of these programmes is that education about burn treatment and about the needs and limitations of the burned children will diminish anxiety related to the unknown. When anxiety decreases, the need for defensive behaviours, such as withdrawal and ridicule, will also decrease and the burned children's peers will be more accepting and supportive of them.

Ideally, the intervention takes place before or on the first day back in class. The actual presentation should be scheduled for a time immediately preceding the burned child's actual return, as it is vital that the information about the child and his/her capabilities is up to date.

(a) The targets of the intervention

Burn team members usually visit the school and present information about burn prevention and the special needs of the burned child who is returning to school. The targets of this type of programme are three fold: namely, the school as a whole; the class teacher of the burn-injured child; and his or her peers. These programmes have been effective in helping both school personnel and the other children to understand the rehabilitation process and prevents the teasing and fear of the burned child that can occur without this understanding (Kammerer, 1988; Kibbee, 1981).

It is important to include the entire school in the orientation because the returning children are not only going to have relationships with the classmates, but with the other learners walking to and from school, at lunchtime, during athletic activities, and passing between classes (Kammerer, 1988). If the choice is available, it is usually better to do the presentation without the burn-injured learners being present as the learners and staff are less inhibited about hurting their feelings or bringing up thoughts that make them sad or otherwise uncomfortable.

(b) Designing a programme

Children and their parents report that if other children know what happened, and why the burned child is required to, for example, wear pressure garments and splints, they are generally accepting and supportive (Knudson-Cooper & Thomas, 1988).

Plans for each child should be individualised. The burn team wants to convey to the patients and their families that the burn injury is only a temporary disruption of their lives. The children may have to learn a new way of doing some things, and may have to move at a slower pace than in pre-burn days, but they can resume activities and with time and practise, will be able to participate. A quick return to school for even a small part of the day reinforces the idea that the children are again able to begin normal life with their peers. Children who are allowed to withdraw experience each day of isolation as confirmation of the fact that they are incompetent, without value, and repulsive to others.

A visit from the burns team includes a meeting with school personnel, followed by an assembly for the entire school. The patient and patient's family participate in preparation and on-site presentation, wherever possible.

According to Blakeney, (1995) all programmes include some basic elements:

- address school administration, classroom teacher(s) and children;
- include patient and parents in planning and, to some extent, presenting;
- present generic educational information;
- present specific information about the individual child returning;
- direct presentations at both intellectual and emotional issues surrounding the return of the burned child.

The old adage about the value of "a picture being worth ten thousand words" is particularly true in preparing those unfamiliar with burn injuries for an introduction to burned children. Scars, amputations, pressure garments, splints, masks and braces may combine to form a visual image that is strange and frightening to the naïve observer. Slides and/or photos provide information and help the audience to become accustomed to viewing these unfamiliar sights.

Dolls can be used to model splints, pressure garments etc. They can also be outfitted with a 'graft' and 'donor site' attached by fabric touch fasteners. Encouraging children to try on the various apparel can help them to empathise with the burned child.

In the USA, burn camps are held in the summer for children to meet others who have similar stories, and to socialise without stigma and staring. Typically, adult burn survivors are invited to visit and share their stories, including what problems they had as a result and how they deal with them. They then encourage children to share their own stories. It is vital to address how it feels to be burned, or be seen as different by other people, how the children feel about their scars, and what it is like to be teased and called names.

If they are provided with education and a stated expectation of empathic, supportive behaviour, most children will respond by behaving in a caring, protective and helpful manner. Activities that help them to identify and empathise with the hurt child are especially helpful in the age group of grades three to seven.. Follow-up consultations with teachers indicate that those who are not responsive to this expectation often meet with chastisement by peers who have created a support buffer for the child with burns who, for a brief time, enjoys "star status" (Doctor, 1992).

Children are aware of their social liaisons and form social groups that, by definition, exclude someone. Teasing and nicknames are primary modes of defining the boundaries of the group, and physical appearance is an easy way to differentiate among their peers (Blakeney, 1995). Fortunately these boundaries are relatively fluid.

Sometimes the child will require temporary placement in special education classes because of physical disability, but it has been found that most children can return to their classes with minor adjustments for the child's special needs (Knudson-Cooper & Thomas, 1988).

Renewed social competence and the sustained re-involvement with peers, school and community are considered valid indicators of long-term adaptation for children with handicapping conditions and chronic illness (Whitt, 1984, in Moore et al., 1996).

3.5 SCHOOL RE-ENTRY OF SOUTH AFRICAN BURN-INJURED CHILDREN

In South Africa, there are currently no school re-entry programmes, although burn team members have visited schools in the past to prepare pupils for the return of the severely burned patient (de Wet et al., 1979). For the most part, children are fortunate to receive any form of counselling or psychological intervention while in-patients, due to the appalling lack of resources available. Psychologists' posts in government hospitals are, by-and-large, either frozen, or dissolved. Red Cross currently has one social worker assigned to cover more than three wards of children.

Up until now, our lack of resources has prohibited the implementation of any school reintegration programmes, as they have been conceptualised in First World countries, with access to First World resources. The need is therefore to create a programme for the reintegration of burned students. This programme would need to be conservative in its use of resources; socio-culturally sensitive to South African issues, and capable of fulfilling its function with respect to assisting and educating the school community to make the return of the burn-injured learner as comfortable and 'hassle-free' as possible.

CHAPTER FOUR: RESEARCH AIMS AND METHODOLOGY

4.1 AIMS

As previously mentioned, American programmes for school reintegration are resource-intensive. They necessitate the use of slide projectors for slide shows, and mock casts, splints and pressure garments for children to explore and experiment with. They also require that a member of the hospital Burns Unit present the programme, and be available to answer any questions that various staff members, teachers or learners may have. The interaction between the burns team member and the school population is traditionally "top-down", and one-sided, as the majority of the programme consists of lecturing in one form or another.

Within the South African context, many of the resources utilised in the USA are not available. The Red Cross Burns Unit staff admit and treat more children to their unit in one year than do many of the specialised hospitals in the USA. Consequently, burn team members are not available to take time off for numerous school visits. Within the educational environment, especially in disadvantaged areas where schools experience difficulties in collecting fees from unemployed parents, the notion of slide shows is completely inappropriate.

Therefore, to ensure the effective use of limited available resources, and make the programme accessible, it was felt that OBE practices should be implemented. These necessitate that the programme has, as additional aims, the intention to foster mutual respect by facilitating a socialising environment that is welcoming of all learners; and activity-driven interactive communication between the programme facilitator and the participants.

The primary aim of the research project was thus to devise an intervention (consisting of a manual and programme) that would prepare and assist primary-school teachers and their classes in adjusting to the return of burn-injured learners. This intervention would be based on the principles of

school reintegration extracted from predominantly American literature on the subject, most notably Blakeney (1995) and Doctor (1992).

After devising the programme, the next aim was to assess the contextual applicability of the programme in terms of: (a) its use of resources; (b) its appeal to, and ease of application for, teachers; and (c) the ability of the programme to engage the learners.

The final aim was to conduct a preliminary evaluation of the efficacy of the programme, in terms of the following: (a) its therapeutic effectiveness in helping the class adjust to the burned learner's return; (b) its impact on the burned learner in terms of protecting against depression, and enhancing the level and quality of peer and familial interaction.

4.2 DESIGN OF THE INTERVENTION

4.2.1 Ethical considerations

There are a number of ethical principles that govern both therapy, and research within the helping professions. These include: informed consent, confidentiality, and beneficence and non-maleficence (Dominowski, 1980; Steere, 1984).

Informed consent is one of the central tenets of qualitative research, as it is based upon the concept of freedom of choice and self-determination of participants. This has very serious implications with regard to this specific study, as informed consent was necessary at each step of the intervention's implementation. It was first necessary to obtain the consent of the Western Cape Education Department, in order to conduct research in a Western Cape school. It was then necessary to obtain permission from the Red Cross Hospital administrator, to search for an appropriate participant. Once a list of names had been obtained, the next step was to contact the family of a possible participant, and to explain to the child's parents, in full, the programme's aims and proposed implementation. The parents of the burned child were then in a position to make an informed decision regarding the family's

participation. Upon receiving their consent, the principal and class teacher were approached and the process explained, so that their agreement and co-operation could be obtained. (Please see Appendix **A** for a copy of the introductory proposal of the programme presented to both principal and teacher). In addition, in terms of the class' participation, it was necessary to get written consent from the learners' parents so that their responses could be audio-taped. Upon receiving the parents' permission, the learners were consulted regarding the possibility of their responses being audio-taped. This provided them the freedom to choose whether or not to participate. The aims of the project were explained, as well as details provided regarding the use and disposal of these audio-tapes.

Participants who are not guaranteed their privacy, are often reluctant to divulge personal information or discuss sensitive topics. With regard to participants who are minors, the issue of confidentiality becomes crucial. All the learners from the burned learner's class who participated in this study were aware that anonymity was guaranteed, and that the information would not be reported on an individual basis, but rather in aggregate form. Participants, such as the burned learner, his family members and his class teacher, whose responses would be reported as individuals, were consulted on the use of pseudonyms in the study. All concerned requested that their real names be used. It was felt that the use of first names would be most appropriate, as it would honour their wishes while safeguarding their privacy.

Another major ethical consideration revolves around the concepts of beneficence and non-maleficence. One of the primary guidelines of therapists is that one should try to do good, and to do no harm to clients (Steere, 1984). Researchers are bound by the same ethical considerations and principles. As this intervention was well-grounded in humanistic principles, it was necessary to consider the 'risk-benefit ratio', and weigh up the possibility of causing psychological harm or distress to the participants while investigating sensitive issues, as opposed to the likelihood of the participants gaining positively from the experience (Dominowski, 1980).

To ensure that the aforementioned principles of beneficence and non-maleficence were manifested in the research, the manual, including the proposed programme, was issued to the class teacher prior to its implementation. For further details in this regard, please consult section **4.4.2. (a)**.

4.2.2 Construction of the manual

The first task was to determine the aims of the manual. The intention was to make it as inclusive as possible, so that a teacher would need no additional resources to understand the situation and implement a programme that would prepare and educate the class to which the burned learner was returning. This meant that the manual needed two distinct sections:

- Section A; an information section with the teacher as the primary target;
- Section B; the programme (informed by the content of the first section), aimed primarily at the learners in the burn-injured learner's class.

To make the manual as comprehensive as possible, extensive reading in and around the subject of burns (as outlined in the previous chapters) was conducted. On the basis of this literature, a brainstorming session was conducted to propose general areas of information for inclusion in the first section of the manual. The general headings and categories generated were then sorted, and improbable, impractical or redundant categories were discarded. After consolidating those categories remaining, and adding new ones that were triggered by reading and re-reading the existing categories, eight categories of general and specific information pertaining to burns injuries and their repercussions remained.

4.2.2 (a) Section A:

(i) Orienting the teacher: it is often difficult to empathise with an individual or situation for which one has no reference point in life experience, so the manual begins with a brief vignette that serves

to orient the teacher to the physical and psychological experience of a burn injury from its onset to hospitalisation.

(ii) Burn injuries - causes and terminology: this deals with the numerous causes of burns injuries, and provides some explanations of the medical terminology currently in use. Where possible, links are made between terms that are used at present, and those that are outdated but more popular. This section hopes to assist teachers in understanding what has occurred on a physiological level, and provides the vocabulary to understand whatever feedback might be forthcoming from the hospital.

(iii) What happens in hospital: details about burn wound care and management during hospitalisation are provided. It deals with possible amputations, deformities and disfigurements that may arise as a result of a burn injury.

(iv) Implications for the future: this section deals with future implications of the physical injuries for the burn-injured individual. This includes the form of rehabilitation that must occur for the wounds to heal completely. It also addresses the various abilities, limitations and needs a burn-injured learner might have.

(v) People's reactions to burns and scars: this addresses society's values regarding physical beauty, and the often inappropriate ways in which people respond when seeing someone with scars resulting from a burn injury. It specifically addresses burn-injured learners' return to school, and the reactions of their peers.

(vi) The burn-injured child's experiences: a variety of emotional and psychological reactions that the child may experience are detailed. This gives teachers some insight into the burned child's viewpoint after the burn, and facilitates some understanding of attendant feelings and fears.

(vii) Consequences for the family: To stress that this crisis affects not only the child, but the entire family, the manual also looks at the family's experiences, feelings, fears and responses. Teachers

may want to support family members, and some insight into their experiences may be of great assistance in this regard. It also provides an understanding of some of the stressors that family members may be experiencing.

(viii) Consequences for the teacher: the feelings and experiences of teachers of burn-injured learners are also addressed. Attitude and value formation are examined, as teachers usually convey their own belief and value systems to their learners. The need for teachers to examine their own attitudes regarding disfigured individuals is therefore stressed in this portion of the manual.

(b) Section B:

The second section of the manual contains information about the burn-injured learner's return to school. It mentions the various principles that underlie school reintegration programmes, and provides a practical programme consisting of workshop-formatted activities to convey the salient information to learners in an engaging and flexible manner. Critical principles from Section A of the manual were extracted and used to inform the activities that would embody these central messages in Section B. A balance between activities and reflection on them was critical, in order to ensure that the central principles would be internalised. A workshop format was chosen based on the information available on OBE, with specific reference to Curriculum 2005 and the Learning Area of Life Orientation (see section **1.6.2** for more detail). Experience and research has shown that activity-based interventions have a higher success rate than lecturing when dealing with children and adolescents (Rooth, 1995).

Finally, a Special Needs teacher at a private school and a workshop co-ordinator for a youth-focused NGO were consulted on the programme to ensure that the activities were age-appropriate, salient, easily implemented, and conservative in their use of resources. (Complete copies of the manual in English, Afrikaans and Xhosa have been included in Appendices **B-D**).

4.3. IMPLEMENTATION OF THE INTERVENTION

4.3.1. Selection of the participant

The first parameter for inclusion in the study pertained to the age of the participant. According to Red Cross (1998), the most common age groups that experience burn injuries are from birth to two years, and from six to eight years of age. A programme that targeted school-going children would be useful to both age groups, as those burned in infancy would be able to make use of it upon commencing school. Thus the first parameter was set as primary school-aged children (between six and thirteen years of age). The upper limit was set at thirteen, as this is Red Cross' age limit for admitting children.

The second parameter pertained to the TBSA affected by the burn, and was set as greater than or equal to five percent. This tends to be the minimum TBSA used in the majority of studies dealing with burns injuries (Hurren, 1995). Additional restrictions were that the child had to speak English or Afrikaans as a home language (as working with a translator would further complicate the process), and that a telephone number to contact the family had to have been furnished. Lastly, the child had to have not returned to school, but had to have been physically capable of returning to school shortly.

The various parameters decreased the number of possible participants to one child, whose burn had not healed sufficiently for him to return to school yet. A meeting was scheduled with his parents, and in this time a full explanation regarding the aims and nature of the research was presented, permitting the parents to make an informed decision regarding their child's participation. Issues that the parents wanted to address were also named during this meeting.

4.3.2 Interviews prior to programme implementation

Having previously received permission from all concerned to implement the programme, it was then necessary to meet with the various participants, in order to glean any relevant information that was needed to modify the programme.

(a) Parental interview

Specific concerns about the burned learner's interactions with family members and peers were elicited, so that these particular issues could be addressed with the class. The parents were also asked what they felt would be the most important issues that the programme convey to their child's class.

(b) Teacher interview

Before implementing the programme, the researcher met with the teacher to explain the nature of the intervention, as well as the aims of the study. Due to the female gender of this particular teacher, the feminine pronoun will be used instead of 'the teacher'. The burn-injured learner's behaviour and interactions with other learners while in class, prior to the burn, were also discussed. Aspects from the manual that might have required additional attention, due to the burned learner's specific needs and circumstances, were highlighted. The programme was explored in detail so that she would be fully cognizant of the logic underlying each activity. This provided her with an additional opportunity to respond should there be any activities she felt inappropriate for her class. Lastly, suggestions were sought in order to better tailor the programme to the burned learner's specific needs.

(c) Participant interview

As the gender of the participant is male, the masculine pronoun will be used to denote this. Prior to the programme being implemented at the school, it was explained in detail to the burn-injured learner, both to reassure him of the content of the programme, and to provide him with the opportunity to set limits regarding what he was prepared to talk about, and which questions or topics he felt were inappropriate or intrusive. He was reminded of the fact that he would not be present

during the intervention, and was given the opportunity to voice his feelings regarding his absence. He was informed that feedback on the programme would be given to him directly after it had taken place.

4.3.3 Application of the programme

(a) The workshop

As previously mentioned, a complete guide to the programme can be found in the manuals, Appendices **B-D**. All verbal feedback from the class was written up on large sheets of newsprint and displayed in the classroom at the end of the programme. The workshop was also audio-taped, to facilitate the formation of evaluative questions. What follows is a brief outline of the programme facilitated on the day:

- Story about a burned tree;
- Discussion centered on the story;
- A brainstorming session with the class around the causes of burns;
- An explanation of how their classmate got burned;
- A brief forced-choice exercise on values, where the learners chose between being beautiful and being happy;
- An exercise in which the learners were asked individually to depict an aspect of themselves that they disliked or about which they were teased;
- A picture or description, of how they would feel if that aspect (depicted in the previous exercise) were the only one anyone else ever saw. The class as a whole were asked to share this picture of how they felt. They were then asked to imagine how their burn-injured classmate might feel upon his return to class the following week;

- The learners divided themselves into groups and wrote what they liked about their burn-injured classmate (before he had been hospitalised for the burn) on "graffiti walls". The mechanism for dividing them into groups is described in section **4.4.4 (a)**;
- The class as a whole were asked to engage in an externalising exercise where they drew the "tease monster", which they described as masculine in gender. They were asked to 'interview' him in order to learn the ways in which he achieved his power over learners;
- The class was then asked to create the opposite "protective force", which they defined as gender-neutral. They were again asked to 'interview' it to learn how it protects the learners;
- From this exercise, the learners extrapolated ways in which they would help the burn-injured learner feel welcome upon his return to school;
- The learners finally entered a "promise circle" in which they pledged to assist the "protective force" and support their burn-injured classmate and one another.

Based on learners' participation in the workshop, some modifications were made to the programme contained within the manual. Most specifically, the instructions provided were expanded on in greater detail. While the updated programmes are contained within the manuals in appendices **B-D**, the original version used in the pilot study is located in Appendix **E**.

(b) Feedback to the burn-injured learner

The "graffiti walls" generated by the class were given to the burn-injured child, so that a bridging effect was achieved between the programme at school and the learner waiting to return to school. He was also given verbal feedback concerning the implementation of the programme.

(c) The burn-injured learner's return to school

A "certificate of bravery" was created, and presented to the learner by one of his fellow classmates upon his return to school. His interactions with his classmates were then observed for the first half hour of school.

4.4 EVALUATION OF THE INTERVENTION

One reason why school reintegration programmes are thought to be necessary is that they ameliorate the depression experienced by the majority of children who are burned. The programmes are also aimed at reducing the ignorance surrounding burn injuries, and thereby decreasing the negative and unpleasant behaviour with which most burn-injured people are confronted. In order to examine whether any of these reasons are valid, it was necessary to establish baseline measurements prior to the commencement of the programme. To assess the impact of the intervention, an embedded case study was conducted, in which the burned learner who returned to school was the primary focus, with the family and school community forming concentric rings around the primary focus. To this end, interviews, focus groups, questionnaires and a variety of assessment techniques were utilised in order to more richly describe the world which the burned learner inhabits. For convenience, the data from the case study will be structured as follows:

- Family history;
- Assessment of the child;
- Scholastic history;
- Evaluation of the programme: (a) child
  (b) parent
  (c) teacher
  (d) peer group

4.4.1 Family History

Two interviews were conducted with the parents of the participant, in order to obtain background information. During the first interview, the mode of data collection consisted of a Multi-Modal questionnaire utilised by school clinics to gather personal and family history, a statement on the

reason for referral, and a basic description of the child's personality. The second interview was semi-structured, and loosely based on the Multi-Modal questionnaire in order to follow-up and gain greater clarity on certain areas of their child's development and interpersonal behaviour. Detailed questions regarding the incident in which the child was burned were also explored. A copy of the Multi-Modal questionnaire and the interview schedule can be found in Appendix **F**.

In addition, after individual sessions with their child, informal feedback sessions with the parents were arranged so that they could be kept informed of the process and implementation of the intervention. These report-back sessions maintained open communication between the parties concerned, so that the parents felt able to report any concerns and observations.

4.4.2 Assessment of the child

During six separate interviews with the participant, a number of different projective, cognitive, and self-evaluative assessment tools were used, to provide further background information on the child, and to attempt to gain some understanding of his internal world. Numerous sessions were necessary as it was evident during the first interview that the participant had a relatively short concentration span and found it difficult to concentrate beyond 20 - 30 minutes.

(i) Projective techniques: The projective techniques were used as language and cultural barriers tended to act as filters in communication between the interviewer and participant, and few objective measures were appropriate and available. The projective techniques included: House-Tree-Person (HTP); Draw-A-Person (DAP): interpreted for emotional indicators; and the Afrikaans version of the Rotter's Incomplete Sentences (Van Niekerk, 1986). The DAP and Rotter's Incomplete Sentences were used in an attempt to understand the child's experience of the burn, and to assess its impact on his emotional well-being.

(ii) Children's Depression Inventory: The Afrikaans version (Webber, 1998) of Kovacs' (1992) Children's Depression Inventory (CDI) was used to gauge the participant's level of depression prior to the implementation of the programme. This measure is internationally recognised for its reliability and validity, but has not been standardised on South African populations. See Appendix **H**.

(iii) Cognitive assessment tools: Assessments of the child's visual-motor integration and approximate overall scholastic ability were employed in an attempt to explore and possibly explain his scholastic difficulties. These included the Bender Visual Motor Gestalt Test (BVMGT) and the Goodenough-Harris scoring of the DAP (Harris, 1963).

4.4.3 Scholastic History

Reports provided by his teachers from previous grades presented a more detailed history of his scholastic progression, and a detailed discussion of his current academic abilities was held with his current teacher. Lastly, a copy of the assessment report from a school-clinic psychologist was provided by his present class teacher, to complement the information about his academic achievements.

4.4.4 Evaluation of the programme

(a) Child

Subsequent to the implementation of the programme at the school, four separate interviews were conducted with the burn-injured learner to complete the following:

- The DAP, which was used again during the post-intervention stage, in an attempt to see whether the child had experienced any positive changes in his environment, which might then be attributed to the implementation of the programme.

◈ The CDI, with which he was reassessed one week after his return to class, and then again three weeks after his return to school, in an attempt to gauge whether or not there had been a significant improvement in his mood. The rationale for this procedure was that depression is a state and not a trait, and therefore would probably not remain stable for extended periods of time (Kovacs, 1992).

◈ A Post-Traumatic Stress Disorder (PTSD) Inventory (Wohlman, 1998), which is based on the diagnostic indicators for PTSD in the Diagnostic and Statistics Manual for Psychiatric Disorders Fourth Edition (DSM-IV). This was used in an attempt to assess the level of anxiety and possible presence of PTSD within the child. See Appendix **I**.

◈ Lastly, the burn-injured learner was asked to report every week whether or not he had been exposed to any incidents of teasing, bullying or name-calling since his return to school.

(b) Parents

On two occasions after the burned child's return to school, brief interviews were held with both parents in order to elicit feedback regarding possible behaviour and/or mood changes they might have noted in their son. The parents were invited to speculate on their understanding of the causes of these behaviour and/or mood changes.

(c) Teacher

Upon completion of the intervention, an interview with the teacher was scheduled to further evaluate the programme and attempt to understand her experience of the return of the burn-injured learner. The questions guiding this interview pertained to her experiences prior to his return, any anticipatory feelings or concerns regarding his return to class, as well as feedback about the programme and her observations regarding its effects on the learners in her class, and their responses to the burn-injured learner in particular. A copy of the interview schedule can be found in Appendix **G**.

(d) Peer group

(i) Pre-intervention evaluation: This data was collected prior to the implementation of the programme at the burned learner's school, where twenty-nine learners from his class, aged between nine and twelve participated in the reintegration programme. The remaining twenty learners in his class who were expected, failed to attend school that day. The learners were randomly allocated to six different groups through their selection of sweets from a pre-assembled packet which contained six different varieties of sweets. While the rest of the class continued with exercises that the teacher had assigned, each sweet sub-group participated in a focus group in a separate room, where questions relating to attitudes to people with scars or strange physical appearances were explored. Use was made of focus groups as no objective measures are currently in existence to gauge the attitudes of primary-school children with regard to burned individuals. This method of interviewing provided a means for eliciting perceptions, feelings, attitudes and ideas of the participants with regard to a specific topic, and was felt to be less threatening for the learners than individual interviews (Vaughn, Schumm & Sinagub, 1996). Once the responses had been transcribed, they were read and re-read, and sorted into categories based on the themes which emerged. Some of these categories merged, and new ones were added based on further readings of the transcripts. The moderator's guide for the pre-programme groups can be found in Appendix **J**.

(ii) Post-intervention evaluation: One month after the programme's implementation and completion, follow-up interviews were conducted with the learners. Of the twenty nine who had originally participated in both the pre-programme focus group and the programme itself, twenty-two were present and participated. The learners were again randomly allocated to six groups depending on which sweet they selected, and asked a few questions regarding the programme, and how they viewed the burn-injured learner's re-entry into the school, and the resultant impact on the school community. The remaining seven, who had been present for neither the pre-programme focus groups, nor the programme, formed a separate group and participated in the post-programme focus

group as a control group. They were asked the same questions as those during the pre-programme focus groups, as well as being asked for feedback regarding the burned learner's reintegration. Once again, these responses were transcribed and classified according to the method of categorisation described above. A copy of the moderator's guide for these focus groups can be found in Appendix **J**.

CHAPTER FIVE: IMPLEMENTATION OF THE PROGRAMME

This chapter will deal with the findings from the three interviews prior to the implementation of the programme, namely those with the family, teacher, and child; as well as data derived from the implementation of the programme at the school. Subsequent chapters will deal with the material from the case study, to assist in the evaluation of the intervention. In this manner, it will be possible to report separately on those procedures and activities which are involved in the implementation of the programme (chapter five), and which procedures were instituted for the purposes of the case study (chapter six).

5.1 FAMILY INTERVIEW

5.1.1 Description of burn incident

The family present at this interview consisted of the mother, Nadeema; father, Mogamat; eldest daughter Madeneyah (age 16); middle daughter, Warda (age 14); the participant Hassiem (age 11); and the youngest daughter Tasneema (age 5). During the initial family interview, in which the nature of the study and terms of participation were discussed, Hassiem's entire family described the incident in which he was burned.

The incident occurred on the 13th September 1998, while Hassiem was in the care of a neighbour. The neighbour's children made a fire in their yard, and one of the children threw turpentine onto the fire. The flames from the fire traveled back along the fumes and spilled liquid, and re-entered the turpentine container, causing it to explode. Hassiem was in the path of some of the flaming fragments of the container, and sections of his hands, face and neck caught alight. Madeneyah caught sight of this, and went to get a hosepipe to extinguish the flames she saw on her brother. After he had

been doused with cold water, a lift was arranged for him to get to the Mitchells Plain Day Hospital. From the Day Hospital, he was then transferred to the Red Cross by ambulance.

5.1.2 Parental concerns

Hassiem's parents were concerned that his burn injury would negatively affect his performance at school, and that he would be teased and isolated from his peers. They were also concerned that this experience would exacerbate his timidity and cause him to withdraw from interpersonal interactions. They worried that his self-esteem would be permanently damaged.

5.2 TEACHER INTERVIEW

Hassiem's teacher, Ilona, described him in class as a quiet, shy child who preferred to remain in the background. She said that he experienced enormous difficulty with his academic work during class, to the extent that he seemed to be unable to read. Her main concern was that some of the bullies in the class might tease Hassiem. She was also concerned that, despite the fact that she had been sending homework for Hassiem with his elder sister, who attends the same school, that he would fall too far behind and be unable to catch up.

Feedback regarding the utility of the manual was obtained, and will be discussed in greater detail in section 7.2.

5.3 CHILD INTERVIEW

Hassiem came across as a reticent, shy child, who finds it difficult to talk in new or challenging situations. His concerns were that the other children might mock him, but this seemed prompted by parental concerns, as opposed to his personal fears. He said that no topics were taboo, and that the children in his class could ask anything with regard to the burn injury and hospitalisation.

children in his class could ask anything with regard to the burn injury and hospitalisation. He appeared a little apprehensive about returning to school, but felt confident that his schoolwork was up to date.

5.4 PROGRAMME IMPLEMENTATION

5.4.1 Data from programme participation

On the day of the programme, the activities in which the 29 learners participated, were as follows:

- After the fable about the burned tree was read to the class, they were invited to comment on what they thought the purpose of the story had been. The learners responded with a list of behaviours that could form a guide of conduct towards their returning classmate. Their suggestions included not being rude to him; not teasing him; playing with him and including him in their activities; and behaving like friends towards him;
- A distinction was drawn between assisting the burn-injured learner to do things for himself, and doing everything *for* him, by drawing a parallel to the protagonists in the story;
- When asked to brainstorm on the causes of burns, the learners generated a list of items that included: fish and lamp oil; fire; petrol and petrol bombs; boiling water; matches; stoves; lighters; gunpowder from crackers and fireworks; gas stoves; irons; and pipe bombs;
- They listened in silence to the burned learner's story of how he got burned, as recounted by the workshop facilitator;
- The entire class chose to stand in the 'happy' part of the room, as opposed to the 'beautiful' part of the room during the forced-choice exercise. Their reasons included: that beauty fades; that what one person thinks is beautiful another thinks is ugly; and that some of them felt they were happy already.

◈ Although the learners were quite restless, they settled down during their drawings of that aspect of themselves that they disliked. Those that could not think of something they disliked about themselves, drew or wrote about an aspect of themselves for which other learners had teased them.

◈ During the second half of that exercise, they drew their feelings when they are teased about that aspect of themselves. 83% of them chose to hand in their drawings, which typically depicted what they described as "heartache, upset, and anger".

◈ When asked to imagine how Hassiem might feel upon his return the following week. The learners suggested that he might feel angry, unhappy, upset, lonely, 'bad', and afraid that no one would like him.

◈ The next exercise saw the learners back in their groups according to their sweet selection. In these groups, the majority of comments written on their graffiti walls were quite general, and referred to things that Hassiem had *not* done (such as teased or "been mean" to them). Many of the learners found this exercise too abstract, and instead wrote messages of welcome for Hassiem, or wrote that they missed and loved him, and felt sorry that he had been burned.

◈ It was initially difficult in the 'tease monster' exercise for learners to distinguish between the 'tease monster' they were being asked to imagine, and the gangsters that inhabit many of their neighbourhoods. Once the nominate artist had given the monster his physical appearance (red eyes, horns, and green slime dripping from the mouth), the learners interrogated the monster, asking how he maintained his power over children. It was eventually decided that the monster enjoyed teasing and bullying children, and increased his power by convincing learners to belittle and bully one another, breaking up friendships and convincing them that they would not be caught or harmed. It was also decided that the monster hated it when learners liked one another, and refused to listen to him. He became weak and powerless when this occurred, as he did not have any hate to sustain him;

◈ Once the 'tease monster' was stuck onto the board, the learners were asked to create his opposing power. They decided upon an 'angel', which the nominated artist then drew. The learners described how the 'angel' acquires power: through building up friendships, and refraining from teasing one another. They were then asked what happens to the 'tease monster' when the 'angel' supports the children, and when they responded that he was weakened and destroyed, they were invited to do so by tearing scraps off the 'tease monster' sketch.

◈ Finally, to recap on the day's events, the learners entered a 'promise circle' in which they agreed to help one another 'listen to the angel', and protect and support Hassiem on his return.

