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Qualitative analysis of a psychological supportive counseling group for burn survivors and families in Malawi

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ARTICLE INFO

Article history:

Accepted 23 September 2016

Available online xxx

Keywords:

Africa South of the Sahara

Burns

Malawi

Psychotherapy

Group

ABSTRACT

Objective: While psychological care, including supportive group therapy, is a mainstay of burn treatment in the developed world, few reports of support groups for burn survivors and their caregivers in the developing world exist. This study records the findings of a support group in Malawi and provides a qualitative analysis of thematic content discussed by burn survivors and caregivers.

Materials and methods: We established a support group for burn survivors and caregivers from February–May 2012 in the burn unit at Kamuzu Central Hospital in Lilongwe, Malawi. Sessions were held weekly for twelve weeks and led by a Malawian counselor. The group leader compiled transcripts of each session and these transcripts were qualitatively analyzed for thematic information.

Results: Thematic analysis demonstrated a variety of psychological issues discussed by both survivors and caregivers. Caregivers discussed themes of guilt and self-blame for their children's injuries, worries about emotional distance now created between caregiver and survivor, fears that hospital admission meant likely patient death and concerns about their child's future and burn associated stigma. Burn survivors discussed frustration with long hospitalization courses, hope created through interactions with hospital staff, the association between mental and physical health, rumination about their injuries and how this would affect their future, decreased self-value, increased focus on their own mortality and family interpersonal difficulties.

Conclusions: The establishment of a support group in our burn unit provided a venue for burn survivors and their families to discuss subjective experiences, as well as the dissemination of various coping techniques. Burn survivors and their caregivers in Malawi would benefit from the establishment of similar groups in the future to help address the psychological sequelae of burns.

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<http://dx.doi.org/10.1016/j.burns.2016.09.027>

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1. Introduction

Burns are a common cause of injury in sub-Saharan Africa, especially amongst children. An international study of pediatric burn survivors indicated that the highest incidence of these survivors is in Africa [1]. Poverty is a significant risk factor for burns, with 90% of burn deaths occurring in low and middle income countries [2]. Malawi has a high prevalence of burn, with one study demonstrating that they accounted for eleven percent of injuries occurring in pediatric patients from 0 to 16 years of age presenting to the emergency department [3] and four percent of all injuries for patients of any age [4]. In Malawi, burns are most likely to occur in individuals less than 5 years in age [5], in individuals with a seizure disorder [6], in the cold season and at evening time [4]. The majority of patients hospitalized for burns in Malawi are less than 30 years in age and most burns are due to scalding [4,5], though burns due to open flame predominate in patients with epilepsy [5–7].

The mortality rate from burn in Malawi is high, ranging from 11% in a hospital with a burn unit [8] to 27% in a hospital without one [4]. The strongest predictor of mortality for these patients is the total body surface area of the burn. Significant efforts in Malawi have helped increase the LA50 (percentage of body surface area burned that is lethal to 50% of patients). In the United States, most burn centers have achieved an LA50 of 90% or higher [9]. The LA50 is significantly lower in Malawi. However, following the establishment of a burn unit at Kamuzu Central Hospital in 2011 the LA50 for patients there rose from 14% to 39% [8].

Despite the surgical and resuscitative advances in Malawi that have led to decreased mortality and also allowed patients with larger burns to survive, there has been only minimal advancement in aiding patients in dealing with the psychological sequelae of burns, which include loss, grief and changes in one's body image. Psychological distress following a burn, even in individuals without a prior psychiatric diagnosis, is associated with longer hospitalizations and delayed recovery [10]. The fact that burns are most common in children less than five years of age in Malawi is also important, since children are most vulnerable to developing disorders of attachment at this age, especially during infancy. Preoccupation with body integrity is a hallmark of children from two and half to six years of age [11], which also makes burns in this age group particularly traumatic.

While psychological care, including supportive group therapy, is a mainstay of burn treatment in the developed world [11], a review of the literature revealed few reports of psychological support groups for burn survivors and their families in the developing world [12,13]. Though it likely affects survivor recovery, the impact of burns on family members of survivors is a neglected area of research [14]. Therefore, the intention of this article is to provide an account of what appears to be the first recorded support group for burn survivors and caregivers in Sub-Saharan Africa, outside of South Africa. We also sought to conduct a qualitative analysis to determine themes that were most often discussed by group participants.

2. Methods

2.1. Establishment of the psychological support group

Our support group was established as a cooperative endeavor by trauma surgeons (AG and MK), a psychiatry resident (BB) and a Malawian counselor (MM) in February 2012 in the burn unit at Kamuzu Central Hospital (KCH) in Lilongwe, Malawi. KCH is a tertiary care hospital with 600 beds, serving approximately five million people from Lilongwe and central Malawi. The burn unit at KCH was created in 2011 and averages between 25 and 40 patient admissions each month [15]. The unit has 31 beds and treats both adult and pediatric patients, while employing 10 nurses and two surgical clinical officers. The University of North Carolina Institutional Review Board and the Malawi National Health Sciences Review Committee granted ethical approval for this study. Though a majority of patients being treated on the unit were under the age of five years, the group was open only to patients age twelve or older due to its thematic content. Children under twelve were invited to participate in a play therapy group, which is not reported here. Though patients younger than twelve were not included in the study group, caregivers of any patient on the unit, regardless of age, were also invited to participate. Sessions were held at a set time for an hour on Thursdays for a total of twelve weeks from February–May 2012. Patients and their caregivers were personally invited to attend the group by the group leader or nursing staff. Written informed research consent was obtained from all group members. If a participant was under the age of 18, child assent was obtained along with parental/guardian consent.

2.2. Group process and format

Rather than solely offering medical information, the purpose of the group was to allow patients and their caregivers to discuss their emotions and struggles while finding mutual support from other group members. Sessions were conducted in Chichewa, the primary language of the area, and led by MM, a Malawian counselor who had completed undergraduate training in counseling.

The counselor usually initiated each session with the introduction of a topic for discussion. These topics included: the experience of being in a hospital, the relationship between psychological stress and patients' physical recovery, coping with physical and emotional pain following burns, managing epilepsy and other risk factors for prevention of burns following hospital discharge, stress management, depression following burns and benefits from participating in group therapy sessions. After introducing the topic, the counselor would speak for 5–10 min about it in a general manner to help facilitate group discussion. Formal scripts for each session topic were not prepared. Following examination of these particular topics by the counselor, the group was opened up for general discussion in an unstructured manner.

2.3. Data analysis

Descriptive data concerning participants was collected and stored in a Microsoft Excel spreadsheet. Data were analyzed

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