5.4.2 Feedback about programme to Hassiem

Directly after the class' participation in the programme, Hassiem received verbal and written feedback on its implementation, and resultant information. An informal report-back was made in which aspects of the programme were explained in detail, including the class's participation and input. The written feedback took the form of the 'graffiti walls' that the groups of learners had created, mentioning what they liked about Hassiem before his burn injury. Many of the comments on the wall pertained to Hassiem's manners and gentle demeanor. The vast majority of statements written on the 'walls' welcomed Hassiem's return to school, commented on the fact that the learners had missed him, and were apologetic about Hassiem's injury. He appeared pleased by the show of support generated by the 'walls', and smiled shyly at some of the comments when they were read to him.

5.4.3 Return to school: observation of Hassiem's interaction in class

On the day of Hassiem's return to school, 46 out of the 49 learners in his class were present. Hassiem arrived late, accompanied by his mother and Tasneema. He appeared awkward and anxious, waiting just inside the doorway, until his teacher, Ilona, noticed him. She greeted him, commenting

that his appearance had not changed, and hugged him. He was then presented with a 'certificate of bravery' by one of his classmates, and he appeared to be embarrassed but proud when receiving it. The learner with whom he shared a desk welcomed him, and while the interactions seemed a little strained, the responses towards him were positive and accepting. A copy of the certificate can be found in Appendix **K**.

CHAPTER SIX: HASSIEM - CASE HISTORY AND PSYCHOLOGICAL ASSESSMENT

To fully comprehend the impact of the intervention on the burn-injured child in terms of his interpersonal interactions at home and at school, as well as self-esteem and possible levels of depression, an embedded case study was conducted (Edwards, 1996). The information contained in this chapter presents the material of the case study in detail. The participant's data, collected from various sources, including: the Red Cross Burns Unit's ward book; parent interviews; interviews with the class teacher; reports from previous school teachers; the school clinic report; the participant's medical file at Red Cross; and a variety of projective, cognitive, and self-assessment tools during individual interviews with the participant himself, is reported below. Certain sections will be grouped together in the interest of logic and continuity, although they may be disparate from the chronological order of events.

6.1 RED CROSS BURN UNIT'S WARD BOOK AND PATIENT'S MEDICAL RECORDS

Hassiem, an eleven year old child from Mitchells Plain, presented at Mitchells Plain Day Hospital on 13 September 1998 with an 8¼ percent superficial to partial thickness fire burn to his face, neck and dorsal area of both hands. He was then transferred by ambulance to Red Cross, where he was treated conservatively, initially with fluid resuscitation and standard pain medication, as well as Flamazin bandages with daily dressing changes. He was discharged to the Sarah Fox Convalescent Home on the 16th of September, and returned home on the 25th of September 1998.

His burn had healed insufficiently for him to return to school, and he was re-evaluated at the Red Cross Burns Out-patient Clinic on the 2nd of November 1998 in order to determine his return date to school. One month after the burn injury, the sites were inflamed and bright pink in colour, but by

three months post-burn, the scars on his neck had faded to a light-pink colour. His scars on his hands, however, remained bright pink and scaly in appearance.

6.2 PARENT INTERVIEWS

During the initial parent interviews, they completed a multi-modal questionnaire, which addressed the following topics:

- Family history;
- Personal and developmental history;
- Basic personality description;

All information in the following sections (**6.2.1 -6.2.3**) was drawn from this initial interview, and is therefore based on his parents' beliefs and impressions.

6.2.1 Family History

Hassiem's parents are in their mid-thirties, and have been married for 17 years. The family's practice of their Moslem faith carries with it a number of attendant cultural beliefs and assumptions: as a male in the Moslem religion, Hassiem is expected to be the breadwinner of his family in the future. His maleness also means that his mother accrues status. The fact that it was her *only son* who was burned, thus has numerous implications regarding the level of guilt experienced by Nadeema, as well as the level of concern regarding his prognosis.

Hassiem's mother is currently unemployed, but has previously worked as an examiner at a clothing factory. His father is a machinist and was also unemployed upon initial contact with the family, although he has subsequently found temporary employment. Both parents left school after completing standard three.

Hassiem has a good relationship with his eldest sister, Madeneyah, but tends to argue with Warda and Tasneema. According to Nadeema, he found it difficult to adjust to Tasneema's birth, as he had been the "baby" of the family for approximately six years prior to her arrival. His relationship with his mother is open and they get on well, although he seems to find it difficult to understand the financial restrictions the family is currently experiencing. Hassiem and his father are very similar in temperament, but at the time of the interview were tending to clash, as Hassiem was not responding to parental requests for assistance or co-operation in joint tasks.

Hassiem's father has a learning disability, and finds it difficult to read and write. Likewise, two of Hassiem's maternal uncles have learning disabilities and spent some time in adjustment classes at school.

6.2.2 Personal History

Hassiem was a planned child, and his mother experienced no difficulties in carrying him to term. His birth was normal, and he was delivered without the aid of forceps. During the first few months of his life he was "lazy about eating" and failed to gain weight at an appropriate rate. He attended a nutrition clinic, and by six months had attained his ideal weight. His mother was extremely ill with Tuberculosis during Hassiem's first six months, and could not hold or nurse him. His developmental milestones were within normal limits. There was a slight developmental lag in his language development, and he began speaking at age two. He had the normal childhood illnesses, such as chicken pox and measles, but has been otherwise healthy.

6.2.3 Basic Personality

According to his mother, Hassiem is a shy, timid child and he tends to be more interested in objects than in people. He makes friends easily, and had not been teased or bullied prior to the burn

injury. He is apparently extremely impulsive, at times very active, and has a relatively short concentration span. He does not display sadness, and is "not afraid of anything"; but will typically cry when angry, and teases or annoys people to demonstrate his feelings of frustration. He tends to demonstrate feelings of happiness through excitement. He displays a negative attitude towards his school and schoolwork; and for quite some time prior to the burn injury had been requesting a transfer to a school which his neighbourhood friends attend. For the researcher's impressions of Hassiem, please consult section **6.4.1**.

6.3 HASSIEM'S SCHOLASTIC PERFORMANCE

This information was gleaned from interviews with his class teacher, previous teachers' reports, and the report from the school-clinic psychologist. It is necessary to understand the educational environment in which Hassiem is situated, so that informed conclusions can be drawn. To this end, some basic information regarding the educational context has been provided. The school that Hassiem attends is staffed by 23 teachers at present, and has a learner population of approximately 800. The average total monthly income of families whose children attend this school is approximately R1 500. Hassiem's grade five class comprises of 49 learners, between nine and twelve years of age, and is taught by Ilona, a senior member of the teaching staff. In the classroom itself, children are seated two or three to a bench, and there are no pictures or other stimuli on the walls, as people who use the school for religious meetings after-hours remove whatever is stuck on the walls.

A full scholastic history of Hassiem was obtained from the school, with the parents' permission. His academic record indicated that Hassiem experienced difficulty in a number of scholastic areas. According to his teachers' reports, he was extremely slow in completing his school work, has found it difficult to understand instructions and has had problems with sound recognition; and consequently with reading, spelling and mathematics.

No records are available from Grade One, but he was transferred from Grade Two to Grade Three, passed Grade Four and has just failed Grade Five.

An evaluation by a school-clinic psychologist, written in 1995, was included in the feedback from the school. According to that assessment, his Performance I.Q. was noted as being 21 I.Q. points higher than his Verbal I.Q. score. His total I.Q. score fell within the range of borderline intellectual functioning. The evaluator recommended that Hassiem be placed in the adjustment class at school; but his parents, not understanding the ramifications of this, did not follow through with this suggested course of action.

6.4 PARTICIPANT INTERVIEWS

6.4.1 Behaviour during assessment

Hassiem presented as shy, withdrawn and awkward at the beginning of the assessment process. He was initially quite co-operative, but later became somewhat reluctant to participate. He did not appear to enjoy the projective techniques, and seemed to find it difficult to engage with unstructured stimuli, especially the drawings. He appeared to have a short attention span, and found it difficult to concentrate for extended periods of time. This might have been due to the background noise created by various family members, as the interview was conducted in a room in the family's home in Mitchell's Plein. As the assessment process continued, Hassiem emerged as volatile and labile in his interactions with the family, and could be quite aggressive and resistant, refusing to cooperate with certain instructions.

6.4.2 Projective Assessment Techniques

The projective techniques took the form of drawings (House-Tree-Person, Draw-A-Person) and Rotter's Incomplete Sentences Test. Copies of Hassiem's various drawings can be found in Appendix **L**, and Hassiem's responses to the Rotter stems can be found in Appendix **M**.

(a) House-Tree-Person Drawing :

According to Ogden (1975) and Wenck (1977), the House-Tree-Person drawings can be interpreted as follows: the house drawings reflect self-perception and quality of family and home life; the tree component is a projection from the deeper, less accessed levels of the personality; and the human figures are primarily a representation of participants as they wish to be. Interpretation of aspects of Hassiem's HTP follows this schema.

Hassiem's drawing suggested strong feelings of social inadequacy and isolation, a lack of enjoyment of interpersonal relationships, and/or a dissatisfaction from mingling with others. His picture displayed a desire to avoid environmental conflict, and a possible fear of the environment. Reticence and tendencies to withdraw were also present. Aspects of his drawings of the house and tree suggested low energy levels and a weak ego. A conscious lack of contact with, or inadequate grasp of reality, was hinted at within his drawing. Feelings of body weakness or inferiority, as well as shyness, withdrawal and depressive tendencies were present.

This analysis is consistent with the impression of Hassiem gained in the course of the interviews.

(b) The Draw-A-Person assessment tool (DAP):

Use was made of Koppitz (1968) and Ogden (1975) to attempt to understand some of the emotional indicators present in Hassiem's drawing. His human figure drawing suggested a controlled evasion of feelings, and resistance to self-revelation, as well as chronic withdrawal tendencies. Many of the indicators in the drawing were strongly suggestive of depression, with feelings of inferiority,

ineffectiveness, insecurity and excessive defensiveness with low self-esteem. A second human figure drawing that Hassiem spontaneously completed, depicted himself and a friend playing "martial arts". In this drawing, dated 26 October 1998, his figure is drawn as half the height of his friend Frederick. This suggested feelings of inadequacy and ineffectiveness; while the action depicted in the drawing spoke of aggressive and hostile tendencies, and a possible defensive attitude (Levy, 1950, in Wenck, 1977). This analysis is consistent with clinical impressions formed during the course of the interviews.

Hassiem made three separate attempts (with erasures) to draw a person facing forward. On each occasion he appeared unhappy about the proportions in the figure's lower extremities. After the third attempt, he drew his 'stock' or rote drawing of himself and his friend "playing martial arts". However, in this picture, drawn on the 10th December 1998, Hassiem's depiction of himself is twice the size of the figure he designates as his friend Frederick.. The drawing shows dependent and depressive tendencies, inadequacy feelings and a pre-occupation with environmental concerns. There also seems to be a controlled evasion of feelings, and a possible anxiety in connection with manual activities.

(c) Rotter's Incomplete Sentence Test:

The Afrikaans version of the Rotter's Incomplete Sentences (Van Niekerk, 1986) was used. Hassiem found it extremely difficult to generate spontaneous responses to the posed sentence stems; and when encouraged to do so, created concrete statements that demonstrated a limited ability to access his feelings. He did not complete the test, refusing to participate further. Although he completed only eighteen out of the proposed forty-five sentence stems, he made reference to his burn directly in four sentences (22%); and indirectly in five sentences (28%). This was somewhat contrary to his presentation, as he displayed little anxiety or concern regarding the burn injury or its effects on his appearance. See Appendix **M** for his sentence stem completion.

6.4.3 Self-evaluation assessment tools

(a) CDI:

The self-evaluative assessment tool was the Afrikaans version (Webber, 1998) of Kovacs' (1992) CDI. Kovacs (1992) based the CDI on the adult Beck Depression Inventory, and the results from the CDI have shown above average validity and internal and inter-rater reliability. It discriminates children with a psychiatric diagnosis of Major Depressive Disorder or Dysthymic Disorder as opposed to those with other psychiatric conditions or non-selected 'normal' children (Kovacs, 1992). However, because it has never been used in the Afrikaans version, nor standardised on South African norms, the results of the CDI must be interpreted cautiously. A copy of the Afrikaans version can be found in Appendix **H**.

On the 26th of October 1998, Hassiem was assessed and the results of his CDI are displayed below. The inventory questions had to be read to Hassiem, as he was unable to read them for himself.

	RAW SCORE	*T-SCORE*	*PERCENTILE: Boys aged 7-12 years*
TOTAL CDI SCORE	12	52	66
NEGATIVE MOOD	3	54	79
INTERPERSONAL PROBLEMS	1	49	70
INEFFECTIVENESS	2	49	63
ANHEDONIA	5	56	81
NEGATIVE SELF-ESTEEM	1	46	53

Hassiem's total CDI score is indicative of a mild depression. Interpretation of the sub-scale scores rests on the fact that T-scores in the range of 45-55 are considered average, and that T-scores of above 65 are considered to be clinically significant. According to these limits, none of Hassiem's sub-scales are clinically significant. His inter-subtest scatter indicates that his score for anhedonia is relatively high in comparison with his other scores in negative mood, interpersonal problems, ineffectiveness and negative self-esteem. Thus, for Hassiem, his experience of depression was marked by a noticeable reduction in enjoyment of previous 'fun' activities.

(b) PTSD Inventory:

Hassiem displayed and reported experiencing minimal symptoms of PTSD. He stated that since his accident, he has occasionally been more wary and hyper-alert to possible danger in the environment. He said that he sometimes has difficulty making decisions, and experiences intense anger and frustration intermittently. He sometimes has difficulty remembering the precise events of the accident, and felt that he enjoys his free time somewhat less than he used to. He stated that he was a little more insecure with regard to the future than before, and still finds it extremely difficult to go near a fire or flames. To consult this inventory, please refer to Appendix **I**.

6.4.4 Cognitive assessment

(a) Bender Visual Motor Gestalt Test (BVMGT):

Hassiem's standardised score on the BVMGT indicated that his visual-motor abilities are equivalent to those of an average 5¼ year old child. His angulation changes, 90° to 180° rotations, and confused and chaotic arrangement of the gestalts on the page was highly suggestive of organicity. The fact that he completed the figures quickly and easily, but inappropriately and without recognition of any inaccuracies, strongly suggests a receptive-perceptual disturbance; and may well account for his reading and writing difficulties (Clawson, 1962; Ogden, 1975).

(b) Goodenough-Harris scoring of DAP:

According to the Goodenough-Harris system of scoring human figure drawings (Harris, 1963), Hassiem has a standardised score which places him in the 13th percentile rank, and is indicative of borderline cognitive and intellectual functioning. To consult his drawing, please refer to Appendix **L**.

6.5 Pre-morbid functioning

Hassiem, prior to his burn injury, had a limited attention span, and various cognitive and perceptual difficulties that made acquiring new information difficult for him. He was unable to read as a result of these barriers to learning. He disliked attending school, and requested to be transferred to a different neighbourhood school, so that he could be with his friends. According to his mother, he was a relatively co-operative child, who got on well with his various family members, although sibling squabbles with his sisters were quite common. His mother described him as an energetic child, who loved to play in the road with his friends, or play TV games at home.

6.6 Impact of the burn on Hassiem's psychosocial behaviour

Hassiem's mother described his behaviour following the accident as unmanageable, as he no longer wanted to stay in the house, and was interacting less with the family, and was shouting excessively. He was also behaving as though people 'owed' him something as a result of his being burned, which was an extension of the way people had behaved towards him while he was in hospital. He felt "loved and proud" when receiving money from people for his condition, and was interacting less with children in his road. He seemed apprehensive about returning to school after his absence, due to his hospitalisation and convalescence. He had limited interaction with the children in the road, and became demanding and unreasonable with regard to financial requests and expectations. His drawings and responses to other unstructured stimuli suggested environmental concerns, withdrawal tendencies and a marked level of insecurity and low self-esteem. His responses to the Rotter's incomplete sentences suggested that the burn was a great deal more focal than Hassiem's behaviour suggested.

CHAPTER SEVEN: EVALUATION OF THE APPLICABILITY OF THE PROGRAMME

The motivation for devising a programme that is appropriate for the South African context is, in part, based on the fact that American programmes are resource-intensive and beyond all hope of replication in the South African context at present. While the underlying premise and principles are sound, such programmes are culturally and contextually inappropriate. Furthermore, in order to make the manual and programme as accessible and appealing as possible, additional needs and requirements had to be met. To this end, this chapter will examine the various elements of the intervention which are pertinent to the issue of its applicability.

7.1 PRINCIPLES AND SPECIFICATIONS OF SCHOOL RE-ENTRY PROGRAMMES

As previously mentioned, the premise upon which school re-entry programmes rest is that with sufficient information about burn injuries, the treatment thereof, and the various effects such treatments can have on children's health (with specific emphasis on their aesthetic appearance), the uninjured learners' anxiety will diminish. The rationale is that since children fear the unknown, once the imagined horrors are either dispelled or explained, they no longer need to resort to various defensive behaviours which are directed at burn survivors and which the latter generally experience as extremely unpleasant (see section **3.4.2**). Thus the main goal of school re-entry programmes is to provide information. The evaluation of the programme devised with regard to this specific expectation, will be addressed in sections **7.3.2**, and **7.4.2 - 3**.

According to Blakeney (1995), all programmes need to include certain basic elements (see section **3.4.2 (b)**). All of the basic elements specified were included in the particular programme devised:

- the school principal, teacher and learners were included as targets of the programme;
- both the burn-injured learner and his parents were included in the planning of the programme, and specific issues regarding the implementation of the programme were discussed with them;

- through the brainstorming session on the causes of burn injuries, generic educational information about burn injuries and treatments was presented;
- specific information about the child's injuries and possible feelings about returning to school were discussed through various exercises;
- the workshop was directed at both intellectual issues, and emotional aspects surrounding the burn-injured learner's return.

7.2 PRINCIPLES GOVERNING THE PROGRAMME: OBE & LIFE ORIENTATION

As previously mentioned, OBE asserts that all children are capable of learning, and that our focus should be on what outcomes - abilities, skills and special knowledges - we wish the learners to acquire and develop, and then to work backwards from this point in order to devise ways of helping them to attain these outcomes (Department of Education, 1997b).

As one of the critical areas of learning, "Life Orientation", formerly known as "Life Skills" in prior curricula, has specific outcomes that learners should learn and achieve at the end of the educational process. These include:

- understanding and accepting themselves as unique and worthwhile human beings;
- using skills and displaying attitudes and values that improve relationships in family, group and community;
- demonstrating value and respect for human rights as reflected in 'Ubuntu' and other similar philosophies.

As the programme is intended to embody the specific outcomes, the various activities and how they relate to the specific outcomes will be explored in this section. In order for the learners to understand and accept themselves as unique human beings, part of the skills to be mastered include being able to express their own moods and feelings using appropriate language (Department of Education, 1997b). This aim was achieved within the programme, by asking children to imagine

how they would feel if someone were to view them solely in terms of the 'defect' they had described or drawn.

By then asking them to imagine how Hassiem might feel upon his return to school, they fulfilled the requirements regarding displaying skills, attitudes, and understanding that improve relationships. Other activities in this programme which fostered these understandings included the discussion centered on the fable at the beginning, and how the learners should behave towards Hassiem. The 'tease monster' and 'angel' exercises affirmed the value and respect for human rights, as well as helping children express values that build relationships between one another.

According to the assessment of a Special Needs teacher within a private school (Israel, private communications, 1998) the programme is in line with the overall ethos of Curriculum 2005, and in particular with the Life Orientation section of the curriculum, and is therefore both applicable and appropriate within the South African educational context.

7.3 ENGAGING THE TEACHER

7.3.1 The introductory letter

Upon contacting the school, the principal and teacher were both issued with an introductory letter that outlined the aims and purpose of the programme, and were asked for their assistance through participation. This letter served to articulate the intentions of the researcher and provided the teacher with an invitation to take part in the intervention, and to assist her burn-injured learner with his reintegration. The letter provides a starting point in the programme, and as such, is the initial mechanism for engaging the teacher. As Ilona agreed to participate after reading the proposal, it can be concluded that it fulfilled its purpose. A copy of the letter can be found in Appendix **A**.

7.3.2 The manual

The manual which has been created is a document that can be made readily available to teachers and/or parents of burn-injured learners through the Red Cross Hospital. It has been written in a style that minimizes the use of jargon (making it easily understandable), and covers many of the basic areas (as described by various literature in the field) necessary in order to enable the reader to be conversant in the field of burn injuries (Blakeney, 1995; Knudson-Cooper & Thomas, 1988).

Ilona indicated that Section A of the manual containing the information (see section **4.2.2 (a)**), had been particularly helpful to her. It was "extremely informative and helpful, especially the section on how to deal with the burn-injured learner on his return".

The manual also needed to be as comprehensive as possible, as teachers often do not have the time to do additional reading in various areas. Ilona reported that the manual covered everything she felt she needed to know about burns and their effects on children and their families, and that it was comprehensible.

7.3.3 Programme

As regards the programme, the teacher saw no need to alter the existing exercises, stating that she felt her class would be able to cope with, and participate in, the programme without modifications. The exercises should be explained in a fashion that is straightforward, with sufficient detail so that the aim of each activity is self-explanatory. Unfortunately, the first version of the programme (located in Appendix **E**) was insufficient with respect to details for implementing the programme exercises. The teacher felt that because the researcher had explained the objective of each exercise, and because she had been able to witness the programme being implemented, she felt she would be able to re-implement the programme should the need arise. Ilona suggested that the programme in the manual be expanded to make it more self-explanatory. The manuals included in Appendices **B-D** contain the updated versions of the programme. This updated version was

checked by the Life Skills Co-ordinator of a youth-focused NGO, to ensure that the instructions were as comprehensive and accessible as possible (Webber, private communications, 1998).

The teacher also indicated that she felt she would be able to adapt the programme in order to use the basic exercises as a vehicle to convey information about other illnesses should there be a need.

7.3.4 Use of resources

The exercises and activities contained in the programme were designed to be conservative in the use of resources. All of the exercises were conducted within the learners' home classroom, limiting the disruption that could occur when the daily activities deviate from the normal school routine. In addition, all the activities can be run with learners using their normal writing implements and school notebooks if the teacher does not have access to crayons or sheets of blank paper (as was the case in the pilot study). Likewise, exercises that suggest that the feedback be written on newsprint can be as successfully conducted with the use of a blackboard. Thus the programme, as implemented within this particular impoverished educational environment, was executed according to its design, and did not require any paring down or additional modification with respect to the use of resources. Given that the environment within which it was implemented is probably at the lower end of the educational spectrum in terms of available resources, it can be concluded that this programme can be implemented in most primary school contexts.

7.3.5 Teacher facilitation

The majority of overseas programmes are written and designed with an external 'expert' facilitator in mind, such as a member of the Burns Unit staff. As previously mentioned, the Red Cross does not have the resources to devote staff to this type of exercise. As a result, one of the guiding principles was to create a programme which a teacher would be capable of facilitating. This teacher facilitation was not possible during the pilot programme as a result of time constraints in

teacher preparation. Hassiem's imminent return to school made it difficult to adequately prepare Ilona to run the pilot programme, and as a result the researcher facilitated Hassiem's reintegration programme at the school. Thus the applicability of teacher facilitation is still in question. However, the teacher felt that the exercises can be easily implemented by teachers, and that she intends to implement the programme in 1999 should the need arise (see section **7.3.3**).

7.4 ENGAGING THE LEARNERS

7.4.1 Learner preparation

Ilona outlined her previous preparation of the class during the post-programme interview. She said that she had asked the children to design and make cards for Hassiem while he was in hospital, and explained that he had been burned. She also asked the class to imagine that one of their younger siblings had been burned, and asked them how they would feel. Having elicited feelings of distress, she then suggested that they bear this in mind when talking to Hassiem.

7.4.2 Successful exercises

The programme was designed in workshop format in order to appeal to the learners, as two-way communication is enhanced in this style of presentation. The learners' willing participation in the various exercises may well have been the function of the sweets they received as part of the pre-programme focus group, but an alternate explanation is that they enjoyed the style of the programme, as it was activity-based, novel and exciting. Their co-operation was evidenced by the fact that they chose to draw additional pictures which they presented to the researcher, and that the majority of the children retained the knowledge of the fable told at the beginning of the programme, as well as the closing activities of "tease monster" and "angel". Ilona concurred, stating that while she was observing the programme's implementation, the children seemed co-operative and appeared to enjoy participating in the exercises and activities.

7.4.3 Exercises with limited success

7.4.3 Exercises with limited success

The exercise which met with limited success was the 'graffiti wall'. The expressed aim of the exercise was to remind the children of the qualities of the burn-injured learner which they appreciated prior to his burn, and in this way, to foster an understanding that while the child's appearance may have changed, he is still the same person with the same qualities, abilities, likes and dislikes 'on the inside'. It is possible that the instructions were unclear or insufficient, which resulted in the children simply writing letters to Hassiem telling him that they missed him (see section **5.4.1**), as opposed to that which they were requested to write. An alternate explanation is that the task was too abstract for that particular age group or that particular group of children, and as a result they chose to fulfill a more concrete task by welcoming him and saying they were sorry about his injury.

This exercise was retained in the manual, with further explanation of instructions, as it was felt that it contributed greatly to the overall purpose of the intervention. It remains the task of each teacher to assess the exercises in the workshop in terms of their suitability for that specific class, and to modify those activities which s/he feels is inappropriate or too difficult for the learners to execute. For this reason, the programme in the manual is referred to as a "proposed programme" with guidelines, rather than rules and enforced procedures.

CHAPTER EIGHT: EVALUATION OF THE EFFECTIVENESS OF THE PROGRAMME

The previous chapter dealt with the utility of the intervention, in order to see whether it could be implemented within South African educational contexts, based on the resources available. This current chapter examines whether or not the intervention has realised its other aims of clinical effectiveness. For ease of reference, these will be addressed according to changes in learners' and teacher's attitudes; the buffer against depression; protection against academic lag; protection against isolation and rejection; and changes in Hassiem's behaviour.

8.1 EVALUATION OF ATTITUDES AND IMPRESSIONS

In order to establish whether or not the programme had been effective in preparing the class for the burn-injured learner's return, it was necessary to examine the class's attitudes towards disfigured individuals prior to the implementation of the programme. Once these had been established, a post-intervention measure evaluated whether or not changes or shifts had occurred. It was also necessary to examine which attitudinal components had been addressed by the programme.

8.1.1 Baseline attitudes

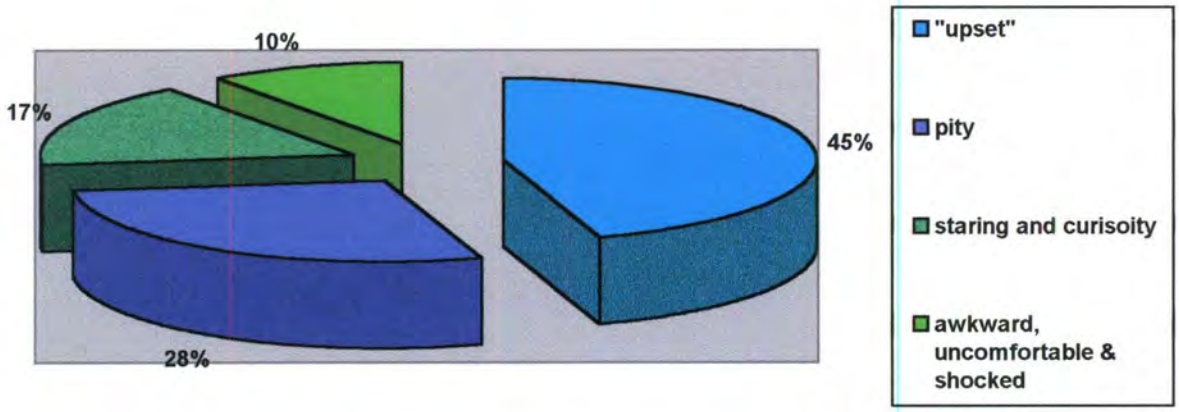
The learners who participated in the programme were evaluated by means of focus groups in order to gauge their attitudes towards children with disabilities. They were then re-assessed (by means of focus groups) after the programme's completion to evaluate the impact of the programme on these attitudes, as well as gain insight on the learners' opinions regarding Hassiem's reintegration.

(a) Pre-programme focus group

The information derived from the 29 learners who participated in the pre-programme focus groups (to ascertain their baseline attitudes towards people with disfigurements and disabilities), is displayed in the pie chart below. For a description of the procedure of dividing the learners into

groups, please consult section **4.4.4 (d) (i)**. For a full list of the questions asked during these focus groups, please see the moderator's guide in Appendix **J**.

(i) Attitudes when encountering people with scars

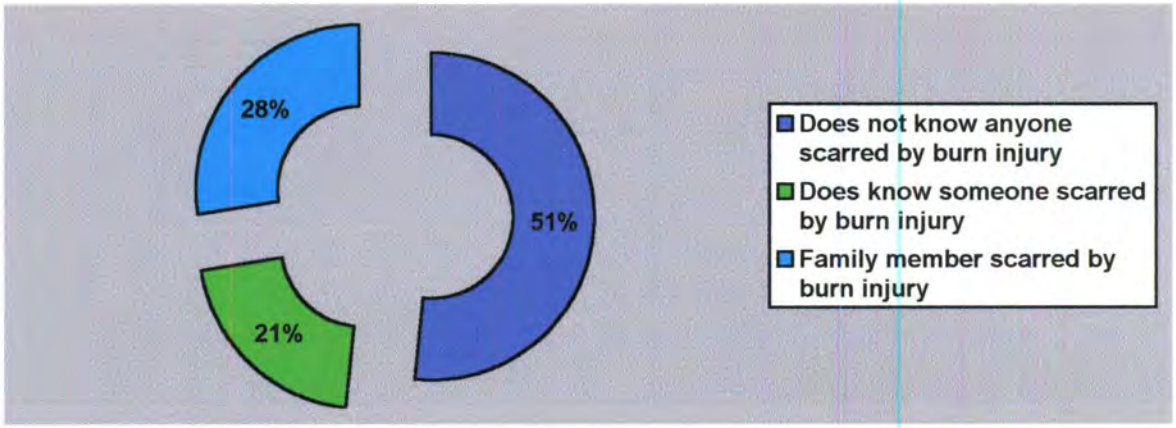


(ii) Feelings when witnessing people being bullied or teased about their appearance

All the learners condemned people who teased or bullied people because their appearances were odd or different, and said they would feel "upset" (66%) or angry (34%) if they overheard someone behaving like this. The learners said they would admonish those harassing the individual, reminding them that the disfigured are people too, and would ask them to put themselves in that individual's place. The responses were overwhelmingly on the side of accepting differences.

(iii) Personal contact with a scarred individual

Of the total number of learners participating, 49% knew someone who had been scarred as a result of a burns injury, with 28% being family members, or extended family members of the learners.



(b) Post-programme focus groups

Out of a total of 49 learners (including Hassiem), 47 were present on the day of the follow-up. However, only 27 had remembered to return their consent forms, authorising the taping of the focus groups. Hassiem did not participate in the post-programme focus groups, as he had forgotten to give the consent form to his parents. Of these 27, 20 had attended both the pre-programme focus groups, and the programme itself. The remaining seven had neither attended a previous focus group, nor the programme, and therefore formed the control group.

The control group discussed the issues posed to the groups during the pre-programme focus groups, and the answers were remarkably consistent. The only area in which they differed was in their responses to the question regarding how they would respond to someone that was teasing a disfigured learner. While saying that they would feel "bad", they unanimously stated that they would not intervene, as that person may then turn to pick on them.

The issues addressed during the post-workshop focus group can be found in Appendix **J**. The discussion centered around how much of the fable about the burned tree they could remember, and whether or not the 'tease monster' and 'angel' had been present in their class during the previous month. Lastly, the discussion focused on the learners' opinions with regard to Hassiem's reintegration into the class. With minimal prompting, every focus group could remember the salient aspects of the story. The various groups all remembered how both the 'angel' and the 'tease monster' had acquired power over the children, but had differing opinions on whether the 'tease monster' had been present (three groups said "yes") or whether the 'angel' had been present (two groups said "yes"). The groups that stated that the 'tease monster' had played a role in their class interactions were also the groups that mentioned specific individuals calling Hassiem names, behind his back. Those that stated the 'angel' had watched over the class, were also the groups who reported that no one had teased Hassiem.

(c) Implications of the focus groups

Based on the literature, which suggests that children form negative reactions to people (or other children) with disabilities at a relatively young age, the expectation regarding the pre-programme focus groups was that the majority of the children would express negative responses to the questions designed to assess attitudes towards the disfigured and disabled (Hurren, 1995). The overwhelming positive responses to the questions on attitudes therefore came as a surprise. However, upon reflection, a number of hypotheses can be proposed to explain these reactions.

Firstly, as a result of the 'experimenter effect', the learners might have been attempting to respond in a manner which they felt the researcher would want or expect. They may have been wanting to demonstrate socially appropriate responses in order to curry favour with, or impress the researcher. Secondly, the fact that they were interviewed in groups may have meant that one 'ringleader' or dominant personality might have set the tone for the responses, with the other learners merely mimicking the original response. This did not seem to be the case, according to the impression formed by the researcher. Thirdly, the socio-cultural environment in which these children live is not a developed, First World society that dictates beauty as being the one principle or value to uphold above all else. The violence within this township dictates that people operate according to an ethos of survival, and the extended kinship structures suggest that support of one another is a central tenet in their lives. Lastly, the mere fact that 49% of the children knew someone who was scarred as a result of a burn, with 28% of these being family members, would suggest that the interaction with disfigured individuals is a common experience, and as a result, not something novel, or something to be feared.

The extent to which the learners remembered the salient elements of the fable about the burned tree astounded the researcher, so that she checked with the teacher in order to make sure that she had not re-read them the story or prompted them in any way. The significance of this is that the learners were able to retain complex information that was presented to them in this manner. This is a clear indication that if a school is pressed for time, and requires a very brief

intervention, the story and a discussion of its message and a suggested code of conduct towards the burn-injured learner may well be sufficient.

The majority of the learners in the focus groups felt that Hassiem had adapted well, and said that they experienced him as no different now, than prior to the burn. Interestingly, there was no difference between the control group and experimental groups' responses, suggesting that the volunteer effect, mentioned in chapter eight may have been in play. Another possible explanation of this is that the teacher's preparation of her class in terms of asking them to make cards for Hassiem, and requesting that they imagine their younger sibling being teased, prepared the groundwork for this programme. The programme then followed-through with suggested ways of behaving towards Hassiem.

8.1.2 Tri-partite target of attitude change: cognitive, affective and behavioural

The programme was aimed at changing the attitudes of both the teacher and learners in Hassiem's class. In order for attitude changes to be effective and lasting, the programme targeting them must address the three different components, namely cognitive, affective and behavioural.

(a) Teacher's attitudes

The cognitive aspects of the teacher's attitudes towards burn-injured and burn-disfigured learners is addressed through Section A of the manual, which provides information about the burn injury and its effect on the child and family. The affective aspect of the attitude is addressed by means of an exercise that asks for personal responses to certain inflammatory statements about disfigured or disabled individuals. Appropriate behaviours when talking to, and dealing with, burn-injured learners are suggested throughout the manual in order to offer the teacher guidelines regarding the behavioural aspect of attitude.

(b) Learners' attitudes

Within this programme, the cognitive aspects pertaining to attitudes were addressed through brainstorming about the causes of burn injuries; the recounting of Hassiem's burn story, as

well as discussing his limitations and abilities upon his return to school. Changes in Hassiem's appearance were mentioned, but it was stressed that his nature and personality had not altered significantly.

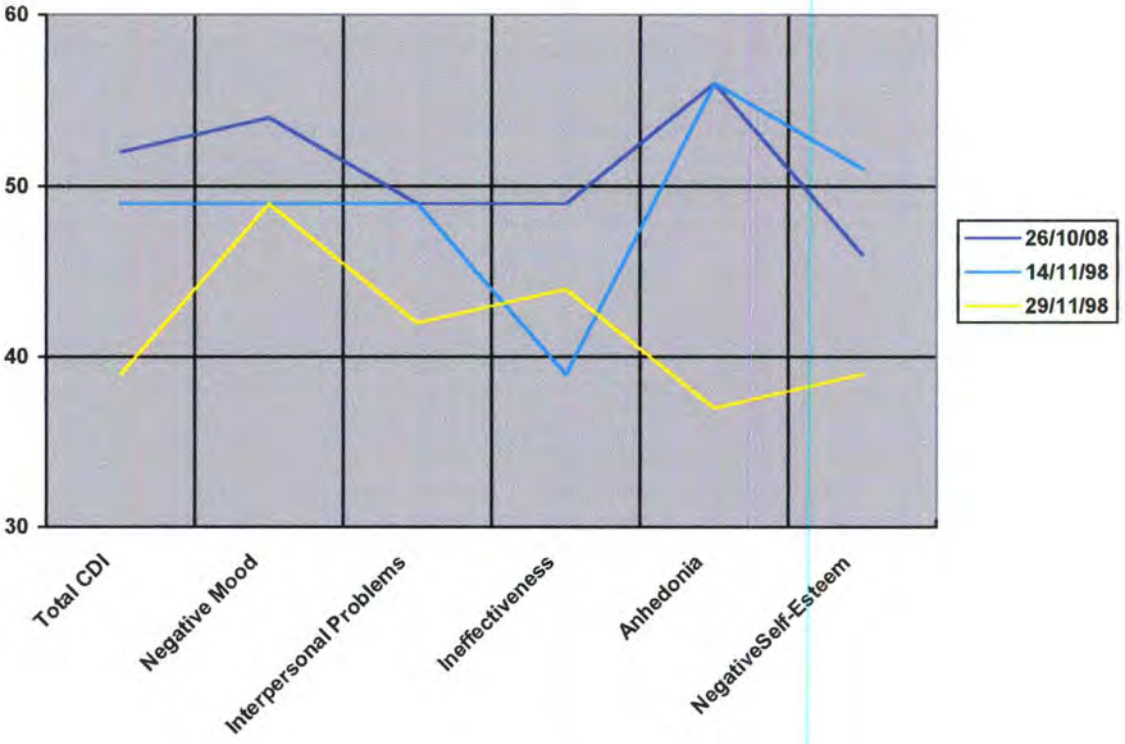
The affective component of attitude change was addressed through activities that dealt with the emotional issues surrounding Hassiem's return to school. These included the fable; the learners' drawings of how they feel when people belittle and tease them; and discussions about how Hassiem might feel about his return to school. The behavioural aspect of attitude was addressed in the fable, with the protagonists in the story modelling appropriate ways of behaving towards burn survivors. Similarly, the 'angel' exercise allowed the learners to voice relationship-building behaviours and ways of being that enhanced positive interactions.

8.2 BUFFER AGAINST DEPRESSION

Hassiem was assessed by means of drawings, additional CDI's, and further interviews in order to draw conclusions regarding the impact of the programme on his psychological and emotional well-being. Despite the imprecision and lack of standardisation of some of the assessment tools used in evaluating Hassiem's mental status, a number of parallels can be drawn with the various tests. Hassiem displayed relatively obvious signs of depression, such as not wanting to socialise with other children, not finding pleasure in any activities he had previously enjoyed, and 'acting out' by shouting at family members and disobeying or ignoring instructions from his parents. These signs of depression were reflected in his drawings, in which social isolation, depression, inadequacy and withdrawal were common to many of them. Furthermore, his CDI registered the initial prevalence of anhedonia, as did some of the sentences from the Rotter's Incomplete Sentence Test.

In order to evaluate whether the intervention had any impact on Hassiem's depression, a comparison was made between his CDI scores prior to, and after the implementation of the programme. He was initially assessed on the 26th of October, 1998. After returning to school on

the 9th of November 1998, Hassiem was re-assessed by means of the CDI on the 14th of November 1998, and then again on the 29th of November 1998. A graph of his scores is depicted below:



As previously mentioned, significant T-scores have a value greater than 65. As none of the T-scores exceed this critical value, Hassiem's depression can be considered mild in comparison with the norms of the CDI. The yellow line depicted above represents Hassiem's final CDI profile, indicating that Hassiem's depression decreased dramatically. Apart from his return to school, nothing changed within his environment, suggesting that the programme has had a positive impact on, and possibly acted as a buffer against, depression.

In his final DAP, which was a repeat of his initial spontaneous drawing of himself and a friend playing, the figure sizes of Hassiem and his friend Frederick were reversed. In the second picture, Hassiem has depicted himself as twice the size of his friend (and incidentally twice the size of his previous depiction of himself prior to the intervention), suggesting that his self-esteem is increasing. However, lest this picture start to look too rosy, indicators of inadequacy and dependency were still very much in evidence in the final drawings. His pictures still showed

environmental concerns, which is entirely appropriate given his living circumstances and the fact that the family still has not spoken to the neighbours at whose house the incident occurred.

8.3 PREVENTION OF ACADEMIC LAG

One of the aims of the programme was to halt or limit the academic lag that can occur when learners are absent as a result of hospitalization and recuperation. According to de Wet et al., (1979), this absence has profound effects on scholastic progression for the burn-injured learners. At first glance, the fact that Hassiem missed 25 school days in Grade 5 as a result of his hospitalisation and convalescence could be construed as the reason for him failing this Grade. However, on closer examination of his scholastic history, together with details of the family and personal histories, as well as the findings from both the BVMGT and the Goodenough-Harris scoring of the DAP, a very different picture begins to emerge.

The family history with regard to learning disabilities, both on the maternal (2 uncles) and paternal sides (father himself), suggests that the problems Hassiem experiences are not only as a result of his burn injury.

His scholastic progression has consisted largely of being transferred to a higher Grade, rather than successfully passing the previous grades. All of his teachers observed similar problems in terms of Hassiem's ability to concentrate, and the prolonged time it took him to complete homework exercises. They noted his difficulty in taking instructions verbally, which was confirmed by the school-clinic psychologist's assessment in which Hassiem's Verbal I.Q. was noted as being significantly lower than his Performance I.Q. This ties in with his slightly delayed verbal milestones. The overall I.Q. reported by the school-clinic psychologist placed Hassiem in the category of borderline intellectual functioning. This was supported by the concreteness of his responses to the Rotter's Incomplete Sentences Test, as well as the Goodenough-Harris scoring of his DAP. The results of Hassiem's BVMGT suggest that another area of difficulty relates to his visual-perceptual abilities.

Thus it is difficult to determine the impact of the programme on Hassiem's scholastic progression. In all likelihood, his learning disabilities had created a barrier to his scholastic progression that this programme was unable to alter. However, based on the individualised attention he received, and the further examination of his perceptual and cognitive difficulties, recommendations could be made for Hassiem to attend the adjustment class. As a result of the relationship that was established between the researcher and the parents, an understanding of what the adjustment class entailed, could be reached. Hassiem will be attending this class from the start of the school year in 1999.

8.4 PROTECTION AGAINST ISOLATION AND REJECTION

According to the bulk of the literature available in the field, (Blakeney, 1995; Cahners, 1979a; Cromes, 1984; Knudson-Cooper & Thomas, 1988; Molinaro, 1978; Partridge & Robinson, 1995) the single most difficult area of adjustment that children with burn injuries face relates to their interaction with peer group members. In private communications, Albertyn (1998) has asserted that many of the children who suffer severe burn injuries and extensive scarring commit suicide as a result of rejection, depression and isolation. de Wet et al (1979) showed that the majority of burn-injured learners found the return to school the most difficult aspect of their rehabilitation, as the teasing and name-calling is often unbearable. For this reason, the central point of the follow-up focus groups, Hassiem's interview, and the interviews with both parents and Ilona, was to examine the extent of teasing and name-calling that Hassiem experienced.

In separate interviews with Hassiem's parents and himself, mention was made of only one incident of teasing that occurred as a result of a Grade Two learner asking Hassiem if he had "*brandsiek*" (mange). Nadeema stated that Hassiem had been upset by this incident, and had threatened to physically assault the child. It is speculated that this child may not have needed to ask that question had the programme been all-inclusive, and not only restricted to Hassiem's class.

Some of the learners in Hassiem's class referred to two other incidents of which they were aware, in which members of the class had either insulted Hassiem behind his back, subsequent to his return (calling him a "burned chip"); or threatened to burn him again. Hassiem was aware of neither incident. Similarly, Ilona said she had neither noticed, nor been informed of, any incidents of teasing or bullying of Hassiem during class. It can be speculated that there may have been more incidents of teasing, bullying and name calling, had the intervention not been implemented (de Wet et al., 1979).

According to Moore et al. (1996), valid indicators of long-term adjustment include renewed social competence and sustained re-involvement with peers, school and community. Ilona was interviewed in connection with Hassiem's classroom interaction with other learners upon his return to class. In her opinion, he now interacts with his classmates significantly better than before he was burned, "as though he has gained more self-confidence". He was apparently more boisterous and outgoing in class, and had begun talking to learners to whom he had never previously spoken. Interviews with Hassiem and his parents yielded the fact that he had returned to Moslem school in the afternoons upon going back to primary school. He was also playing with the neighbourhood children. In the post-programme focus groups, his classmates shared that they felt Hassiem's return to school had been positive, and that he was 'fitting in' well.

This is contrary to what is usually predicted for a burn-injured child, and the conclusion drawn is that the programme positively influenced the children, decreasing their need for defensive behaviours such as bullying and name-calling, leading Hassiem to feel more comfortable and accepted in class.

8.5 DECREASE THE LIKELIHOOD OF CONDUCT DISORDER

A final aim of the programme relates to decreasing the defensive behaviours of the burn-injured learner, and thus decreasing the possibility that conduct disorders will arise. According to the parental and family interviews, Hassiem participated in a behaviour pattern in which people

pitied him, and gave money as a way of apologising or trying to compensate for the injury. This appeared to set up an expectation that he deserved or was owed money as a result of his injury. Between the beginning of the assessment period, and the end, after the implementation of the programme, this attitude seemed to shift, with Hassiem asking his mother for some money so that his classmates would not feel compelled to give of theirs.

As a result of people giving him money, upon his discharge from hospital, Hassiem had sufficient money to purchase a toy gun. He informed his mother he wished to use the gun to shoot the child who had poured turpentine onto the fire. He wanted to shoot this child in the hands, where his injuries were most severe. These feelings of anger and a wish to mutilate others have been explored in the research, and are quite common, especially amongst boys who have been burned. These aggressive tendencies were also present in his drawings, as well as in his threat to beat up the child who teased him about his burn injury if he repeated the taunt. At the end of the intervention, Hassiem's DAP still depicted "playing martial arts", suggesting that the programme had possibly not eliminated all aggressive tendencies. However, given the violent community environment of Mitchell's Plein in which Hassiem is currently being raised, these expressions of aggression are not unexpected.

CHAPTER NINE: CONCLUSIONS

9.1 THE FAMILY

The 'ties that bind' with regard to family relationships, tend to pull even tighter when a child has been burned. The emotional strain that families experience is indescribable at best, and distilled nightmare at worst. Aside from the guilt, depression, anxiety, grief and anger that can arise in family members, is confusion, as there is no one to turn to for assistance. According to Bernstein et al. (1992) a child's ability to cope with severe pain is significantly affected by important relationships, especially parents and their emotional states. If parents are unsupported, they will be less emotionally available to support their children. How children cope with later stigmatisation hinges on the support of family members, and so their emotional availability is crucial to their children's healthy development and rehabilitation.

In this instance, Hassiem's extended family supported the nuclear one, and provided his parents with support and some practical assistance (by way of transport to and from the hospital). There is little room for doubt that without such a supportive family, Hassiem would have adjusted to the burn injury as well as he did. He stated on many occasions that he "felt loved" by his entire family. It is this familial support that sustained him prior to the implementation of the intervention.

A limitation of this embedded case study was that insufficient attention was devoted to parental coping and support. While this was not the primary target of the intervention, it is an vitally important aspect that cannot be neglected. Future research in the South African context should endeavor to examine the impact of family support and interconnectedness as a buffer to depression, conduct disorders, and negative self-esteem. There might also be scope to include the parents and family members in implementing the programme within the school.

An additional limitation of the study was the minimal attention devoted to the sibling understanding of the experience. In this particular case, parenting of the other children became more difficult as a result of the time being spent by the parents at the hospital. This had a large

impact on some of the siblings' or other children's functioning. Siblings display many of the same emotions that the parents experience, and while the scope for exploring this aspect did not exist within this project, it is a vital area in need of exploration (both nationally and internationally).

9.2 THE INTERVENTION

The importance of the school community cannot be underestimated. The socialisation that takes place within the classroom setting prepares children for the behaviour of the 'outside world'. With sufficient support from peers, burn-injured learners can develop and maintain a positive body image and a sense of self-esteem. By the same token, peers' negative actions and behaviours can be severely damaging to the nascent self-image that the burn-injured learner is painstakingly trying to "re-grow".

This programme succeeded in its aims to provide information about burns and their effects in an inviting and stimulating manner for both teachers and learners, in a time-limited framework of four hours. By so doing, it probably acted as a buffer against the depression that so easily arises after a burn injury. The programme also fulfilled it goal by being flexible enough to be adjusted to suit the age group or even the issue or illness being dealt with by the teacher. It is socio-culturally appropriate, and makes use of resources in a conservative fashion, so that resource-restricted environments can make use of, and benefit from, the manual and programme.

According to his parents, teacher, and classmates, Hassiem has been re-integrated into his class with minimal teasing and unpleasantness, and is functioning at a higher level in terms of peer interaction. He seems to have developed a greater sense of self-confidence, as evidenced by his behaviour in class and the interpretation of some of his drawings.

Limitations of the study in connection with the programme relate to the fact that as a pilot study, it was only implemented in a single class, as opposed to the whole school. It is unlikely that the programme would have eliminated bullying and name-calling entirely, but implementing it on a large scale would have provided opportunities to examine other learners'

responses to some of the more abstract exercises. This is a goal that should be endorsed by further research and investigation.

Another limitation of the study in terms of its applicability, was that teacher facilitation of the programme was not achieved. This is an area that requires additional investigation. The programme has currently been implemented by the researcher, and while it has been checked and endorsed by relevant educators, its applicability in the educational context with teachers as facilitators is still in question.

9.3 FURTHER RECOMMENDATIONS

While the programme has been designed as self-sustaining and independent of external input in terms of outside facilitation, the intervention as a whole requires additional feedback from external sources. An important part of the intervention is the preliminary interviews with teacher, parents and burn-injured learner, where parameters of the programme are set in terms of what is permissible and what should remain private. Without these interviews, parents are at a loss as to why the programme should be implemented, and what benefits it will bring about; teachers are left without adequate knowledge of the child's current limitations, and special concerns and needs; and the child is again faced with the situation in which decisions are being made about him/her without any input. The Red Cross is so severely understaffed, that the liaison function needs to be adopted by some other body or organisation. One possible suggestion is that the Education Department function as the liaison between the community and the hospital, and facilitate these meetings at the Red Cross prior to the child's discharge, as part of the discharge planning. By so doing, we will ensure that these children return to school with the best possible chance at rehabilitation and adjustment, and thus minimise the barriers to learning that can arise.

Another possibility, suggested by Ilona, involves the participation of local community services such as the Fire Department, as additional input around burn safety would be most beneficial. Another benefit of getting outside input pertains to the response of learners to an external facilitator, and the novelty of a break in routine.

beneficial. Another benefit of getting outside input pertains to the response of learners to an external facilitator, and the novelty of a break in routine.

Further research into the area of burns injuries and subsequent adaptation may promote interest in it, and ensure that this neglected corner of children's trauma receives greater focus. This may well result in better programmes, or additional ways of addressing some of the numerous problems, concerns and needs that arise from burns.

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APPENDIX A:

INTRODUCTORY LETTER TO THE SCHOOL

School Re-integration programme

Every year, hundreds of school-aged children suffer burns injuries, many of them severe. The pain they experience through the burn, and hospital treatment for the burn is indescribable. So from an *emotional* point of view, these children have been changed by their experiences. But that's not all. They've also changed from a *physical* point of view - their appearance has altered as a result of scars, amputations, and/or various splints and pressure garments they need to wear.

For teachers, the thought of a burned learner returning to the classroom may seem a bit overwhelming. There may well be fears of not being able to cope with the special needs, fears that the other learners will tease and be cruel, as well as concerns regarding adjustment to the entire situation.

Studies from overseas have shown that when a school and class is prepared for the return of a burned learner, the level of anxiety of *everyone* is decreased.

The manual designed addresses the following issues:

- The physical effects of a burn on the body
- The various causes of burn injuries
- What a typical burn-injured child experiences in terms of the burn and hospital treatment
- What effects on the family the burn incident has
- The emotional impact of the burn on the child, and his/her fears
- The emotional impact of the burn on the teacher
- How the other learners might respond to the burned learner
- How to handle a burn-injured learner upon his/her return
- A suggested programme to help prepare the class for the burned learner's return.

APPENDIX B:

ENGLISH MANUAL

SCHOOL RE-ENTRY PROGRAMME FOR BURNED LEARNERS

Written and compiled by

Ula Horwitz

NOVEMBER 1998

Dear Teacher,

Thank you for agreeing to participate in this programme to help your burned student re-enter the classroom as easily and painlessly as possible.

It is our understanding that this programme will also help burned learners' classmates to understand what has happened to their friend, and to help make them feel as comfortable and "normal" as possible when they return to school.

A lot of the time, burned children are frightened of returning to school because the think that their classmates will not accept them because of their burn injuries, and that they will tease, bully and pick on them.

This booklet will:

- describe what happened to the child in hospital
- talk about what types of feelings and reactions she/ he might have
- discuss what the family is going through
- help you to look at some of your feelings about having a burned child return to your class
- outline a programme that can act as a guide when you explain to your class what has happened.

Thank you once again for your co-operation

CHILDREN'S BILL OF RIGHTS & RESPONSIBILITIES

On the wall of the lounge at Teen Centre in Rondebosch, Cape Town

Content

- Children's Rights and Responsibilities

To help you understand...

Trying to imagine what your returning learner has gone through can be quite difficult if you have never been exposed to a burn injury before.

The following story is similar to what a lot of burned children experience:

You are a little child, of about six or seven, who has just been burned. Whether it is as a result of playing with matches (which your mom told you not to do), or because you pulled on a chord that was attached to the kettle, or whether someone burned you by accident or on purpose right now isn't important.

You hurt.

The pain is so severe that you can hardly breathe, and you don't have the energy to cry anymore.

You get taken to the hospital, where doctors and nurses separate you from your family, and take you away to a room that's full of machines and metal things you've never seen before and don't understand.

The pain is unbearable, and you are frightened and lonely.

When you next wake up again, you have tubes coming out of your nose and arms, with other tubes going down your throat. It's hard to breathe, and parts of you that were not hurting before are now painful. You're covered in bandages, and the doctors and nurses won't let you roll over or move around.

Your family is missing and the nurses keep hurting you, even after they say the medicine will help.

And you don't understand what is going on.

And the pain is so great you think you're dying.

You have to stay in the hospital for about a month. Your family comes to visit you sometimes, but you're lonely and frightened a lot of the time. Parts of you are strapped up with splints and it is really uncomfortable. Other parts are just unbearable. You feel like you are being punished for something you did wrong.

You start wanting to go home, but you're afraid that people are going to look at you funny or be mean and nasty to you because you look different now. Maybe none of the other children will want to play with you at school. Maybe no one will walk next to you. Maybe they will call you names. Maybe you won't be able to do the same things you used to, and you are worried you will get left behind.

This little story is quite possible. And so many children do get left behind and isolated. Now that you have put your foot into the burned learner's world, lets look around and see what else is going on.

How burns come about

Burns happen when hot liquids (scalds), hot solids (contact burns) or flames (flame burns) destroy some, or all, of the different layers of cells which form the human skin.

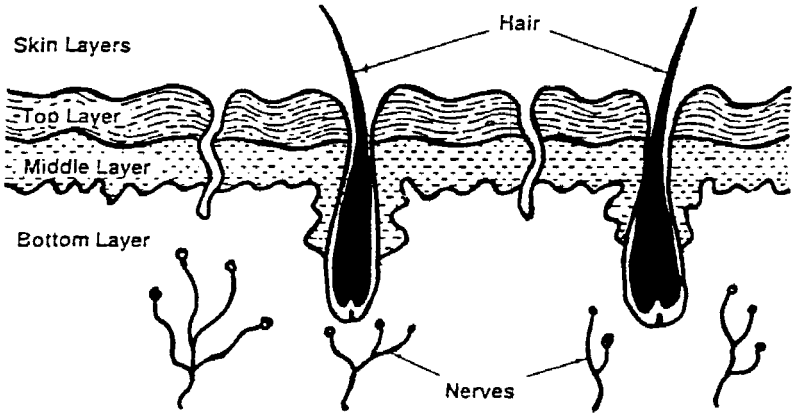
Superficial burns, such as those caused by sunburn, hot water, or by touching a hotplate, heal within two weeks, leaving a red area that fades after about 6 months. Those kinds of burns are not severe and the learner doesn't have to be hospitalised. This guide is concerned with learners who have been more severely burned.

Burns are assessed in terms of how much surface of the body area they cover, how deep they go, and which part of the body they are located on.

You may have heard people refer to the depth of burns in terms of "first, second or third degree". **First-degree burns** can be referred to as **superficial partial thickness burns**, **second-degree burns as deep partial thickness** burns, and **third degree burns are known as full thickness burns**.

Full thickness burns result from contact with hot metal, flames, chemicals, or from scalding by hot water over 50° C. Full thickness burns go right through all the layers of the skin, removing all living tissue and making a skin graft necessary.

Deep partial thickness burns are burns that remove most of the skin layers but leave pockets of the skin around hair follicles and sweat glands. These pockets eventually produce new skin cells to help in the healing process. Partial thickness burns are those that have not penetrated through many layers.



To recap...

Severe burns tend to be deep (going through many layers), cover a larger area of the body, and/or are located on important, fragile and very mobile parts of the body, such as the face, hands, feet, joints and perineum. These can result in disability and/or disfigurement.

What happens in hospital

The length of hospitalisation for a severe burn is relatively long. In the first few days, the doctors and nurses need to stabilise the child, because she/he will lose a lot of fluids. If this is not done, the child could die from dehydration.

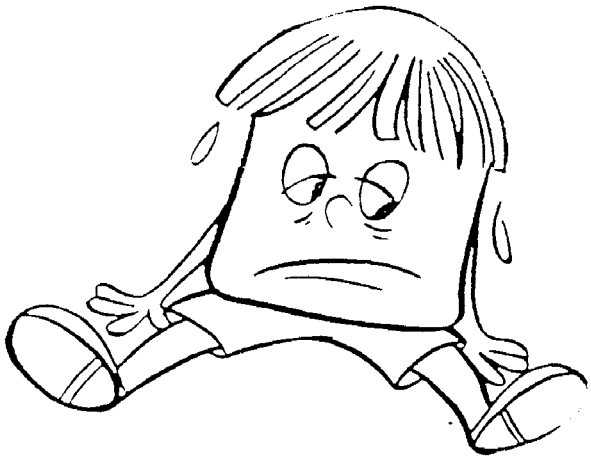
Their other important task is to make sure that the wound is as clean as possible, because infections can also kill the child at this early stage. To keep the wound clean, they need to change the dressings often, and remove the dead skin around the edges of the wound. This can be extremely painful for the child.

Both deep partial thickness burns and full thickness burns result in scarring. They are treated by a surgeon shaving away the layers of dead skin and placing a thin layers of healthy skin taken from elsewhere on the body (a donor site) onto the burned area to cover the injured part. This is known as a skin graft. Not all burns need skin grafts.
The child might lose fingers, toes, ears, and nostrils depending on how bad the burn is. Sometimes the doctors have to amputate a limb in order to help the child survive.

If the skin over joints heals without being stretched, the limb might be pulled skew and a "contracture" will have occurred. Physiotherapists and Occupational therapists (OT) in hospital make sure that the child stretches the affected areas properly, but this must be carried on at home. It is important that the parents/family learn from the physiotherapist and OT, so that they can do the proper stretching exercises with the child at home.

Another important thing to remember is that the scars and wounds can take a long time to heal AFTER the child leaves the hospital. Sometimes up to 6 months to 2 years after the injury. Because the skin covering the wound is

fragile, there are lots of things that can damage it, such as sunburn, playing roughly etc. Severe temperature changes will also affect the burned and half-healed areas.



Consequences of burns

What this means...

Burned children may have to wear splints to keep the limbs and joints in the right places. They might also have to wear "pressure garments" which limit the amount of scarring that will develop. It is important that the child wear those garments 23 hours a day - only removing them to wash!

The scars will be a different colour from the surrounding skin (usually very pink, shiny and angry looking), and they will probably also be raised, or have funny patterns or bumps on them. The colour will eventually fade, but unless the pressure garments are worn, the scars can grow bigger.

Where a skin graft has taken place, the skin cannot produce its own oils, and so it will itch badly (lotions and skin creams help).

As children grow, the scars might not stretch, and so they might need to go back into hospital to have them released, so that they do not interrupt their normal development.

Often when the child is very badly burned, cosmetic surgery to rebuild parts of their bodies (like ears, nose etc.) might be necessary. Sometimes this means that the doctors have to insert something like a balloon under the skin, which they slowly fill with saline solution, so that the skin will stretch. What

this means is that the child's shape might be distorted, and they will look different. So the child's appearance will be constantly changing over the years as she or he grows and develops, and as further operations are done.

So, where that leaves us is...

The burned learners returning to your class may be wearing splints, pressure garments, masks etc. to help protect the scars and help the body heal.

They will probably have lost a lot of weight from staying in hospital for so long. They might be slower and weaker in the beginning. They might also have lost certain body parts such as fingers and toes, which will make some of the school activities and exercises more difficult. They might be on medication to prevent or soothe the itching that develops, and they might still be taking pain medicine. They will also have to take care not to damage the new and fragile skin covering their wounds.

The itching can be a problem for the first three to six months after the burn. The learner must understand that scratching causes the newly healed skin to break down. A cool environment, moisturizing creams and distractions in the form of normal school activities are all helpful.

The new skin is fragile, and so blisters often develop. These pose no threat to the burned learner or other learners in the class.

The burned learner should be encouraged to participate in all activities within the limits of current physical ability. These activities help the burned learners

to increase and regain their strength, mobility and endurance. In day-to-day activities, injury should not be a worry, and this should be made clear to the other learners.

What it does not mean...

It does NOT mean that:

-the learner will never be able to fit back into the classroom

-the learner is going to be disabled forever (necessarily)

-the learner has to now go to a special school

-the learner will never accomplish or achieve!!

People's reactions to burn injuries and scars

Many cultures make "beauty" one of their most important values. People who don't fit the mold of what is "normal" are often judged unfairly.

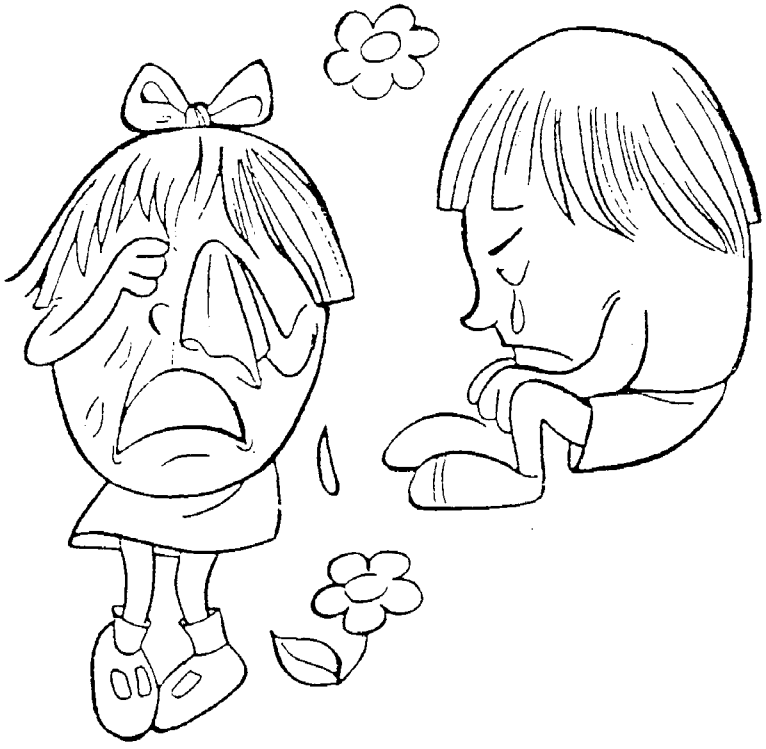
Meeting people with scars and disfigurements often makes people feel uncomfortable. Because we don't know how to behave, and we are curious, we often do things that are inappropriate, like stare, or ask really personal questions, or become embarrassed and avoid them completely. Sometimes children in certain cultures are scared by "fairy tales" of deformed monsters, and they are actually afraid of people with burn scars. Other children might respond by calling names, giggling or being rude.

Studies have shown that the most difficult thing for children with burns to do is to return to school and be accepted into their peer group. The majority of these children, without some kind of intervention, end up feeling lonely and

rejected and not worthy of positive attention. Bullying and teasing increase these feelings, and are the reasons most often mentioned for not wanting to go back to school.

Those that continue to go to school often find themselves walking to school and back alone, and sitting by themselves during breaks.

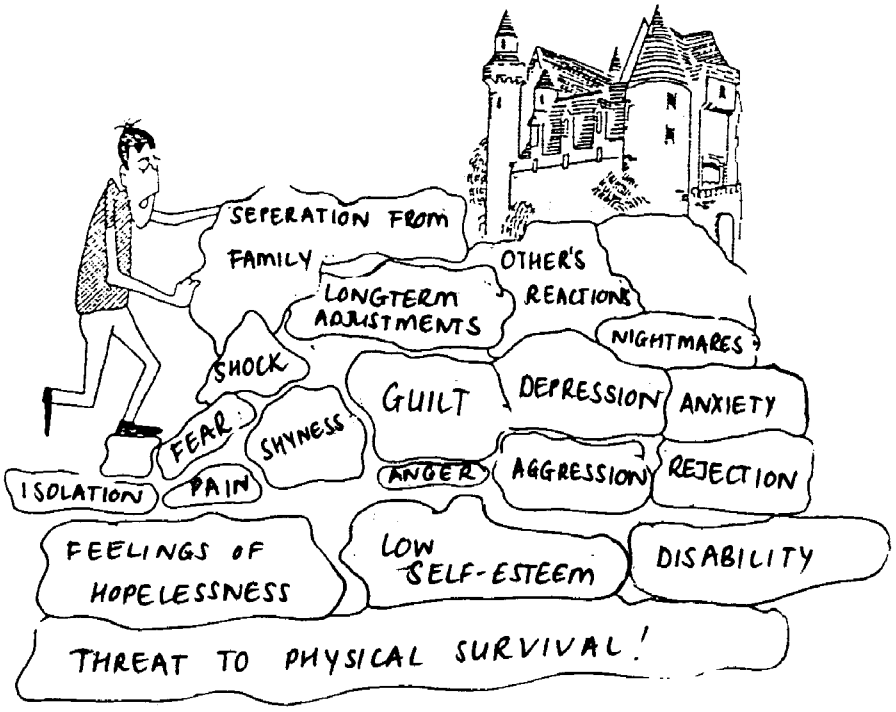
Depression is one of the most common responses to burns injuries. Some of those children who are severely depressed end up committing suicide because of the isolation and abuse they experience



What the burned child has to deal with

Learners with severe burns can have many of the problems faced by learners with disabilities, but they have the added complication that the burn has suddenly changed their appearance, life style and feelings.

The story in the beginning gave you some idea of what the burned learner experiences, but lets spell it out more specifically. All of the following can act as barriers to the learner returning to an optimal level of performance and comfort within the classroom situation.



What the family is going through

Parents of children who have been burned are going through enormous stress: they're not sure if their child will survive, and if she or he does recover, how they will look and what they will physically be capable of.

They might have had all kinds of dreams for the child that will not happen now, or will be different as a result of the burn injury.

Many family members feel guilty about the accident that caused the injury (including the child!), regardless of whether they could have prevented it or not.

Family members may try to spend a lot of time at the hospital, and have to give their other children to relatives and friends to look after while they're at the hospital. Or, they might not be able to get to the hospital because of the distances, money or amount of time involved. This will add to the guilt.

The anxiety and depression of the parents may make it difficult for them to take care of the child once she or he has been discharged from the hospital.

They may also be worried about what their neighbours, relatives and friends will say about the child's physical appearance. Many parents keep their burn-injured children at home, rather than send them out into the community to face the rejection and isolation that their changed physical appearance prompts.

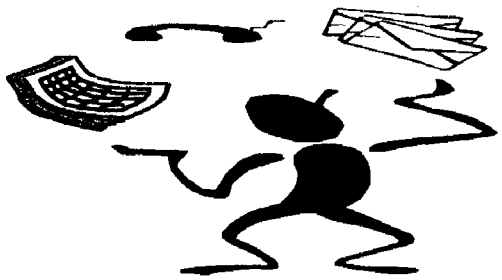
The burned child's brothers and sisters might get teased for the way their sibling looks. They might also get resentful of the amount of money, time and attention that the burned child gets. They are also worried and upset by their sibling's injury, and need to be reassured as well.

What this means for you as a teacher...

The parents are going to need support too!

They may have unrealistic expectations as to how quickly their child will recover, and may try to make unfair demands on you. The other possibility, is that they may have resigned themselves too quickly to their child's current limitations, and may resist your attempts to help the burned learner's return to a former level of competence.

On the other hand, many parents recognize their children's abilities and can therefore be a useful and valuable resource in terms of planning and decision-making. Parents know their children with burn injuries have the same needs as other children. Often what might be different is how these needs are met.



Values and attitudes

Values are the beliefs or standards that we give importance to, for example, some people value friendships, others' value independence.

Attitudes are the opinions we have about certain issues, such as a learner's positive or negative outlook on (attitude towards) homework tasks.

Our attitudes and values are created by the world around us, the people we live with, the various sources of opinions we are exposed to (what we see, hear and read) and by our life experiences.

As a teacher, you not only teach facts, but values and attitudes too!! It is most important that you are aware of your OWN attitudes and values.

A quick exercise

On a spare piece of paper, please write down your immediate thoughts to the statements written below. Write only whether you strongly agree or strongly disagree. This is for you only - no one else will see your answers!

- People's physical appearances have no effect on me.
- I feel completely comfortable with "special needs" children in my class.
- People with scars are unhappy.
- All scars are ugly.
- I find it difficult to act "normal" around people with scars.
- I feel sorry for people with scars.
- I would not want to survive a burn injury if it left me scarred.

The responses to these statements are personal, but it is very important that you are aware of how you feel about them. They may have made you feel uncomfortable, or brought up memories, thoughts or feelings that are unpleasant. Take some time to look at which statements were the most disturbing for you, and try to look at WHY you had difficulty with them. What principles, beliefs or attitudes were they affecting or challenging? You might find it helpful to write these reasons down, as they may change over time.

Your feelings as a teacher

Next to the family, the school is the most important place for a child's social adjustment and normal development. Many of the same emotions that affect a burned child's family (grief, fear, anger, denial) can also affect your ability to cope with the new responsibilities that the burned learner brings with him/her.

Many teachers are worried that the other children will be cruel or insensitive to the burned learner. They are also unsure of how to deal with the burned learner him/herself! A positive warm attitude from all school staff to the burned learner usually prompts an identical response from other learners.

The most important thing you can do is to remember that it is the child's appearance that has changed. INSIDE, SHE OR HE IS STILL THE SAME PERSON! They still have the same likes, dislikes and aptitudes.

All learners want and need to be accepted. They need friends. The learner with a burn injury has these same needs. It is important to see beyond the burn injury to the whole child. Apart form the injury, the child is like any other.

The burn-injured learners may have different abilities now, as a result of their injuries, and it is important to ask the hospital and Burns Unit staff about restrictions and limitations. They will also tell you if the child is on any medication (for example for pain, or for itching), and how this might affect the child during school hours. Don't be afraid to ask questions!!

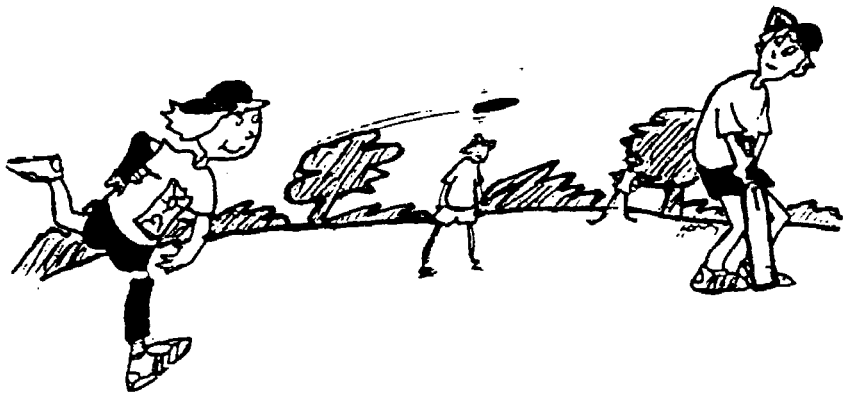
It is important to explain to the class that the burned learner needs to be as independent as possible, and do as many things for him/herself as she can.

Returning to the classroom

Once the burned learner has returned to the regular classroom your tasks as teacher consist o setting realistic goals, the acceptance of the burned learner's changed appearance, coping with emotional and behavioural problems, and understanding the nature and consequences of the burned learner's injuries.

It is important to strike a balance between the learner's temporary physical difficulties and what the learner needs to do to maintain a good self-image. Care and support are necessary, but overprotection can smother the learner!

A programme outline



Studies have shown that children who return to school within a few weeks of being discharged from the hospital, tend to make a more positive adjustment.

To help ease their path back to school, it is necessary to help the other children understand what has happened to their classmate. Much of the negative and inappropriate behaviour displayed towards burn-injured people is as a result of fear and ignorance. When the anxiety is decreased, the

defensive behaviours like ridicule and withdrawal will no longer be necessary, and the burned child's peers will be more supportive of him or her.

Further studies have found that if children are provided with the necessary information, and are told of the teacher's expectations regarding empathic, supportive behaviour, most children respond appropriately.

For the programme to be most effective, it needs to be conducted a day or two before the burned child returns to school.

Goals

- To help the other children to empathise with, and understand what their burned classmate has experienced. And by so doing, to decrease their anxiety and the defensive behaviours that accompany their anxiety.

- To provide the returning burned learner with as positive and accepting a learning environment as possible.

Principles

The following is merely a suggestion for the format that such a "reintegration/ re-entry programme" could follow. Obviously, adjustments would need to be made regarding the age group of the children involved.

The programme should aim to address the following principles and issues:

- What are burns, how they occur, and what effects they have on the body;
- The specifics involving the child's accident - including hospitalisation and the various treatments and procedures;

- The concept of values, how they are generated, and how they influence everyone's behaviour;
- Feelings and reactions to people who look/ behave "differently";
- How bullying and teasing can affect people;
- The fact that their classmate has changed outside, but that inside she or he is still the same person.

Aids/equipment/ material necessary

- crayons
- paper for individual drawings
- magazine pictures of burn/ incendiary sources
- newsprint/ cardboard for group drawings/ graffiti wall

Proposed programme

1) Story (30 minutes)

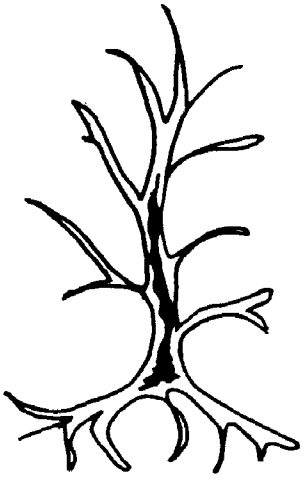
Explaining through a model what happened to the injured classmate, and modelling appropriate behaviours and responses. Children's participation is very important, and their questions should guide the story.

Possible script for the story

Based on stories by Nancy Davis in Once upon a time: therapeutic stories to heal abused children (1990) (Revised ed.). Oxon Hill, Maryland: Psychological Associates of Oxon Hill. Pp. 63-66; 99-104.

The burned Tree

Once upon a time there was a tree in the veldt that didn't look alive and green like other trees. It looked as if it had been struck by



lightening and had stopped growing - like someone had come along and cut down its branches until they were little stubs. Most of the trees in that part of the veldt thought it was dead because some trees are able to stand long after the life has gone out of them. But they were wrong, because deep down this tree was alive!

It just didn't know how to grow and develop into a beautiful tree with leaves as the other trees had done, because it had been hit by lightening and badly burned.

Sometimes after being burned a tree goes into shock and gives up the will to grow and to live and to be like other trees. And sometimes the shock of the lightening and the storms makes a tree believe that it can't grow, and that it has to stay the same, looking burned and dead.

One day and elephant came along, and thinking that the tree was dead, started to push it over.

"Hey! Ow!!!" yelled the tree.

Surprised, the elephant looked around and said "Who's there? Who's talking to me?"

"It's me!" said the tree. "You're hurting me! Stop pushing me over!"

"I can't believe it" said the elephant. "You don't look alive. You look all burned and dead. Your branches are all broken and you don't even have any leaves. I was pushing you out of my way because I thought you were dead already!".

"I'm not dead" said the tree. "I'm not even sick!"

The elephant looked most confused. "Well, if you're not dead and you're not sick, why do you look so awful?"

Sadly, the little tree replied, "I don't know how to grow. I don't know how to get leaves. I don't know how to look alive again because the lightening hit me so hard that I have forgotten how to grow. None of the birds make nests in my branches and the animals don't use me for shade. Everyone just ignores me or says how ugly I look. The other trees all think I'm dead".

The elephant, who had much experience with trees, decided to help and explained that he must first remove all the dead and burned ends of the branches. Reaching in and out of the branches with his trunk, he snapped off the burned ends until all the dead parts were gone and new life could start growing. Next, the elephant called a meeting of the animals and told them he needed their help.

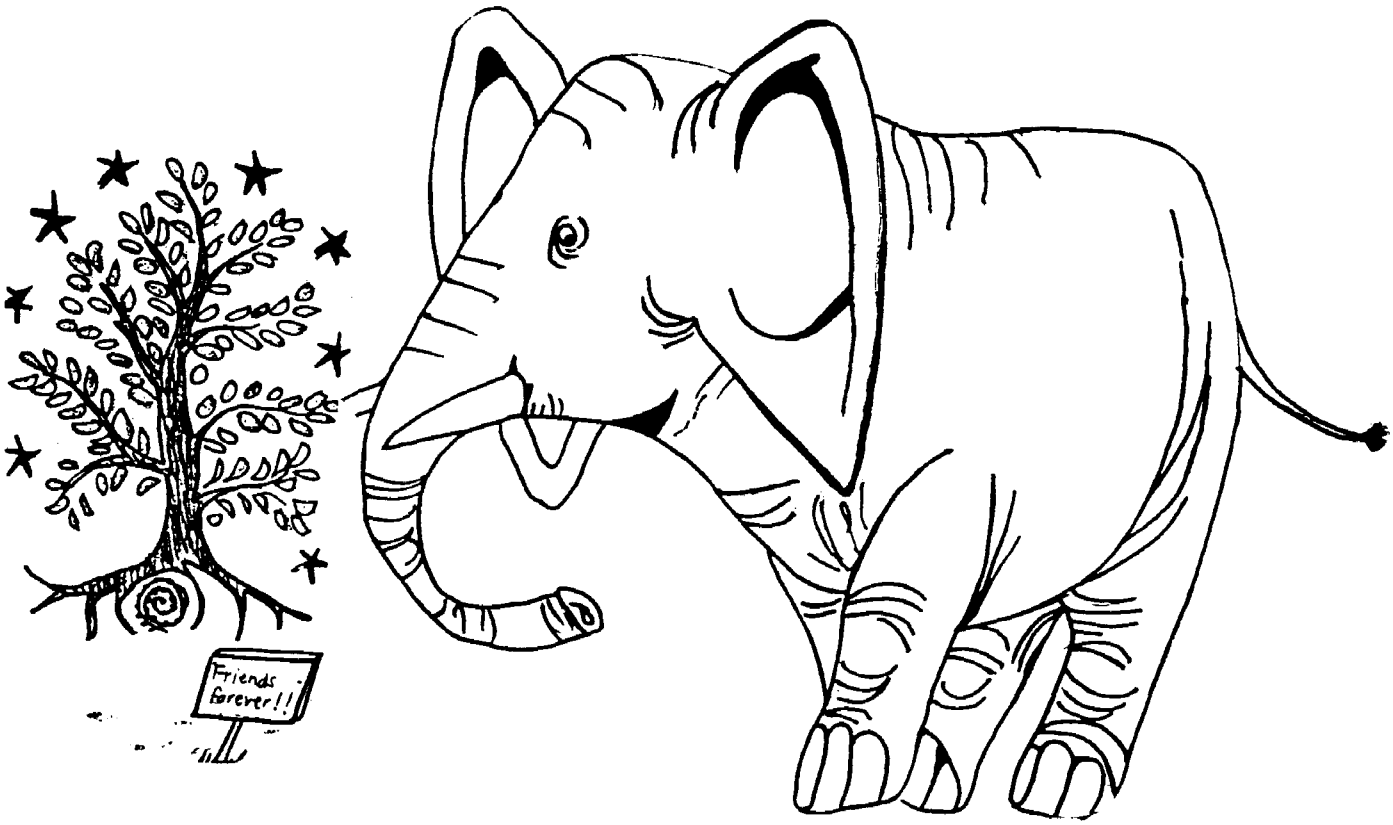
Because elephant hardly ever asked the other animals for anything, they all listened carefully to what he had to say. He explained to them what had happened to the tree, and asked the animals to help the tree grow strong again. The animals agreed to help elephant, and brought special fertilizer and put it all around the base of the tree.

Then elephant spoke to the trees around the burned tree. He explained that the tree would need sunshine and water to help it grow leaves. The trees all agreed to help the little tree in whatever way they could. They started talking to the tree, and including it in their conversations when they swayed in the wind.

The little tree soon discovered that it did know how to grow, and it did know how to develop, and it did know how to look beautiful and full of green leaves

just like the other trees. It began to sprout new leaves and to grow and to develop, and before long, it was hard to see where exactly the lightening had hit!

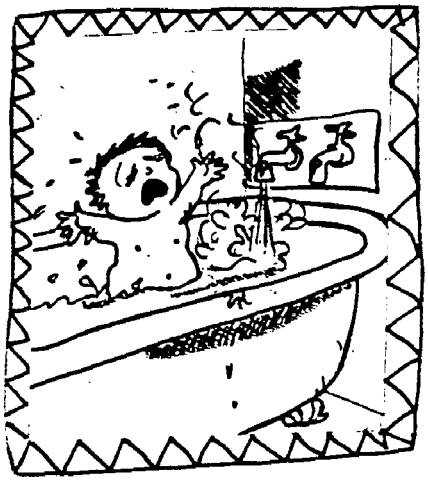
The elephant and the tree became close friends after that. Because the elephant had helped the tree grow to be so beautiful and healthy, the tree decided to do something special for the elephant. It asked the elephant to carve a sign about their friendship. The sign was hung on the front of the tree so that everyone who walked by would realise just how much difference a trusted friend can make in the way your life goes.



- **Examples of questions that can be asked after the story:**
- Why do you think I'm telling you this story?
- What is important about it?
- How would you want to be treated if you were the tree?
- What kind of behaviour do you think is going to be helpful to *x* when s/he returns?

2) Explore the concept of burn - (10 minutes)

Brainstorm ideas regarding what can burn us , writing them up on a piece of paper or the blackboard. Try to get a list of at least 5 to 10 items.



- **Possible questions that can be asked**
- What types of things burn us?
- What gets hot enough to burn
- Does anyone know someone who has been scarred as a result of a burn?
- What caused that scar?
- Does anyone know how learner *x* was burned?

3) Burned learner's story - (10 minutes)

If you have contact with the burned learner and his/her family, ask permission from them to share the story of how the child was injured.

- Share the story with the class, making sure that you do not blame the child who was burned, or use them as an example of what not to do. It is helpful to state that it was an accident, before telling the story.
- Allow time for questions from the class, and ask them if there is anything they would specifically like to know about the incident or hospitalisation. These questions and issues can be relayed to the burned learner, preparing him or her for the return to school.

4) Concept of values - (20 minutes)

This exercise discusses and deals with things that are important to us. For younger children, the concepts of "right and wrong" can be employed.

- Spend some time asking children for examples of behaviour that fits into those two categories, and write these examples up on large sheets or on the blackboard.
- With older children, a forced choice exercise follows, where the children must choose between being "happy" and being "beautiful"., and designate two corners of the room where they must stand once they have made their choice.
- Ask for their reasons as to why they chose a particular corner.

5) Scarring - (10 minutes)

Using the concepts that the children have just named as part of the previous exercise, e.g. "beauty is only skin deep"; "beauty fades as one grows older" etc. , describe what the burn does to skin layers, and that their classmate's appearance might be a little different from what they remember.

6) How do people react when someone looks different - (45 minutes)

Give out two pieces of paper per learner, and some crayons.

- Ask your learners to think about something of themselves they don't like and to draw a picture of it. This can be a physical characteristic, such as their weight, height, sound of their voice, ability to play sport etc.; or an emotional characteristic, such as their temper. Tell them that these pictures are only for them to see, and that they don't have to share it with anyone else if they don't want to.
- Now, ask them to pretend that that is all anyone knows/can see about them. Request that they draw another picture about how this feels.
- Ask them to share their feelings, i.e. what they drew in the second picture. Write their list of feelings up on the board/ a big sheet of newsprint. Once you have a list of about five or six feelings, ask them how they think their burned classmate will feel on that first day when s/he returns to school. Add any of these feelings that have not been mentioned to the class's list.

7) What did they like about burned classmate before the accident? - (20 minutes)

There are two options for this exercise, and you can choose whichever exercise to which you think your learners will respond best.

- The "imibongi" or praise singer exercise, where the learners have to mention a positive quality of the returning classmate. It might be helpful for you to ask every now and again during this exercise: "Do you think that this (positive quality) will have changed during the time that *x* was in hospital?". It is also vital to take notes of what the learners mention, as this can be

passed on to the burned learner, and act as a bridge between the class's feelings and the burn-injured learner.

- OR: a "Graffiti wall", which you have created. Draw lines that represent bricks on a piece of newsprint paper, possibly making more than one if you have a large class. It is difficult for more than about 10 learners to work on the same piece of paper at the same time! During this exercise, the class must write down what they like about the returning classmate. This written form should be given to the returning learner.

8) The 'tease/bully monster' - (20 minutes)

You need to invite the class to select an 'artist', who will draw the class's ideas on a large piece of paper/ on the board. Once this has been done, ask the class to describe their idea of the tease monster, and name it. Let the nominated artist draw this example on the board.

- Once you have an "identikit" of the monster, ask the class to mention the type of things that a 'tease monster' does.
- To help them along, you can pose such questions as:
  - I wonder how the monster gets its power?
  - I wonder how the monster communicates with the children?
  - I wonder how the monster convinces the children to do nasty things to one another?
  - What do you think happens to the monster when children say and do nasty things to each other, do you think it gets stronger?
  - What do you think the monster likes?
  - What effect do you think the monster has on all children?
  - Do you think that the children the monster 'controls' are happy or like the things that they are doing to other children?
  - What do you think the monster hates?
  - What do you think makes the monster weaker?

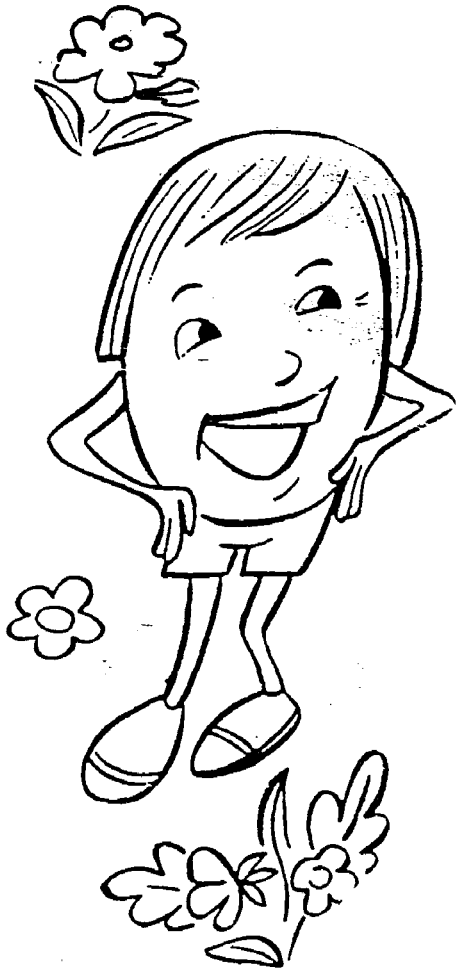
9) Protective spirit - (20 minutes)

Suggest to the learners that the "tease monster" has an opposite, and ask them to nominate an artist again. Ask the children for suggestions as to what the 'protective force' might look like, and get the artist to draw these on a big sheet of paper/ blackboard. Try to get some kind of consensus if there are too many confusing images. Also get them to name this picture, e.g. "fairy godmother", 'angel' etc.

- Once you have a sketch of the "protecting force", ask the children to describe its power.
- You can help them by asking questions such as:
  - I wonder how the protective force gets its power?
  - I wonder how it communicates with the children?
  - I wonder how it protects the children?
  - What do you think happens to the protecting force when children say and do nasty things to each other, do you think it gets stronger or weaker?
  - What do you think that the children can do to make the protecting force stronger?
  - What do you think the protecting force likes?
  - What effect do you think it has on all children?
  - What do you think the protecting force dislikes?
  - What do you think makes it weaker?
  - How do you think the protecting force can help you?
  - How do you think the protecting force can help *x*?
- You can then ask the class what they would like to do to the 'tease monster'. If they answer that they would like to destroy it, let them each come and tear off a strip of the monster/ rub a portion of him out off the board.
- OR: For every positive point they mention about the protecting force, ask them how this affects the monster, and for every useful tip that a child suggests, let them tear off some of the tease monster, until there is nothing left!

10) Promise circle - (2 minutes)

Ask children to stand in a circle and promise to help look out for one another.



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APPENDIX C:

AFRIKAANS MANUAL

SKOOL HERINTERGRASIE PROGRAM VIR LEERDERS MET BRANDWONDE

Saamgestel deur

Ula Horwitz

Vertaal deur
Karin Webber

NOVEMBER 1998

Geagte Onderwyser

Baie dankie vir u bereidwilligheid om deel te neem aan hierdie programme om te verseker dat u leerder met brandwonde so maklik en pynloos as moontlik teruggeplaas kan word in die klaskamer.

Die program beoog ook om leerders met brandwonde se klasmaats te help om te verstaan wat met hulle maat gebeur het en om die leerder self te help om meer gemaklike en "normaal" te voel wanneer hulle terugkeer skool toe.

Dikwels is kinders met brandwonde bang om terug te keer skool toe omdat hulle dink dat hulle klasmaats hulle nie sal aanvaar nie weens hulle brandwonde en dat hulle moontlik geterg of uitgesonder sal word.

Die pakket sal:

- beskryf wat met die kind gebeur het tydens sy/haar hospitalisasie
- die verskillende emosies en reaksies wat hy/sy mag ervaar aanspreek
- bespreek wat die familie deurmaak
- u help om na sekere van u eie gevoelens te kyk rakende die terugkeer van 'n kind met brandwonde in u klas
- riglyne voorsien vir u program wat gebruik kan word wanneer u vir die klas verduidelik wat gebeur het.

Weereens baie dankie vir u samewerking.

Inhoudsopgawe

CHILDREN'S BILL OF RIGHTS & RESPONSIBILITIES

On the wall of the lounge at Teen Centre in Rondebosch, Cape Town

Om u te help om beter te verstaan...

Om jouself te probeer indink in die situasie van 'n leerder wat terugkeer nadat hy/sy gebrand het, kan moeilik wees as u nog nie van te vore te doen gehad het met brandwonde nie.

Die volgende storie is baie soortgelyk aan die ervaring van baie kinders met brandwonde:

Jy is 'n jong kindjie, wat nou net gebrand het. Of dit gebeur het omdat jy met vuurhoutjies gespeel het (al het jou ma gesê jy moenie), of omdat jy die ketel se koord getrek het, of omdat iemand jou perongeluk of aspris gebrand het, is nie nou belangrik nie. Jy is seer. *Die pyn is so erg dat jy voel of jy nie kan asemhaal nie en jy het net nie meer die energie om te huil nie.*

Jy word hospitaal toe geneem waar die dokters en verpleegsters jou skei van jou familie. Jy word na 'n kamer geneem wat vol masjiene en ander metaal goed is wat jy nog nooit van te vore gesien het nie en wat jy nie verstaan nie.

Die pyn is ondraaglik en jy is bang en alleen.

Wanneer jy weer wakker word, het jy buise wat by jou neus en arms uitkom en nog 'n buis wat in jou keel afgaan. Die is moeilik om asem te haal en dele van jou lyf wat nie van te vore seer was nie, voel nou ook seer.

Jou hele lyf is toe met verbande en die dokters en verpleegsters sê jy mag nie omrol of beweeg nie.

Jou familie is nie daar nie en die verpleegsters maak jou aan mekaar seer al sê hulle ook die medisyne sal help. Jy verstaan nie wat aangaan nie. Die pyn is so erg dat jy voel of jy doodgaan.

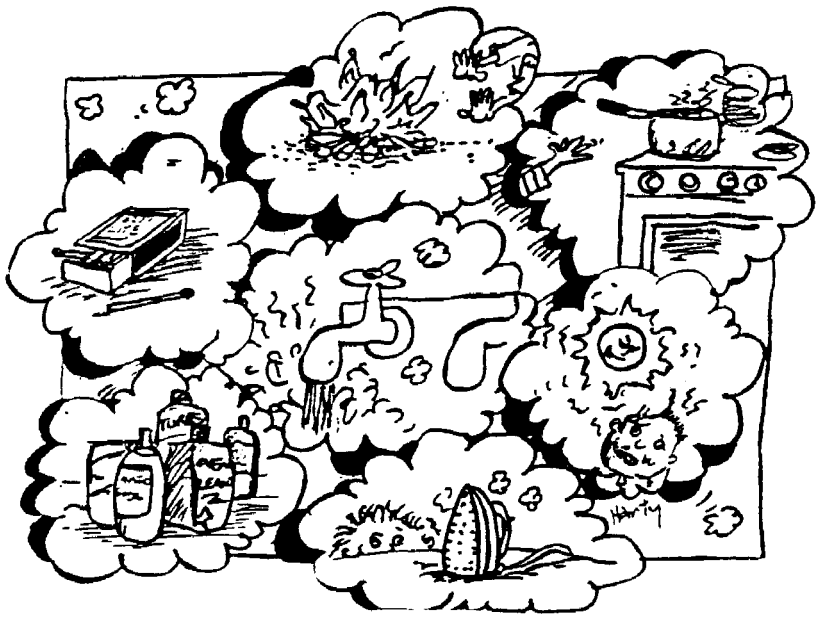
Jy moet vir omtrent 'n maand in die hospitaal bly. Jou familie kom af te toe vir jou kuier, maar jy voel baie keer alleen en bang. Sekere dele van jou lyf word met spalke vasgemaak en dit is baie ongemaklik. Ander dele voel net draaglik. Jy voel of jy gestraf word vir iets wat jy verkeer gedoen het.

Jy begin voel dat jy wil huis toe gaan, maar jy is ook bang dat mense vir jou gaan lag of dalk lelik gaan wees met jou, want jy lyk nou anders. Miskien sal niemand by die skool meer met jou wil speel nie. Miskien sal niemand langs jou wil loop nie. Miskien sal hulle met jou spot en jou name noem. Miskien sal jy nie meer die dinge kan doen wat jy van te vore gedoen het nie en jy is bang dat jy agtergelaat sal word.

Hierdie storietjie is heeltemal moontlik. So baie kinders word agtergelaat en geisoleer. Noudat jy begin verstaan hoe die wêreld van die leerder wat gebrand het is, kom ons kyk wat nog verder in hierdie wêreld gebeur.

Hoe brandwonde ontstaan

Brandwonde ontstaan wanneer warm vloeistowwe(vogbrand plek), warm vaste stowwe (kontak brandwond) of vlamme (vlam brandwond) alles of gedeeltes van die verskillende lae van die menslike vel beskadig en vernietig.

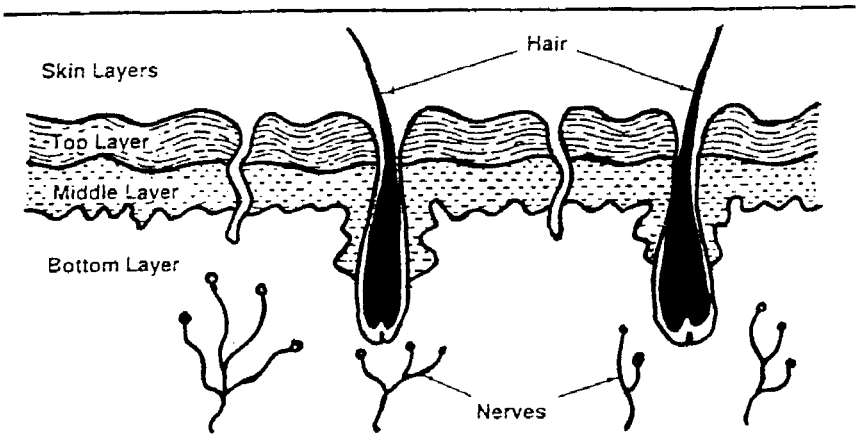


Oppervlakkige brandwonde, soos die wat veroorsaak word deur sonbrand, warm water of as jy jouself brand deur aan 'n warm plaat te vat, herstel binne ongeveer twee weke. Dit laat 'n rooi area wat verdwyn na omtrent 6 maande. Hierdie tipe brandwonde is nie ernstig nie en die leerder hoef nie gehospitaliseer te word nie. Hierdie handleiding is gerig op die leerder met ernstige brandwonde.

Brandwonde word ge-evalueer in terme van die grootte van area van die liggaam wat dit bedek, hoe diep die brandwond is en op watter deel van die liggaam dit gevind word.

U mag dalk al gehoor het dat mense praat van die diepte van 'n brandwond in terme van "eerste, tweede of derde graadse" brandwonde. **Eerste graadse brandwonde** word beskryf as oppervlakkig met gedeeltelike verdikking van die vel, **tweede graadse brandwonde** as diep met gedeeltelike verdikking van die vel en **derde graadse brandwonde** staan bekend as vol verdikde brandwonde.

Derde graadse brandwonde ontstaan as gevolg van kontak met warm metaal, vlamme, chemiese stowwe of as gevolg van 'n vogbrand met water warmer as 50C. Hierdie tipe brandwond gaan deur al die lae van die vel en vernietig alle weefsel. Dit maak dus 'n veloorplanting nodig.
Diep gedeeltelike verdikde brandwonde **(tweede graadse)** is brandwonde wat meeste van die lae van die vel verwyder, maar tog gedeeltes van die vel rondom die haarfollikels en sweetkliere agterlaat. Hierdie gedeeltes van die vel wat behoue gebly het, help later weer om nuwe selle te vervaardig tydens die genesings proses.



Om op te som...

Ernstige brandwonde neig om diep (gaan deur baie lae van die vel) te wees, hulle beslaan grooter areas van die liggaam en/of word op belangrike, sensitiewe en beweegbare dele van die liggaam gevind soos die gesig, hande, voete, gewrigte en perineum. Hierdie brandwonde kan lei tot gestermdheid en/of deformiteite.

Wat gebeur in die Hospitaal?

Die tydperk van hospitalisasie vir ernstige brandwonde is redelik lank. Gedurende die eerste paar dae moet die dokters en verpleegsters die kind stabiliseer, aangesien hy/sy baie vloeistowwe verloor het. Indien dit nie gedoen word nie kan die kind sterf as gevolg van dehibrasie.

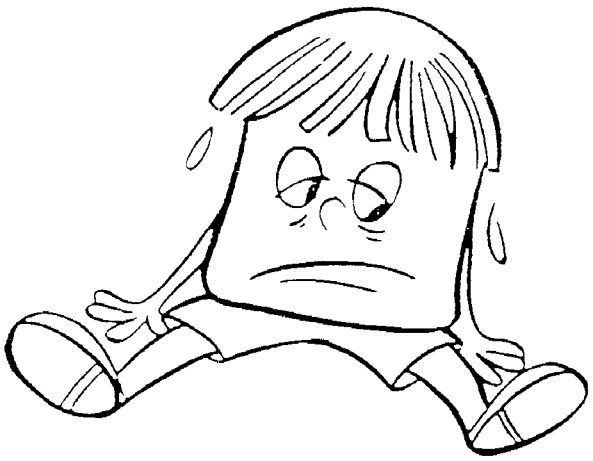
Hulle ander belangrike taak is om te verseker dat die wond so skoon as moontlik gehou word, aangesien 'n infeksie in hierdie vroeë stadium ook fataal vir die kind kan wees. Om die wond skoon te maak moet hulle die verbande gereeld omruil en die dooie vel rondom die wond verwyder. Dit kan geweldig seer wees vir die kind.

Beide tweede en derde graadse brandwonde lei tot die vorming van letsels. Hulle word behandel deur 'n chirurg wat die lae van die dooie vel afskraap en dit dan vervang met 'n stuk gesonde vel van êrens anders op die kind se liggaam. Hierdie nuwe stuk vel word gebruik om die gebrande area te bedek. Dit word 'n vel oorplanting genoem. Nie alle brandwonde het 'n veloorplanting nodig nie.

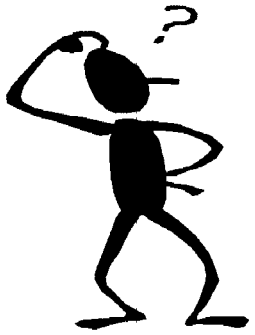
Die kind mag dalk ook vingers, tone, ore of ander liggaamsdele verloor afhangende van hoe diep die brandwond is. Partykeer is dit nodig dat die dokter sekere dele amputeer ten einde te verseker dat die kind sal leef.

Indien die vel rondom 'n gewrig herstel sonder dat dit gestrek word, kan dit die ledemaat skeef trek en 'n kontraktuur sal ontwikkel. Fisioterapeute en Arbeidsterapeute indie hospitaal maak seker dat die kind deur middel van oefeninge die geaffekteerde ledemate sterk. Dit is ook baie belangrik dat hierdie oefeninge ook by die huis gedoen word. Dit is dus belangrik dat die ouers/familie die oefeninge leer by die terapeute sodat hulle sal weet hoe om dit by die huis te doen.

Dit is ook baie belangrik om te onthou dat die letsels en wonde lank neem om te herstel, selfs lank NADAT die kind reeds uit die hospitaal ontslaan is. Dit kan 6 maande tot 2 jaar duur. Aangesien die vel wat die wond bedek baie dun is, is daar baie dinge wat weer die vel kan beskadig soos byvoorbeeld sonbrand en rowwe spel. Geweldige veranderinge in die tempratuur sal ook die herstel van die gebrande en half-herstelde area beïnvloed.



Gevolge van brandwonde



Wat beteken dit dus...

Kinders wat gebrand het mag dalk spalke moet dra om te verseker dat die ledemate of gewrigte in die regte posisie bly. Hulle sal dalk ook "druk-kledingstukke" moet dra wat die vorming van letsels sal verminder. Dit is belangrik dat die kind hierdie 23 uur 'n dag moet dra - dit kan net afgehaal word wanneer hy/sy bad of was.

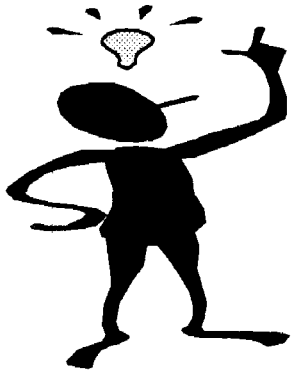
Die letsels is ook 'n ander kleur as die omringende vel (gewoonlik baie pink en blink) en hulle kom ook opgehewe voor met snaakse patrone en bulte op die letsel. Die kleur sal geleidelik ligter word, maar indien die druk-kledingstuk nie gedra word nie, sal die letsels steeds grooter word.

In die areas waar 'n veloorplanting gedoen is, kan die vel nie meer sy eie olies produseer nie en die vel sal baie jeuk (lyfroom sal hiervoor help).

Soos wat die kind ouer word, sal die letsel nie altyd rek nie en soms is dit nodig dat die kind weer teruggaan hospitaal toe sodat dit losgemaak kan word om te verhoed dat dit die kind se normale ontwikkeling beïnvloed.

Dikwels in gevalle waar die kind baie ernstig gebrand het, is dit nodig dat sekere liggaamsdele (neus, ore ens.) deur middel van plasitiese chirurgie herbou moet word. Dit mag beteken dat die dokter 'n balon onder die vel moet plaas wat geleidelik met 'n soutoplossing gevul word en op die manier die vel rek. Dit mag tot gevolg hê dat die kind se liggaamsvorm verander en

dat hulle anders lyk. Dit het dan ook tot gevolg dat die kind se voorkoms gedurig sal verander soos hy/sy ouer word en wanneer verdere operasies gedoen word.



Dit laat ons dus met...

Die leerders wat terugkeer skool toe mag dalk nog hulle spalke en druk-kledingstukke dra om die letsels te beskerm en die liggaam te help met die herstel proses.

Hulle mag dalk ook baie gewig verloor het, as gevolg van hulle lang hospitalisasie. Hulle mag ook stadiger en swakker wees in die begin. Hulle mag dalk ook seker liggaamsdele verloor het, byvoorbeeld vingers en tone, wat sekere skool aktiwiteite en oefeninge moeilik sal maak. Hulle mag dalk op medikasie wees wat die jeukerigheid sal voorkom of dit sal verlig en hulle sal dalk ook nog medikasie vir die pyn neem. Hulle sal natuurlik ook versigtig moet wees om nie die nuwe vel wat hulle wonde bedek te beskadig nie.

Die jeukerigheid kan nog 'n probleem wees vir die die eerste drie tot ses maande. Die leerder moet verstaan dat wanneer hy/sy krap dit die nuut gevormde vel beskadig. 'n Koel omgewing, bevogtigings rome en ander manier van afleiding soos normale skool aktiwiteite kan alles help sodat die hy/sy nie gedurig krap nie.

Die nuwe vel is dun en dikwels vorm daar blasies. Hierdie blasies hou geen risiko vir die leerder of sy/haar klasmaats in nie.

Die leerder wat gebrand het, moet aangemoedig word om aan alle aktiwiteite deel te neem wat binne sy/haar huidige fisiese vermoëns is. Hierdie aktiwiteite help die leerder om weer sy/haar krag, beweegbaarheid en uithouvermoë op te bou en te herwin. In alledaagse aktiwiteite behoort besering nie 'n bron van kommer te wees nie en dit moet ook duidelik gemaak word aan die ander leerders.

Wat beteken dit nie...

Dit beteken NIE dat:

- ***die leerder nooit weer sal kan inpas in die klaskamer nie***
- ***die leerder noodwendig vir altyd gestremd sal wees nie***
- ***die leerder na 'n spesiale skool moet gaan nie***
- ***die leerder nooit iets sal bereik nie***

Mense se reaksie teenoor brandwonde en letsels

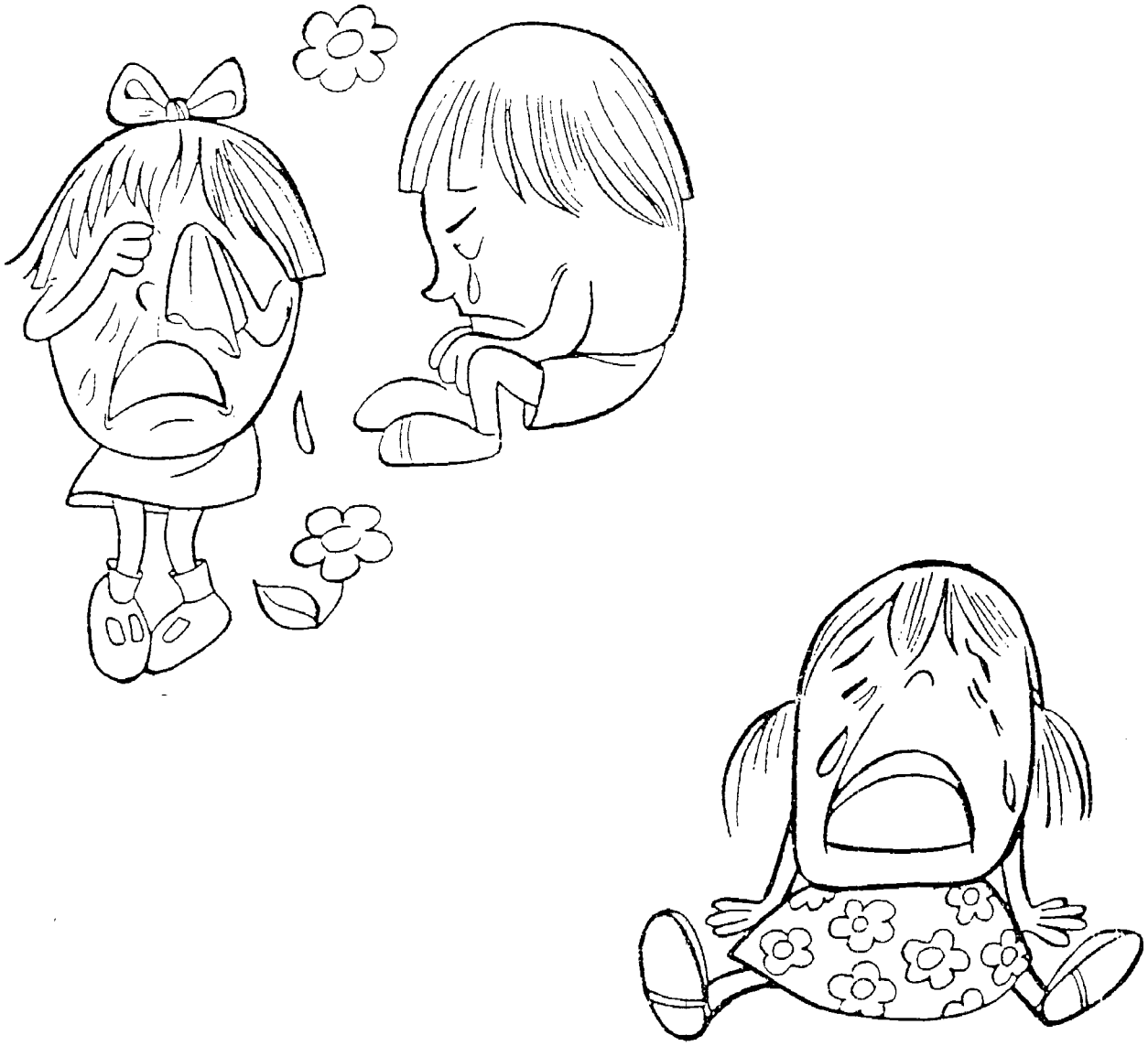
In baie kulture is "skoonheid" of 'n mooi voorkoms iets waaraan baie waarde geheg word. Mense wat buite die norm val van wat as "normaal" gesien word, vind dit dikwels moeilik om in te pas en word dikwels onregverdig beoordeel.

Om mense te ontmoet met letsels en deformiteite laat ander mense dikwels ongemaklik voel. Aangesien on s nie seker is hoe om op te tree nie doen ons dikwels dinge wat ontoepaslik is, soos om te staar of om regtig baie persoonlike vrae te vra of ons voel ongemaklik en skaam en vermy dit heeltemal. Soms word kinders in sekere kulture bang gemaak deur "fee verhale" van lelike monsters en hulle is dan selfs bang vir iemand wat brandwonde het. Ander kinders mag dalk reageer deur so 'n persoon name toe te jou of ongeskik te wees.

Navorsing het getoon dat die ding wat vir kinders met brandwonde die moeilikste is, is om terug te keer skool toe en aanvaar te word deur hulle portuurgroep. Die meerderheid van hierdie kinders, indien geen vorm van

intervensie gedoen word nie, voel alleen en verwerp en hulle voel dat hulle geen positiewe aandag verdien nie. Om gespot en geterg te word vererger hierdie gevoelens en dit is die grootste rede hoekom hierdie kinders sê dat hulle nie wil terugkeer skool toe nie. Daardie kinders wat wel skool toe gaan vind dat hulle baie keer alleen is en niemand het om mee te speel nie.

Depressie is een van die algemeenste reaksies op brandwonde. Sommige van daardie kinders wat so gewelddige depressief raak, pleeg selfmoord omdat die isolasie en verwerping wat hulle ervaar net te veel word.



Ervarings en gevolge vir die kind

Leerders met brandwonde ervaar baie van die selfde probleme as gestremde leerders, maar hulle het ook addisionele probleme soos die feit dat die brandwonde skielik hul voorkoms, lewenstyl en gevoelens verander het.

Die storie aan die begin het u 'n kykie gegee na die ervarings van 'n kind wat gebrand het, maar kom ons kyk meer spesifiek hierna. Die volgende aspekte kan almal struikelblokke wees op die leerder se pad om terug te keer na 'n optimale vlak van funksionering en gemak binne die klaskamer.

Gevolge vir die familie

Ouers van kinders wat gebrand het ondervind geweldige stres. Hulle is nie seker of hul kind sal leef nie en indien wel hoe hy/sy sal lyk of waartoe hulle fisies instaat sal wees.
Hulle mag dalk allerlei drome vir hulle kind gehad het wat nou nie meer moontlik lyk nie of wat anders sal moet wees as gevolg van die brandwonde.

Baie familielede voel baie skuldig oor die ongeluk wat gebeur het (insluitend die kind) ongeag van die feit of hulle dit kon verhoed het of nie.

Familielede mag dalk probeer om baie tyd in die hospitaal te spandeer wat moontlik beteken dat ander kinders in die huishouding nou in die sorg van vriende en familie gelaat moet word. Vir ander ouers mag dit dalk nie moontlik wees om by die hospitaal te wees nie as gevolg van die afstand, geld of die tyd wat betrokke is. Dit dra alles by tot die skuldgevoelens.

Die angstigheid en depressie van die ouers mag dit moeilik maak vir hulle om na die kind te kyk wanneer hy/sy eers ontslaan is uit die hospitaal.

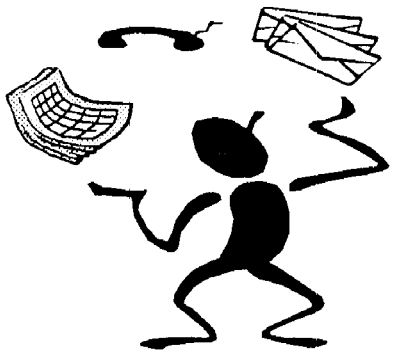
Hulle mag ook bekommerd wees oor wat die bure, ander familielede en vriende sal sê oor die kind se voorkoms. Baie ouers hou hulle kinders wat gebrand het by die huis, in plaas van om hulle terug te stuur skool toe omdat hulle bang is vir die verwerping en isolasie wat die kind se fisiese voorkoms tot gevolg mag hê.
Die broers en susters van die kind wat gebrand het mag dalk ook geterg word weens die voorkoms van hulle broer/suster. Hulle mag ook kwaad word teenoor die een wat gebrand het as gevolg van al die tyd, geld en aandag wat aan hom/haar bestee word. Hulle is ook bekommerd en ontsteld oor die beserings van hulle broer/suster en hulle het baie versekering en ondersteuning nodig.

Gevolge vir u as onderwyser

Die ouers gaan u ondersteuning ook nodig hê!

Hulle mag dalk onrealistiese verwagtinge hê oor hoe vinnig hulle kind sal herstel en mag dalk onregverdige eise aan u stel. Die teendeel hiervan is dat hulle te vinnig vrede gemaak het met die kind se huidige beperkinge en weerstand bied teen u pogings om die leerder weer te integreer in die klaskamer en sodoende sy/haar potensiaal te ontwikkel na die vlak wat die voorheen was.

Aan die anderkant kan ouers ook hulle kind se vermoëms en vaardighede raaksien en baie waardevol wees in terme van beplanning en besluitneming. Ouers weet dat hulle kind wat gebrand het dieselfde behoeftes het as ander kinders. Wat dalk moontlik anders mag wees is die wyse waarop daardie behoeftes aangespreek en bevredig word.



Houdings en Waardes

Waardes is die standaarde of idees waaraan ons waarde heg en wat vir ons belangrik is, byvoorbeeld party mense heg baie waarde aan vriendskap, ander aan onafhanklikheid.

Houdings is ons opinies omtrent sekere aspekte, soos 'n leerder se positiewe of negatiewe uitkyk (houding teenoor) sy huiswerk.

Ons waardes en houdings word bevorm deur die wêreld rondom ons, die mense saam met wie ons leef, die verskillende bronne van opinies wat ons daagliks aan blootgestel word en ons eie lewenservarings.

As 'n onderwyser dra u nie net kennis oor nie, maar ook houdings en waardes rakende sekere aspekte. Dit is dus baie belangrik om bewus te wees van JOU EIE houdings en waardes.

'n Vinnige oefening

Skryf op 'n stuk papier u onmiddelike reaksie op elk van die volgende stellings neer. Skryf net of u saam stem of nie saam stem met die stelling nie. Hierdie antwoorde is net vir u - niemand anders gaan dit sien nie.

- Mense se fisiese voorkoms het geen effek op my nie
- Ek voel heeltemal gemaklik met kinders met "spesiale behoeftes" in my klas
- Mense met letsel is ongelukkig
- Alle letsels is lelik
- Ek vind dit moeilik om "normaal" op te tree rondom mense met letsels
- Ek voel jammer vir mense met letsels
- Ek sou nie 'n brandwond wou oorleef as dit my met letsels gaan laat nie

U reaksie op hierdie stellings is persoonlik, maar dit is baie belangrik dat u weet hoe u voel oor elkeen van hulle. Hulle mag u dalk ongemaklik laat voel het of herinneringe teruggebring het - herinneringe of gevoelens wat nie so aangenaam is nie. Neem 'n bietjie tyd om te kyk na watter stelling vir u die moeilikste was en ondersoek HOEKOM dit vir u moeilik was. Watter beginsels, waardes of houdings het hulle geaffekteer of getoets? U mag dit behulpsaam vind om u redes neer te skryf aangesien hulle oor 'n verloop van tyd mag verander.

U gevoelens as 'n onderwyser

Naas die familie is die skool die belangrikste omgewing waarin 'n kind se sosiale aanpassing en normale ontwikkeling plaasvind. Baie van dieselfde emosies en gevoelens wat die familie ervaar (hartseer, angstigheid, woede, ontkenning) mag ook u vermoë om die nuwe verantwoordelikhede wat die leerder met brandwonde bring, te hanteer.

Baie onderwysers is bang dat die ander kinders naar of onsensitief sal wees teenoor die leerder met brandwonde. Hulle voel ook onseker oor hoe om die leerder met brandwonde self te hanteer! 'n Positiewe, warm houding van al die personeel teenoor die leerder met die brandwonde lei gewoonlik ook tot 'n soortgelyke reaskie van die ander kinders.

Die belangrikste ding om te onthou is dat dit net die kind se voorkoms is wat verander het. AAN DIE BINNEKANT IS HY/SY NOG STEEDS DIESELFDE PERSOON! Hulle het nogsteeds dieselfde voorkeure, afkeure en potensiaal.

Alle leerders wil en behoort aanvaar te word. Hulle het maats nodig. Die leerder met brandwonde het dieselfde behoeftes. Dit is belangrik om verby die brandwond te kyk en die kind in geheel te sien. Afgesien van sy besering is die kind net soos ander kinders.

Die kind met brandwonde mag dalk nou ander vermoëns hê as gevolg van sy/haar besering en dit is belangrik om die hospitaal of Brandwonde eenheid te vra watter beperkings of voorsorgmaatreëls daar is. Hulle sal ook vir u sê as die kind op enige medikasie is (byvoorbeeld vir die pyn of jeukerigheid) en hoe dit die kind moontlik gedurende skooltyd kan beïnvloed. Moenie bang wees om vrae te vra nie!

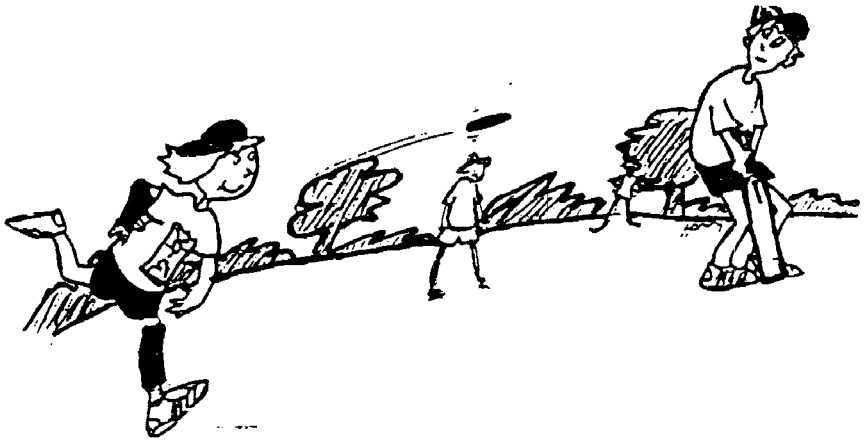
Dit is belangrik om aan die klas te verduidelik dat die leerder met brandwonde toegelaat moet word om so onafhanlik as moontlik te wees en dinge vir homself/haarself te doen.

Terug in die Klaskamer

Wanneer die leerder met brandwonde teruggekeer het na die klaskamer is u taak as onderwyser om realistiese doelwitte te stel, die aanvaarding van die leerder se veranderde voorkoms, die hantering van emosionele en gedragsprobleme en begrip vir die aard en gevolge van die leerder se beserings.

Dit is baie belangrik om 'n balans te verkry tussen die leerder se huidige/tydelike fisiese beperkinge en dit wat die leerder nodig het om te verseker dat sy/haar selfbeeld opgebou kan word. Sorg en ondersteuning is nodig, maar oorbeskerming kan die leerder oorwelddig en benadeel!

Riglyne vir 'n Program



Navorsing het getoon dat kinders wat binne 'n paar weke na ontslag uit die hospitaal, terugkeer skool toe 'n meer positiewe aanpassing maak.

Om die pad van herintergrasie vir die kind makliker te maak, is dit belangrik om aan die ander kinders te verduidelik wat met hulle klasmaat gebeur het. Baie van die negatiewe en ontoepaslike gedrag wat teenoor mense met brandwonde geopenbaar word, is as gevolg van onkunde en vrees. Wanneer die angstigheid verminder word, is negtiewe gedrag soos

verkleinering en onttrekking nie meer nodig nie en die leerder met brandwonde se maats sal baie meer ondersteunend wees teenoor hom/haar.

Verder navorsing het getoon dat as kinders met die nodige inligting voorsien word en indien die onderwyser 'n duidelike verwagting stel van empatie en ondersteunende gedrag, meeste kinders toepaslik reageer.

Vir die program om werklik effektief te wees behoort dit een of twee dae voordat die leerder met die brandwonde terugkeer na die skool met sy/haar klasmaats gedoen word.

Doelstellings

- om die ander kinders te help om empatie te toon teenoor hulle klasmaat en te verstaan wat hy/sy ervaar het. Deur dit te doen word hulle angstigheid verminder en ook die gepaardgaande negatiewe gedrag
- om aan die leerder met brandwonde, in sover dit moontlik is, 'n positiewe en aanvaardende omgewing te bied waarbinne leer kan plaasvind

Beginsels

Die volgende is slegs 'n riglyn van hoe so 'n herintergrasie program kan lyk. Aanpassings sal noodwendig gemaak moet word afhangende van die ouderdom van die kinders met wie die program gedoen word.

Die program moet ten doel hê om die volgende beginsels aan te spreek:

- Wat is brandwonde, hoe vind dit plaas, en hoe affekteer dit die persoon se liggaam;
- Die besonderhede rakende die kind se ongeluk - insluitend hospitalisasie en die verskeie behandelings en prosedure;

- Die konsep van waardes, waar hulle vandaan kom en hoe hulle ons gedrag beïnvloed;
- Gevoelens en reaksies teenoor mense wat anders lyk of optree;
- Hoe terg en ander negatiewe gedrag 'n persoon laat voel;
- Die feit dat hulle klasmaat aan die buitekant verander het, maar dat hy/sy aan die binnekant nog net dieselfde persoon is

Hulpmiddels en ander materiale wat benodig word

- kleur kryte
- papier vir individuele tekeninge
- prente van brandwonde of ander letsels
- groot papier vir groep tekeninge en die "graffiti muur"

Voorgestelde Program

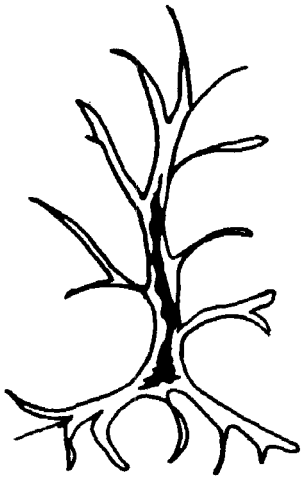
1) **Storie** - verduidelik met behulp van 'n model wat met die klasmaat gebeur het en oefen toepaslike gedrag en reaksies. Die kinders se deelname is baie belangrik en hulle vrae moet die storie lei en rig. **(30 minute)**

Moontlike draaiboek vir die storie

Gebaseer op storie deur Nancy Davis in "Once upon a time: therapeutic stories to heal abuse children (1990) (Revised ed.) oxon Hill, Maryland: Psychological Associates of Oxon Hill, Pp.63 – 66; 99 – 104

Die gebrande boompie

Eendag, lank gelede was daar 'n boompie in die veld wat dood gelyk het. Die boompie het nie groen blare gehad soos die ander bome nie. Dit het gelyk of die weerlig die



boom getref het en toe het die boom opgehou groei - amper asof iemand gekom het en die takke afgesny het totdat daar net kort stompies oor was. Baie van die ander bome in die veld het gedink dat daardie boom dood was, want meeste bome kan bly staan lank nadat hulle dood is. Die bome was verkeerd! Diep binne in die boompie was hy nog lewendig!
Die boompie se enigste probleem was dat hy nie geweet het hoe om te groei en ontwikkel in 'n pragtige boom met blare soos die ander bome nie. Die boom is deur weerlig getref en het erg gebrand. Partykeer wannneer 'n boom deur weerlig getref word, gaan die boom in skok en gee dit moed op dat dit weer sal groei en sal leef soos al die ander bome. Partykeer is daardie skok so groot dat die boom glo dat hy nie meer kan groei nie en dat dit maar altyd dieselfde gaan bly - gebrand en dood.

Eendag het 'n olifant verby gekom. Die olifant het ook gedink die boompie is dood en het begin om die boom om te stamp.

"Hey! Eina!" het die boompie geskreeu.

Die olifant was baie verbaas en het rondom hom gekyk, "Wie is daar? Wie praat met my?"

"Dis ek", het die boompie gesê. "Jy maak my seer! Hou asseblief op om my om te stamp!""

"Ek glo dit nie", het die olifant gesê. "Jy lyk dan dood. Jy lyk heeltemal gebrand en uitgedroog. Jou takke is almal gebreek en jy het nie eers

blare nie. Ek wou jou uit my pad stamp, want ek het gedink jy is alreeds dood."

"Ek is nie dood nie. Ek is nie eers siek nie", het die boompie geantwoord.

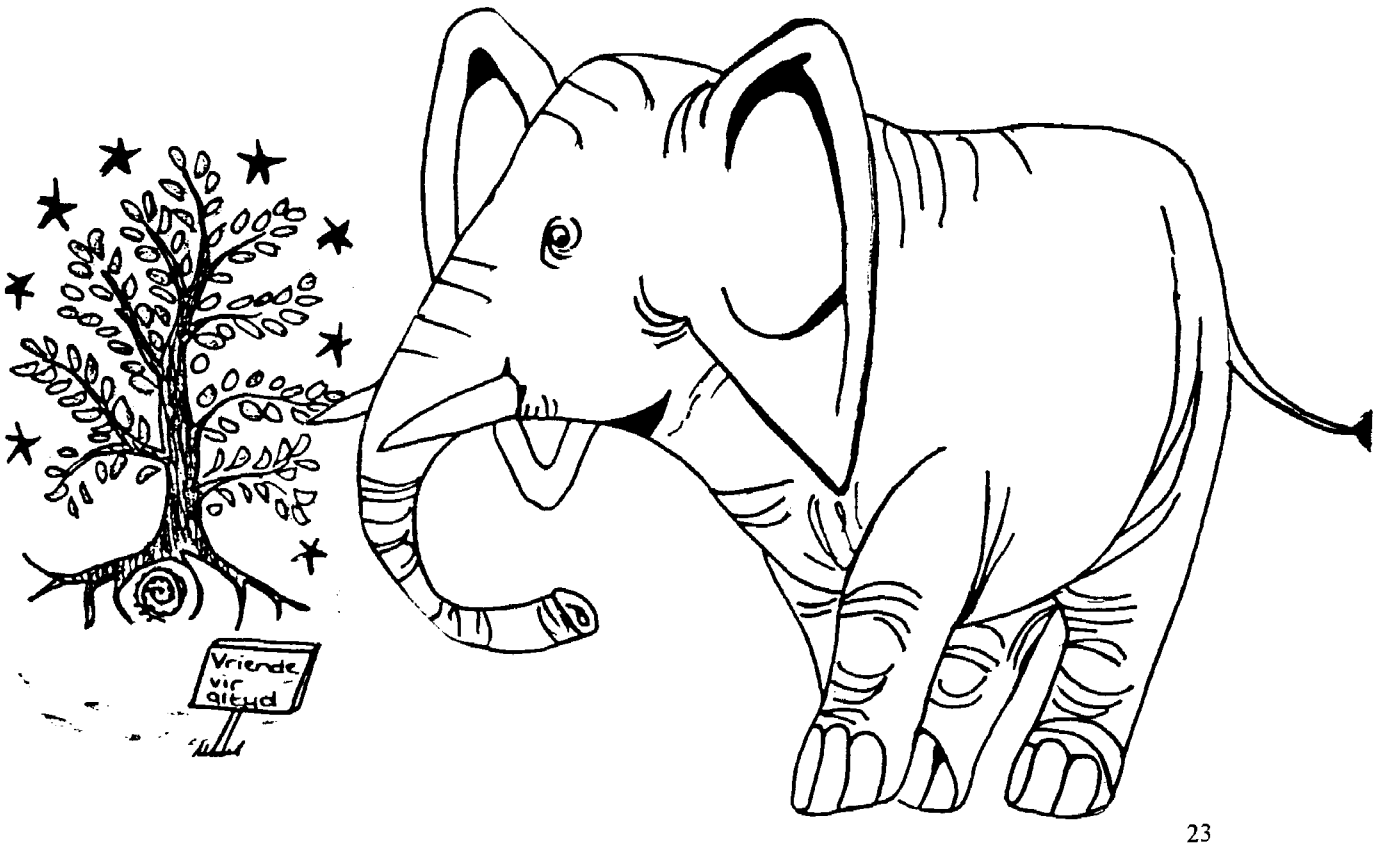
Die olifant was baie deurmekaar. "As jy nie dood is nie en jy is nie siek nie, heokom lyk jy dan so sleg?"

Die boompie het hartseer geantwoord," Ek weet nie meer hoe om te groei nie. Ek weet nie hoe om blare te maak nie. Ek weet nie hoe om lewendig te lyk nie, want die weerlig het my so hard getref dat ek alles vergeet het. Die voëls maak nie meer hulle nessies in my takke nie en die ander diere kan nie meer in my skaduwee sit nie. Almal ignoreer my of sê ek is baie lelik. Almal spot met my en die ander bome dink ek is dood."

Die olifant, wat baie ondervinding met bome gehad het, het toe besluit om die boom te help. Die eerste ding wat die boompie moes doen, was om al die dooie en gebrande stukkies van sy takke af te haal. Met sy slurp het die olifant al die dooie stukkies afgebreek en weggegooi sodat die nuwe lewe weer in die boom kon begin. Toe het die olifant 'n vergadering gehou met al die ander diere en vir hulle gesê dat hulle ook kon help om die boom weer beter te maak. Aangesien die olifant nie gewoonlik iets van die ander diere gevra het nie, het hulle almal baie versigtig geluister na wat hy gesê het. Hy het verduidelik wat met die boompie gebeur het en al die diere gevra die boompie te help om weer sterk en mooi te groei. Al die diere het ingestem om te help. Hulle het kunsmis en water gebring en dit rondom die boom se wortels gepak. Toe het die olifant met die bome rondom die gebrande boom gepraat. Hy het verduidelik dat die boompie

sonlig en water sou nodig hê om weer blare te maak. Die bome het almal belowe dat hulle die boompie sou help. Hulle het begin om met die boompie te praat en maats gemaak met hom. Wanneer hulle almal saam gesels het, terwyl hulle in die wind gewaai het, het hulle hom ook ingesluit in die geselskap.

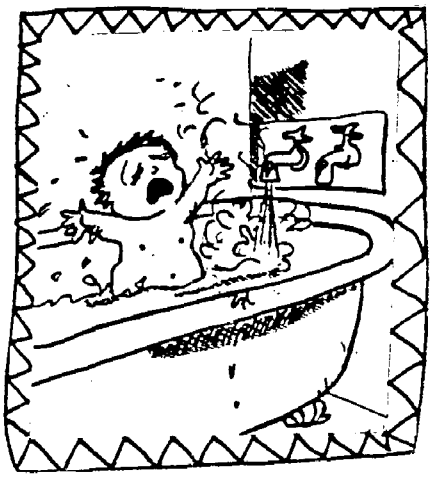
Die boompie het gou geleer dat die wel geweet het hoe om te groei en mooi te lyk en hy het gou baie nuwe groen blare gehad en het net so mooi soos die ander bome gelyk. Kort voor lank kon 'n mens nie eers meer sien dat dit deur weerlig getref is nie. Die olifant en die boompie het baie groot maats geword. Omdat die olifant die boompie gehelp het om weer mooi en sterk te word, het die boompie besluit om ook iets spesiaal vir die olifant te doen. Hy het vir die olifant gevra om 'n kennisgewing te maak wat sê dat hulle vriende is. Die kennisgewing is toe voor die boompie gehang en almal het baie gou besef dat dit baie help om 'n maat te hê wat jy kan vertrou en wat jou kan help wanneer jy dit nodig het.



- **Voorbeelde van vrae wat na die storie gevra kan word:**
- Hoekom dink julle het ek die storie vir julle vertel?
- Wat is belangrik omtrent die storie?
- Hoe sou jy behandel wou word as jy die boompie was?
- Wat dink jy sou hulpvol wees vir X as hy/sy terugkom skool toe?

2) Ondersoek die konsep van brand (10 minute)

Laat die kinders hulle idees gee van al die maniere waarop ons kan brand - gebruik ook prente van die bronne van brandwonde.



- **Voorbeelde van vrae wat gevra kan word:**
- Watter dinge kan ons alles brand?
- Wat word warm genoeg om ons te brand?
- Ken enige iemand dalk 'n persoon wat 'n letsel het as gevolg van 'n brandwond?
- Wat het die letsel veroorsaak?
- Weet enige iemand hoe X gebrand het?

3) Die leerder met brandwonde se storie (10 minute)

Indine u kontak het met die familie van die leerder wat gebrand het, vra hulle toestemming om met die res van die klas te deel hoe hy/sy gebrand het.

- Deel die storie met die klas. Maak seker dat jy nie die leerder wat gebrand het beskuldig nie en hom/haar ook nie gebruik as 'n voorbeeld van wat om nie te doen nie. Dit is raadsaam om vooraf te sê dat dit 'n ongeluk was voordat jy die storie vertel.
- Gee geleentheid vir die klas om vrae te vra en vra of daar enige iets spesifieks is wat hulle wil weet omtrent die ongeluk of die hospitalisasie. Hierdie vrae kan ook oorgedra word aan die leerder met brandwonde as deel van die proses om hom/haar voor te berei vir wanneer hulle terugkom skool toe.

4) Konsep van waardes (20 minute)

Hierdie oefening gaan oor die dinge wat vir ons belangrik is. Vir jonger kinders gaan dit oor die konsep van "reg en vekeerd".

- Spandeer 'n bietjie tyd om vir die klas te vrae vir voorbeelde van gedrag wat in die twee groepe val. Skryf dit op die bord neer.
- Gaan aan (met ouer kinders) met 'n geforseerde keuse oefening waar die kinders moet kies tussen "gelukkig wees" en "mooi wees". Kies twee kante van die klaskamer waar hulle moet gaan staan om te wys watter opsie hulle gekies het.
- Vra vir hulle om te motiveer hoekom hulle 'n betrokke keuse gemaak het.

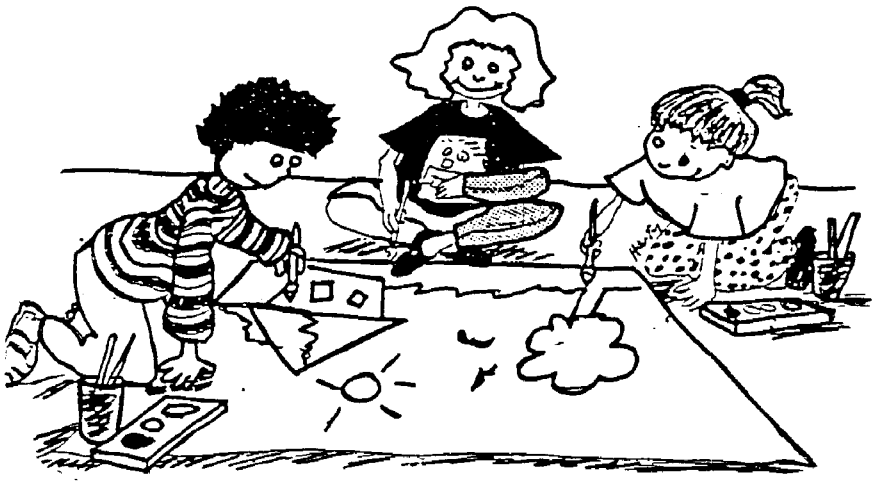
5) Letsels (10 minute)

Deur gebruik te maak van die konsepte wat die klas in die vorige oefening genoem het, beskryf wat 'n brandwond doen aan die lae van die vel en verduidelik dat hulle klasmaat se voorkoms moontlik anders mag wees as hulle hom/haar weer sien.

6) Hoe reageer mense teenoor iemand wat anders lyk? (45 minute)

Gee vir elke leerder twee velle papier en kryte

- Kinders word gevra om te dink aan iets van hulleself waarvan hulle nie hou nie en dit dan te teken. Dit kan 'n fisies karaktereienskap wees, soos hulle gewig, lengte, stem, vermoë om sport te speel ens; of 'n emosionele aspek, soos hulle humeur. Sê vir hulle dat die prente net vir hulle is en dat hulle dit nie met enige iemand hoef te deel as hulle nie wil nie.
- Vra dat hulle hulleself nou moet verbeel dat dit al is wat mense van hulle weet of kan sien. Vra vir hulle om nog 'n prent te teken van hoe dit hulle laat voel.
- Vra hulle om hul gevoelens met die klas te deel, dit wat hulle in die tweede prent geteken het. Skryf hulle gevoelens op die bord neer. As daar omtrent vyf of ses gevoelens is, vra hulle hoe hulle dink hulle klasmaat dalk mag voel. Voeg enige ander gevoelens wat dalk mag bykom ook by die lys.



7) Waarvan het hulle gehou in die klasmaat van hulle voor die brandwond? (20 minute)

Hierdie oefening het twee dele e jy mag die een kies wat die beste in jou klas sal werk.

- Die eerste is die 'n prys-sanger waar die leerders al die goeie en positiewe eienskappe van hul klasmaat moet noem. Dit kan ook help om te vra of hulle dink dat hierdie eienskappe verander het terywl die kind in die hospitaal was. Dit is belangrik dat die onderwyser notas sodat dit weer teruggevoer kan word aan die kind wat terugkeer skool toe.
- OF: "Graffiti muur" waar die klas alles neerskryf waarvan hulle hou omtrent die klasmaat met die brandwonde. Teken lyne wat bakstene voorstel op die bord of 'n groot vel papier. Indien die klas baie groot is kan jy moontlik meer as een maak, want dit is moeilik vir meer as 10 kinders om op dieselfde papier te werk. Hierdie lys word dan ook aan die kind gegee wanneer hy/sy terugkom skool toe.

8) Terg-monster (20 minute)

Vra vir die klas om 'n 'kunstenaar' aan te stel wat die klas se idees op 'n groot vel papier kan teken. Wanneer dit gedoen is vra vir die klas om te beskryf hoe hulle dink die "terg-monster" lyk en hulle kan ook vir hom 'n naam gee. Laat die 'kunstenaar' die monster teken.

- Wanneer jy 'n beeld het van hoe die monster lyk, vra vir die klas wattter tipe dinge die 'terg-monster' doen.

Om hulle te help, kan jy die volgende vrae vra:

- Ek wonder hoe die monster sy krag kry?
- Ek wonder hoe die monster met kinders praat?
- Ek wonder hoe die monster kinders oorreed om naar te wees teenoor mekaar?
- Wat dink jy gebeur met die monster as kinders nare dinge sê of doen, dink julle hy word sterker?
- Waarvan hou die monster?
- Watter effek dink jy het die monster op alle kinders?
- Dink jy die kinders wat die monster "beheer" is gelukkig of dat hulle hou van die nare dinge wat hulle doen?

- Waarvan hou die monster nie?
- Wat maak die monster swakker?

9) Die "beskermings-mag" (20 minute)

Stel voor dat daar 'n teenoorgestelde van die 'terg-monster' is en vra dat hulle weer iemand aanstel om te teken. Die onderwyser laat die kinders dan 'n **"beskermingsmag"** maak wat die kind sal beskerm teen die "terg monster". Vra vir die klas hoe hulle dink die 'beskermingsmag' lyk en laat die 'kunstenaar' dit teken. Hulle kan ook vir die "beskermingsmag " 'n naam gee, bv. die Goeie Fee ens.

Die onderwyser vra dan vir die kinders hoe hulle dink hierdie "beskermingsmag" kan help om kinders te help om mekaar te beskerm en te ondersteun. Die onderwyser kan die kinders lei deur sensitiewe aspekte wat dalk hier na vore mag kom.

- Vra vir die kinders om die 'mag' te beskryf":

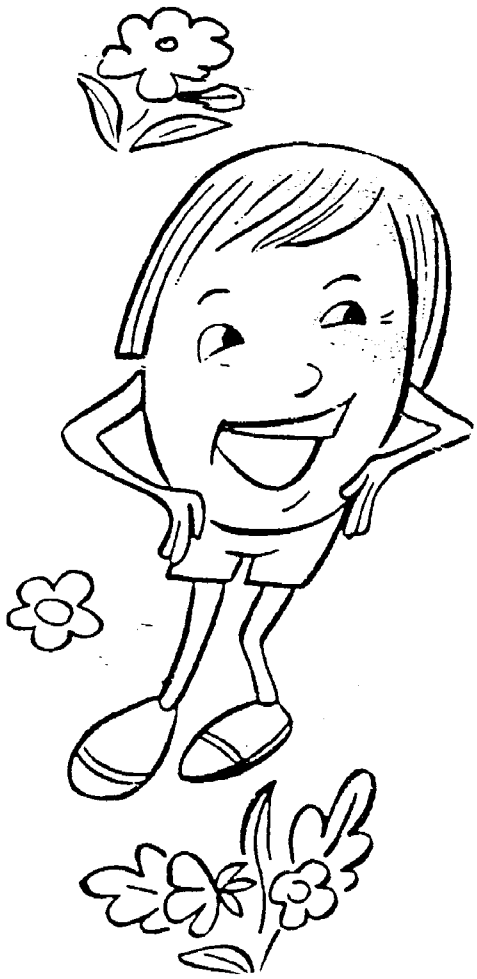
  Die volgende vrae mag dalk help:

- Ek wonder hoe kry die beskermingsmag sy krag?
- Ek wonder hoe praat hy met kinders?
- Ek wonder hoe beskerm hy kinders?
- Wat dink julle gebeur met die beskermingsmag as kinders nare dinge sê of doen, dink jy dit word sterker of swakker?
- Wat kan kinders doen om die beskermingsmag sterker te maak?
- Waarvan hou die beskermingsmag?
- Watter effek het dit op alle kinders?
- Waarvan hou die beskermingsmag nie?
- Wat maak hom swakker?
- Hoe dink jy kan die beskermingsmag jou help?
- Hoe dink jy kan die beskermingsmag vir X help?

- Vra vir die klas wat hulle met die 'terg-monster' wil doen. As hulle hom wil vernietig laat elke kind 'n stuk van die tergmonster afskeur totdat daar niks oor is nie.
- Of vir elke goeie idee wat hulle noem oor die beskermingsmag, kan 'n stuk van die monster afgeskeur word totdat daar min of heeltemal niks van hom oor is nie.

10) Belofte sirkel (2 minute)

Vra die kinders om in 'n sirkel te staan en te belowe dat hulle na mekaar sal kyk en mekaar sal help.



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IPROGRAM YOKUBUYELA ESIKOLWENI KWABANTWANA ABATSHILEYO

Ibhalwe yalungiswa ngu

Ula Horwitz

NOVEMBER 1998

Mfundisi-Ntsapho Obekekileyo,

Ndiyabulela ngokundivumela ndithathe inxaxheba kule program ukunceda umfundi obetshile abuyele eklasini ngokulula kangangoko.

Siyayiqonda into yokuba le program izakunceda nabalingane balo mfundi utshileyo ukuba bayiqonde inngozi eyehlele umhlobo wabo ngako oko bazive bekhululekile kukuhlala naye esikolweni kwakhona.

Ixesha elininzi abantwana abatshileyo bayoyika ukuphindela esikolweni kuba becinga ukuba abafundi beklasi yabo ayizukubamkela ngenxa yale ngozi, baze babanxwale,babacinezele badlale ngabo.

Le ncwadana iza:

- kucacisa into eyenzeka emntwaneni esibhedlele
- ithethe ngentlobo zendlela eyamkeleka ngayo le ngozi
- icacise indlela usapho eyamkela ngayo
- incede nawe ukuba umphathe njani na umntwana otshileyo xa ephindela e klasini
- idwelisa iprogram ezakuku nceda xa ucacisela iklasi yakho into eyehlileyo

Enkosi kakhulu ngenkxaso yenu.

Okufumanekayo

- Amalungelo abantwana nokufanele kukuba bakwenze

CHILDREN'S BILL OF RIGHTS & RESPONSIBILITIES

On the wall of the lounge at Teen Centre in Rondebosch, Cape Town

Ukukunceda ukuba uqonde

Ukuzama ukucinga ukuba umntwana otshileyo ubuyela njani na eklasini kunzima kakhulu ukuba zange ubekule meko ngaphambili.

Eli bali lilandelayo lingumzekelo woninzi lwabantwana abakhe batsha:

Ungumntwana omncinane omalunga neminyaka emithandathu nesixhenxe sandulukutsha Noba kungenxa yokudlala ngematshisi(aho umama wakho ebekunqandile) okanye utsale umtya weketile yombane, okanye umntu ukutshise ngengozi okanye ngamabom;okwangoku ayibalulekanga loo nto.

Wenzakele.

Intlungu zikuphethe kakhulu kangangokuba awukwazi nokuphefumla awusenawo namandla oku khala. Uthathwe wasiwa esibhedlela apho ogqira nonesi bakohlula kusapho lwakho,bakuse kwigumbi eligwele bubuxhakaxhaka bentsimbi ongazange wabubona wabuqonda ngaphambili.

Intlungu azinyamezeleki, uyoyika uwedwa.

Xa uphinda uphaphama ubona imibhobho ephuma empumlweni nasezingalweni, eminye imibhobho ihla emqaleni awukwazi kuphefumla kubuhlungu wonke umzimba. Wogqunywe ngamalaphu ,ogqira nenesi abavumi nokuba ushukume nakancinci nokuba uphakame Ukhumbula usapho lwakho ,onesi bayakuthunuka nangona besithi iyeza lizakukunceda.

Awazi nje ukuba kuqhubeka ni

Intlungu zikongamele ucinga ukuba uyafa.

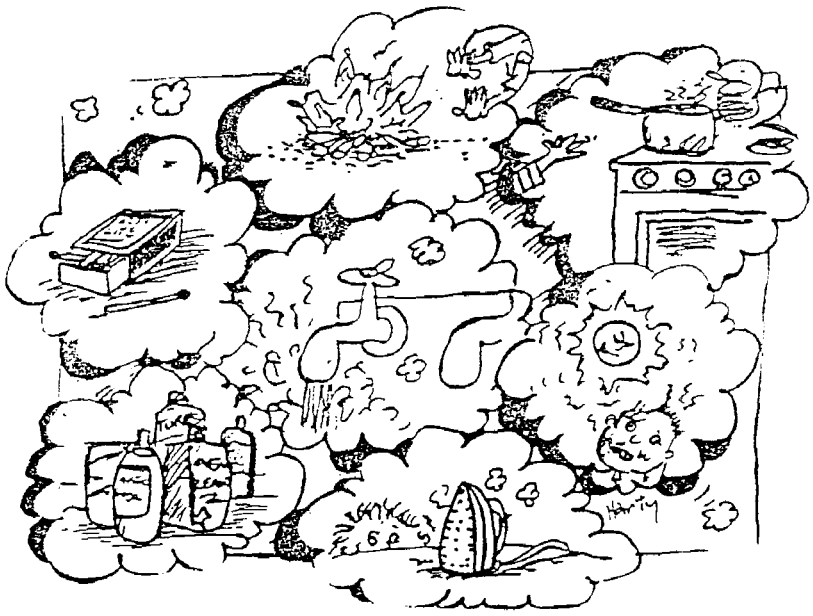
Uzakuhlala esibhedlele inyanga yonke. Usapho lwakho lumne lukundwendwela ngamanye amaxesha ,kodwa unesithukuthezi uyoyika amaxesha onke. Amalungu akho omzimba axhaswe ngezinti awukhululekanga,uziva ngathi uyohlwaywa ngento embi oyenzileyo

Ufuna ukugoduka,kodwa uyoyika ukuba abantu bazothini xa bekubona sowunje. Mhlawumbi soze kubekho mntwana uzakuphinda adlale nawe. Mhlawumbi akho mntu uyakuhamba nawe. Uza kubizwa ngamagama.mahlawumbi awuzukukwazi ukwenza izinto obukwazi ukuzenza, uziva uzakusala emva.

Eli balana lisenokwenzeka. Baninzi abantwana abashiywe emva. Njengoba uliva elibali lomntwana otshileyo masibone ukuba kwenzekani.

Zenzeka Njani Izilonda Zokutsha

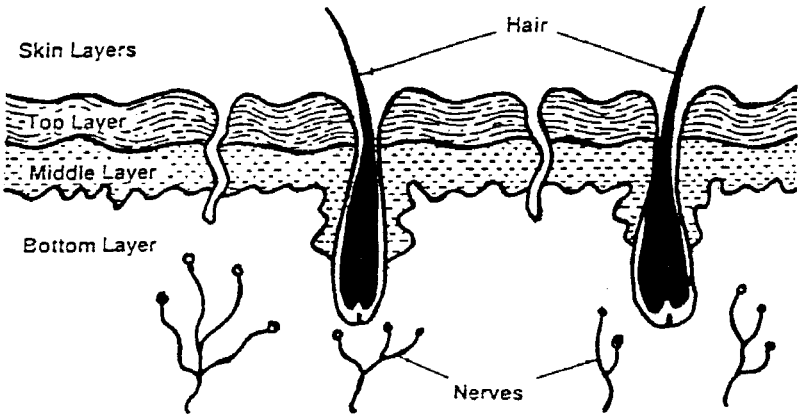
Izilonda zokutsha zenzeka xa amanzi atshisayo,izinto ezilukhuni ezitshisayo okanye amalangatye etshabalalisa inxenye okanye lonke ufele lomntu.



Ukutsha nje okungaphezulu okufana nokutshiswa lilanga, amanzi ashushu okanyeukubamba isitovu esitshisayo, konke oku kuphila ngeveki ezimbini, zikushiye nendawo ebomvu ephinde ijike emva kwenyanga ezintandathu. Ezo ntlobo zokutsha azikho buhlungu kakhulu, umfundi akanakulaliswa sibhedlele. Le ncwadana ke ingabafundi abatshe kakhulu.
Amanxeba okutsha ajongwa ngokuba alapha phezulu elufeleni okanye anzulu na nokuba akweyiphi indawo yomzimba

Unokuba ukhe uve abantu bethetha ngeqondolokuqala,elesibini nelesithathu lokutsha. Elokuqala ke leli lilapha phezulu, elesibini linzulwana elesithathu lelinzulu ke kakhulu. Eli ke lisisphumo sokoyama inkcenkce eshushu, idangatya, ikhemikhali nokutshiswa ngamanzi ngapha kwama qondo angama50eC. Eli qondo lihamba nzulu lisusa ulwantwentwe lolusu leli lifanele upetsho lolusu.

Anzulwana ngamanxeba okutsha asusa phantse lonke ulusu kodwa lushiye ingxowana zolusu ezijikeleze uboya namadlala okubila. Ezi ngxowana ekugqibeleni zivelisa ulusu olutsha olunceda ukuphola. Ukutsha okungephi koku kungatyhutyhanga kakhulu ulusu.



Ukushwankathela.....

Amanxeba okutsha adla ngoba nzulu(agqithe kwiilwantwentwe ezininzi zofele) zithathe indawo enkulu emzimbeni enjengobuso, izandla iinyawo,amalungu njalo njalo. Ezi zinto zingansiphumo sokukhubazeka nokujijeka.

Kwenzeka Ntoni Esibhedlela

Ixesha lokugcina umntu otshe kakhulu esibhedlela lide kakhulu. Kwintsuku ezimbalwa zokuqala ogqira nonesi kufuneka bamnonelele kakhulu umntwana otshileyo kuba uyakulahlekelwa zincindi zomzimba. Ukuba oku akwenziwa umntwana angafa kukoma okubangelwa yilahleko yencindi zomzimba.

Enye into ebalulekileyo kukuqinisekisa ukuba inxeba ligcinwa licocekile, kuba iintsholongwane zingambulala umntwana kusekutsha. Ukugcina inxeba licocekile, kufuneka amalaphu okubopha inxeba atshintshwe qho, kususwe nezikhokho ezijikeleze inxeba. Ibuhlungu kanobom ke emntwaneni loo nto.

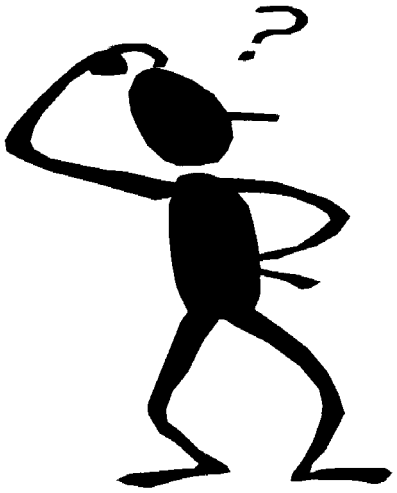
Ukutsha okungenzulu kuyaphi nokunzulu kakhulu kwenza iziva. Iziva zinyangwa ngugqira ngokuthi asuse ufele olufileyo olungaphezulu aze asike kwalapha emzimbeni abeke kule ndawo itshileyo. Le nto ke yaziwa ngokuba lupetsho lofele.

Umntwana angalahlekwa yiminwe, zinzwane, zindlebe nempumlo, kuxhomekeka ukuba ukutsha oko kubi kangakanani na. Ngamanye amaxesha ogqira bayanyaneleka ukuba balishunqule ilungu lomzimba ukusindisa ubomi bomntwana.

Ukuba ufele olugqume imisipha luphila lungolulwa, ilungu elo lomzimba lingatsaleka libegoso. Ezibhedlela ogqira abaqeqeshelwe ukolula imizimba yabantu baqinisekisa ukuba umntwana uyolula ngokufanelekileyo loo ndawo atshe kuyo, kodwa ke nasekhaya kuyafuneka baqhube njalo. Kubalulekile ke ukuba abazali nosapho lonke lufunde kogqira ukuze baqhubekeke nokolula umntwana ekhaya.

Enye into ebalulekileyo emasiyikhumbule yeyokuba iziva nezilonda zithatha ixesha elide ukuphila emva kokuba umntwana ephumile esibhedlela, ingazinyanga ezintandathu kuye kwiminyaka emibini emva kwengozi. Ngenxa yokuba ufele olugqume isilonda libuthathaka, zininzi izinto ezingalwenzakalisa, ezinje ngelanga nokudlala okungakhuselekanga njalo njalo. Ukutshintsha kwemo yezulu ngokukhawuleza kuliphatha kakubi inxeba lokutsha nenxeba elisapholayo.

Iziphumo Zokutsha



Ithetha ukuthini lento

Abantwana abatshileyo banxiba izinto ezixhasa amalungu nemisipha ukuba ihlale endaweni yayo. Banganxiba nempahla ezicinezela izilonda ukuze iziva zingandi. Kubalulekile ukuba ezompahla zinxitywe iiyure ezingama 23 ngemini, zikhululwe xa zihlanjwa qha.

Iziva zing umbala owohlukileyo kwibala lomntu(zidla ngoba pinki, zikhazimle zibonakale zinoburalarume) zikhangeleka zingamaqhuma ziyimizobo engaqhelekanga. Lo mbala uye ubamfiliba, uba impahla ecinezela izilonda iyanxitywa iziva azinakubheka phambili.

Kwindawo epetshwe ufele, ufele alukwazi ukuvelisa incindi yendalo, ngoko ke loo ndawo iyarawuzela kakhulu (ufele luncedwa ngamafutha).

Xa abantwana bekhula iziva zisenokungeluki ngoko ke kufuneke baphindele esibhedlele ziyokukhululwa ukuze zingaphazamisani nokukhula kwabo.

Xa umntwana etshe kakubi kungafuneka enzelwe amalungu omzimba (anjengendlebe, impumlo njalo njalo). Ngamanye amaxesha ogqira bafakela into enjengebhaloni phantsi kofele ethiwa incindi ye Salina ngokucothayo

ukuze ufele loluke. Le nto ke ithetha ukuba ukumila komntwana kuzakuphazamiseka babonakale bekumila kumbi. Ngoko ke imbonakalo yomntwana iyakuthi chu itshintsha minyaka le ekhula evuthwa, nanjengoko utyando luqhubeka.

Ngoko ke oko kusishiya nokuba .....

Abafundi abatshileyo babuyela eklasini yakho befake izinto ezixhasa amalungu nemisipha, impahla ecinezela amanxeba, abanye bezigqume ubuso okanye bethambise amafutha njalo njalo ukunceda ukukhusela iziva nokunceda umzimba uphile.

Mhlawumbi bayakubuya be bhityile kukuhlala esibhedlele. Bayakuhamba kade, babebuthathaka ekuqaleni. Abanye bayakubuya bengenamalungu omzimba anjengeminwe nenzwane, ezo nto zenze ukuba kubenzima ukwenza imisebenzi nemithambo esikolweni. Abanye boba bephantsi konyango ukunqanda nokuthomalalisa ukurawuzela abanye bangaba besadla amayeza entlungu. Kufuneka belumke kakhulu bangatshabalalisi ufele olutsha olu ethe - ethe olugqume amanxeba.

Ukurawuzelelwa kungayingxaki ukususela kwinyanga ezintathu kuye kwezintandathu emva kokutsha.

Umfundi kufuneka aqonde okokuba ukuzonwaya kubanga ufele olutsha lophuke. Indawo epholileyo,nezithambiso nokungathathi nxaxheba kwizinto zesiqhelo zesikolo kungaluncedo.

Ufele olutsha lubuthathaka, ngoko ke amadyunguza asoloko evela . Ezi zinto azoyikisi kumfundi otshileyo okanye kubafundi abaseklasini.
Umfundi otshileyo kufuneka akhuthazwe athathe inxaxheba kuzo zonke izinto ezenziwayo anakho ukuzenza kule meko akuyo . Ezi zinto zinceda abafundi abatshileyo bandise, bomelele kwakhona, bazulazule kwaye bayinyamezele lemeko bakuyo. Kwizinto ezenziwayo imini nemini, ukwenzakala mabangazihluphi ngako nabanye abafundi mabangazihluphi ngale nto

Into engayithethiyo...

Le nto ayithethi okokuba:

- umfundi akasoze aphinde alunge ukuba seklasini
- umfundi uza kukhubazeka ngonaphakade
- umfundi ngoku kufuneka aye kwisikolo sabakhubazekileyo
- umfundi soze aphumelele

Into eyenziwa ngabantu xa betshile beneziva

Intlanga ezininzi zenza ubuhle ibe yeyona nto ibalulekileyo ebomini, Abantu abangayingenanga loo nto bagwetywa ngokungafanelekanga.

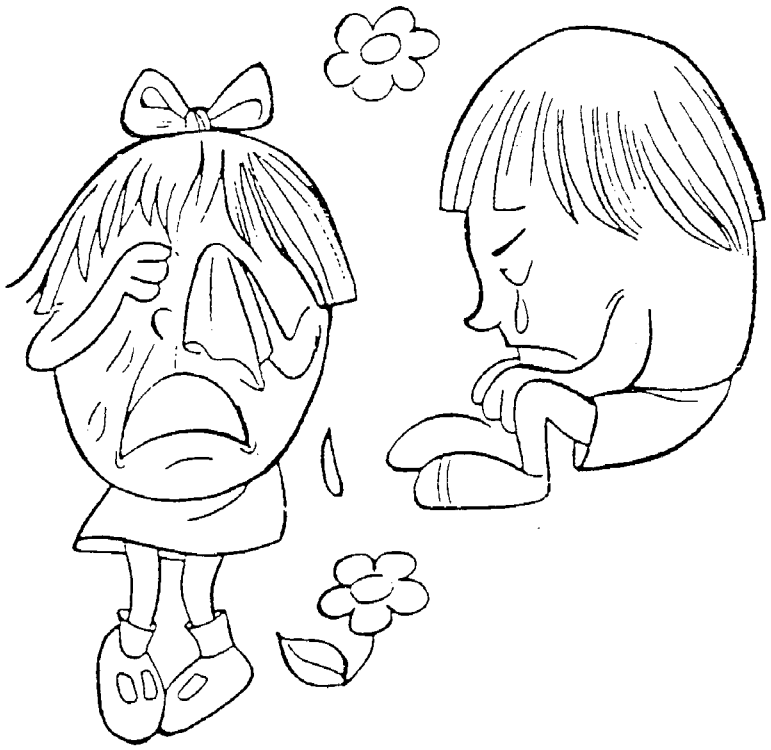
Ukudibana nabantu abaneziva nabazizilima soloko isenza abantu bazive bengakhululekanga kuba asazi ukuba masiziphathe njani yaye sifuna ukwazi, sisoloko sisenza izinto ezingafanelekanga ezinjengokuqwalasela, okanye sibuze kanye imibuzo eyimfihlelo, okanye sibenentloni sibaphephe mpela, ngamanye amaxesha abantwana kwezinye intlanga boyikiswa zintsomi zezigebenga ezizilima baze baboyike abantu abanziva zokutsha. Abanye abantwana babathiye amagama, babahleke, babathuke (babeluhlaza)

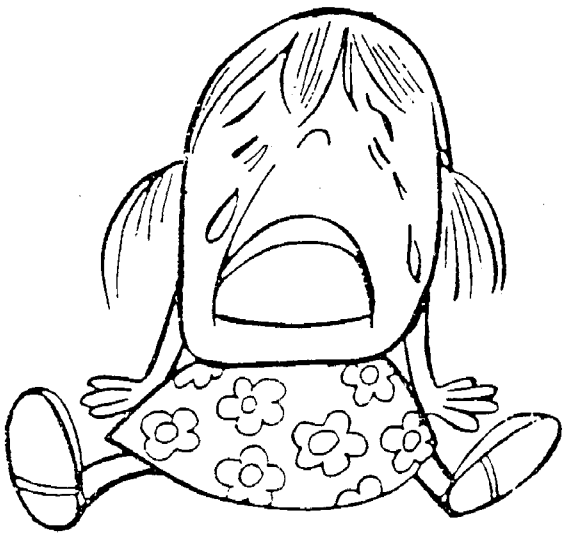
Imbali zibonisile ukuba into enzima ebantwaneni abatshileyo ukuyenza, kukubuyela esikolweni nokwamkeleka kubalingane. Uninzi lwaba bantwana abangenakunqandelwa,baphelela ekubeni bazive bebodwa bengafanelekanga, bengahoyekanga.

Ukucinezelwa nokunxwalwa ziyawandisa lo mvandedwa, zaye zingunobangela osoloko uchazwa wokuba bangafuni ukubuyela esikolweni.

Abo baqhubeka besiya esikolweni soloko bezifumana behamba bebodwa ukuya nokubuya esikolweni, bahlale bebodwa ngentlazane.

Umvandedwa yenye yezinto eziqhelekileyo ezizalwa zingozi zokutsha. Abanye babobantwana abanomvandedwa baphelela ekuzibulaleni ngenxa yesithukuthezi nempatho mbi.

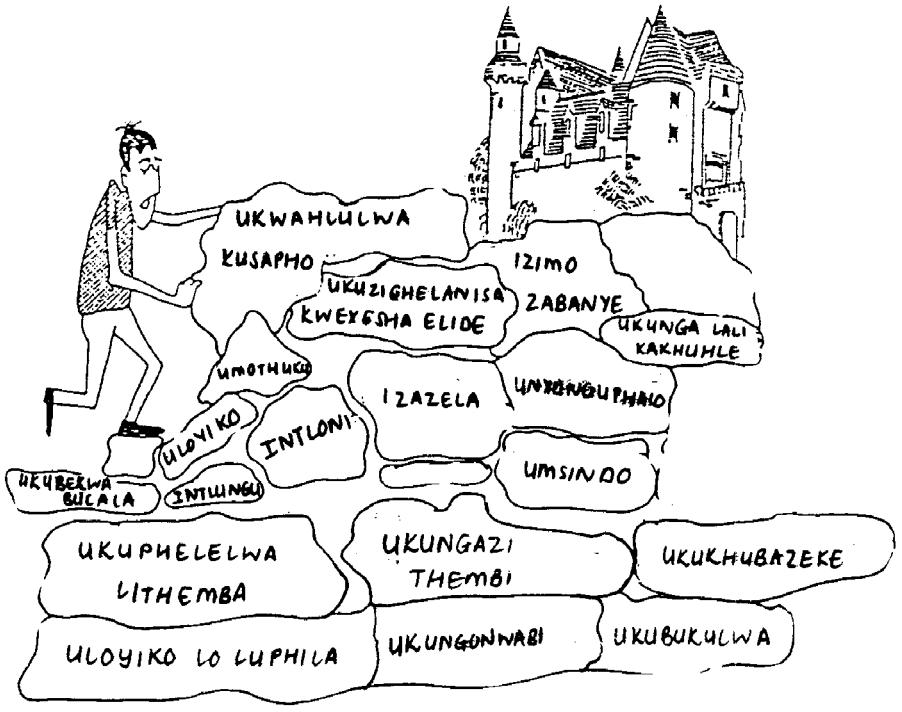




Ingxaki Umntwana Otshileyo Ajongene Nayo

Abantwana abatshe kakhulu banganengxaki ezininzi ezifana nabakhubazekileyo,kodwa zithande ukuthi chatha kuba zivele ngesiquphe, nto leyo eyenza inkangeleko yabo nendlela yokuphila kwabo yohluke.

Ibali ekuqaleni likunike imbono efunyanwa ngumfundi otshileyo kodwa ke ngoku le meko masiyicalucalule ngolu hlobo: Konke oku okulandelayo kungayimiqobo kumfundi ekubeni aqhubekeke ezifundweni zakhe ngokwengqondo yakhe .



Ingxaki Ezijongene Nosapho

Abazali babantwana abatshileyo basengxakini enkulu ;kuba abaqinisekanga nokuba uzakuphila na umntwana, ukuba ngaba usindile inkangeleko yakhe yoba njani na,uyokwazi ukuzenzela nto na. Iminqweno/amaphupha abazali ebebenayo ayinakufezekiswa. Usapho lusoloko lunesazela ngokutsha komntwana noxa bekungekho nto bebenokuyenza ukuthintela ingozi. Amalungu osapho ayazama ndlela zonke ukuchitha ixesha elininzi esibhedlela logama abanye abantwana babo bebashiye kwizalamane nezihlobo. Maxa wambi abakwazi kufikelela esibhedlela ngenxa yomgama omde nokuswela imali;nto leyo ebashiya nesazela. Unxunguphalo lwabazali ngemeko yomntwana ingenza kubenzima ukumonga xa selekhululwe esibhedlela.

Ngenxa yobubi benkangeleko yomntwana otshileyo abazali basenokucingela ukuba abamelwane,izalamane nezihlobo ziyakumenza intlekisa, ngoko ke babone ukuba kungcono ukumgcina ngendlu.

Abantakwabo nabo bakwimeko yonxunguphalo kuba besenokuba yintlekisa kwintanga zabo. Kwakhona basenokungayithandi inkcitho mali nenkathalelo eyodwa efunyanwa ngumntakwabo. Ngelinye icalo oku kwabo banxunguphele ngengozi eyehlele umntakwabo,ngoko ke bayayifuna intuthuzelo nabo.

Inantsingiselo ni lento Kumfundisi ntsapho

Abazali bafuna ukukhuthazwa nabo.Basenokulindela inkqubo entle kwamsinya kanti kulindeleke ukuba ithathe ixesha. Ngaxa limbi basenokutyhafa kamsinya bacinge ukuba sobe umntwana akwazi ukuqhuba njengesiqhelo kwizifundo zakhe. Kanti ke abanye abazali bayayiqonda kakuhle imeko yomntwana wabo bayawabona namathuba ,benze izicwangciso ezizizo zokuhlangabezana nomntwana.

Amaxabiso Nesimo

Amaxabiso yinkolo okanye imeko ethi siyinike ukubaluleka, umzekelo abanye abantu baxabisa ubuhlobo, abanye baxabisa ukuzimela.

Isimo zimbono esinazo ngezinto ezithile ezinjenge ndlela abathi abafundi bawuthande ngawo umsebenzi wesikolo owenziwa ekhaya.

Izimo zethu namaxabiso adalwa lilizwe elisijikelezileyo,abantu esihlala nabo,nembono ezininzi esikuzo(esizibonayo, esizivayo nesizifundayo) namava ethu ngobom. Njengomfundisi-ntsapho awufundisi nje zincwadi zodwa kodwa namaxabiso nezimo. Kubalulekile ke ukuba wena uzibone ezakho izimo kunye namaxabiso.

Umsebenzi Okhawulezileyo

Kwisiqwenga sephepha bhala okucingayo ngokukulandelayo. Bhala kuphela ukuba uyayixhasa okanye awuyixhasiimpendulo zizakubonwa nguwe kuphela.

- Inkangeleko yabantu ayinalutho kum
- Ndiziva ndonwabe mpela nabantwana abakhubazekileyo
- Abantu abaneziva abonwabanga
- Zonke iziva zibi
- Ndifumana ingxaki ukusebenza ngokukhululekileyo nabantu abaneziva
- Ndibavela usizi abantu abaneziva
- Andifuni kuphila xa nditshile uba ndizakuba nesiva

Impendulo zale mibuzo ziyimfihlelo yakho,kodwa ibaluleke kakhulu into yokuba uzazi ukuba ucinga ntoni na ngazo. Zingakwenza uzive ungakhululekanga, okanye zikuvusele amanxeba. Thatha ixesha lakho ukhethe ukuba zeziphi kanye kwaye kutheni unengxaki ngazo. Zenzani kwinkolo yakho. Zibhale phantsi ezi zizathu mhlawumbi zingatshintsha emva kwexesha.

Imbono Zakho Njengetitshala

Ngakusapho, isikolo yeyona ndawo ibalulekileyo ebomini bomntu kuba ufundiswa ukuziphatha. Ubuhlungu uloyiko, umsindo nokukhanyela kosapho olutshelwe ngumntwana ingayiphazamisa inkqubo yakho yokuziqhelanisa nabantwana abatshileyo ababuyela esikolweni.

Otitshala abaninzi bayahlupheka becinga ukuba abanye abafundi baza kumkhohlakalela umfundi otshileyo.
Abaqinisekanga yindlela yokwamkela umntwana obetshile. Ukumamkela kakuhle umntwana obetshile yenza nabanye abafundi benje njalo.

Into ebalulekileyo onokuyenza kukukhumbula ukuba yinkangeleko nje yangaphandle ngaphakathi umntwana usengulowa ngazo zonke izinto.

Bonke abafundi kufuneka bamkelekile Bafuna izihlobo. Nabatshileyo banezomfuno. Ngaphandle kokwenzakala bonke abantwana bayafana.

Abafundi abenzakale ngokutsha banenkqubela eyahlukileyo ngoku ngenxa yomonakalo, kwaue kuyafuneka kubuzwe ogqira nabasebenzi ngezinto ekufuneka zenziwe nemazingenziwa,bayakuxelela yonke into. Bazakukuxelela nabathatha amayeza entlungu norawuzelelo nokuba izakumphazamisa njani na umntwana apha esikolweni. Ungoyiki ukubuza imibuzo!!

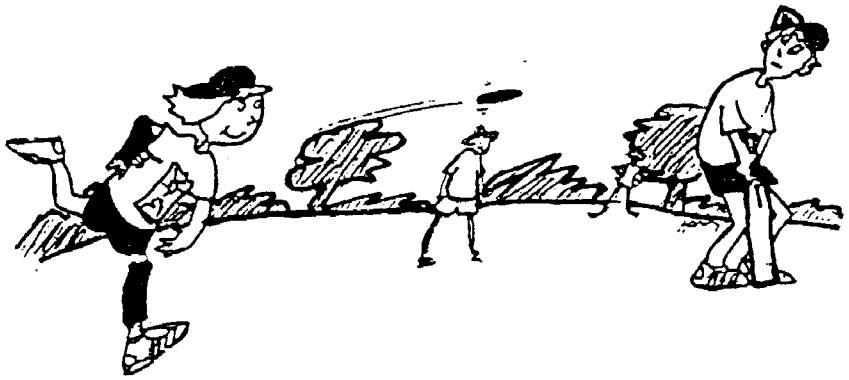
Ibalulekile into yokuba uyixelele iklasi ukuba umfundi otshileyo kufuneka ezimele azenzele izinto ezininzi ngokwakhe.

Ukubuyela eklasini

Akuba umntwana obetshile ebuyela kwiklasi yakhe yesiqhelo imisebenzi yakho njengomfundisi-ntsapho;lungisa imibono yomntwana, mazi ukuba inkangeleko itshintshile, angabonakalisa ingxaki esimilweni uze ubonakalise ukuba uaziqonda iziphumo zokutsha komfundi lowo.

Kubalulekile ukuba uzame ukuzalanisa ubunzima beli xeshana lokwenzakala nokuthi umfundi akufune ukuziphuthuma. Ukunonophela nokuxhasa kuyafuneka kodwa ungazibaxi kuba umfundi uyakusuka afekethe.

Ukucalucalula Iprogrami



Imbali zibonakalisa ukuba abantwana ababuyela esikolweni kwivekana ezimbalwa bekhutshiwe esibhedlela badla ngokuzibandakanya ngokulula.

- Ukubancedisa kuloo nto zama ukucacisela abanye abafundi ngako konke okwehlele yena. Izinto ezenza ukuba umntwana angamkeleki ncam kwabanye xa ebuyela esikolweni kukoyika nokungazi.

Amancedo/nezixhobo zonke ezifunekayo

- iikrayoni
- iphepha lokuzoba
- imifanekiso yokutsha ngobuninzi bayo
- iindaba namabokisi emizobo eqela ngalinye.

Ipogrami ecetywayo

1) Ibali (30 mizuzu)

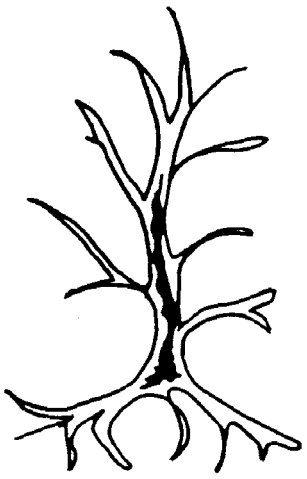
Elicacisa ngemizobo okwenzeka kumfundi owenzakeleyo kubonakaliswe zonke izinto ezinjenge ngemo nendlela eyamkelwe ngayo loo ngozi. Abantwana kufuneka bathathe inxaxheba ngokuzeleyo nemibuzo yabo ekhokhela ibali.

Isicatshulwa sebali esinokufumaneka

Esisekwe kumabali ka Nancy Davis "kwathi kaloku ngantsomi: amabali angokuphilisa abantwana abahlukunyeziweyo (1990) Revised ed Oxon Hill, Maryland: Psychological ASSOCIATES OF Oxon Hill Pp 63-66; 99-104

Umthi Owatshayo

Kwathi kaloku ngantsomi kwakukho umthi edlelweni owawunga bonakali uphila ungeluhlaza nje nge minye yayibonakala ngathi ibethwe ngumbane yaza yayeka ukukhula njengomntu ofike wawususa amasebe ade azizigcunyana uninzi lwemithi kuloo ndawo yedlelo yacinga ukuba ufile kuba eminye imithi inakho



ukuma emva kokuba ubomi bumkile. Kodwa zaziphazama,kuba nzulu phakathi lo mthi wawusaphila.

Lo mthi wawungakwazi ukukhula kuba wawubethwe ngumbane waza watsha kakubi. Ngamanye amaxesha emva kokuba umthi utshile uyancama ungaze ukhule uphile njengeminye imithi. Ngamanye amaxesha ukubethwa ngumbane nenkqwithela zenza umthi kukholelwe ukuba soze uphile, ubukeke utshile ,ufile.

Ngenye imini indlovu yeza , yacinga ukuba umthi ufile,yawutyhala

"wena! Owu !!! " wakhala umthi
Yothuka indlovu yabhekabheka yathi "Ngubani lowo? Ngubani othetha nam"
"Ndim" watsho umthi. "Uyandenzakalisa! Sukundityhala"

"Andiyikholelwa" yatsho indlovu. "awubonakali uphila . utshile,ufile. Amasebe akho ophuke onke,awunalo negqabi eli. Bendikususa endleleni yam kuba bendicinga ukuba wafa kudala"

"Andifanga" watsho umthi. "Andiguli nokugula" Yajonga indlovu ixakiwe."ke, ukuba awufanga ,kwaye ungaguli, kutheni ukhangeleka umbi." Ulusizi ,waphendula umthi "andikwazi kukhula . Andazi ukuba ndingawafumanaphi amagqabi. Andazi ukuba ndinga thini ndibonakale ndiphila kwakhona kuba umbane wanditshisa ndatsho ndalibala nokukhula. Akho ntaka yakhela indlu yayo kumasebe am, nezilwanyana aziwusebenzisi

umthunzi wam. Wonke umntu akandihoyanga okanye athi ndimd . Eminye imithi icinga ukuba ndifile."

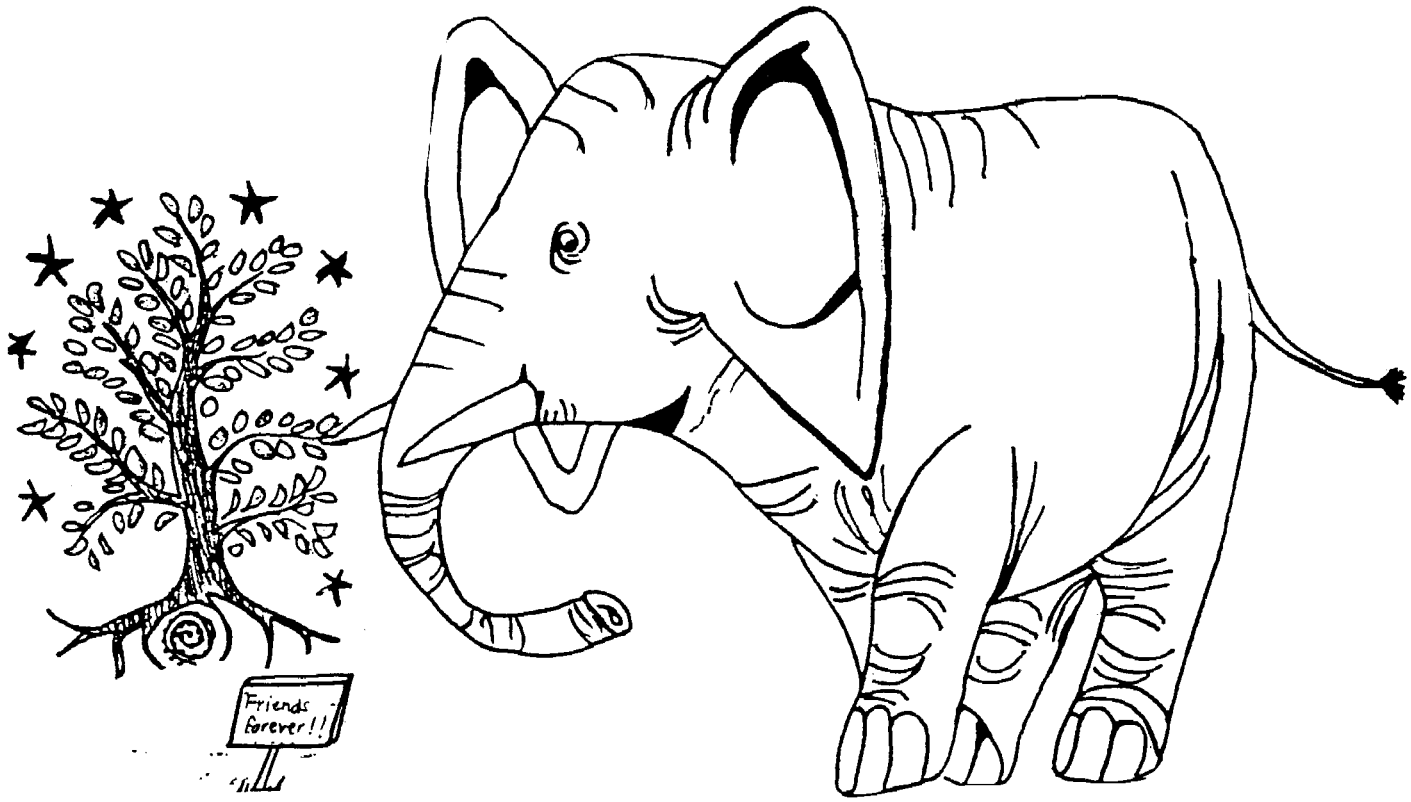
Indlovu yona inamava ngemithi,yagqiba kwelokuba imncede, yaza yacacisa yathi kufuneka kuqala ususe ezindawo zitshileyo nezifileyo zamasebe. Yamnceda indlovu yazisusa zonke ezoo nto zindala ngomboko wayo yathi kuza khula ngokutsha. Yaza yabiza intlanganiso yezilwanyana wathi ucela uncedo.

Kuba zange khe zibizwe yindlovu ngaphambili zaphulaphula ngobunono izilwanyana kuyo yonke into eyayiyithetha. Yazixelela ngento eyehlela umthi, waza wazicela ukuba zincede umthi ukhule kwakhona. Zavuma izilwanyana,zezisa isichumiso esisodwa, zasibeka apha ezingcanjini zomthi.

Indlovu yathetha emithini ejikeleze lo utshileyo. Wayicacisela ukuba lo mthi uzakufuna ilanga namanzi ukuze ube namagqabi. Imithi yavuma ukunceda lo mthi nangayiphina indlela. Yathetha nalo mthi yawubandakanya kwincoko zawo xa idudulwa ngumoya. Uthi omncinci kwamsinya wafumanisa ukuba uyakwazi ukukhula, uyakwazi ukuxanda nokuba mhle nokuba namagqabi amahle njengeminye imithi. Yaqalisa ukudubula yenza yonke into,wamde, akwabi sacaca noba umbane wakha wabetha.

Indlovu nomthi baba zizihlobo emva koko. Kuba indlovu yanceda umth ukuba ukhule,ubemhle, ubenobom, umthi wacinga ukwenzela indlovu into enkulu. Yacela indlovu ukuba ibhale isalathiso ngobuhlobo babo.

Saxhonywa phambi komthiukuze wonke umntu ohamba apho afunde ukuba umntu ngumntu ngabanye abantu.

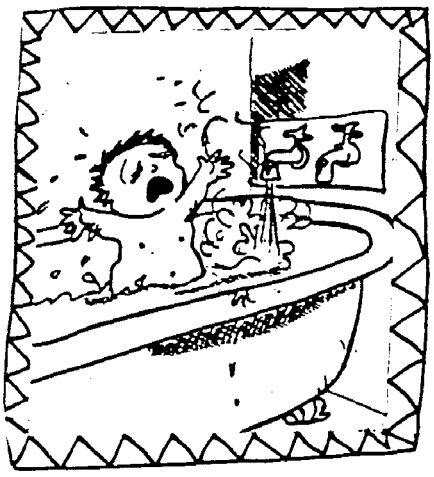


- **Imizekelo yemibuzo enokubuzwa ngelibali**

- Kutheni ndibalisa eli bali?
- Yintoni ebalulekileyo ngalo?
- Wawungathanda ukuphathwa njani ukuba ubungumthi?
- Ucinga ukuba umfundi otshileyo xa ebuya lingamnceda ntoni eli bali?

2) Xilonga imeko Yokutsha (10 mizuzu)

Cinga imbono ngento ezingasitshisa, uzibhale phantsi ephepheni nokuba kusebhodini. Zama ukubhala uluhlu olunoba yimizuzu emihlanu kuye kwelishumi



- **Imibuzo enokubuzwa**

- Zintoni iintlobo zezinto ezisitshisayo
- Yintoni ebashushu ize ikutshise
- Ingaba kukho umntu onesiva sokutsha

- Yintoni eyenza isiva
- Ingaba ukho owaziyo ukba umfundo othile watsha

3) Ibali lomfundi owatshayo (10 mizuzu)

- Ukuba kukho umntwana otshileyo zama ukucela imvumo kubazali phambi kokuba ubalise ibali lokutsha kwakhe.
- Balisa ibali, kodwa uqinisekise ukuba awumnyembi umntwana lowo utshileyo wenze umzekelo wezinto ezingenakwenziwa. Iyakunceda ukuba uthi ungekaqali ukubalisa uchaze ukuba yayiyingozi.
- Vumela abafundi babuze imibuzo, ubabuze nokuba akho nto bafuna ukuyazi kanye kanye ngokungeniswa esibhedlela.

4) Malunga nemibono (20 mizuzu)

- Lo msebenzi uxoxa ngezinto ezibaluleke kuthi. Ebantwaneni abancinci sebenzisa u"ilungile no ayilunganga"
- Chitha ixesha ubuza abantwana, umzekelo wesimo esihambisana nalamagama angentla uyibhale le mizekelo ephepheni elikhulu okanye ebhodini.
- Ebantwaneni abadala ukhetho olunyanzelisayoluyalandela apho baza kukhetha phakathi ko"konwaba" no "ndimhle" wenze iikona zibe mbini apho abakhetha elinye beme kuyo abakhethe eliya beme kuleya.
- Buza izizathu zokukhetha oko bakukhethileyo,

5) Iziva (10 mizuzu)

Sebenzisa "ubuhle lulusu olunzulu nje" ubuhle buyatshabha xa umntu ekhula njalo,njalo. Chaza into eyenziwa ziziva eluswini lomntu atsho ke ezekelisa ngalo ulapha eklasini.

6) Injani na imeko yabantuxa bebona umntu owohlukileyo (45 mizuzuz)

Banike amaphepha nekrayoni. Bacele babhale ,bazobe ngabo nezinto abangazithandiyo, ingakukutyeba,ubude,ilizwi, njalo,njalo. Baxelele ukuba imifanekiso abayenzileyo yeyabo kuphela .

- Ngoku baxelele ukuba benze ngathi kuphela yilo nto kuphela umntu ayibonayo,baphinde bazobe omnye umfanekiso ngale mbono ingentla ke ngoku
- Bacele bachaze imbono zabo zoku kuzoba kwesibini uze uzibhale ebhodini malunga nesihlanu nesithandathu, ubabuze ukuba bacinga ntoni ngomfundi otshileyo weklasi yabo ngemini yokuqala yokubuyela esikolweni,nawe ke wongeze.

7) Yintoni ababeyithanda kumfundi otshileyo phambi kwengozi (20 mizuzu)

Kungakhethwa kwizinto ezimbini kulo msebenzi, ukhethe oqonda ukuba abantwana bophendula kakuhle

- Imbongi okanye ukuncoma umculi apho abafundi bachaza zonke izinto ezintle zomfundi obetshile obuyileyo.Lonke ixesha ubuze ukuba bacinga ukuba ingaba itshinthile na kulo obetshile
- Okanye wenze umfanekiso wodonga lwezitena apho emnye uzakubhala izinto azithandayo ngomfundi lowo ubuyileyo etshile. Bakugqiba ngomzobo lowo bawunike yena

8) Umnxwali nomcinezeli wesigebenga (20 mizuzu)

Abafundi mabakhethe umzobi ozakuzoba imibono yeklasi kwiphepha elikhulu okanye ebhodini ngesi sigebenga, bayibize ngegama umzobi amane ebhala iumbono ngamnye. Babhale ke nezinxwalo zesi sigebenga.

Ukubanceda ungabuza le mibuzo:

Ngesi sigebenga sikhohlakeleyo singabonakaliyo:

- Ingaba isigebenga siwafumana phi amandla?
- Ingaba sithetha njani nabantwana?
- Ingaba sibalukuhla jani abantwana benze izinto ezimbi?
- Ucinga ukuba sithini xa abantwana bethetha benze izinto ezimbi? Ucinga ukuba siyomelela?
- Yintoni ocinga ukuba isigebenga siyayithanda?
- Sinanxaxheba ni isigebenga ebantwaneni
- Ucinga ukuba esisigebenga siyabalawula abantwana abenza izinto ezimbi kwabanye?
- Ucinga ukuba yintoni ethiywe sisigebenga
- Yintoni etyhafisa esisigebenga?

9) Imimoya Ekhuselayo (20 mizuzu)

Bacele ukuba bacinge ngesichasi sesisi gebenga . Banyule umzobi kwakhona . Ubabuze ukuba bacinga ntoni na ngemimoya ekhuselayo. Alo mfanekiso bawuthiye igama lokuba "yingelosi" namanye amagama amnandi. Mabachaze lo mfanekiso.

Bancede ngokubabuza imibuzo:

- Ingaba umoya okhuselayo uwafumana phi amandla?
- Ingaba uthetha kanjani nabantwana?
- Ingaba ubakhusela njani abantwana?
- Ucinga ukuba kwenzeka ni xa abantwana bethetha besenza izinto ezimbi?
- Ucinga ukuba uyomelela okanye uba buthathaka?
- Bangenzani abantwana ukuwenza lo moya womelele?
- Ucinga ukuba lo moya uthanda ntoni?
- Ufaka njani umoya ebantwaneni?
- Lo moya uthiye ntoni?
- Ingaba wenziwa buthathaka yintoni?
- ungakunceda njani lo moya?
- Ungamnceda njani ke umhlobo wethu lo moya?

- Ungababuza ukuba bangasinxwala njani isigebenga, uba bathi bangasitshabalalisa bavumele umntu ngamnye akrazule isuntswana okanye basicime ebhodini.
- Ngembono ezintle zomoya okhuselayo babuze ukuba isigebenga siva njani, ngezintle izinto mabakrazule isuntswana zomnxwali de kuphele tu

10) Isangqo Esithembisayo (2 mizuzu)

Bacele abantwana benze isangqa bathembise ukuncedana.

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APPENDIX E:

ORIGINAL PROGRAMME

Returning to the classroom - a programme outline

Studies have shown that children who return to school within a few weeks of being discharged from the hospital, tend to make a more positive adjustment.

To help ease their path back to school, it is necessary to help the other children understand what has happened to their classmate. Much of the negative and inappropriate behaviour displayed towards burn-injured people is as a result of fear and ignorance. When the anxiety is decreased, the defensive behaviours like ridicule and withdrawal will no longer be necessary, and the burned child's peers will be more supportive of him or her.

Further studies have found that if children are provided with the necessary information, and are told of the teacher's expectations regarding empathic, supportive behaviour, most children respond appropriately.

For the programme to be most effective, it needs to be conducted a day or two before the burned child returns to school.

-goals

- To help the other children to empathise with, and understand what their burned classmate has experienced. And by so doing, to decrease their anxiety and the defensive behaviours that accompany their anxiety.
- To provide the returning burned learner with as positive and accepting a learning environment as possible.

-principles

The following is merely a suggestion for the format that such a "reintegration/ re-entry programme" could follow. Obviously, adjustments would need to be made regarding the age group of the children involved.

The programme should aim to address the following principles and issues:

- What are burns, how they occur, and what effects they have on the body;
- The specifics involving the child's accident - including hospitalisation and the various treatments and procedures;
- The concept of values, how they are generated, and how they influence everyone's behaviour;
- Feelings and reactions to people who look/ behave "differently";
- How bullying and teasing can affect people;
- The fact that their classmate has changed outside, but that inside she or he is still the same person.

-structure/ proposed outline

1) story - explaining through a model what happened to the injured classmate, and modelling appropriate behaviours and responses. Children's participation is very important, and their questions should guide the story. **[30mins]**

2) Explore concept of burn - brainstorm ideas regarding what can burn us - based on pictures of burn sources.
[10 mins]

3) Concept of values - things that are important to us. Concept of "right and wrong" for younger children. **[10 mins]**

Continues into a forced choice exercise, (for older age groups) where the children must choose between being "happy" and being "beautiful". **[20 mins]**

4) **How do people react to someone who looks different?**

Children are asked to think about something of themselves they don't like and to draw a picture of it (for older children, can use paper plate masks). **[5 mins]**

Asked to pretend that that is all anyone knows/can see about them. Asked to draw picture about how it feels. **[10 mins]**

Asked to imagine and discuss how burned classmate might feel.**[15 mins]**

5) **What did they like about burned classmate before the accident?**

"imibongi" or praise singer exercise - have to mention a positive quality of the returning classmate. Regular questions from facilitator about whether this will have changed in hospital. Teacher/ facilitator must take notes, to feed back to returning child. **[20 mins]**

OR: "Graffiti wall" where class writes down what they like about returning classmate. Given to returning classmate. **[10 mins]**

6) **Stretch exercise** - teacher gets children to climb imaginary mountain to go look for bully monster **[5 mins]**

7) Teacher gets class to draw a combined "monster" who is the **bully monster**. Class must name the monster. **[5 mins]**

Teacher/ facilitator speaks for voice of monster - asks children to interview the "puppet" about its bullying tactics, and how it manages to get so many children to hurt so many others... **[15 mins]**

Teacher then gets class to draw **"protecting force"** which children name (e.g. "Fairy God-Mother" etc.) **[5 mins]**

Teacher interviews children about how this protective force will help children to look out for one another . Teacher can facilitate responses that are sensitive to issues at hand! For every useful tip, tear off some of bully monster**[15 mins]**

8) PROMISE CIRCLE - ask children to stand in a circle and promise to help look out for one another. **[2 mins]**

-aids/equipment/ material necessary

- crayons
- paper for individual drawings
- magazine pictures of burn/ incendiary sources
- newsprint/ cardboard for group drawings/ graffiti wall

Back in the Classroom

Once the burned learner has returned to the regular classroom your tasks as teacher consist o setting realistic goals, the acceptance of the burned learner's changed appearance, coping with emotional and behavioural problems, and understanding the nature and consequences of the burned learner's injuries.

It is important to strike a balance between the learner's temporary physical difficulties and what the learner needs to do to maintain a good self-image. Care and support are necessary, but overprotection can smother the learner!

Possible script for the story

Based on stories by Nancy Davis in Once upon a time: therapeutic stories to heal abused children (1990) (Revised ed.). Oxon Hill, Maryland: Psychological Associates of Oxon Hill. Pp. 63-66; 99-104.

The burned Tree

Once upon a time there was a tree in the veldt that didn't look alive and green like other trees. It looked as if it had been struck by lightening and had stopped growing - like someone had come along and cut down its branches until they were little stubs. Most of the trees in that part of the veldt thought it was dead because some trees are able to stand long after the life has gone out of them. But they were wrong, because deep down this tree was alive!

It just didn't know how to grow and develop into a beautiful tree with leaves as the other trees had done, because it had been hit by lightening and badly burned.

Sometimes after being burned a tree goes into shock and gives up the will to grow and to live and to be like other trees. And sometimes the shock of the lightening and the storms makes a tree believe that it can't grow, and that it has to stay the same, looking burned and dead.

One day and elephant came along, and thinking that the tree was dead, started to push it over.

"Hey! Ow!!!" yelled the tree.

Surprised, the elephant looked around and said "Who's there? Who's talking to me?"

"It's me!" said the tree. "You're hurting me! Stop pushing me over!"

"I can't believe it" said the elephant. "You don't look alive. You look all burned and dead. Your branches are all broken and you don't even have any leaves. I was pushing you out of my way because I thought you were dead already!".

"I'm not dead" said the tree. "I'm not even sick!"

The elephant looked moist confused. "Well, if you're not dead and you're not sick, why do you look so awful?"

Sadly, the little tree replied, "I don't know how to grow. I don't know how to get leaves. I don't know how to look alive again because the

lightening hit me so hard that I have forgotten how to grow. None of the birds make nests in my branches and the animals don't use me for shade. Everyone just ignores me or says how ugly I look. The other trees all think I'm dead".

The elephant, who had much experience with trees, decided to help and explained that he must first remove all the dead and burned ends of the branches. Reaching in and out of the branches with his trunk, he snapped off the burned ends until all the dead parts were gone and new life could start growing. Next, the elephant called a meeting of the animals and told them he needed their help.

Because elephant hardly ever asked the other animals for anything, they all listened carefully to what he had to say. He explained to them what had happened to the tree, and asked the animals to help the tree grow strong again. The animals agreed to help elephant, and brought special fertilizer and put it all around the base of the tree.

Then elephant spoke to the trees around the burned tree. He explained that the tree would need sunshine and water to help it grow leaves. The trees all agreed to help the little tree in whatever way they

could. They started talking to the tree, and including it in their conversations when they swayed in the wind.

The little tree soon discovered that it did know how to grow, and it did know how to develop, and it did know how to look beautiful and full of green leaves just like the other trees. It began to sprout new leaves and to grow and to develop, and before long, it was hard to see where exactly the lightening had hit!

The elephant and the tree became close friends after that. Because the elephant had helped the tree grow to be so beautiful and healthy, the tree decided to do something special for the elephant. It asked the elephant to carve a sign about their friendship. The sign was hung on the front of the tree so that everyone who walked by would realise just how much difference a trusted friend can make in the way your life goes.

APPENDIX F:

MULTI-MODAL QUESTIONNAIRE

MULTI-MODAL FAMILY HISTORY QUESTIONAIRE

SECTION ONE

Family Data

Child's name: _____ Today's date: _____

Birthdate: _____ Age: _____ Sex: _____

Information provided by: _____ Telephone no.: _____

Mother's name: _____ Age: _____

Education: _____ Occupation: _____

Father's name: _____ Age: _____

Education: _____ Occupation: _____

Is there a history of learning disability in the family? _____

Give details: _____

_____

_____

Marital status: _____ Years of marriage: _____

Reaction to birth of other siblings? _____

_____

_____

List all people living in the household (including parents):

NAME	RELATIONSHIP TO CHILD	COMMENT ON QUALITY OF RELATIONSHIP	AGE

Please elaborate further if there are problems in these relationships:

_____

_____

_____

_____

SECTION TWO

Presenting problem

Briefly describe your child' s current difficulties:

How long has this problem been of concern to you?

Who else is concerned with this problem?

When was this problem first noticed?

What seems to help the problem?

What seems to make the problem worse?

Has your child been assessed or treated for this problem or similar problems? If yes, when and with whom?

Is your child being medicated? If yes, by whom?

Give details of medication:

SECTION THREE

Social and Behavioural Checklist

Please tick any behaviour or problem that you child currently exhibits:

_____ Prefers to be alone

_____ Does not get along well with brothers and sisters

_____ Is aggressive

_____ Is shy or timid

_____ Is more interested in things (objects) than in people

_____ Bites nails

_____ Sucks thumb

_____ Rocks back and forth

_____ Bangs head

_____ Holds breath

_____ Eats poorly

_____ Makes friends easily

_____ Has problems keeping friends

_____ Has been bullied or teased before

_____ Is stubborn

_____ Is much too active

_____ Is clumsy

_____ Has blank spells

_____ Is impulsive

_____ Shows daredevil behaviour

_____ Is slow to learn

_____ Has a negative attitude towards school

_____ Has a negative relationship with his/her teacher

_____ Has trouble sleeping: if yes, describe: _____

_____ Engages in behaviour that could be dangerous to self or others. If yes, describe: _____

_____ Has special fears, habits or mannerisms. If yes, describe: _____

_____

Other. Please describe: _____

SECTION FOUR

Developmental History

Pregnancy: Planned _____ Unplanned _____

Any previous miscarriages? _____

Any complications during pregnancy?

Physical: _____

Emotional: _____

Were forceps used in the delivery? Yes_____ No _____

Was a Caesarian section performed? Yes_____ No _____

If yes, for what reason? _____

Was the child premature? Yes_____ No _____

If so, by how many months? _____

Were there any feeding problems? Yes_____ No _____

If yes, please describe _____

Were there any sleeping problems? Yes_____ No _____

If yes, please describe: _____

As an infant, was the child quiet? Yes_____ No _____

As an infant, was the child alert? Yes_____ No _____

Were there any special problems in the growth and development of the child during the first few years? Yes_____ No _____

If yes please describe:_____

_____

Milestones:

Please indicate the age at which your child first demonstrated the following:

Sitting: _____ Crawling: _____

Standing: _____ Walking: _____

Talking: _____

Any significant childhood illnesses: _____

_____

Current state of health: _____

_____

SECTION FIVE

Family Medical History

Place a tick next to any illness or condition that any member of the immediate family has had. When you tick an item, please not the member's relationship to the child.

TICK	CONDITION	RELATIONSHIP TO CHILD
	Alcoholism	
	Cancer	
	Diabetes	
	Heart trouble	
	Psychological problem	
	Depression	
	Suicide attempt	
	Other: _____	

SECTION SIX

Other information

What are your child's favourite activities?

1. _____ 2. _____ 3._____

4. _____ 5. _____ 6._____

What activities does your child like least?

1. _____ 2. _____ 3._____

4. _____ 5. _____ 6._____

What discipline techniques do you usually use when your child behaves inappropriately?

Tick	Disciplinary techniques
_____	Ignore problem behaviour
_____	Scold child
_____	Spank child
_____	Threaten child
_____	Reason with child
_____	Redirect child's interest
_____	Send child to room
_____	Take away some food or activity
_____	Don't use any techniques
_____	Other techniques - describe _____

Who does the disciplining in the family? _____

Which techniques are usually effective _____

_____

Which disciplinary techniques are usually ineffective? _____

_____

What activities do the family do together? _____

How does your child show the following emotions:

Anger:_____

Sadness:_____

Fear: _____

Happiness:_____

Frustration:_____

What irritates you about your child? _____

_____

What are your child's assets or strengths? _____

_____

Past psychosocial stressors (e.g. financial, moves, deaths etc.): _____

_____

Current psychosocial stressors: _____

_____

Is there any other information that you think may help us in working with your child?

_____

_____

_____

_____

_____

_____

Any other professionals consulted e.g. psychologist, occupational therapist, physiotherapist, speech therapy? If yes, please indicate names, dates, and whether reports are available,_____

_____

_____

APPENDIX G:

TEACHER'S INTERVIEW SCHEDULE

INTERVIEW SCEDULE FOR TEACHER INTERVIEW

- What anticipatory thoughts, feelings and behaviours did you experience with regard to Hassiem returning?
- How did you find out he was burned?
- You said earlier that you saw him in hospital, what was that like for you?
- How did you explain to your class about Hassiem's injury?
- Whose idea was it to make the cards? What prompted this?
- How was Hassiem's homework arranged? What did it mean for you to have this ongoing contact?
- Are there remedial classes available to assist in Hassiem's catching up of work?
- How would you describe Hassiem's academic performance?
- How did you find the manual? What about it was helpful/ unhelpful?
- The programme that is outlined in the manual is just a suggestion. What would you like to see added or removed from it? How do you think your class will cope with it?
- How did you experience the programme?
- What suggestions do you feel would improve the programme's implementation?
- Do you feel confident to implement the programme yourself? Why?
- How do you think your learners felt about the programme?
- How did you feel about Hassiem's return?
- How did Hassiem appear upon his return - physically, emotionally, and aesthetically?
- What was your impression of the classroom environment on the day of his return? How would you describe the peer interactions between Hassiem and the rest of the class?
- Did you notice any differences between those who attended the programme and those who did not?
- Have you been aware of any incidents of teasing or bullying relating to Hassiem?
- How do you feel he has integrated into the class? What do you attribute this to?
- What kind of training have you received for this kind of situation?
- What kind of training would you like to have had?
- Looking back, is there anything you might have handled differently?
- Did you re-read the fable from the programme to the learners?
- Would you recommend this programme to other schools and other age groups? Why?

APPENDIX H:

CHILDREN'S DEPRESSION INVENTORY: AFRIKAANS TRANSLATION

CDI

Item 1

- ❑ Ek voel elke nou en dan hartseer
- ❑ Ek baie keer hartseer
- ❑ Ek is altyd hartseer

Item 2

- ❑ Niks sal ooit vir my uitwerk nie
- ❑ Ek is nie seker of dinge vir my sal uitwerk nie
- ❑ Dinge werk OK uit vir my

Item 3

- ❑ Ek doen meeste dinge OK
- ❑ Ek doen baie dinge verkeerd
- ❑ Ek doen alles verkeerd

Item 4

- ❑ Ek geniet baie dinge
- ❑ Ek geniet sekere dinge
- ❑ Ek geniet niks

Item 5

- ❑ Ek is altyd sleg/stout
- ❑ Ek is baie keer sleg/stout
- ❑ Ek is elke nou en dan sleg/stout

Item 6

- ❑ Ek dink elke nou en dan aan slegte dinge wat met my kan gebeur
- ❑ Ek is bekommerd dat slegte dinge met my sal gebeur
- ❑ Ek is seker dat baie slegte goed met my sal gebeur

Item 7

- ❑ Ek haat myself
- ❑ Ek hou nie van myself nie
- ❑ Ek hou van myself

Item 8

- ❑ Alle slegte dinge is my skuld
- ❑ Baie slegte dinge is my skuld
- ❑ Slegte dinge is nie gewoonlik my skuld nie

Item 9

- ❑ Ek dink nie daaraan om myself dood te maak nie
- ❑ Ek dink daaraan om myself dood te maak maar ek sal dit nie doen nie
- ❑ Ek wil myself doodmaak

Item 10

- ❑ Ek voel elke dag om te huil
- ❑ Ek voel baie dae om te huil
- ❑ Ek voel net soms om te huil

Item 11

- ❑ Dinge pla my altyd
- ❑ Dinge pla my baie keer
- ❑ Dinge pla my soms

Item 12

- ❑ Ek hou daarvan om by mense te wees
- ❑ Ek hou nie daarvan om baie by mense te wees nie
- ❑ Ek wil glad nie by mense wees nie

Item 13

- ❑ Ek kan nie besluite neem nie
- ❑ Dit is vir my moeilik om besluite te neem
- ❑ Dit is vir my maklik om besluite te neem

Item 14

- ❑ Ek lyk OK
- ❑ Daar is sekere slegte punte omtrent my voorkoms
- ❑ Ek is lelik

Onthou om te beskryf het you die afgelope twee weke gevoel het ...

Item 15

- ❑ Ek moet myself al die tyd druk om my skoolwerk te doen
- ❑ Ek moet myself baie keer druk om my skoolwerk te doen
- ❑ Dis nie 'n groot probleem om skoolwerk te doen nie

Item 16

- ❑ Ek sukkel elke aand om te slaap
- ❑ Ek sukkel baie aande om te slaap
- ❑ Ek slaap redelik goed

Item 17

- ❑ Ek is soms moeg
- ❑ Ek is baie keer moeg
- ❑ Ek is altyd moeg

Item 18

- ❑ Ek voel meeste dae nie lus om te eet nie
- ❑ Ek voel baie dae nie lus om te eet nie
- ❑ Ek eet goed

Item 19

- ❑ Ek bekommer my nie oor pyne nie
- ❑ Ek bekommer baie keer oor pyne
- ❑ Ek is altyd bekommerd oor pyne

Item 20

- ❑ Ek voel nie alleen nie
- ❑ Ek voel baie keer alleen
- ❑ Ek voel altyd alleen

Item 21

- ❑ Ek het nooit pret by die skool nie
- ❑ Ek het net soms pret by die skool
- ❑ Ek het baie keer pret by die skool

Item 22

- ❑ Ek het baie vriende
- ❑ Ek het 'n paar vriende maar ek wens ek het meer gehad
- ❑ Ek het geen vriende nie

Item 23

- ❑ My skoolwerk is redelik
- ❑ My skoolwerk is nie so goed soos van te vore nie
- ❑ Ek doen baie sleg in vakke waarin ek voorheen goed gedoen het

Item 24

- ❑ Ek kan nooit so goed soos ander kinders wees nie
- ❑ Ek kan net so goed soos ander kinders wees as ek wil
- ❑ Ek is net so goed soos ander kinders

Item 25

- ❑ Niemand is regtig lief vir my nie
- ❑ Ek is onseker of iemand lief is vir my
- ❑ Ek is seker dat iemand lief is vir my

Item 26

- ❑ Ek doen gewoonlik wat vir my gesê word
- ❑ Ek doen meeste van die tyd nie wat vir my gesê word nie
- ❑ Ek doen nooit wat vir my gesê word nie

Item 27

- ❑ Ek kom oor die weg met mense
- ❑ Ek is baie keer in 'n bakleiery
- ❑ Ek is altyd in 'n bakleiery

APPENDIX I:

POST-TRAUMATIC STRESS DISORDER INVENTORY: AFRIKAANS TRANSLATION

	NOOIT	SOMTYDS	DIKWELS	MEESTAL
1. Het U/ jy terugvlitse van die ongeluk?				
2. Voel U/ jy soms asof U/ jy besig is om weer die ongeluk te oorleef?				
3. Sukkel U/ jy om aan die slaap te raak of skrik jU/ y snags skielik wakker?				
4. Wil jy jouself ontrek van mense ?				
5. Is jy meer waaksaam ?				
6. Is jy gedurig bewus van moontlike gevaar?				
7. Sukkel jy om te konsentreer?				
8. Sukkel jy om besluite te neem?				
9. Het jy herhaaldelike nagmerries?				
10. Het jy ligaamlike symptome soos bv. Hoofpyn, maagpyn, hartklopping, of voel jy dalk sweterig?				
11. Voel jy asof jy buite beheer is?				
12. Het jy enige van die volende gevoelens op die oomblik... 12.1 Geweldige Vrees?				
12.2 Geweldige Skuld?				
12.3 Geweldige Gevoelloosheid?				
12.4 Geweldige Woede?				
12.5 Geweldige Frustrasie?				
12.6 Geweldige Tranerigheid?				
12.7 Geweldige Eensaamheid?				
13. Sukkel jy om naby 'n vuur of vlamme te wees?				

	NOOIT	SOMSTYDS	DIKWELS	MEESTAL
14. Sukkel jy om te onthou wat met die ongeluk gebeur het?				
15. Vermy jy bewusbaar gedagtes en gevoelens wat met die ongeluk te doen het?				
16. Geniet jy jou vrye tyd minder as vantevore?				
17. Vind jy dit moelik om met vriende om te gaan?				
18. Voel jy meer onveilig oor die toekoms as voorheen?				

As jy besig was om die vrae te beantwoord voordat die ongeluk gebeur het, sou jou antwoorde anders wees? **JA** ❐ **NEE** ❐

Was daar enigiets positief wat uit die ondervinding jou getref het?

_____

_____

_____

_____

_____

_____

APPENDIX J:

FOCUS GROUPS: MODERATOR'S GUIDES

MODERATOR'S GUIDE FOR PRE-PROGRAMME FOCUS GROUPS

Aim

To gauge the baseline attitudes of learner's from Hassiem's class towards people with disfigurements and scars.

Method

Learners were assigned to random groups through their selection of one of five different types of sweets from a basket. Of each particular sweet-type, there were ten sweets in the basket, to create five groups of ten learners each.

Questions asked

The questions were originally posed in Afrikaans, as this was the medium in which the learners were most adept and comfortable.

- Do you know what a scar is? What it looks like?
- What do you think of people with scars?
- How do you feel about them?
- How do you feel when you see them?
- How do you feel about someone who looks different sitting next to you on the bus? Why?
- Would you choose someone who looks strange or different as your best friend? Why?
- Would you invite someone who looks strange or different to your party? Why?
- Would you sit with someone who looks strange or different during school break? Why?
- Would you choose someone who looks strange or different to play on your soccer team? Why?
- Would you still be friendly with someone who looked strange if the rest of the children made fun of *you* or teased *you* for it?
- How would you feel if someone was teasing someone else just because they looked strange or different?
- Would you say or do anything? If so, what?
- Do you think it's okay for someone who looks strange or different to go to the same school as other children who look "normal"?
- Do you know anyone who has scars as a result of being burned? If yes, is it a relation?
- What caused the burn?

POST-PROGRAMME FOCUS GROUPS

Aim

To evaluate how much of the programme the children had retained, and to gauge how well they thought Hassiem had been reintegrated upon his return.

Method

The learners were divided into groups in the same manner as the pre-programme focus groups - that is, dependent on their selection of a category of sweets.

Introduction

An opportunity was provided the learners to refuse to participate, despite the fact that their parents had given permission for them to do so. When all agreed to participate, the nature of the research was then explained to the learners. Issues pertaining to the confidentiality of their responses were discussed, and they were also informed of how the audio-tapes of their responses would be disposed of.

Questions asked in connection with the programme

Each question, after the second one listed below, was derived from the previous response from the children. At no time were the answers given to them, and the majority of the learners who participated in the programme responded to the questions.

- Who remembers the story I told you the last time I was here?
- What was it about?
- How did the tree get burned?
- And then what happened?
- What did the elephant say?
- Why did he think the tree was dead?
- What did the tree say?
- And then what happened?
- How did the animals help?
- How did the trees help?
- And then what happened?

Questions asked about Hassiem's assimilation and adjustment

- Do you remember the 'tease monster' that Mary-Anne drew?
- What do you remember most about it?
- How did the 'tease monster' get power over the children?
- What did he tell them to do?
- Has the spirit of the 'tease monster' been present in your classroom since Hassiem's return?
- How do you know?
- Has anyone teased Hassiem since he's been back?
- Why do you think that is?
- Has the 'angel' been present in your classroom?
- Why do you think that is?
- How do you think Hassiem has fitted into the classroom?

Closing statements

The learners were thanked for participating in the programme, and for assisting Hassiem in reintegrating into the classroom.

APPENDIX K:

CERTIFICATE OF BRAVERY

Award for Bravery

This certifies that

Hassiem

has, with bravery and courage, handled his burn injuries and hospital treatment

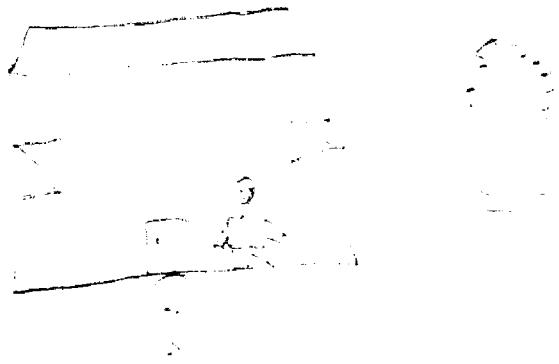
Special Merit Award

Signature Date

Signature Date

APPENDIX L:

HASSIEM'S DRAWINGS



NAME: HASSIEM

AGE: 11 YEARS

DATE: 26TH of OCTOBER 1998

DRAWING: HOUSE-TREE-PERSON

NAME: HASSIEM

AGE: 11 YEARS

DATE: 26TH OF OCTOBER 1998

DRAWING: DRAW-A-PERSON

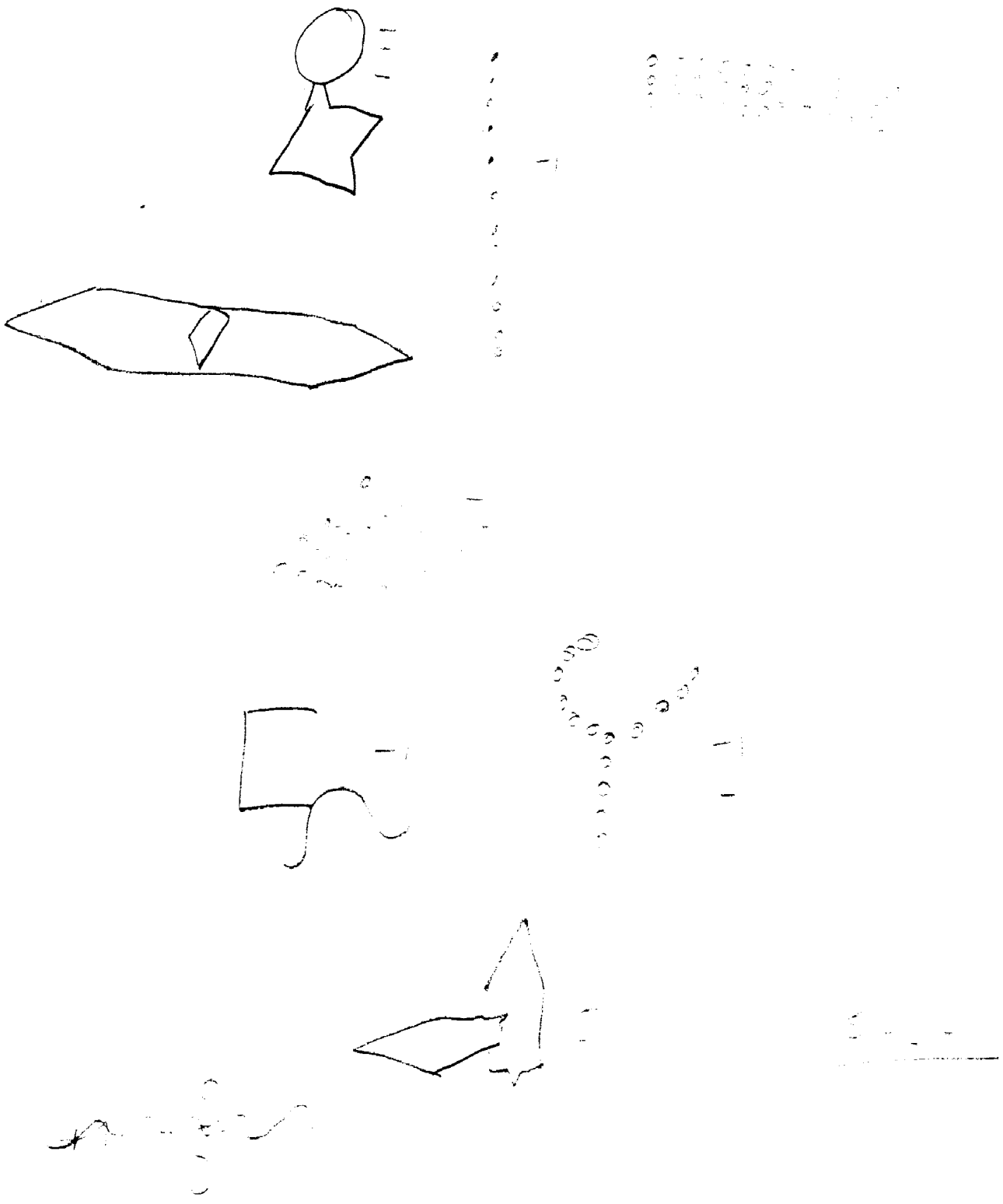
NAME: **HASSIEM**

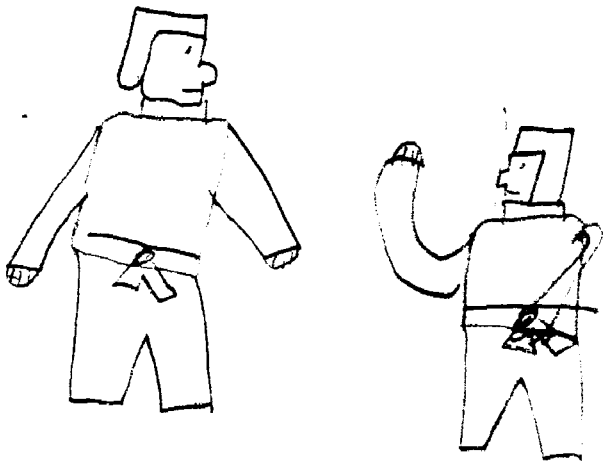
AGE: **11 YEARS**

DATE: **26TH of OCTOBER 1998**

DRAWING: **DRAW-A-PERSON (spontaneous contribution)**

NAME:	**HASSIEM**
AGE:	**11 YEARS**
DATE:	**29TH of NOVEMBER 1998**
TEST:	**BENDER VISUAL MOTOR GESTALT**





HASSIEM

FREDERICK

NAME: **HASSIEM**

AGE: **11 YEARS**

DATE: **10TH of DECEMBER 1998**

DRAWING: **DRAW-A-PERSON**

APPENDIX M:

ROTTER'S INCOMPLETE SENTENCES

ONVOLTOOIDE SINNE TOETS

Naam: Hassiem Skool: *x* Primêre Skool Std.: 3B

Datum: 1 November 1998/ 4 November 1998

Deur hierdie sinne te voltooi, kan jy aandui hoe jy oor verskillende sake voel. Jy moet met elke sin probeer om jou werklike gevoelens uit te druk. Probeer elke sin voltooi. Maak ook seker dat elke sin 'n volsin is.

1. Ek hou van…my ma.
2. Die gelukkigste oomblik…was toe die ander kinders saam met my gespeel het.
3. Ek voel…lekker omdat ek by die huis is.
4. Snags in my bed…slaap ek.
5. Selfs my beste vriend(in)… weet dat ek gebrand is.
6. Ek wil baie graag… speel.
7. As ek dit eendag kan bekostig…wil ek 'n mountain bike koop.
8. Ek verdra nie…iemand wat vir my vloek nie.
9. My vriende weet…alles.
10. Ek is spyt…ek is gebrand.
11. Die beste…vriend speel elke dag saam met my.
12. Mense wat my nie verstaan nie…dink ek is stout.
14. 'n Moeder…is goed omdat ek hou van haar.
15. My grootste vrees…is 'n spook.
16. Ek kon nooit…huil.
20. Ek sal nooit vergeet…ek het gebrand nie.
24. Die toekoms…is vir my 'sad' omdat ek seergekry het.
25. Ek kan nie…huil nie.